



Understanding the client-service
engagement in social service
provision: The Q-nique case study



March 2016

Prepared with support from the Ministry of Business,
Innovation and Employment; and PACT Wellington

CLIENT REPORT No: FW 16012

PREPARED BY: Graeme Nicholas and Tua Tauheetia-Su'a

REVIEWED BY: Maria Hepi

ACKNOWLEDGEMENTS

The authors thank the staff and management of Q-nique for their participation and support of the research. The authors also thank the Pacific Cultural Navigation Service clients and representatives of the Hutt Valley District Health Board and the Q-nique Board for their generosity in agreeing to be interviewed and for contributing their insights.

The research team acknowledge the support of MBIE through the contract: Making Services Reachable (C03X1301).

Manager



Rob Lake

Manager, Risk & Response
and Social Systems

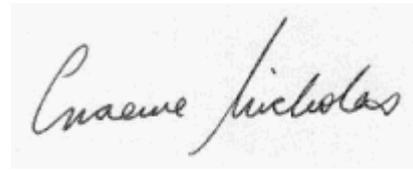
Peer reviewer



Maria Hepi

Scientist, ESR
Social Systems

Author



Graeme Nicholas

Senior Scientist, ESR Social
Systems

DISCLAIMER

The Institute of Environmental Science and Research Limited (ESR) has used all reasonable endeavours to ensure that the information contained in this client report is accurate. However ESR does not give any express or implied warranty as to the completeness of the information contained in this client report or that it will be suitable for any purposes other than those specifically contemplated during the Project or agreed by ESR and the Client.

CONTENTS

EXECUTIVE SUMMARY	1
1. INTRODUCTION.....	4
1.1 THE RESEARCH QUESTION	4
1.2 THE CONCEPT OF 'HARD TO REACH'	4
1.3 THE PROJECT	4
1.4 OUR APPROACH AND USE OF TERMS	5
1.4.1 Engagement and the uptake of service	5
1.4.2 Taking a systems view of engagement.....	5
1.4.3 What we mean by service	5
1.5 THE CASE	6
2. Q-NIQUE PACIFIC CULTURAL NAVIGATION SERVICE.....	7
2.1 Q-NIQUE PACIFIC CULTURAL NAVIGATION SERVICE (PCNS).....	7
2.2 PACIFIC PEOPLE IN NEW ZEALAND AND HUTT VALLEY.....	7
2.3 HISTORY AND NATURE OF PCNS.....	7
3. METHODOLOGY	11
3.1 UNDERLYING HYPOTHESIS	11
3.2 CASE SELECTION	11
3.3 DATA COLLECTION.....	11
3.4 INTERPRETIVE MODELS AND METHODS	12
3.5 ANALYTICAL METHODS	12
4. FINDINGS.....	14
4.1 WHAT DOES IT TAKE TO MAKE A CAKE?	14
4.1.1 The client-system	14
4.1.2 The provider-system.....	14
4.1.3 Bringing together the ingredients.....	15
4.2 MIXING, BAKING AND TASTING: MAKING THE CAKE	17
4.2.1 What's the recipe? (rules to follow, utensils to use)	17
4.3 IT'S A MATTER OF TASTE: WHAT ARE YOU LOOKING FOR?.....	18

4.3.1	Part of life, or a focused intervention?	18
4.3.2	Delivering the service, or changing lives?.....	19
4.3.3	What is the job? Cultural imperatives versus contracted service	20
4.3.4	The means and the ends: What if engagement is the intervention?.....	21
4.3.5	Who’s agenda?	21
4.4	THE CAKE IS BAKED! – OR IS IT A KAKALA?	22
4.5	THE PROOF IS IN THE EATING.....	22
5.	SYNTHESIS AND DISCUSSION	23
5.1	MICROFOUNDATIONS OF CLIENT-SERVICE ENGAGEMENT AT Q-NIQUE PCNS	23
5.2	RESOURCES OFFERED	24
5.2.1	Service agency (service skill holder).....	24
5.2.2	Client system.....	24
5.3	RESOURCE INTEGRATION	25
5.3.1	Framing.....	25
5.3.2	Implementation.....	25
5.3.3	Improvisation.....	26
5.4	RECIPROCAL VALUE PROPOSITIONS	26
6.	CONCLUSION	28
	APPENDIX A: ENQUIRY FRAMEWORK.....	29
	APPENDIX B: INTERPRETIVE MODELS	30
B.1	DEVELOPMENT WORK RESEARCH.....	30
B.2	A SERVICE CO-CREATION MODEL.....	31
B.3	SYSTEMIC SERVICE ANALYSIS TOOL (SSAT).....	33
B.4	PACIFIC RESEARCH APPROACH.....	34
	APPENDIX C: Q-NIQUE INFORMATION BROCHURE	36
	REFERENCES	43

LIST OF FIGURES

FIGURE 1: CHANGING OWNERSHIP OF PCNS.....	8
FIGURE 2: A SERVICE-VALUE CO-CREATION MODEL.....	23
FIGURE 3: ACTIVITY THEORY MODEL	30
FIGURE 4: A SERVICE-VALUE CO-CREATION MODEL.....	31
FIGURE 5: FOUR CULTURAL VALUES OF PACIFIC RESEARCH	35

EXECUTIVE SUMMARY

Introduction

The case study reported here is part of a larger study, *Making Services Reachable* (MSR), funded by the Ministry of Business, Innovation and Employment: Using a service ecology approach to co-design and build improvements in service uptake and outcomes for families/whānau of 'hard to reach' populations.

The term hard-to-reach is recognised as problematic, as it can label and stigmatise, as well as placing the onus and attributes of being hard-to-reach solely upon populations. The project team has named the research as 'Making Services Reachable', recognising that hard-to-reachness is a value that is 'co-created' from the interactions between services and clients.

The project treats service as an ecology of entities rather than as a simple provider-recipient transaction.

In order to improve the uptake of services by 'hard to reach' populations we seek to identify factors that enable and enhance an engaged relationship between those offering services and the populations for which they are intended. Our assumption is that uptake of services is in large part a product of engagement between the service provider and the potential service user.

The case study

The current report is on one of three case studies conducted for the project. It examines client-service engagement at Q-nique Pacific Cultural Navigation Service (PCNS). Q-nique was run by a trust "to provide a range of services to people ... with mental health concerns and health and disability needs".¹ Q-nique PCNS works with Pacific people with moderate to severe mental health needs "to assess needs, establish recovery goals and relapse prevention plans, and provide the support needed to achieve great outcomes".²

During the course of our case study the ownership, governance, geography and management of the PCNS has undergone considerable change. Our analysis and findings will reflect implications of the organisational history for client-service engagement.

Methodology

The underlying hypothesis of the project is informed by service science (Maglio, Kieliszewski, & Spohrer, 2010; Spohrer & Maglio, 2008; Vargo & Lusch, 2008), and can be spelled out as follows:

The uptake of service by a client (individual, family, aiga or whānau) is a process of collaboration between the client-system and the provider-system to create service-value.

¹ Trust Deed [1613456 - Q-NIQUE TRUST].

² *Pacific Cultural Navigator Service: "Vakaola Pacific Navigation Service" - part of Health Solutions Network Trust* (2013)

As an exploratory study the project is not designed to carry out a strict comparison between cases, although later work will seek to generalise implications for practice from the aggregated findings of the three case studies.

Data collection was carried out through

- in-depth interviews drawing on the *Talanoa* method³ with key informants that expressed governance, management, frontline worker, client, funder, cultural advisor, and referrer perspectives
- documentary analysis of websites, protocols and administrative documents
- group discussion with a client representative committee
- workshop with staff, client representative and cultural advisor.

A common 'enquiry framework' based on the core concepts drawn from the three interpretive models described below guided the three case studies.

Three theoretical models have been chosen to assist in shaping our enquiry, interpreting data from the case study and discussing the case in relation to the other two cases in the project. The three models are: Development Work Research (DWR), a service co-creation model, and Systemic Service Assessment Tool (SSAT). In addition, this particular case study has drawn on a Pacific research model.

Findings

We present our findings using the metaphor of baking a cake. Just as the cake has its own properties that are a result of combining the ingredients and processes used in the baking, so client-service provider engagement is the result of combining ingredients and processes. Service-as-experienced can be seen as an emergent property (like the cake) that is more than the sum of the elements that contribute to it.

We outline the 'ingredients' that go to make up engagement; we identify the process of combining the ingredients; we assess the service engagement 'cake' by reviewing what the key participants are seeking and, finally, how their feedback is elicited, received and processed. The purpose of this description is to postulate a range of factors that are generally necessary for effective service engagement. Such factors can be seen as microfoundations: the choices and interactions that shape outcomes.

The current case study is not capable of delivering a high degree of confidence with regard to microfoundations of service-value. However, it offers some plausible hypothetical microfoundations to be tested against other case studies and literature before claiming a micro-macro relationship. The report uses a service-value co-creation model to propose potential microfoundations based on the present case study.

The proposed microfoundations can be summarised as:

- Sufficient fit between the history and reputation of the service agency and the culture and history of the intended service clients.
- Sufficient fit between the expectations and requirements of key funders and the mission and client needs of the service agency.

³ "A phenomenological research approach which is ecological, oral and interactive.... A personal encounter where people story their issues, their realities and aspirations" (Vaiioleti, 2006).

- Sufficient fit between frontline workers and their clients in terms of culture and understanding of the nature of the service offering and relationship.
- Sufficient trust between clients and frontline workers that is supported by the client's aiga.
- Sufficiently functional ecosystem of service complementing the service offer of the focal agency.
- The ability of each party in a service relationship to negotiate sufficient accommodation of how the relationship is framed such that each party can recognise potential benefit in the relationship.
- A 'relational priority' infusing the service offer and service experience.
- The ability of each party to negotiate and adapt how the service relationship is conducted so there are reciprocal value offers that are meaningful to each party.

These microfoundations need to be compared with and tested against other findings from the other case studies in this project and from the published literature.

Consistent with a foundational premise in Service-Dominant Logic (Vargo & Lusch, 2008), we find the service relationship at PCNS best characterised as a service offer rather than programme delivery. We use the concept of 'reciprocal value propositions' to describe the negotiated accommodation between client expectations, capabilities and needs, and the service agency expectations, capabilities and needs that we observed at PCNS. Service value was co-created by clients, clients' families, case workers, management, other agencies and funders.

1. INTRODUCTION

1.1 THE RESEARCH QUESTION

The case study reported here is part of a larger study, *Making Services Reachable* (MSR), funded by the Ministry of Business, Innovation and Employment [Contract C03X1301]. The full title of that study is:

Using a service ecology approach to co-design and build improvements in service uptake and outcomes for families/whānau of 'hard to reach'⁴ populations.

The overall research question specified by the funder is:

How do we enable families/whānau to succeed to ensure that all New Zealand children fulfil their potential? What are the critical causal influences on positive outcomes for family/whānau, and are there connections between them? How do these critical influences differ for 'family' and 'whānau'?

The undergirding principle of the research is that a determinant of wellbeing for families/whānau is their ability to engage effectively with service providers.

1.2 THE CONCEPT OF 'HARD TO REACH'

There is a lack of clarity and divergent opinions in the international literature around the use of the term hard-to-reach however Brackertz (2007) argues that hard-to-reachness should broadly include demographic, cultural, behavioural and attitudinal, and structural features to define populations deemed as 'hard-to-reach'. Boag-Munro and Evangelou (2012) specifically list 12 features of 'hard-to-reachness' that are commonly referred to in international government reports and research. These include: vulnerable, under-served, socially excluded, disengaged marginalised, non-(or reluctant) user, high risk or at risk, families with complex needs, and minority groups. Such terms along with others resonate with the New Zealand governmental context.

1.3 THE PROJECT

The MSR project comprises three case studies (one of which is reported here), cross-case analysis, development of a provisional model of critical success factors for improving uptake of services in relation to 'hard to reach' populations, testing and refining the model, and dissemination of findings in the social service sector.

The project treats service as an ecology of entities rather than as a simple provider-recipient transaction. It draws on systems thinking (Checkland, 1999; Midgley, 2000; Ulrich, 2003) and service science (Maglio & Spohrer, 2008; Spohrer & Maglio, 2008; Vargo, Maglio, & Akaka, 2008) as analytical frameworks to view service as a system

⁴ Throughout the report we use quotation marks around 'hard to reach' to indicate that the term is problematic. The term is specified by the funder as part of the research question; however, its use can suggest that the critical issue is a property (hard-to-reachness) of some population that seems to be not making use of services provided for them (Boag-Munro & Evangelou, 2012; Brackertz, 2007). Our research is premised on an alternative perspective: that the perception of being 'hard to reach' is from the viewpoint of the service provider, and that it may be more fruitful to discover the various factors that make a service more or less reachable from the viewpoint of the potential client.

of interactions that includes the immediate service provider and service user and influences from their respective contexts.

The aim is to develop a model that will guide the design and evaluation of services in ways that support 'hard to reach' populations to connect with and take up services in ways that improve outcomes for families/whānau.

Cross-case analysis will use selected systems thinking methods and models to characterise each case and to support dialogue by researchers across the cases so potentially critical factors for uptake of service can be proposed. In particular, cross-case analysis will use Critical Systems Heuristics (Ulrich & Reynolds, 2010), Activity Theory (Engeström, 1987), and a framework developed in our own earlier research on service systems (Gregory et al., 2009; Nicholas & Foote, 2012).

Throughout the project kaupapa Māori and Pasifika perspectives guided data collection and analysis, and reference is made to Māori and Pasifika models of research and service design including Whānau ora (Boulton, Tamehana, & Brannelly, 2013; Durie, Cooper, Grennell, Snively, & Tuaine, 2010) Fonofale (Pulotu-Endemann, 2009), Guidelines for Researchers on Health Research Involving Māori (Health Research Council, 2010) and Pacific Health Research Guidelines (Health Research Council, 2014).

1.4 OUR APPROACH AND USE OF TERMS

1.4.1 Engagement and the uptake of service

In order to improve the uptake of services by 'hard to reach' populations we seek to identify factors that enable and enhance an engaged relationship between those offering services and the populations for which they are intended. Our assumption is that uptake of services is in large part a product of engagement between the service provider and the potential service user.

In this study we are using the word engagement to refer to a relationship in which the client is actively deriving some value. In other words, engagement refers to more than enrolment or attendance, it says something about the quality of the relationship between the client and the service agency.

1.4.2 Taking a systems view of engagement

We have also assumed a systems view of relationship and engagement; that is, we have assumed that the quality of client-service engagement is a product of multiple relationships, capabilities and capacities that influence behaviours of the client and those offering the service, respectively.

1.4.3 What we mean by service

The term *service* is open to confusion as it can be used in several ways. Oxforddictionaries.com lists nine definitions of *service* and details a further 15 distinctive ways of using the word.⁵ In relation to our current project we need to distinguish three possible uses. Service may refer to:

- A service agency or organisation (we use the term *service agency*)
- A particular programme offered by an agency (we use the term *programme*)
- An act of serving (we use the term *offer service*)

⁵ <http://www.oxforddictionaries.com/definition/english/service>

- An interaction between parties from which at least one party draws value (we use the term *service value*)

The main focus of this report is to identify factors that contribute service value for clients.

1.5 THE CASE

The current report is on one of three case studies conducted for the project. It examines client-service engagement at Q-nique Pacific Cultural Navigation Service (PCNS). PCNS offers a support service to Pacific people who live in the Lower Hutt District Health Board (DHB) area that have moderate to severe mental health conditions. Criteria for case selection are outlined below, under *Methodology*.

2. Q-NIQUE PACIFIC CULTURAL NAVIGATION SERVICE

2.1 Q-NIQUE PACIFIC CULTURAL NAVIGATION SERVICE (PCNS)

The PCNS is described in its information brochure:⁶

The service is for Pacific people, youth and adults, with moderate to severe mental health and or addiction problems; who live in the Hutt Valley District Health Board area.

The service may be provided in the community - including home visits, hospital and church based settings.

Support is provided on both an individual and group basis. People may self refer to the Pacific Navigator service, or entry may be via family doctors, community mental health teams, other agencies, and families.

In 2013 the PCNS had 32 clients of whom 19 were Samoan and 5 were Tokolauan, with other Pacific ethnicities making up the remainder. PCNS had four Pacific case workers (none of whom were Samoan).

2.2 PACIFIC PEOPLE IN NEW ZEALAND AND HUTT VALLEY

At the time of the 2013 Census, Pacific peoples accounted for 7.8% (344,400) of the total population in NZ; the four regions where most Pacific people live are Auckland, Wellington, Waikato and Canterbury (Statistics New Zealand, 2014). Eight of the 20 District Health Boards (DHB) are characterised by high Pacific populations: the highest is in Counties Manukau, trailed by Auckland, Waitemata, Capital and Coast, Canterbury, Hutt Valley, Waikato, Hawkes Bay respectively. The Ministry of Health placed more emphasis on these eight DHBs to improve Pacific health, hence various Pacific services were developed to meet the health needs of Pacific peoples. PCNS began as was one of the services established to support Pacific peoples with mental health needs in the Capital and Coast DHB and Hutt Valley DHB areas.

In the Wellington region Capital and Coast DHB and Hutt Valley DHB serve a total population of around 42,016 Pacific peoples, with approximately 70% in Capital and Coast and the rest in the Hutt Valley. Pacific populations have higher rates of mental health problems compared to the rest of the New Zealand population (Ministry of Health, 2012), however there are no available data on how many Pacific people suffer mental health issues in the Wellington region.

2.3 HISTORY AND NATURE OF PCNS

This report refers to the case study site as Q-nique PCNS. However, it is important to note that PCNS is simply one manifestation of a service agency that has changed its ownership, governance and location over time. We consider it important for interpreting our study to understand some of the history. Figure 1 shows the changing ownership of the programme.

⁶ *Pacific Cultural Navigator Service: "Vakaola Pacific Navigation Service" - part of Health Solutions Network Trust (2013)*

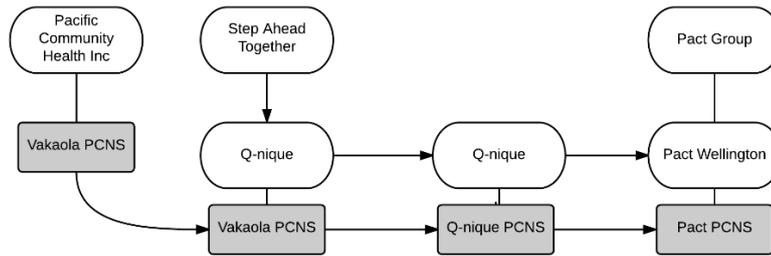


Figure 1: Changing ownership of PCNS

PCNS, at the time we initiated the study (2013), was a ‘Pacific by Pacific’ service nested within a culturally non-specific provider, Q-nique Limited. PCNS had previously been operated by the Pacific Community Health Incorporated, under the name Vakaola. It operated in both Porirua and Lower Hutt and was, in part, a response to the Ministry of Health focus on Pacific peoples’ health in the Wellington region.

Vakaola was promoted⁷ as:

Vakaola - Pacific Community Health delivers a free support service that primarily targets Pacific people and others within the wider Wellington region and beyond.

It aims to meet the community mental health support needs of the Pacific people by providing a quality support service. It has a holistic approach encompassing but not restricted to mental, socio-cultural, spiritual support and the best health outcomes of Pacific Island peoples and others.

Vakaola was positioned as a ‘by Pasifika for Pasifika’ service, and attempted to match clients with a support person of like culture or ethnicity to provide its support service.

Vakaola merged with Q-nique after an intervention by the District Health Board (DHB) funder. It appears that the funder was seeking a “more robust” umbrella organisation with whom to contract. Subsequently the Capital and Coast DHB terminated its ‘Vakaola’ contract with Q-nique for services in Porirua, leaving Q-nique with a contract for the programme with Hutt Valley DHB.

Q-nique had previously been known as *Step Ahead Together*, a service offering shelter and mental health services for homeless people. It had been started with funds from the Lower Hutt Parish of St Peter and St Paul.⁸

Q-nique Limited was incorporated in 2002. The Q-nique Trust was formed in 2005, “to provide a range of services to people ... with mental health concerns and health and disability needs”.⁹ The trust espoused an approach of partnership with whānau/families, hapū, iwi and other social and community networks, and

⁷ 2011. <http://www.hotfrog.co.nz/business/wellington/wellington/vakaola/vakaola-pacific-community-health-our-services-45989> Accessed 26 August, 2015.

⁸ 2014. http://www.pactgroup.co.nz/pact_and_q_nique_merge.html Accessed 26 August, 2015.

⁹ Trust Deed [1613456 - Q-NIQUE TRUST].

encouraged personal development, awareness, self-advocacy and independence of service users.

For a time Q-nique held the Vakaola contracts and managed the Vakaola programme, notwithstanding that the Pacific Community Health (Vakaola) board continued to exist and meet. Q-nique ceased supporting that board in 2013.

The integration of the Pasifika programmes within Q-nique presented a challenge to the staff brought over from Vakaola. It required some adjustment by staff that had been used to working in a wholly Pasifika context. This transition was facilitated to some extent by the appointment of a Pasifika 'supervisor' to meet regularly with the Pacific case workers (navigators). He worked with the group to reflect on both cultural and clinical matters. There were four focuses of this work, organisational issues, practice issues, professional development, and group training.¹⁰ As the supervisor put it,

My role, then, was to come in and try and help the staff continue to maintain what they were already doing, but also to attune them into the new organisation.

In 2013 the PCNS was described by Q-nique in an information brochure in the following terms:¹¹

Pacific Cultural Navigators will work with people to assess needs, establish recovery goals and relapse prevention plans, and provide the support needed to achieve great outcomes.

Activities will include:

- health education and promotion; advocacy, engagement; assessment including cultural assessment; treatment; rehabilitation; case management; direct personal support; liaison with clinical services, review processes and discharge planning;*
- support for matters to do with housing needs; financial support services; education, training; and getting into and sustaining employment;*
- and where required assisting with relationship or family issues, family education and/or reconciliation.*

Navigators will be Pacific staff with the right skills, qualifications and experience, who are well linked to community services and agencies, so individuals and families using the service will have access to seamless connected pathways of care with a focus that 'no door will be the wrong door'. Staff are compassionate, caring, and non-judgmental, and will do what they can to assist, providing a confidential service.

Contact with Navigators will vary according to individual needs.

Someone to walk with you...

¹⁰ Interview with cultural supervisor

¹¹ *Pacific Cultural Navigator Service: "Vakaola Pacific Navigation Service" - part of Health Solutions Network Trust (2013)*

From 1 April 2015, Q-nique merged with Pact to become Pact Wellington. Pact had formally purchased Q-nique Limited and replaced the directors of Q-nique in February that year.

Pact had its beginnings in Dunedin in the 1870's as an aid society for patients and prisoners. Currently,

Pact provides support for more than 1600 people with intellectual or other disabilities; those recovering from mental illness; and people with experience of mental illness who are developing alcohol, drug, nicotine and gambling problems. [Pact] employ more than 460 staff, providing services in the West Coast, Otago, Southland and Wellington.¹²

The Pact Wellington PCNS is promoted on the Pact website as providing “community support for Pacific people with mental illness and/or addiction problems, who live in the Hutt Valley”.

Pacific cultural navigators work with people to assess needs, establish recovery goals and relapse prevention plans, and provide the support needed to achieve great outcomes.

Activities include:

- *health education and promotion, advocacy, engagement, assessment including cultural assessment, treatment, rehabilitation, case management, direct personal support, liaison with clinical services, review processes and discharge planning*
- *support for matters to do with housing needs, financial support services, education and training, and getting into and sustaining employment, and*
- *where required, assisting with relationship or family issues, family education and/or reconciliation.*

In both 2014 and 2015 the Q-nique manager responsible for the PCNS changed. In 2015 the chief executive of Pact Wellington changed. There has also been some change among the front-line support workers, although two support workers have continued through.

Thus, during the course of our case study the ownership, governance, geography and management of the PCNS has undergone considerable change. Our analysis and findings reflect some implications of the institutional history for client-service engagement.

¹² http://www.pactgroup.co.nz/about_us.html Accessed 26 August, 2015

3. METHODOLOGY

3.1 UNDERLYING HYPOTHESIS

The underlying hypothesis of the project is informed by service science (Maglio et al., 2010; Spohrer & Maglio, 2008; Vargo & Lusch, 2008), and can be spelled out as follows:

The uptake of service by a client (individual, family, aiga or whānau) is a process of collaboration between the client-system and the provider-system to create service-value.

Where:

- The ‘client-system’ is the set of relationships that sufficiently describe client resources and needs in relation to the service sought;
- The ‘provider-system’ is the set of relationships that sufficiently describe the mandate, resources and context of the service provider in relation to the service offered;
- ‘Service-value’ is an improvement in the situation of the service user, and is ultimately determined by the intended beneficiary of the service (Vargo & Lusch, 2008).

Investigating this hypothesis to inform a practical model suggests that in each of the case studies we develop an understanding of the service as a system of actors with distinct perspectives in which the client is seen as a ‘co-creator’ of value, the service provider cannot deliver value but only offer value propositions, both the client and the service provider are seen as ‘resource integrators’, and value is determined by the intended beneficiary of the service (Vargo & Lusch, 2008).

3.2 CASE SELECTION

Selection of case study sites was based on four criteria: potential to inform the research question and test our underlying hypothesis, usefulness for including Māori, Pasifika and culturally non-specific approaches, expressed commitment to being involved in the research, and availability of existing data on engagement and outcomes. The three service agencies selected were He Waka Tapu, The Family Help Trust, and Q-nique PCNS. This report focuses on Q-nique.

3.3 DATA COLLECTION

The project is an exploratory qualitative study using case studies (Eisenhardt & Graebner, 2007; Stake, 2005). That is, the project examines three case sites of social service engagement with clients to develop principles to guide future design and evaluation of services for ‘hard to reach’ populations. The case study sites were chosen for their potential to yield useful insights for that task rather than for comparability. As an exploratory study the project is not designed to carry out a strict

comparison between cases, although later work will seek to generalise implications for practice from the aggregated findings of the three case studies.¹³

Data collection was carried out through

- in-depth interviews (Johnson, 2002) drawing on the *Talanoa* method¹⁴ (Tamasese et al., 2005; Vaioleti, 2006) with key informants that expressed governance, management, front-line worker, client, funder, cultural advisor, and referrer perspectives
- documentary analysis of websites, protocols and administrative documents
- a focus group discussion with a client representative committee
- two workshops with staff, clients and cultural advisor.

Interviews included 12 clients, four case workers, a Q-nique employment assistance specialist, three managers, a member of the Q-nique board, a cultural advisor to PCNS staff, and a Pacific health director from Hutt Valley and Wairarapa DHBs.

A common 'enquiry framework' based on the core concepts drawn from the four interpretive models described below guided the three case studies. The enquiry framework is summarised in Appendix A.

3.4 INTERPRETIVE MODELS AND METHODS

Four theoretical models have been chosen to assist in shaping our enquiry, interpreting data from the case study and discussing the case in relation to the other two cases in the project. The four models are: Development Work Research (DWR), a service co-creation model, Systemic Service Assessment Tool (SSAT), and a Pacific research model. Each model is described in Appendix B.

What the four models share is an assumption that the way in which service is offered and experienced cannot be understood fully by only looking at the immediate service transaction (such as a meeting between a cultural navigator and a client); it is necessary to see service as the complex product of a network of relationships and interactions involving persons, organisations, history, concepts, policies, processes, and technologies. The four models described in Appendix B function as aids or frameworks to describe such relationships and interactions so we can identify what factors might enable and enhance client-service engagement and the uptake of service.

3.5 ANALYTICAL METHODS

Qualitative analysis of data was undertaken using the analytical software platform Dedoose.¹⁵ Interviews were recorded, transcribed and coded. Coding and subsequent thematic analysis was primarily deductive, directed by relevance to the underlying hypothesis, rather than inductively directed by the data content (Braun & Clarke, 2006). However, some inductive coding gave the opportunity for identifying themes that did not sit comfortably within our theoretical framework. Our thematic

¹³ This distinction between exploratory and comparative case studies follows Stake (1995, 2005) cited by (Durepos & Mills, 2013).

¹⁴ "A phenomenological research approach which is ecological, oral and interactive.... A personal encounter where people story their issues, their realities and aspirations" (Vaioleti, 2006).

¹⁵ <http://www.dedoose.com/>

analysis used a coding frame derived from our underlying hypothesis and the interpretive models and methods detailed above.

Coding has been actively discussed between the researchers involved with the case studies to promote consistency.

As Braun and Clarke explain (2006, p. 82), “a theme captures something important about the data in relation to the research question, and represents some level of *patterned* response or meaning within the data set”. In our study we identified themes at 'latent' or interpretive level rather than identifying semantic or explicit themes (Braun & Clarke, 2006).

In line with our underlying hypothesis that views the critical relationship between service provider and client as part of a wider 'service system' (Maglio, Vargo, Caswell, & Spohrer, 2009) involving a client-system and a provider-system, we have looked to data from individuals in the system as windows into systemic relationships rather than as direct evidence of what is important in understanding client-service engagement.¹⁶

¹⁶ Braun and Clarke (2006) would call this a 'constructionist' approach.

4. FINDINGS

We present our findings using the metaphor of baking a cake. Just as the cake has its own properties that are a result of combining the ingredients and processes used in the baking, so client-service provider engagement is the result of combining ingredients and processes. Service-as-experienced can be seen as an emergent property (like the cake) that is more than sum of the elements that contribute to it.

We outline the ‘ingredients’ that go to make up engagement; we identify the process of combining the ingredients; we assess the service engagement ‘cake’ by reviewing what the key participants are seeking and, finally, how their feedback is elicited, received and processed.

4.1 WHAT DOES IT TAKE TO MAKE A CAKE?

Understanding the service as a system of systems, with historical and cultural background

As stated in our ‘underlying hypothesis’ we are viewing the uptake of service by a client (individual, family, aiga or whānau) as a process of collaboration between the client-system and the provider-system to create service-value. Where: the ‘client-system’ is the set of relationships that sufficiently describe client resources and needs in relation to the service sought; the ‘provider-system’ is the set of relationships that sufficiently describe the mandate, resources and context of the service provider in relation to the service offered; and, ‘service-value’ is an improvement in the situation of the service user, and is ultimately determined by the intended beneficiary of the service (Vargo & Lusch, 2008).

4.1.1 The client-system

Our research identified five dynamics that seem to influence client service value and engagement within the client-system:

- Family, aiga, parents
- Other community groups and service agencies, possibly including church
- History of involvement with Q-nique and its predecessors
- History of personal mental health and treatment
- Referral pathway and referral agency

4.1.2 The provider-system

Our research identified four dynamics that seem to influence client service value and engagement within the provider-system:

- The background, history and reputation of the agency
- The background, history and commitment of front-line workers
- Policies and procedures of the agency
- Policies and procedures of funders

4.1.3 Bringing together the ingredients

What does each key participant offer the service relationship?

Clients, case workers and agency management all actively offer resources that influence the service relationship.

Clients

Clients are far from passive recipients in the service relationship. Given that clients are not required to access the PCNS programme a fundamental element they bring to the relationship is the choice about what to access and how they make use of what is offered. Clients who spoke with us made it clear that they are active in seeking and using what they want from the programme. One client said, of her accessing the programme, *“I used to, but just not as often. It’s just that I have other things on as well. So when I do have time, I do come in”*.¹⁷ Another stated, *“I just made my own decision that I wanted to go there, I wanted to join the programme”*.

Because the programme is a navigation service, the specific needs of the clients at any given time are not obvious and require, to some extent, the client to seek what they need.

Clients’ comments also suggest that they need to be persistent, patient, discriminating and tolerant in order to get what they want from the service relationship. For example, some thought that the content of the group programme could be “boring” or not relevant, but they put up with that because they had a sense of belonging and community by turning up. Others spoke of not having a case worker of their own ethnicity or culture, but that they accommodate the worker they have *“because you can’t have everything here”* as there is a shortage of the right ethnicity of worker. Another client spoke of the transition of management of the programme from Vakaola to Q-nique and noted that this required her to travel to a different centre and actively seek re-connection with the programme. Some clients showed a strong commitment to their own wellbeing; for example, one client stated:

I had to fight and keep fighting that somewhere along the line I will be connected up to the right people.

And another:

We [mentally ill people] must do it themself [sic] if they are to get somewhere. And even if the struggle is far, it’s far away but you can make headway, just like a turtle; the story of the turtle and the hare.

Some clients felt that they had a hand in shaping the service offered by PCNS. At an organisational level the client group had a formal structure (a consumer representative committee) to discuss their involvement and have input into decisions about the programme. It was important to some clients that they *“had something to offer also”*. At an individual level clients felt they were partially responsible for the service relationship, and showed tolerance that it was not all that they wanted. As one client said,

I need solid support, and – you know – it feels as if I’m doing some of the work and I am the one that navigates the navigator; and its time as a patient to relax a little bit and them showing us the support ... and we’re the ones that

¹⁷ We use italics to indicate quotes from interviews.

are supposed to tell them – and then it's like, some of the things is not their fault – it just doesn't work that way.

Finally, one client identified mutual trust as key to the service relationship:

I would say it's a good service, you can learn a lot, you can be supported well, there is always phone calls, there's always appointments and all those other stuff. And the social worker will look after you and trust you. ... Just to believe in this kind of illness, what they carry as trust because if they got to trust patient and the patient got to trust the support worker. That's the main thing I see.

Case workers

The case workers brought a strong commitment to working in a Pasifika way within an agency that was not inherently Pasifika. They also offered the service relationship a quality of being with the client that invites the client to contribute to their own outcomes. The way they approach a client can be characterised as open enquiry (“*tell me what is wrong: what are you looking for?*”), supportive accompanying (“*I will stand next to you*”), brokering relationships and opportunities, and persistence (“*I just keep talking till I have engaged with them*”). As one worker put it, speaking as if to a client:

'What are you guys looking for ... Well, it won't happen overnight, but it will happen. But, I mean, at the same time, as long as you work with me, I work with you, but I'm not going to find you a job, but I will be beside you.'

Agency management

The agency provides the infrastructure for positive engagement with clients: an activity programme, allocated case workers, meeting rooms, client record database, policies and protocols for working with clients, and knowledge of and relationships with other agencies and programmes relevant to the needs of clients. The main processes are outlined in the *Support Planning Pathway* (Q-nique, 2013).

The agency receives formal feedback from clients through surveys and a consumer delegate advisory group. The advisory group is seen as having significant input into activities.

One of the key tools provided by Q-nique to is the client goal planning process. It is generally a very dynamic instrument in that the plans change in response to client engagement. A manager commented:

Sometimes they will change just about every time you meet them; the client wants something different and 'Oh, I don't want to do that' and 'I want to do that', and sometimes you find they've done a goal plan; they've actually managed to do it well on their own.

The agency was able to add value to its clients by linking them to programmes that could complement PCNS. The main example was an employment assistance programme funded by the Ministry of Social Development. Both clients and support workers spoke of that programme as adding value. It needs to be noted, however, that the funding from the employment programme was only temporary and was discontinued not long after our interviews.

4.2 MIXING, BAKING AND TASTING: MAKING THE CAKE

How is the service understood, configured, negotiated and delivered?

4.2.1 What's the recipe? (rules to follow, utensils to use)

Here we outline the procedures, policies and tools that enable clients to gain value from client-service engagement.

Clients' perspectives

Clients spoke of the provision of particular opportunities, such as the organised gatherings on Fridays, the food provided at gatherings and special activities.

They also spoke of the experience of general support through phone calls and assistance with transport. Little reference was made to specific programme content, although one person did refer to learning new skills of safety and personal confidence. Clients also referred to useful discussion on their care plan or goals. Discussion of the care plan also provided a focus for involving the client's family or aiga. Clients spoke of the value of being visited, both at home and while in respite care.

Most clients reflected on the value of the relationship offered through their involvement with PCNS. The relationship with the support workers is critical. Client feedback included appreciating the sense of being known and having the worker in their lives. As one client put it:

So, I found that it was quite comforting, I was thankful that they acknowledged that because I wasn't eating, I just couldn't sleep. I was going through quite a bit so ringing me up to see if I'm all right, just knowing that we are how we're doing, what we are going to do for a week, encouraging that there are things to do, there are programmes outside of Q-nique that we can, that are offered to us we can go to a programme that's a whole week programme.

Activities and language that connected with the client's particular culture were identified as important, sometimes through reference to a positive experience, sometimes by reference to a lack of cultural connection.

The manner in which clients experience their support worker appears to be a key factor in how service is offered. One client summarised this in the word 'humble'.

It was not harsh, it was always humble you know. Yeah they both are humble. ... humble, and telling me, encouraging me, or encouraging us as a group that we're never alone, you know, there are such people that ... could be any of our rugby idols or – it can be anybody that in the past has actually suffered depression, and stigma and psychosis and schizophrenia and those names to lift up our spirits.

Finally, from feedback from clients, there is a positive use made of the relationship between PCNS workers and other services, for example, mental health nurses and respite care providers. Such division of labour will be discussed further in the next section.

Agency perspectives

The procedures, policies and tools influencing client engagement and value that we identified from the agency management perspective included a documented process and standard for client access, entry, support, mentoring, discharge planning and

declining entry to services: the *Support Planning Pathway*.¹⁸ That document refers to the use of a range of other instruments, such as:

- Service information brochures
- Code of Health and Disability Services Consumers' Rights
- Q-nique Philosophy and Principles
- Referral forms
- Q-nique use of validated outcome tools – policy and procedure
- Q-nique brochure: "Your Life, Your Views, Your Voice – Quality of Life Questionnaire
- Health and Disability Sector Standards (NZS 8134.0:2008).

Referrals typically come through the Needs Assessment and Service Coordination (NASC). "NASCs are organisations contracted by the Ministry of Health to work with disabled people and their family, whānau, aiga, or carers, to identify their strengths and support needs, outline what disability support services are available, and determine their eligibility for Ministry-funded support services."¹⁹

Client management is done through a database called Recordbase.²⁰

4.3 IT'S A MATTER OF TASTE: WHAT ARE YOU LOOKING FOR?

What do key participants in the service relationship seek?

PCNS is generally seen by those involved as a source of culturally tailored support. A manager from the agency summarised the purpose:

Support from a health service that isn't doctors and nurses; coming from a cultural background. So we are trying to link like with like culture-wise, so somebody they will be comfortable with.

4.3.1 Part of life, or a focused intervention?

One distinction in understanding the purpose of the service engagement that is observable in our data is whether the 'programme' is seen as an on-going element in a client's life or as a focused intervention. This distinction represents a tension within the service relationship that is likely to influence attitudes and practice in relation to concepts such as 'up-take of service' and 'client-service engagement'.

From one perspective PCNS is seen as part of a client's social 'ecology' or social 'capital' which is integrated into their sense of self and wellbeing. From this perspective there is little expectation of 'exiting' the programme, or of achieving particular goals in respect of the programme.

From the other perspective, however, the programme is seen as a focused intervention for a particular therapeutic or remedial purpose. From this perspective it makes sense to have plans, goals and an anticipated exit from the programme.

¹⁸ The version of the *Support Planning Pathway* consulted for this project was dated December 2013 (Revision 4.0) and includes some notes for further consideration and editing.

¹⁹ <http://www.health.govt.nz/your-health/services-and-support/disability-services/getting-support-disability/needs-assessment-and-service-coordination-services>

²⁰ "Recordbase is web-based software used by non-government organisations around the world to manage their client information, report on contractual requirements and assist with service planning and outcome measurement." <http://www.wildbamboo.co.nz/>

As a manager in the agency put it:

You know, you are a client for life and [the PCNS] is an essential part of your life whereas, from [a] more Pākehā health professional perspective, you are engaging with this person ... for a limited time to meet some health outcomes, and 'goodbye'.

As indicated in that quote, there is likely to be some culturally influenced assumptions behind the two perspectives. There is also a certain realism about the mental health status and stage of life of some PCNS clients in relation to any assumption that the goal of the programme is some progression to independence. As a manager put it:

The basic question of keeping [a client] as independent as possible for as long as possible, and if they get a little bit more independent, so well and good; but you are never going to work towards total independence if you have got an aged related, you know, declining condition.

Clients spoke of the importance of a safe community provided through their involvement with the agency. At times the language about the programme was that of an alternative family or aiga. A sense of belonging was important to clients. As one client put it:

I was looking for somewhere, you know, just somewhere like a safe haven. I wanted somewhere to go to so I would be able, not to be humiliated by my elders ... talking to myself publicly.

Some clients added weight to the importance of the community aspect of the programme by contrasting that with programme content (specific topics and activities). One client said:

Oh, the day activities are boring. It doesn't have anything to do with our illnesses. ... [So why do you and other people come?] It's like a whānau. It's very whānau orienting and this is where we catch up.

When clients or their families' spoke of the value they received from involvement with the PCNS they often referred to ways that the support PCNS offered could contribute to their confidence, sense of independence and general well-being. For some this is seen as support that will help them reach some life goals (e.g. confidence around people, a driver's licence, a job, some skills). For one set of parents of a client the hope was for respite from caring and some long-term care for their son as they aged.

The immediate value clients saw from their involvement with PCNS was simply getting out of their homes, structure to the day and social contact.

4.3.2 Delivering the service, or changing lives?

Front-line workers in the agency showed a focus on changing the lives of their clients rather than on any measured service delivery. The approach they report using is very relational: at times confronting and challenging clients, at times supportive, at times very practical assistance. When asked about how long clients stayed in the programme, one worker said:

I am actually okay with [clients staying in the service for long periods]... it is a continuum. So that spectrum of wellness or unwellness for me is just a given. Because I think we're all like that; we all need love and support and to be awhi-ed [embraced]. And then there could be some primary care required.

As another informant observed, when reflecting on the influence of current funding models for services:

We're engaging in a purchasing arrangement, which is a business arrangement. The provisory service is not about purchasing services, it's about actually looking at, making sure each community has access to services, or being engaged with these services.

So, the detail of what a given funding contract is for does not seem to define the service offering. One front-line worker expressed this using the metaphor of the village:

It really does come down to a connection – and ... because of the village concept ... in particular with our services, this three degrees of separation and the way our contracts, our multi-faceted contracts work – so, okay, we may only have the Vakaola contract, but hang on, we can provide a wrap-around service with employment based opportunities, and a whole raft of other services that can complement part of the wellness plan for the client.

Others also spoke of the importance of providing an integrated package relating to the life circumstances of the client.

4.3.3 What is the job? Cultural imperatives versus contracted service

The previous theme is closely related to the question of how those providing a service programme see their own role. The PCNS workers showed, in various ways, that they saw themselves primarily as members of a Pasifika community and subject to cultural imperatives rather than as representatives of an agency carrying out a defined contract.

One illustration of this tension between cultural imperatives and a defined contracted service relates to the cultural expectation that the client is not an isolated individual and activities need to be more collective or communal. This has implications for planning and cost. For example, if travel is involved for an activity the numbers will be more than the immediate clients, as family/aiga members or friends may want to come along. And, Pasifika engagement typically requires provision of food, which also needs to cater for more than the immediate clients.

Such tensions have been reported to us as an element behind the financial unsustainability of the Vakaola service before it was brought into Q-nique. However, some clients and some workers recall the greater fit that Vakaola had with Pasifika ways, and suggest that approaches that respect Pasifika norms of hospitality and community are still important in the client-service engagement.

So, those sort of things could be seen as costly compared to your one-on-one, easy accounted for, sort of visits and that kind of thing. Whereas your collective activities which you might want, may be considered too costly and may fall by the wayside. But still they are quite a relevant component of people's recovery, particularly when they're trying to deal with mental health issues and things like that.

Another way in which PCNS workers showed that they saw themselves working within the Pasifika community was expressed by one observer:

Well this is how Pacific people see their jobs, it's a service and they chose these [jobs] to serve their community so therefore to them there's no hourly amount.

And:

It's this whole concept, from the Samoan perspective, that service is your job, your way to authority is through service. So by actually taking on board your

job as a service to the people then you have a different commitment and this is what some ... are saying, is that it's moving from that service principle to a more eight to five kind of situation. And that's how you break into these little hard to [reach], is through this kind of perseverance and the belief in your own service to the community, that you're doing it not for you but for them, so it's a completely different perspective. ...and that's why culture is such an important thing.

4.3.4 The means and the ends: What if engagement is the intervention?

It is perhaps the nature of a cultural navigation service such as PCNS, and perhaps distinctively Pasifika, that for some in the PCNS client-service engagement is not seen as a means to an end but as an end in itself, at least an intermediate object of the relationship.

As one worker put it:

But, you see, once we make that engagement, of once they say "yes" and we come in, that's the time, it's like you bring the sun into the house, it just brighten up. But I said, "I'm not promising that I'm going to make a change but I'll do my job and I'll do it right but I can't do it by myself, I need you".

Others observed:

With the Pacific ways, when we do a first assessment our people are very shy, very quiet. ... Our role is to see, to reach, when we look at the person we have been trained to reach beyond what they currently have. So we will be able to ensure that we give them the right support. We have to listen ... to their story because I believe the culture is a big part of the job to ensure that they come forward.

it doesn't matter what you do or what research or what kind of paperwork you get from the doctors and from the health, at the end of the day you've got to speak to the client. "You tell me what's wrong with you". Because I mean once you pick up that piece of paper this is the diagnosis from the doctor, GP, blah blah blah, you've already made a mental picture in your head, you've already started judging them.

It totally depends on which principles the organisation is guided by, or what values they operate from. If your principle is about access of your service by the clients, and that you will set the fiscal resources to allow for that, then we are operating from a different point of view.

4.3.5 Who's agenda?

We heard quite distinct perspectives on what kind of agenda should guide programme content. This particularly relates to the group activities in the PCNS programme, but may reflect attitudes to other client-service interactions. From the client perspective we heard that sometimes the subject matter seemed boring or not relevant. The examples given by interviewees suggested that the clients would value information that helped them understand and manage their own mental health conditions, but that they were sometimes presented with programmes focused on other health and social wellbeing promotion. This tension was reinforced in our interviews with front-line staff that showed a commitment to a programme that supported a broad understanding of wellbeing, and in a view expressed from the DHB that seemed to prioritise general health promotion as an objective:

We're struggling with promotion, health information ... to our Pacific community only because of the workforce. There isn't sufficient Pacific people on the

ground to play that part. The question is actually, if we were to sit back how do we do? Who is in the community? Is it the community people that speak? Tongan, Samoan themselves, why don't we engage with them, pick up their champions and tell a story for them? We utilise them in terms of utilising different services that produce this.

So, for those providing the service the agenda may be quite broad: an opportunity to engage with Pasifika families to enhance outcomes through general support and health promotion. This appears to be at odds with the more immediate needs and agenda of particular clients accessing the service; they are more likely to seek safe community, and useable information to help them understand their own condition.

It is like there is a hidden agenda of health promotion through the explicit service of cultural navigation. The dilemma of the legitimacy of methods in the cause of public health is an important subject. As Lupton (2013) states, “the overriding moral imperative in public health endeavours tends to be focused on the attempt to pursue a utilitarian ‘health for all’ ideal” and that can over-ride other considerations. In the present study, differences of agenda between the funder, service agency and clients represents a lack of match with clients that has the potential to undermine constructive engagement.

4.4 THE CAKE IS BAKED! – OR IS IT A KAKALA?

Helu-Thaman (1992) describes the process Kakala model as a metaphor. Making a kakala (wreath or garland) involves the process of: toli (gathering), tui (weaving) and luva (gifting) from a Tongan perspective. This is the similar process in many island nations in making a garland or lei/ula (worn around the neck for special guests). The process of what it takes to make a cake reflects the illustration of making the kakala.

The findings reflect the values embedded in the Pacific research model (Appendix B.4) such as communal relationships, reciprocity, respect and holism are also important in supporting client engagement. It is imperative that these values are addressed not only in the research approach but are also addressed in the connections and the linkages between Pacific clients and all agencies involved in their care and support.

4.5 THE PROOF IS IN THE EATING

How does the client experience of service influence the configuration and delivery of the service, and client outcomes?

In addition to periodically surveying clients to understand their experience of PCNS, Q-nique also worked with a client advisory group that met regularly, discussed elements of the programme, and made specific suggestions on how to improve the programme.

5. SYNTHESIS AND DISCUSSION

5.1 MICROFOUNDATIONS OF CLIENT-SERVICE ENGAGEMENT AT Q-NIQUE PCNS

We have identified some attributes of a service system linking Q-nique PCNS and clients. However, attributes are not, in themselves, causal or even influential. What is required is to propose particular attributes of the system as microfoundations of positive and sustained service-value for clients. The concept of microfoundations is a way to account, at least in part, for macro-level outcomes (such as positive and sustained service value for clients) by understanding the interactions of micro-level actors and factors. As Barney and Felin (2013) argue, “the underlying constituent elements ... need to stay in sharp focus when explaining aggregate, including emergent, social phenomena”. Microfoundations are the choices and interactions that shape outcomes. We want to balance attention to microfoundations while giving due regard to emergent phenomena that, in turn, influence behaviour at the micro-level.

The current case study is not capable of delivering a high degree of confidence with regard to microfoundations of service-value. However, it offers some plausible hypothetical microfoundations to be tested against other case studies and literature before claiming a micro-macro relationship.

We use the service-value co-creation model (Figure 2) described in Appendix B.2 to propose potential microfoundations based on the present case study. We explore two key questions:

- What are the distinctive ‘resources’ or competencies that each party to the service relationship brings to the engagement?
- What are the distinctive ‘arts’ of framing, implementation and improvisation that enable engagement and uptake of service?

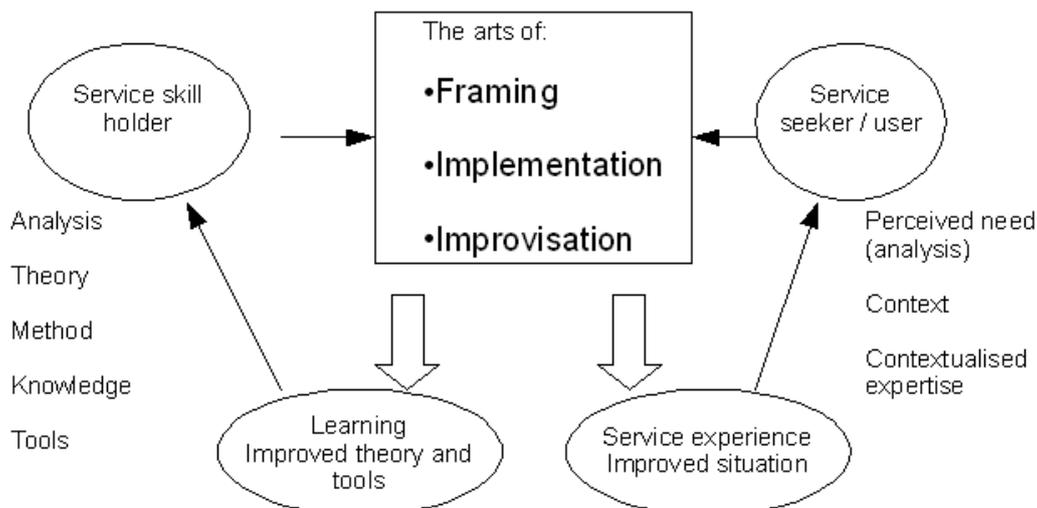


Figure 2: A service-value co-creation model

5.2 RESOURCES OFFERED

5.2.1 Service agency (service skill holder)

Our findings suggest that the value proposition by the service agency is shaped by its history, funder and the perspectives and practices of frontline workers. We have identified four qualities of particular note with regard to PCNS that may suggest microfoundations for positive and sustained client service-value and engagement.

1. The history of the programme: A number of clients referred to the earlier manifestation of PCNS, Vakaola. That programme was clearly 'by Pacific for Pacific', and had a commitment to matching case workers and clients according to culture. While the client relationship had survived the transition of PCNS to a 'mainstream service', and several clients appreciated that the previous regime may not have been sustainable, we suggest that the legacy of cultural fit has contributed to establishing positive and sustained client service-value and engagement.

Proposed microfoundation: Sufficient fit between the history and reputation of the service agency and the culture and history of the intended service clients.

2. Funder relationship: PCNS is funded as a health intervention. This has a number of implications for the programme. It ensures a close link with District Health Board (DHB) mental health programmes; it appears to position PCNS staff capability as supplementary cultural expertise for the DHB; it appears to encourage a view by funder and provider that the programme can be a vehicle for general health promotion activities; and it establishes a tension between a recovery paradigm for the intervention and a long-term support paradigm. It is also the relationship with the funder that led to a Pacific programme being run within a 'mainstream' agency. This arrangement may not be able to sustain a sufficient cultural fit for clients long-term.

Proposed microfoundation: Sufficient fit between the expectations and requirements of key funders and the mission and client needs of the service agency.

3. Perspectives of frontline workers: The support workers viewed their work, at least in large part, through a cultural lens. They demonstrated a commitment to engage with clients in ways that respect and work with Pacific cultural expectations and norms, even when this may not have fitted well with the 'mainstream' structures of Q-nique.
4. Practices of frontline workers: The model of engagement offered by frontline workers can be described as accompanying. This approach is deliberately distinct from but complementary to clinical care. Group programmes, home visits and supportive phone calls are relational before they are instrumental. While the relational approach may seem light on measurable inputs or outcomes it may be contributing a vital component in supporting clients to make use of a range of service offerings and opportunities available under different auspices.

Proposed microfoundation: Sufficient fit between frontline workers and their clients in terms of culture and understanding of the nature of the service offering and relationship.

5.2.2 Client system

Our findings show clients accessing and influencing PCNS as part of a wider 'ecosystem' which they inhabit. Clients are not isolated individuals in relationship with

PCNS. They bring with them the effect or product of other critical elements in their lives. This ecosystem, typically, includes their family/aiga, other social support agencies, and clinical care. Each of these other parts of their lives contribute positively or negatively to their wellbeing, and support or detract from the contribution of the others. In addition, clients bring to the relationship with PCNS their own history (particularly their past experience of agencies), their appreciation (or lack of appreciation) of their own needs and condition, and their intellectual, social and cultural capabilities. PCNS is largely a social process that potentially enhances clients' social and cultural capabilities.

Proposed microfoundations: Sufficient trust between clients and frontline workers that is supported by the client's aiga.

Sufficiently functional ecosystem of service complementing the service offer of the focal agency.

5.3 RESOURCE INTEGRATION

A core concept in service system research is that each participant in a service relationship is a resource integrator (Vargo & Lusch, 2015). In other words there is no passive recipient in service. In our service-value co-creation model we characterise the reciprocal resource integration between clients and service skill holder as framing, implementation and improvisation. The capacity and capability of each party to undertake resource integration is linked to their resources that they bring to the relationship (described above). And an outcome of resource integration by each party to a service relationship is enhanced ability to bring to subsequent service relationships.

5.3.1 Framing

As stated earlier, framing refers to the set of assumptions or perspectives brought to a question or situation. In the current study, framing is the way in which expectations, history, values, motives and prior knowledge may shape the offering and uptake of service. Framing is one of the ways in which a person or organisation can accommodate a situation that is less than what they seek. For example, some PCNS clients would prefer a programme specific to their own cultural identity; however, by framing the programme and themselves as Pasifika they are able to find sufficient fit with the programme to make use of it.

Proposed microfoundation: The ability of each party to a service relationship to negotiate sufficient accommodation of how the relationship is framed, such that each party can recognise potential benefit in the relationship.

5.3.2 Implementation

Again, as stated earlier, implementation focuses on *how* something is done rather than *what* is done. In the current study implementation is the combination of procedures, actions, habits, rules and tools that shape the offering and uptake of service.

Evidence from PCNS (clients, case workers, management and funder) suggests that a core microfoundation of positive and sustained client service value and engagement at PCNS is what one client described in terms of humility. The service offering by the agency is humble in that it does not try to do too much; it puts engagement with the client ahead of any agenda to 'deliver' programme content; case workers demonstrate high levels of empathy with their clients; and the espoused and demonstrated way of working with clients is to facilitate and accompany the client as they access other opportunities.

As one of the Q-nique management team commented, “*you have to have a level of engagement, or develop a level of engagement with the client so you have a shared meaning of what Q-nique can offer them and what might be useful for them*”.

From the clients’ perspective implementation of engagement with PCNS is described in relational terms. For clients PCNS is not so much an agency delivering ‘a service’ it is something to belong to. Further, the relationship between the case workers and clients is built upon trust and respect that is supported by the family or aiga.

We characterise the humility, empathy and accompanying approach to service, outlined above, as a ‘relational priority’. The quality of relationship established between the agency (and particularly the frontline workers) and each client and their aiga has priority over the delivery of any programme content.

Proposed microfoundation: A ‘relational priority’ infusing the service offer and service experience.

5.3.3 Improvisation

Finally, as a means for resource integration, improvisation refers to adaptation and adjustment in the service relationship.

It was notable that PCNS management and case workers deliberately avoided assumptions about what their clients might need, and even what their condition might be. While referrals typically specified the reason for the referral the approach at PCNS was to engage with the client in setting goals, to do so with an open mind as to the current state of the client vis a vis any formal diagnosis or referral, and to repeatedly renegotiate goals with the client.

In addition, programme elements such as group activities were subject to discussion, feedback and suggestions from client participants (mainly through the client advisory group).

From the clients’ perspective improvisation, or adaptation was required to get the most out of their allocated case worker and adapting to organisational limits as what is offered. Most obviously, clients adapted to the limited cultural fit available by working within a pan-Pacific frame rather than within their own particular Pacific culture.

From the agency perspective, improvisation included accessing available funding sources and interpreting contracts and funder expectations to suit a service offering relevant to their clients. An example of this was the way in which Ministry of Social Development funding enabled a complementary employment assistance programme to be offered for a time, and then elements of that programme were incorporated in the service offering in other ways when the funding ceased.

Proposed microfoundation: The ability of each party to negotiate and adapt how the service relationship is conducted so there are reciprocal value offers that are meaning full to each party.

5.4 RECIPROCAL VALUE PROPOSITIONS

Consistent with a foundational premise in Service-Dominant Logic (Vargo & Lusch, 2008), we find the service relationship at PCNS best characterised as a service offer rather than programme delivery. In other words service is seen as the result of a value proposition that is taken up in some way by a client. As Ballantyne et al (2011) have summarised, the concept of value proposition was first used to name a “deliverable value offering to customers”. “The value proposition described the performance expected of the product, and its relationship to customer's needs and

the total cost to the customer” (Ballantyne, Frow, Varey, & Payne, 2011). However, the concept of value proposition has, more recently, been used to describe a reciprocity or negotiation between a provider and a client.

Value in this sense is not so much a strategy or a set of customer benefits but an all inclusive reckoning, where negotiation is the path by which participants share in the creation of value.

(Ballantyne et al., 2011)

Such an understanding of ‘reciprocal value propositions’ well describes the negotiated accommodation between client expectations, capabilities and needs, and the service agency expectations, capabilities and needs that we observed at PCNS. Service value was co-created by clients, clients’ families, case workers, management, other agencies and funders.

6. CONCLUSION

Our study of the PCNS has identified a list of plausible but hypothetical microfoundations for positive and sustained client service value and engagement.

The proposed microfoundations can be summarised as:

- Sufficient fit between the history and reputation of the service agency and the culture and history of the intended service clients.
- Sufficient fit between the expectations and requirements of key funders and the mission and client needs of the service agency.
- Sufficient fit between frontline workers and their clients in terms of culture and understanding of the nature of the service offering and relationship.
- Sufficient trust between clients and frontline workers that is supported by the client's aiga.
- Sufficiently functional ecosystem of service complementing the service offer of the focal agency.
- The ability of each party to a service relationship to negotiate sufficient accommodation of how the relationship is framed such that each party can recognise potential benefit in the relationship.
- A 'relational priority' infusing the service offer and service experience.
- The ability of each party to negotiate and adapt how the service relationship is conducted so there are reciprocal value offers that are meaning full to each party.

These microfoundations need to be compared with and tested against other findings from the other case studies in this project and from the published literature.

APPENDIX A: ENQUIRY FRAMEWORK

The following is a framework for enquiry to guide the selection and analysis of key documents, outcomes data, and key informant interviews across the three case study sites.

The questions below indicate what we need to find out. They are not the questions to be asked in an interview. Interviews will be exploratory rather than use set questions. This framework can serve as an aide memoir to ensure that the interview conversations cover the appropriate areas.

While information from the case study sites may range between ‘the way things are’ and how they should or could be, the focus of data collection is on the way things are and how they came to be that way. The later workshops will enable consideration of how things could or should be different.

What we need to find out:

- Who and what make up the service as a system?
 - What is the basic ‘constellation’ of activity systems that would provide sufficient understanding of how the client-service engagement functions?
 - What perspectives or voices need to be understood in order to understand the dynamics and contradictions of how client-service engagement functions?
 - Who are the critical actors in bringing about client-service engagement (subjects), what is the focus of their action (object), and what outcomes do they seek and experience?
 - For each critical actor (subject), what tools, rules, community and division of labour influence their activity?
- What does each key participant offer the service relationship?
[This assumes that service is an interaction, not a simple transmission of a product, and that the interaction is based on value propositions (an offering of value to the other)]
- What does each key participant seek from the service relationship?
[What value and outcomes matter to each actor? What is the object or purpose of the activity?]
- How is the service understood, configured, negotiated and delivered?
[Not just what is done, but how is service framed, implemented and improvised?]
- How does the client-experience of service influence the configuration and delivery of the service, and client outcomes?
[What feedback mechanisms and processes?]
- What historical and cultural background is necessary to understand how the client-service engagement functions?
[How has the current practice developed? What historical and cultural drivers and constraints have influenced the development of practice?]

APPENDIX B: INTERPRETIVE MODELS

Four theoretical models have been chosen to assist in shaping our enquiry, interpreting data from the case study and discussing the case in relation to the other two cases in the project. The four models are: Development Work Research (DWR), a service co-creation model, Systemic Service Assessment Tool (SSAT), and a Pacific research model.

B.1 DEVELOPMENT WORK RESEARCH

DWR is an application of cultural-historical activity theory (CHAT) (Engeström, 2004). The approach assumes that organisations and collective activities develop, not as a result of simple adoption of method, nor by accident, but over time through a process of collective learning that produces culturally new patterns of activity. To understand and influence practice, then, it is useful to consider learning as an activity with “its own typical actions and tools” (Engeström, 2001, p. 139).

Engeström has also developed a graphic model of a collective activity system (Engeström, 1987) that highlights the role of various ‘mediating artefacts’ (tools and signs, rules, community, division of labour) (Figure 3).

The subject, in this model, is the one acting; the object is the object of attention. Any given activity system can be examined for different subjects.

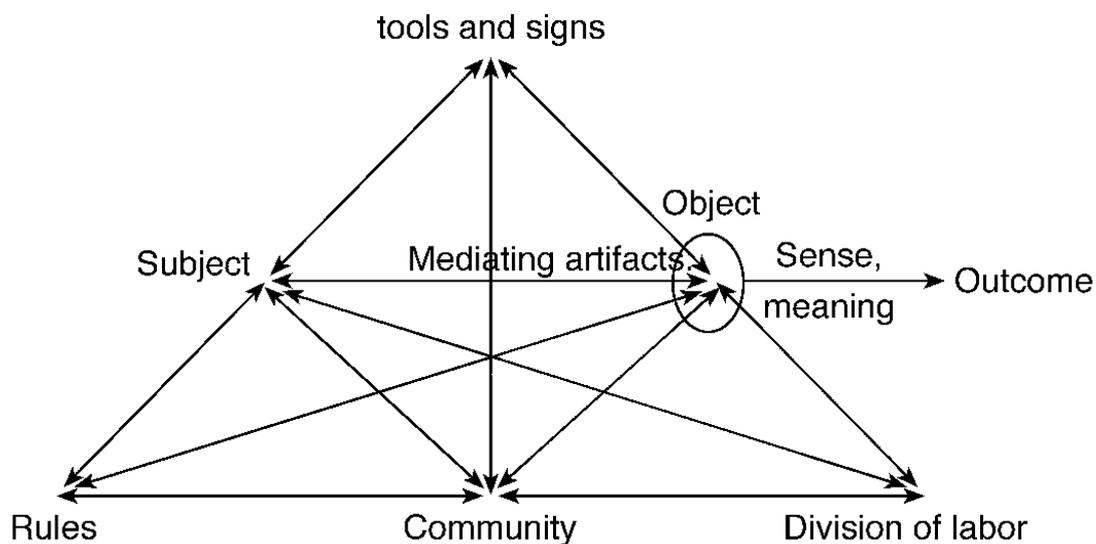


Figure 3: Activity Theory Model

This model provides a way to describe human activities and can be used as a basis for comparing activities, to show differences and contradictions between alternative perspectives, and to show how two or more activity systems may interact. Engeström claims that if we want to confront the various actors that make up an activity, “we must be able to touch and trigger some internal tensions and dynamics in their respective institutional contexts, dynamics that can energize a serious learning effort on their part” (Engeström, 2001, p. 140).

For our study, then, the question that DWR will help describe is, what factors have developed in this case that influence or shape how service is offered and experienced? What are the tools, rules, community, and divisions of labour that are somehow embedded in each offering and uptake of service at this agency?

B.2 A SERVICE CO-CREATION MODEL

The model in Figure 4 (Gregory et al., 2009) incorporates principles of service science (Maglio et al., 2010; Spohrer & Maglio, 2008) and service-dominant (S-D) logic (Vargo & Lusch, 2004; Vargo & Lusch, 2015; Vargo, Lusch, Akaka, & He, 2010) with a framework developed by Donald Schön (1987). It conceptualises service as a collaborative process of creating value-in-use (Vargo et al., 2010) in which it is “the knowledge and skills (competencies) of the providers and beneficiaries that represent the essential source of value creation” (Vargo et al., 2010, p. 129). In the case of social service interactions the service seeker contributes perceived need, an understanding of context and expertise particular to the context, and the service skill-holder contributes capability in analysis, theory, method, knowledge and tools.

For clarity the model provides the minimal proximal actors: a service skill holder and a service seeker/user. In reality, each of these actors represents a complex network or system. For example, a service seeker may be part of a system involving family, aiga or whānau and other agencies. Each proximal actor will have its own history, culture, competence, tools and value propositions.

The service interaction is understood as a process of mutually shaping the frame, the implementation and any improvisation (Schön, 1987, p. 13) required to create value for each party. The value-in-use for the service seeker/user is an experience of service and an improved situation. The value-in-use for the service skill-holder may include financial and professional benefits and the opportunity for learning and the enhancement of theory and tools. There may also be requirements, expectations and outcomes for third parties, such as a funder, agency or government.

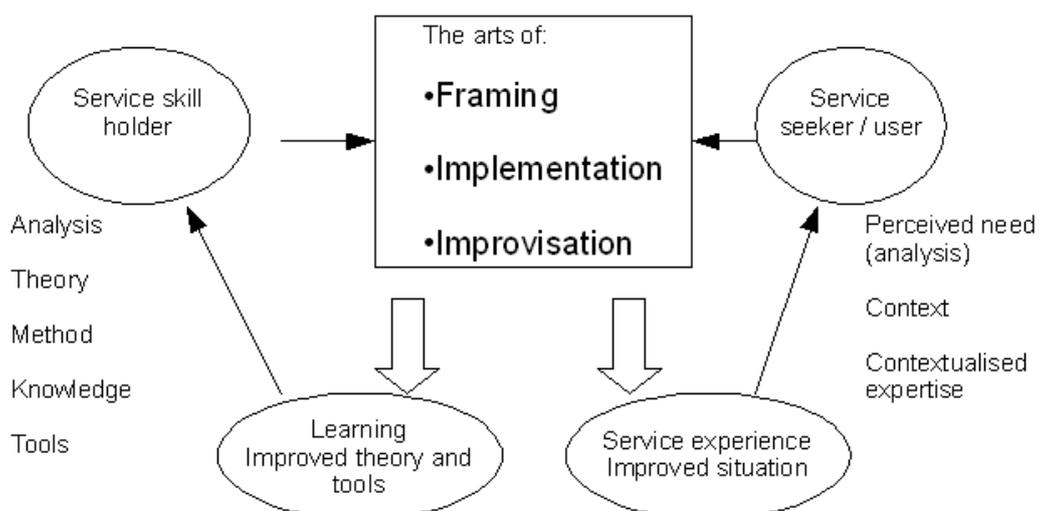


Figure 4: A service-value co-creation model

For our study, the questions that the service-value co-creation model will help us describe are:

- What are the distinctive 'resources' or competencies that each party to the service relationship brings to the engagement?
- What are the distinctive 'arts' of framing, implementation and improvisation that enable engagement and uptake of service?
- What constitutes meaningful outcomes or value for each party?

Framing

The concept of *framing* refers to the set of assumptions or perspectives brought to a question or situation. As Bolman and Deal describe the term,

Frames are both windows on the world and lenses that bring the world into focus. Frames filter out some things while allowing others to pass through easily. Frames help us order experience and decide what to do.

(Bolman & Deal, 1997, p.12)

For our study, the *art of framing* can be interpreted as the way in which the combination of expectations, history, values, motives and prior knowledge may shape the offering and uptake of service.

Implementation

Implementation shifts focus from *what* is done to *how* something is done. Often the focus is some programme or intervention that simply needs to be applied. Implementation focuses on how an intervention is designed and carried out in concrete situations. "Any particular situation is a complex field of multiple, interdependent, conflicting forces" (Argyris, Putnam, & McLain Smith, 1985, p.19).

For our study, the art of *implementation* can be interpreted as the particular combination of procedures, actions, habits, rules and tools that shape the offering and uptake of service.

Improvisation

Improvisation refers to situations in which "deliberate but unplanned actions are executed, aiming to help ... respond to unforeseen opportunities or threats" (Mendonça, Pina e Cunha, Kaivo-oja, & Ruff, 2004). Burns (2006) applies the concept of improvisation in terms of supporting organisational change in complex systems. The concept is equally applicable to a service engagement supporting personal or family/aiga action. Burns argues for a "complexity-based approach" that

collapses the distinction between action and decision-making, as emergent understandings fashion new pathways for action in the "real time" of their creation.

(Burns, 2006, p.183)

He writes of the way in which engagement with another is a process of 'sense making' that leads to practices and norms becoming embedded (Burns, 2006). Burns sees this as improvisation, quoting Shaw (2002, p.172) calling practitioners to,

appreciate ourselves as fellow improvisers in ensemble work, constantly constructing the future and our part in it as daily activity as we convene or join or unexpectedly find ourselves in conversations.

(Burns, 2006, p.183)

For our study, the art of *improvisation* can be interpreted as the way in which adaptation and adjustment happen in the service relationship to shape the offering and uptake of service.²¹ Adaptation and adjustment, in turn, depend on capability and capacity, which raises the question of the role of human, social and cultural capital in shaping service.²²

B.3 SYSTEMIC SERVICE ANALYSIS TOOL (SSAT)

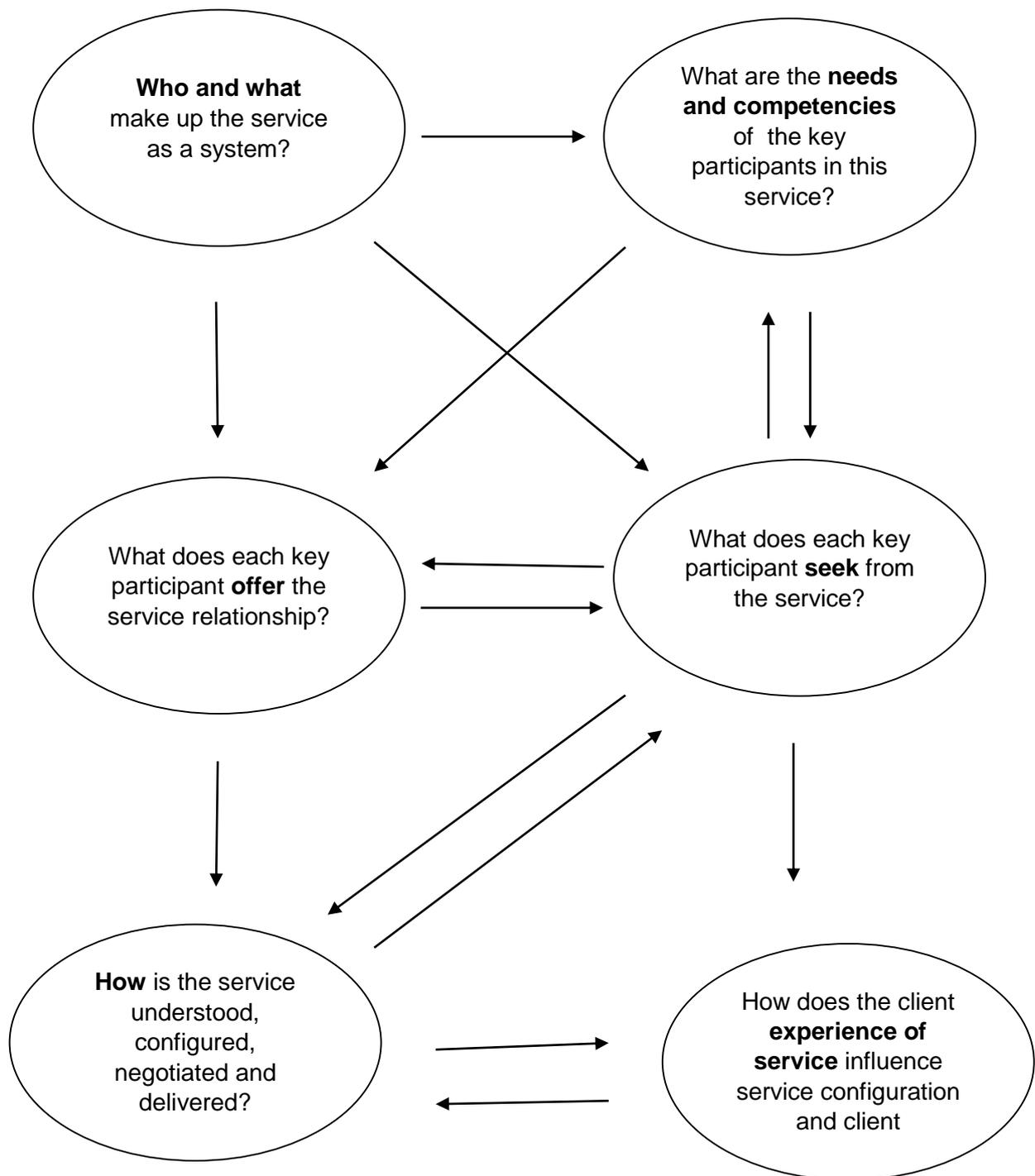
Our enquiry draws on the concept of a service system (Maglio et al., 2009), an understanding of value co-creation among service systems (Vargo et al., 2008), and the model of value co-creation illustrated in Figure 2 above. We have schematically represented the key elements to adequately describe a service in the SSAT (Nicholas & Foote, 2012)

The SSAT model (below) proposes six areas of enquiry to understand and improve a service. Service, in this context, simply means applying resources for the benefit of another (Maglio et al., 2009). Thus all interactions where some value is exchanged can be seen as service.

For our study, SSAT has guided both the data gathering and analysis. It functions as a kind of checklist to ensure adequate understanding of service as a system.

²¹ See too the concept of co-configuration of work described and illustrated in terms of improvisation by Engeström (2005).

²² For discussion on the sociological and economic use of the terms human capital, social capital and cultural capital see Dalziel and Saunders (2014), and Portes (1998).



B.4 PACIFIC RESEARCH APPROACH

The Pacific Health Research Guidelines (Health Research Council, 2014) noted that Pacific research design, methods, and approaches must be informed by the Pacific world views. Despite the differences between Pacific nations, they all hold cultural values and beliefs that underpin their worldviews. When researching Pacific people, it is pivotal to address Pacific cultural values and knowledge by recognising their

communal relationships, reciprocity, holism and respect for others (Health Research Council, 2014).

Figure 5 shows the links between the four important cultural values and Pacific research (Health Research Council, 2014, p. 5).

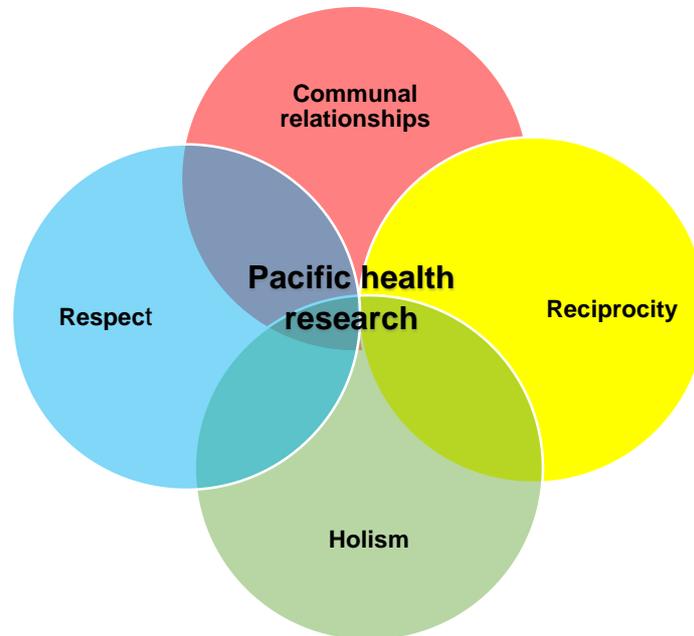


Figure 5: Four cultural values of Pacific research

The four cultural values

Communal Relationships: The links between the client, family, community, health workers, service providers, researchers, the environment and others (communal versus individualism).

Reciprocity: Pacific culture includes giving and receiving through exchanging of gifts. Reciprocity establishes coherence between researchers, participants, and the community. Whilst collecting information, it is a two-way process built on trust and research which should have some benefit for the people under study.

Holism: The integration of a number of relationships which demonstrate Pacific culture and how they structure their world. The community knowledge needs to be exchanged with positive outcomes and benefits that restore balance between the individual and community to improve their health.

Respect: Respect has to be a key factor in the relationship between the researchers and the communities from the beginning to the end of the research process.

For our study, the Pacific research approach has served to alert us in data collection and analysis to ways in which the four cultural values may influence the provider system, the client system, service uptake or service-value.

APPENDIX C: Q-NIQUE INFORMATION BROCHURE



Welcome to Q-nique!

Information about our range of mental health, alcohol and other drugs services (youth and adult), and employment services

1. About Q-nique Trust

We have a proud tradition over more than 25 years of providing community based services for people with health and disability needs, mental illness, and alcohol or drug issues.

We aspire to be unique!... We make sure that by entering our services we assess with you all your needs and ensure "...this door is the right door..." to our range of services, and the range of other services in the region, to address your individual and unique needs.

Your needs may relate to: specific health needs, mental health needs, drug and alcohol needs, disability related needs, and also to housing or accommodation issues, training and vocational needs, and employment. We are well connected to other providers and specialists in the region and to the District Health Board specialists and services; and great at making any referrals on your behalf!

We are a not for profit organization aiming for excellence in everything we do.

The WellTrust Youth Alcohol and Drug Service and Vakaola Pacific Community Health Service are now offered as part of Q-nique service offerings.

Our Consumer Advisors, Staff, Leadership Team and Trustees, continue to be inspired by our Mission which is to "Support and promote independence and social equity for individuals" within the context of family, and community.

For each individual our goal is to encourage personal development, increase self-awareness, empowerment for self-advocacy, recovery and ongoing wellbeing so that you can live the life you want to.

History

We started from small beginnings as a community service working alongside people in the Hutt Valley who were experiencing mental illness. In 1987 the United Nations declared that year as the International Year of

Shelter for the Homeless. Two Religious sisters in the Lower Hutt Catholic Parish of St Peter and Paul were inspired by this declaration, and subsequently Q-nique (then called Stepping Stones) was developed with seed funds from the Parish.

The Service originally provided shelter for a small number of homeless people experiencing mental health illness. With time and ongoing review of philosophy and approach, changes were made to the name of the organisation to better reflect the thinking at the time. Stepping Stones was changed to Step Ahead Together in 1993, and in 2002 to Q-nique Ltd; later to become registered as an Incorporated Society with Charitable Trust status in 2005.

Q-nique is the largest regional non government organisation (NGO) in Wellington and the Hutt Valley. We are funded by the District Health Boards, the Ministry of Health, and the Ministry of Social Development. We also work with a range of community groups such as general practitioners, Primary Health Organisations (PHO's), counseling services, budgeting services, and other employment related services.

2. Partnership approach

We aim to be flexible and responsive so that together we can plan for your future and recovery, and/or support you to achieve your goals and dreams.

There is a strong emphasis on consumer input at all stages of service delivery, and as part of this, we have a number of paid roles for consumer advisors and service user representation.

3. Application of Philosophy – New Zealand Disability Strategy 2001

Each person considering using our range of services is encouraged to have the support of family or friends where appropriate from the earliest involvement (such as at initial interviews) and throughout all goal planning, evaluation or review activities.

Individual Goal Plans are developed with each individual person and where relevant with the family/Whanau/legal representative or an advocate.

Referring services also have opportunity to contribute to support planning with consent of each individual.

All consents are obtained as per the requirements of the Code of Rights known as "the Code" in writing and kept on the individual's file.

4. Our range of services - overview

Mental health services

Mobile Navigation Services in the Hutt Valley;
Mobile Pacific Navigation Service in the Hutt Valley;
Planned Respite Care House: for Wellington region and the Hutt Valley;
Longer term or transition House: for the Hutt Valley; and

Youth community based mobile support service: Hutt Valley only.

Alcohol and other Drugs services

Alcohol and other drugs Live-in Programme (adult), in partnership with CareNZ,

for Wellington region and the Hutt Valley;

Alcohol and other drugs community based mobile support service: for Wellington region and the Hutt Valley;

Youth community based mobile support service: Hutt Valley only; and WellTrust Youth Alcohol and Drug service, Wellington region and Hutt Valley.

Disability Support Services – across Wellington region and the Hutt region

5 residential homes for people with intellectual and/or physical disability; and

Supported Living community based mobile service.

Employment and vocational services – across Wellington region and Hutt region

Employment services;

Community Participation and Vocational service;

Transition from School Service (with ORRS funding); and

the PATHS Regional Service (reducing health barriers to employment, and getting into sustainable employment service.)

5. How to enter services

Q-nique and Vakaola Pacific services

Mostly people gain access to our Services through referral from the District Health Boards Needs Assessment and Service Coordination Services.

We also take direct referrals for some of our Services – such as directly from the person (self-referral), family, whanau, or community mental health team members, general practitioners, and others in the community; such as Work and Income for supported employment services. To find out more about what might suit best and who to contact please contact us, so we can assist with entry to our services.

For details of how to access WellTrust services – see later in document.

More service details:

6. MENTAL HEALTH SERVICES

Our adult Mental Health Services are provided for people who are over 18 years of age and who are, or have been, under the care of Community Mental Health Services.

We know that recovery can be dependent on support, and staff focus on providing appropriate support and on building on each individual's strengths.

We provide practical support around each person's day to day needs such

as having a good house, or work, supportive social relationships, and where required assisting with relationship or family issues or reconciliation, education and leisure pursuits and all those things that make all the difference to living well.

Community Navigation Service

This support service assists people in their own home or in the community setting to meet their mental health, social and basic living needs. This could include support for employment. Contact with Navigation Workers will vary according to individual needs.

Mobile Pacific Navigation Service in the Hutt Valley

This service is for Pacific people and others with experience of mental illness, over 18 years of age, who live in the Hutt Valley. Pacific cultural Navigators assist people to meet their mental health, cultural, social and basic living needs. This could include support for employment. Support is provided in individual, family and group settings by arrangement.

Community Navigation Services for Youth

This service is for young people aged from 12 to 18 years in the Hutt Valley District Health Board area who require support with mental health, alcohol or other drug related issues. This service provides young people (and the family or significant others as agreed) with one on one or group/family support. We can also provide advocacy or liaison services, support for education, training and employment.

If an individual or family needs additional support we can refer you to other appropriate services.

How do I access these services?

Referral can be made by individuals (self-referral), a health professional, a family member or by a significant other such as a friend.

Planned Respite Care

From time to time a person's situation means they need a break from their own routine, to keep well. Q-nique provides the opportunity to take planned time out to recharge and help get back to everyday living. This service has the goal of preventing any relapse; this kind of support may be crucial in supporting a person keep their employment. Referral can also be made to the Q-nique employment services.

The Planned Respite Service is provided in a five bedroom Home/Whare located in Lower Hutt. This service supports individuals or a couple to take time out from their usual residence.

There is a staff member on site during the day and an on call person is available after hours for anyone who may need assistance.

How do I access these services?

All referrals must be made by the community mental health teams or relevant District Health Board Case Manager through Mental Health Service Coordination.

Long-term or Transition House

This service is for people in the Hutt Valley District Health Board area who are no longer able to live independently at home, and they may be in the older age bracket. We have a five bedroom Home/Whare located in Lower Hutt which is staffed 24 hours a day.

Individuals are supported to maintain and maximize their independence and are encouraged and supported to maintain their wellbeing through community social and in-house activities. They can be referred to the Q-nique Community Participation Contract and Supported Employment Contract, where this was applicable.

For some people this residential-based support may be a critical step towards the achievement of independent living.

How do I access these services?

All referrals must be made through the Hutt Valley Service Coordination Service.

How much do these services cost?

These services are free to individuals.

7. ALCOHOL AND OTHER DRUG SERVICES

From the Q-nique range of service offerings, the Alcohol and Other Drug Services (AOD Services) are provided for people in the Hutt Valley and Capital and Coast District Health Board, who are over 18 years of age and who are willing to change their use of alcohol and other drugs.

Community Support Service

The Community Support Service assists people living in their own home to meet their specific needs related to alcohol or other drug issues, and other needs such as social and basic living needs. This service may also include our team providing direct support or providing liaison/advocacy regarding matters such as accommodation, seeking financial support or employment and/or training. We also help with assisting with relationship or family issues or reconciliation.

Referral can be made by individuals (self-referral), a health professional, and a family member or by a significant other such as a friend.

Residential Live-in Programme (Te Aniwaniwa)

Our Residential Support service comprises a live-in programme which includes an 8-12 week in-house Individualised Programme, plus an intensive Outpatient Programme run by CareNZ.

Social Detoxification Service

Social detoxification for purposes of methamphetamine managed withdrawal and the withdrawal of other drugs will be provided in a community-based facility or community setting such as the individual persons own home. This may precede the person entering a live in AOD Programme.

WellTrust Youth AOD service

Access to WellTrust services can be made by simply walking into their premises on level 2, 14 Laings Road; or via a phone call (04) 568 00370; or via their website www.welltrust.org.nz.

WellTrust takes self-referrals and referrals from parents/caregivers/whanau, and from a range of agencies via: school guidance counselors, police youth aid officers, CYF Social Workers, Probation Officers, GPs, and others...

How much does it cost?

Services are funded by the District Health Boards so are free.

How do I access these services?

Referral can be made by individuals (self-referral), a health professional, and a family member or by a significant other such as a friend.

Service Details – Disability Support Services:

8. DISABILITY SUPPORT SERVICES

Our Disability Support Services are provided for people who are over 18 years of age who have a physical and/or intellectual disability.

Our service supports the New Zealand Disability Strategy with the vision of a fully inclusive society. We aim to promote each person's quality of life and enable community participation and maximum independence, so that each person can live life their way, on their own terms.

Supported Independent Living Services

The Supported Independent Living Community Service aims to maintain or increase each individual's independence in their own home to meet their social and basic living skills. This service may include staff providing direct support, liaison or advocacy regarding matters such as seeking accommodation, financial support or employment and/or training. Support hours provided will depend on each individual's needs.

Residential Services

We currently have 5 Homes operating in the Hutt Valley region providing 24 hour care and support for people with varying physical and intellectual disabilities and needs who are no longer able to be supported in their own homes.

Our Residential Service aims to maintain or increase each individual's independence, and provide support and opportunities for habilitation and/or rehabilitation to have a normal life.

How much do these services cost?

Services are funded by the Ministry of Health so they are free.

How do I access these services?

All referrals must be made through your local Needs Assessment Service Coordination office

Hutt Valley region: Life Unlimited ph (04) 569-3102

Greater Wellington region: Capital Support ph (04) 237-2570

For more information on any of these services, please contact our Disability Support Services (DSS Manager) on (04) 570 2320.

For more information on any of these services, please contact:

**Mental Health, Alcohol and other Drugs Services (MH-AOD) Manager,
Brian Pickering on (04) 570 2320.**

Karen Corban, Disability Support Manager (DSS Manager) on (04) 560 5425.

For WellTrust Youth AOD Services please contact Murray Trenberth, General Manager on (04) 568 00370.

Please feel free to contact us for any more details.

This is the information we provide about after hours support:

For an emergency/crisis assistance out of office hours please call one of the following:

CATT Team for Hutt Valley Health DHB on (04) 5666 999 or

Te Haika for Capital & Coast DHB on 0800 745 477. These services provide 24 hour assessment and short-term treatment services for people experiencing a serious mental health crisis and for whom there are urgent safety issues.

Warm Regards,



Angela Crawford, Chief Executive, Q-nique Ltd

REFERENCES

- Argyris, C., Putnam, R., & McLain Smith, D. (1985). *Action Science: Concepts, methods and skills for research and intervention*. San Francisco: Jossey-Bass Publishers.
- Ballantyne, D., Frow, P., Varey, R. J., & Payne, A. (2011). Value propositions as communication practice: Taking a wider view. *Industrial Marketing Management*, 40(2), 202-210.
- Barney, J., & Felin, T. (2013). What Are Microfoundations? *The Academy of Management Perspectives*, 27(2), 138-155.
- Boag-Munroe, G., & Evangelou, M. (2012). From hard to reach to how to reach: A systematic review of the literature on hard-to-reach families. *Research Papers in Education*, 27(2), 209-239.
- Bolman, L. G., & Deal, T. E. (1997). *Reframing Organizations: Artistry, Choice, and Leadership* (2nd ed.). San Francisco: Jossey-Bass.
- Boulton, A., Tamehana, J., & Brannelly, T. (2013). Whānau-Centred Health and Social Service Delivery in New Zealand: The challenges to, and opportunities for, innovation. *MAI*, 2(1), 18-32.
- Brackertz, N. (2007). *Who is hard to reach and why?* (Working Paper): Swinburne University of Technology. Faculty of Life and Social Sciences. Institute for Social Research.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Burns, D. (2006). Evaluation in Complex Governance Arenas: the Potential of Large System Action Research. In B. Williams & I. Imam (Eds.), *Systems Concepts in Evaluation: An Expert Anthology* (pp. 181-196). Point Reyes: EdgePress.
- Checkland, P. (1999). *Systems Thinking, Systems Practice: a 30-year retrospective*. Chichester: John Wiley & Sons.
- Dalziel, P., & Saunders, C. (2014). *Wellbeing Economics - Future Directions for New Zealand* (eBook ed.). Wellington: Bridget Williams Books Limited.
- Durepos, G., & Mills, A. J. (2013). Introduction: Positivist Case Study Research in Business. In A. J. Mills & G. Durepos (Eds.), *Case Study Methods in Business Research* (Vol. II, Positivist Case Study Research in Business, pp. vii-xviii). Los Angeles: Sage.
- Durie, M., Cooper, R., Grennell, D., Snively, S., & Tuaine, N. (2010). *Whānau Ora: report of the taskforce on whānau-centred initiatives*. Wellington: Ministry of Social Development.
- Eisenhardt, K. M., & Graebner, M. E. (2007). Theory building from cases: opportunities and challenges. *Academy of Management Journal*, 50(1), 25-32.
- Engeström, Y. (1987). *Learning by Expanding: an activity-theoretical approach to developmental research*. Helsinki: Orienta-Konsultit.
- Engeström, Y. (2001). Expansive Learning at Work: toward an activity theoretical reconceptualization. *Journal of Education and Work*, 14(1), 133-156.
- Engeström, Y. (2004). New forms of learning in co-configuration work. *Journal of Workplace Learning*, 16(1/2), 11-21.
- Engeström, Y. (2005). Activity Theory and Expansive Design. Retrieved from http://projectsfinal.interactionivrea.org/2004-2005/SYMPOSIUM%202005/communication%20material/ACTIVITY%20THEORY%20AND%20EXPANSIVE%20DESIGN_Engestrom.pdf

- Gregory, W., Nicholas, G., Anderson, M., Foote, J., Midgley, G., Sheat, A., et al. (2009). *Serving the public sector: A new approach for co-created value*. Paper presented at the 53rd Meeting of The International Society for the Systems Sciences.
- Health Research Council. (2010). *Guidelines for Researchers on Health Research Involving Māori*. Auckland: Health Research Council of New Zealand.
- Health Research Council. (2014). *Pacific Health Research Guidelines*. Auckland: Health Research Council of New Zealand.
- Helu-Thaman, K. (1992). Looking towards the source: A consideration of (cultural) context in teacher education. *ACCESS - Critical Perspectives on Education Policy*, 11(2), 44-50.
- Johnson, J. M. (2002). In-depth Interviewing. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of Interview Research: Context & Method* (pp. 103-119). Thousand Oaks: Sage Publications.
- Lupton, D. (2013). *Revolted Bodies: the Pedagogy of Disgust in Public Health Campaigns* (Sydney Health & Society Group Working Paper No. 3). Sydney: Sydney Health & Society Group.
- Maglio, P. P., Kieliszewski, C. A., & Spohrer, J. C. (Eds.). (2010). *Handbook of Service Science*. New York: Springer.
- Maglio, P. P., & Spohrer, J. (2008). Fundamentals of service science. *Journal of the Academy of Marketing Science*, 36(1), 18-20.
- Maglio, P. P., Vargo, S. L., Caswell, N., & Spohrer, J. (2009). The Service System is the Basic Abstraction of Service Science. *Information Systems and E-Business Management*, 7, 395-406.
- Mendonça, S., Pina e Cunha, M., Kaivo-oja, J., & Ruff, F. (2004). Wild cards, weak signals and organisational improvisation. *Futures*, 36(2), 201-218.
- Midgley, G. (2000). *Systemic Intervention: Philosophy, Methodology, and Practice*. New York: Kluwer Academic / Plenum Publishers.
- Ministry of Health. (2012). *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017* (No. HP5604). Wellington: Ministry of Health.
- Nicholas, G., & Foote, J. (2012). *A Service System Review of Opioid Substitution Treatment through Pegasus Health and the Mount Medical Centre* (Client Report No. FW12003). Christchurch: Institute of Environmental Science and Research Limited.
- Portes, A. (1998). Social Capital: Its Origins and Applications in Modern Sociology. *Annual Review of Sociology*, 24, 1-24.
- Pulotu-Endemann, F. K. (2009). *Fonofale Model of Health*. Paper presented at the Workshop on Pacific models for health promotion. Retrieved from <http://www.hauora.co.nz/resources/Fonofalemodelexplanation.pdf>
- Q-nique. (2013). *Support Planning Pathway: Service Delivery Policy & Procedures* (Revision No. 4). Lower Hutt: Q-nique.
- Schön, D. A. (1987). *Educating the Reflective Practitioner*. San Francisco: Jossey-Bass.
- Shaw, P. (2002). *Changing Conversations in Organizations: A complexity approach to change*. London: Routledge.
- Spohrer, J., & Maglio, P. P. (2008). The emergence of service science: Toward systematic service innovations to accelerate co-creation of value. *Production and Operations Management*, 17(3), 238-246.
- Stake, R. E. (1995). *The art of case study research*. Thousand Oaks: Sage.
- Stake, R. E. (2005). Qualitative case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research*. Thousand Oaks: Sage.
- Statistics New Zealand. (2014). 2013 Census QuickStats about culture and identity. Retrieved 20 October, 2015, from <http://www.stats.govt.nz/Census/2013->

census/profile-and-summary-reports/quickstats-culture-identity/pacific-peoples.aspx

- Tamasese, K., Peteru, K., Waldegrave, C., & Bush, A. (2005). O le taeao afua, the new morning: a qualitative investigation into Samoan perspectives on mental health and culturally appropriate services. *Australian and New Zealand Journal of Psychiatry*, 39(4), 300-309.
- Ulrich, W. (2003). Beyond methodology choice: critical systems thinking as critically systemic discourse. *Journal of the Operational Research Society*, 54, 325–342.
- Ulrich, W., & Reynolds, M. (2010). Critical systems heuristics. In M. Reynolds & S. Holwell (Eds.), *Systems Approaches to Managing Change: A Practical Guide* (pp. 243–292). London: Springer.
- Vaioliti, T. M. (2006). Talanoa research methodology: a developing position on Pacific research. *Waikato Journal of Education*(12), 22-34.
- Vargo, S. L., & Lusch, R. F. (2004). Evolving to a New Dominant Logic for Marketing. *Journal of Marketing*, 68(1), 1-17.
- Vargo, S. L., & Lusch, R. F. (2008). Service-dominant logic: continuing the evolution. *Journal of the Academy of Marketing Science*, 36, 1-10.
- Vargo, S. L., & Lusch, R. F. (2015). Institutions and axioms: an extension and update of service-dominant logic. *Journal of the Academy of Marketing Science*, 1-19.
- Vargo, S. L., Lusch, R. F., Akaka, M. A., & He, Y. (2010). Service-Dominant Logic: A review and assessment. In N. K. Malhotra (Ed.), *Review of Marketing Research* (Vol. 6, pp. 125-167): Emerald Group Publishing Limited.
- Vargo, S. L., Maglio, P. P., & Akaka, M. A. (2008). On value and value co-creation: A service systems and service logic perspective. *European Management Journal*, 26(3), 145-152.



THE SCIENCE
BEHIND THE
TRUTH

**INSTITUTE OF ENVIRONMENTAL
SCIENCE AND RESEARCH LIMITED**

▀ **Kenepuru Science Centre**
34 Kenepuru Drive, Kenepuru, Porirua 5022
PO Box 50348, Porirua 5240
New Zealand
T: +64 4 914 0700 F: +64 4 914 0770

▀ **Mt Albert Science Centre**
120 Mt Albert Road, Sandringham, Auckland 1025
Private Bag 92021, Auckland 1142
New Zealand
T: +64 9 815 3670 F: +64 9 849 6046

▀ **NCBID – Wallaceville**
66 Ward Street, Wallaceville, Upper Hutt 5018
PO Box 40158, Upper Hutt 5140
New Zealand
T: +64 4 529 0600 F: +64 4 529 0601

▀ **Christchurch Science Centre**
27 Creyke Road, Ilam, Christchurch 8041
PO Box 29181, Christchurch 8540
New Zealand
T: +64 3 351 6019 F: +64 3 351 0010

www.esr.cri.nz