

## **Focus On:**

### Knowing the People Planning

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#### **What it is**

- Knowing the People Planning (KPP) is a simple form of market research that uses the experience of consumers to assess how well local mental health systems are working and to identify where improvement is needed.
- Intentions for improvement can then be incorporated in a plan developed with local stakeholders.
- KPP is not intended to replace other methods of service planning and assessment and can be used in conjunction with them.
- The main test of its usefulness is whether consumers get some benefit from it.

#### **How it arose**

For the past 4 years, the mental health services in the South Island of New Zealand have worked together to explore ways of improving services for adults with long-term mental health disorders (schizophrenia, bi-polar, severe depression, and borderline personality disorders). All stakeholders (consumers, their families/whanau, Maori, clinicians, purchasers and providers) participate. I have been the convenor and researcher. KPP is the latest of a number of ideas arising from this work and although it is at the early stages of development, the idea has aroused some interest because of its grassroots focus upon the experience of people using services and the services in action. The methods are simple and have common sense appeal.

The roots of KPP lie in previous South Island Network projects but it was first mooted as a separate concept in 2000. After a round of consultations about its possible value the idea was tried out in four localities in August 2001. The results have only recently been discussed within the Network and the next stages of application explored.

#### **The Clientele**

One of the key features of the Network projects has been to focus on people rather than statistics. It is widely known in the field of long-term care that:

- The number of clients is relatively small - about 5 in every 1,000 adults in contact with secondary care services at any time. In the South Island's adult population of 660,000 this amounts to about 3,500 people.
- The people are well-known because they use services over many years even though their contact may be intermittent because for long periods they have no need of secondary care services.

- Individual clients may have periods when they are ‘high need’ but, drawing from a long experience of mental health problems, they are unlikely to remain so.

For all these reasons, it makes sense to relate everything to use by people rather than try to understand what is going on by looking at statistics e.g. number of community visits, or number of discharges. Because of the small number, you can know the people.

Some community mental health teams in the South Island already have client registers but the information has not been used for service planning. The aim is to make this practice more general and to apply the information to improve service response. Consumers and their families, both Maori and Pakeha, have been widely consulted; they like the idea and have given it the thumbs-up.

### **The Field Trials - Theory**

The work of secondary care services for long-term consumers is to assist them understand and manage their mental health problems and get more out of life.

Suppose there was only one client: to assess how well the service was working you would need to look at the care-programme for that person and know whether its prescriptions were being delivered and having the intended beneficial effects. Sector community mental health teams in the South Island have long-term caseloads in the order of 150 to 450 people. These are numbers small enough to make such analyses practical at sector level.

The method is for case managers to review the experience of their clients and assess what is working and not working for them and where change is needed. The reported results can then be discussed with local stake-holders to arrive at a local plan or statement of intentions for the forthcoming year. At the end of the year, the process re-commences with a review of progress on implementing those intentions.

The process is a developmental experience for those involved. After five years of use the questions asked and the subjects covered will change as participants gain a better grasp of looking at the local picture in totality. I envisage it as a game from which nobody is excluded because of lack of expertise. However, skills will develop with practice. Another important factor to bear in mind is that there is no point of completion. It is not like planning and erecting a building: a project that has a concluding point. The process is one of constant adaptation to the current needs of clients, needs that will change from year to year. What fits in 2002 may be quite inappropriate in 2010, even if the name of the service components remains the same.

### **The Field Trials – Practice**

I have a long experience of applying the traditional service planning methods where set models of provision are allocated as so many units (beds, funded day places, full time staff members etc) pro rata to population. You calculate the number, subtract it from current financial allocations and the gap is your entitlement. There are two key aspects to this type of system:

- There always seems to be an assumption of the need for more resources. But the South Island is already close to – some Boards are above – the allocation level set by

the government. Does this mean, because there is no case for extra resources there can be no planning?

- Planning systems tell you what you need - they are top-down, broad-brush methods for discovering gaps in resource allocations and service patterns dictated from above.

With this experience behind me, I had anticipated the trials would provide magnified pictures of local areas to reveal small 'gaps' to be filled. But the results proved to be more complex than lists of extras to add to local services.

### **Poor fit between need and available solution**

- In one locality there were five clients who yearned for daytime activity and occupation but who disliked and would not attend the local centre. There were vacant places for them and also hospital beds when their loneliness and the burden on their families precipitated crisis requiring admission to hospital. There was no shortage of resources (acute beds and day places) – simply that they were not configured to meet their need.
- A common problem that came up was the work placements and day centres that have no alternative but to send clients home when they become unwell. Sitting alone there, with no support, it is only a matter of time before admission to an acute hospital bed.
- There are the clients who receive the appropriate medication but do not take it.
- A client who did well on a medication that has now been withdrawn on grounds of cost, presumably by New Zealand's medicines purchasing agency, is now having more and longer periods of hospitalisation because nothing suits as well. Effective and acceptable medication is every bit as important as work, income and good housing to the good health of a long-term client. They are interdependent.

Traditional planning methods are not designed to elicit this kind of information. Doing something to address these needs depends in part on redeploying existing resources, not necessarily acquiring more. Crucially, there has to be a willingness to act to make the necessary local adjustments - something to which I will return later.

### **'Major insuperable problems'**

Case managers in one place complain of regulations precluding them from taking some action of help to their clients. Yet elsewhere, their colleagues have discovered the way through the regulatory thicket. To assist with spreading information the Network is considering a web-site that lists local solutions to common problems.

### **The impact of the organisation**

Talking to case managers brought home to me just how the hierarchy above them can affect clinical practice – sadly, too often like a shadow rather than sunshine. Examples of this are:

- Service departments at Corporate Office behaving imperiously, apparently because community teams are perceived to be far down the hierarchical pecking-order.
- Higher levels of management leaving all clinical matters to the teams, though to solve some clinical problems high levels of managerial authority are needed.
- Perceptions (as it turned out, false perceptions) of the constraints imposed by the Ministry on local discretion in service configurations.

## **No winners only losers**

Years ago, in a long stay geriatric ward, I came upon old women knitting a perpetual 10 rows. By some simple means – a weight suspended at the bottom – the rows they had knitted just a few moments previously unravelled to re-join the wool available to stitch into rows above. It was a form of perpetual motion, re-cycling with no outcome or reward.

My conversations with case managers left me with the impression that despite their passion for the work, the cold reality is its similarity to the old ladies' knitting. It just keeps on coming, more of the same, and nobody - other than they and their clients - seems to pay much regard how well they do it. The exception to this being on those rare occasions something goes radically wrong. You can do badly, but you can never do well.

Yet it is possible to mark improvement and good performance. Analysing care programmes makes it possible to create manageable objectives by quantifying need. Take the well-known problems of finding suitable work and accommodation. The difference with KPP is to know that there are 7, 12, or 15 individuals currently in need. Instead of being a vague, general problem the task becomes an achievable objective. You don't have to solve the problems of the world, just recruit help from the community for the few individuals locally. At the end of the year you will know whether you are winning or losing.

A word of caution needs to be entered here. On the road to recovery clients will experience advances and set-backs. Not all the set-backs can be attributed to poor service performance. Assessing local experience calls for sound judgement based on experience and comparative information.

## **Discussion and Next Steps**

Planning methods have traditionally been concerned with equitable distribution of resources to provide a range of basic services. Accreditation methods tell us something about the structural arrangement for the provision of service and not how they work in practice. They both have their place.

KPP takes account of a basic feature of service use, that the people on whom most money is spent are small in number and around for a long time. To serve them best we need to know something about their experience so that the resources we have can be constantly adapted to meet their changing needs. They also need to be used in ways that meet individual need, so that the solution is tailored for the client rather than the client fitted to the 'service'.

The field trials have shown that the information collection is practical and can be done. It will be a simple step to put it in a form for local discussion with stakeholders to determine targets and priorities for every locality. The changes to local services will be at the margin. KPP is not a radical challenge to the way we do things at present, it is simply concerned with adapting local response to changing needs of local clients.

However, thorny problems will also be revealed whose solution cannot simply be put down to lack of resources and will require some organisational courage if they are to be addressed. The basic change is from seeking more resources to putting what we have to better use. This will mean moving money around, changing working arrangements, challenging the way

things are done. Some of the people who are most in favour of the concept see this as the biggest obstacle to its effective application. Methods that stimulate the initiative to tackle these changes are needed.

At the conclusion of the field trials there was some interest in conducting a more thorough trial of the KPP method. 5 Health Boards will take place in the exercise during 2002 after which there will be more to report. However, there is no mystery in the process and one can only hope that if the idea appeals to anyone who encounters it, they will have a go. Academic colleagues sometimes tell me that what I talk about 'isn't rocket science' and they are right. But human services are not rocket science – human beings are far more complex and self-willed than rockets. You cannot dictate, you can only hope to engage with fellow humans and do the best you can.