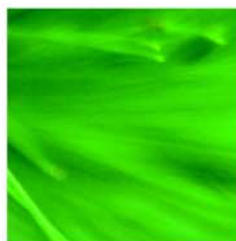
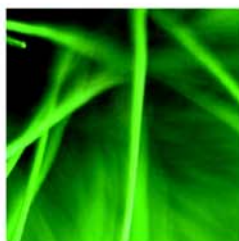
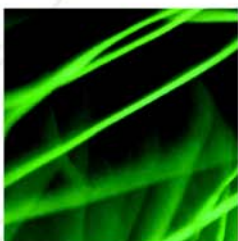


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ENHANCING SYSTEMS TO MEET  
THE NEEDS OF LONG-TERM  
MENTAL HEALTH SERVICE USERS

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DECEMBER 2008

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## INTRODUCTION

This report identifies systems District Health Board (DHB) mental health clinical services have in place to meet the needs of long-term service users. Long-term service users include all those who have used secondary mental health services for a consecutive period of two years or more. Fifteen per cent of the 100,000 people who use secondary care mental health services each year in New Zealand have been in contact with services for two or more years. A 2006 Ministry of Health report outlined how this group accounts for approximately 65 per cent of the acute bed days; and more than 90 per cent of social support services provided by non-governmental organisations (NGOs)(King and Welsh 2006).

To meet the specific needs of long-term service users many DHBs have either implemented Knowing the People Planning (KPP) or have introduced other systems. KPP was designed as a tool to identify and respond to the needs of long-term mental health service users. It was developed in 1999 and implemented in New Zealand since 2002. This work has been led by David King and supported by the Ministry of Health.

In December 2007, Te Pou worked with David King and the Ministry of Health to develop a project which would (a) examine how KPP was implemented in DHBs who had utilised it, and (b) discuss KPP with those DHBs who had elected not to implement KPP.

## BACKGROUND

The biggest users of mental health services are a small number of individuals, each of whom are usually well known in the local services. These heavy users of psychiatric services comprise 10-30% of psychiatric patients. The individuals tend to have psychotic illnesses often with comorbid personality disorders and drug and alcohol misuse. These patients have high levels of need (Wiersma 2006) and use between 50% and 80% of service resources (Kent, Fogarty et al. 1995; Junghan and Brenner 2006). It has been argued that more effective management of this group would reduce their use of services and free up resources for other health-care users (Andrews 2006).

The Ministry of Health estimates that 100,000 New Zealanders are treated by specialist mental health services every year: 85% are discharged within two years, the majority in the first year. The remaining 15% may well have been in care continuously for 10 or more years.<sup>1</sup> These long-term service users will often experience chronic mental health conditions and have high needs.

KPP has evolved as a survey method for evaluating service response to service user need within the New Zealand context. The survey and associated ten key features were developed through extensive consultation with service users, their whanau and clinicians. The tool is designed to support local level service planning based on service user needs. The target group is service users with enduring mental

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<sup>1</sup> Source: <http://www.moh.govt.nz/moh.nsf/indexmh/healthtargets-developmentandmeasurement-quarterlyreports-mentalhealth>. Retrieved on 30 May 2008.

illness (defined by being in the service two or more years).<sup>2</sup> The tool aims to support the service to know their long-term service user group and identify areas of met need and areas of unmet need. KPP offers a practical approach to assessing service user needs, identifying gaps/unmet need, and evaluating the results.

KPP has been in use in some DHBs in New Zealand since 2002. It has been funded by the Mental Health Directorate of the Ministry of Health. The developers have built a website that contains a tool kit to support the implementation of KPP in local services.<sup>3</sup>

KPP influences service development in two ways. Firstly, it provides a survey tool for measuring how well the service addresses specific areas of need for those with experience of enduring mental illness. Secondly, it promotes a service delivery model that contains elements of assertive follow-up, ensuring continuity of care and key aspects of social inclusion such as housing situation and employment status.

KPP involves collecting data to identify the actual number of people with specific needs. It can also be used to identify specific and more flexible individualised supports that an individual may need.

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<sup>2</sup> As the KPP website resources highlight that while KPP was designed for people making long-term use of mental health services, [it] can be used to plan for other client groups” ([www.kpp.org.nz](http://www.kpp.org.nz)).

<sup>3</sup> Source: <http://kpp.org.nz/>

## BOX 1: ABOUT KNOWING THE PEOPLE PLANNING

Services implement KPP through a number of steps. First, clinicians are asked to fill out a simple survey form for all service users in their caseload who have been in contact with mental health services for two or more years. The survey can be filled out at three monthly, six monthly or annual intervals in line with service planning activities. The survey form includes ten questions that focus on the following areas:

1. Length of contact with the service
2. Discharged in the last 12 months
3. Treatment/Care plan that has been updated. Identify if change is required
4. Crisis/Relapse prevention plan completed
5. Registered with a GP (and have good supportive GP)
6. Psychiatric medications
7. Type of accommodation
8. Activity, occupation or work
9. Leisure activity – times per week
10. Crisis respite or acute admission

The responses are entered into a spreadsheet to provide a summary of the clinician's case load and a set of alerts where individual service users require specific areas of need to be addressed. A summary service information sheet can also be provided to individual service users. This data is then aggregated at the team and/or service level and utilised for evaluating how well services are meeting service user needs in these areas.

The data collected supports service goals for meeting the needs of those service users experiencing enduring mental illness. These include:

1. Care plans are regularly reviewed and updated
2. Crisis plans are in place and used by services and service users
3. Social support is provided where needed in areas of work, housing
4. Coordination for all health and social support
5. Accountability – a comprehensive service with common aims
6. Evaluation of the service

In addition, there are another four key features which are promoted as part of KPP. These include:

1. Health advice for both mental and physical health conditions
2. A focus on personal growth and self-management
3. Guaranteed access and recognition should an individual need re-entry to service provision
4. Contact with the service user to be maintained come what may

## METHOD

Those DHBs who had some experience using KPP or a similar approach were invited to take part in face to face individual and/or group interviews. All the other DHBs were invited to participate in a phone interview.

Nine focus groups and 29 individual interviews were conducted during 11 site visits. Thirty-six staff took part in the focus groups with an average of four people per group. A further eight interviews were conducted by telephone. In total 65 people were interviewed. Interviews were recorded where consent was given.

Questions were based on the 10 key features of KPP, and included both quantitative (Yes/No) and open ended questions. The survey questions (see appendix one for full set of questions) included:

- current strategies to address the needs of long-term service users
- whether they are using or planning to use any aspects of the KPP system
- gaps they could identify in meeting the needs of the long-term group
- successes and challenges that had arisen when implementing any strategy aimed at meeting the needs of long-term service users
- support they would like to better meet the needs of this group
- recommendations for future implementation strategies to support DHBs.

The survey and site visits relied on self-report and focused on DHB experiences of implementing KPP and other initiatives targeting the long-term service user. Consequently, the evaluation did not assess the effectiveness of the implementation of KPP or other initiatives to meet the needs of those experiencing enduring mental illness.

## WHAT WE FOUND

Nineteen out of 21 DHBs (90%) participated in this survey. Of the 19 DHBs, eight participated in a telephone survey and eleven in a site visit.

### MEETING THE NEEDS OF LONG-TERM SERVICE USERS

Each DHB was asked about the services and systems they had in place to meet the needs of long-term service users. They were also asked if there were specific systems or services in place for this group.

Of the 19 DHBs, 10 were implementing KPP as a system for planning and reviewing how well they were meeting the needs of the long-term service user group. One DHB was planning to implement KPP in order to address the needs of this group.

### USE OF KNOWING THE PEOPLE PLANNING AMONG DISTRICT HEALTH BOARDS

Gathering information for service development and clinician feedback was also identified as a key component of KPP. Some staff noted that KPP was a simple and cost effective tool to support services and clinicians to meet the needs of long-term service users.

Ten DHBs were using KPP and one was planning on implementing it. Of the eleven DHBs, only three DHBs had been using KPP for more than five years. The majority (n=6) had been using KPP for 3 years or less.

Eight DHBs have now fully implemented and are using KPP throughout their mental health services.

**Table 1: Knowing the People Planning implementation in District Health Boards**

Number of DHBs	Level of KPP implementation	Overview of KPP implementation	IT Status	Clinician buy in
8	All Services	Already championing KPP-fully implemented	<ul style="list-style-type: none"> <li>▪ 3 had problems</li> <li>▪ 3 had no issues</li> <li>▪ 1 one unsure</li> <li>▪ 1 missing data</li> </ul>	<ul style="list-style-type: none"> <li>▪ 3 had mixed views</li> <li>▪ 3 saw the value</li> <li>▪ 1 was unsure</li> <li>▪ 1 missing data</li> </ul>
2	One Community mental health service	Already championing KPP-fully implemented	<ul style="list-style-type: none"> <li>▪ 1 had no issues</li> <li>▪ 1 had problems</li> </ul>	<ul style="list-style-type: none"> <li>▪ both DHBs saw the value</li> </ul>

## NON-KNOWING THE PEOPLE PLANNING DISTRICT HEALTH BOARDS

Reasons for not implementing KPP varied across the nine remaining DHBs. Two DHBs, had already implemented KPP-like systems. One DHB was planning to implement KPP in the future.

DHBs not implementing KPP described a variety of reasons for not doing so. One DHB did not implement KPP because it was not mandatory and felt they do not have the time and resources. It was believed that the data collection reduced service user contact time. They were concentrating on embedding HoNOS and PRIMHD into their current system.

**Table 2: District Health Boards who have not implemented Knowing the People Planning**

Number of DHBs	Overview of implementation for long-term service users
1	Planning for implementation of KPP
1	Have not implemented KPP however could-be interested
2	Have KPP like system in place across all services
5	Have not implemented KPP and are not interested

# BENEFITS, CHALLENGES, AND LEARNINGS FROM THE DISTRICT HEALTH BOARDS WHO HAVE IMPLEMENTED KNOWING THE PEOPLE PLANNING

## **Benefits associated with implementation of Knowing the People Planning**

Interviews with staff involved in KPP identified a range of benefits from service user and clinician level benefits through to team and service level benefits. Many of the benefits associated with implementation of the KPP survey tool focused on the ways it supported meeting the needs of long-term service users using a structured approach.

Clinicians identified how the tool helped them focus on individual service user needs and areas to work on care planning with individual service users. A number identified how initially the survey of their service users was seen as an additional piece of paperwork, but that it became increasingly useful for planning with service users. One staff member reiterated how the tool helped her get to know the service users she supported when she first joined the organisation.

Clinicians also mentioned the ease of use of the KPP survey tool, as well the benefits of rapid feedback and presentation of relevant information about their caseloads.

Team and service level benefits in terms of having good data from which to plan was frequently mentioned by DHB staff. Staff highlighted some very specific benefits which included:

- using real data rather than relying on anecdotal evidence
- having specific numbers of service users affected by particular issues and using this to develop services
- providing a structure to planning days that was based on identified service user needs.

## **The use of Knowing the People Planning**

Use for planning priorities and evaluating how the service was progressing towards particular priorities for long-term service users was a key theme in the interviews.

The flexibility of the survey tool to add additional questions was commonly seen as both a strength and challenge to meet local planning and review needs.

Two DHBs emphasised a shift from simply collecting data to making use of the, particularly in terms of support for addressing the needs of long-term service users.

KPP as a clinician driven approach to planning was also a key reflection. A couple of practices helped facilitate the clinician driven approach to planning and service development.

- discussions around the meaning of each question and gaining common agreements on criteria and definitions
- rapid feedback of data summaries at both individual clinician and team level
- the use of the summarised data for planning days and planning services
- enabling clinicians to determine what data will be collected and to add specific questions of interest to the team.

Other DHBs described ways KPP could be extended to support a focus on service outcomes and review of the impact of new initiatives. A South Island DHB discussed how they had made the link between KPP and HONOS and how this had provided some useful reports for service development and review.

### **Key concerns and learnings**

Staff interviewed identified concerns specific to their DHBs around implementation. The concerns appeared to be influenced by the stage of KPP implementation and also the level of resourcing within the DHBs for supporting KPP.

For example, most interviewees at one DHB identified data integrity and reliability as a core issue. They raised concerns about obtaining clear definitions and agreement among staff for each question. There were problems with different interpretations of the questions and key terms between staff. This created problems in comparing results between clinicians and over time. Differing interpretations was due to new staff not being trained in the survey tool use, and a lack of clear written guidelines and agreed definitions for the survey tool.

One DHB staff member reflected critically on the capacity of the data to show significant change. The group were identifying percentage changes, but questioning whether or not this was a statistically significant change or due to chance.

Another area of concern regarding the implementation of KPP and the use of the data was determining which service users should be included in the KPP group. This had taken one DHB some time to resolve. For example, whether to include those who had re-entered the service, or just those who had been with the team 2 years or more.

A couple of the DHBs questioned the focus on service users with enduring mental illness who had been in services for two or more years. One question was raised about extending KPP to include anyone who might be identified as a high user of services. Questions were also raised about shifting the focus on the two year plus group to an early intervention focus.

Two factors were most commonly identified by participants as supporting the successful implementation of KPP. Firstly, leadership at both national and local service levels. The site visits by KPP leaders and national forums had been influential for some staff deciding to implement KPP. At a local level, many of the DHB staff identified specific leaders who were key in promoting and getting KPP implemented. Secondly, although KPP is promoted as a tool that can be implemented without additional staffing resources, those DHBs who had a co-ordinator or dedicated data analyst appeared to more successfully embed KPP. A dedicated co-ordinator or analyst for KPP seemed to support rapid feedback of data summaries to staff. There were marked differences in how useful staff thought KPP was between those where rapid feedback was a feature and those that experienced delays in getting summaries back to staff. Sites where rapid feedback was provided valued KPP more.

Slowness in feedback of data summaries to clinicians was identified as a disincentive to participation and viewing KPP as a valuable tool. This made it feel like just another data collection exercise for management.

**Table 3: Summary of key benefits and concerns**

Key Benefits	Key Concerns
<ul style="list-style-type: none"> <li>▪ Having leaders who promote the implementation of KPP</li> <li>▪ Having a KPP coordinator</li> <li>▪ Feedback from data collection</li> </ul>	<ul style="list-style-type: none"> <li>▪ Obtaining clear definitions and agreement among staff</li> <li>▪ Identifying which service users belong in the 2 year or more group</li> </ul>

## CONCLUSIONS

KPP has been supported by the Ministry of Health through a grant. The grant supported the voluntary implementation of KPP among New Zealand DHBs. This evaluation aimed to understand more about DHB experiences of implementing KPP and areas of need to support further implementation amongst DHBs. The survey of DHB initiatives in this area highlights how nearly half of DHBs (n=10) have introduced KPP to evaluate and plan for meeting the needs of the long-term service user group. Eight DHBs have implemented KPP across all of their services. Two DHBs had introduced systems of data collection that were similar to KPP. The other DHBs described initiatives that targeted all service users rather than specifically targeting the long-term service user group.

The DHBs who had implemented KPP described a range of benefits associated with its implementation. These benefits included the:

- ease of use of the survey tool
- rapid feedback of results to both individuals and teams
- use of real time data to inform team and service level planning
- service planning based on identified service user needs
- flexibility of the tool for adaption to local needs and issues

There were areas that required further development and consideration in the development and use of KPP. Many of the areas of concern link to the flexibility of the tool and how it is implemented at local service levels. The flexibility of the tool enabled people to add and change questions. However, this could result in questions that were not well formulated or questions that could be interpreted in different ways. Any misinterpretation impacts on data integrity and use of the results for service planning. Another area of strength of the tool was rapid feedback to clinicians of the results and their immediate usefulness for local service planning. Yet in some DHBs there were delays in getting feedback to clinicians and it was not used for local planning. For KPP to be relevant, data collection systems need to enable rapid feedback and alignment with local planning processes.

KPP transforms service planning from an exercise of crude approximation, to an accurate and up-to-date measurement of need of current long-term service users. Improving service performance can then be addressed and the results evaluated for the service user group. Using KPP has the potential to change the views of the adequacy of mental health services from matters of opinion to matters of fact.

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