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EVALUATION: KNOWING THE PEOPLE PLANNING

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Forward

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“Knowing the People Planning” (KPP) is a management tool that utilises the experience of mental health service consumers to evaluate and plan services, and to improve and personalise individual care plans through identifying consumer needs. “Knowing the People Planning” (KPP) process has been developed in New Zealand over the past few years. David King and Barry Welsh have pioneered this approach to the management of people who make long term use of mental health services. These observations are based on contact with David and Barry as well as attendance at conferences, meetings, presentations, workshops and other events where KPP has been discussed.

I have read the Evaluation of KPP prepared by Cate Curtis and endorse its view that KPP should continue to be developed.

Background

KPP is a response to the fact that historically, not all long term users of service had their needs met because service providers did not always keep an inventory or register of these people and their specific requirements. A view was held in some services that there were simply too many people with long term needs for the specific requirements of these individuals to be documented.

Furthermore, if a client failed to attend for an appointment, they would not be followed up. In such circumstances, the service would not see it as a responsibility to find out why the client did not show.

In addition to services provided by community mental health centres, clients were expected to make use of other available services (such as drop-in centres). Overall, there was little remedy or few alternatives to those who had not like the available services. Such CMHCs did not see it as a responsibility to design or tailor services to the specific needs and preferences of individuals.

There were of course many exceptions to the above and early KPP visits identified places in New Zealand where excellent services were being provided to long term users and where all of this client group were known to providers. However, as recently as 5 years ago, there was a lack of consistency in service planning and management and KPP is a response that sought to identify the components of a service that clients sought.

The KPP model

KPP is a *dynamic* system for the planning and management of service delivery. Its point of emphasis five years ago is different from what it stands for today. Furthermore, while it has been developed within mental health services, it could equally be applied to other services, particularly those services referred to as services for long term conditions (LTCs).

When it was first developed, particular attention was paid to identifying the number of people who made long term use of mental health services within South Island health districts. If KPP was to work, it would be necessary to know all the individuals concerned so that their particular needs could be addressed. This was a point of emphasis because of the requirement to establish whether there were manageable numbers of such people. Service providers were able to demonstrate that indeed the numbers of people making long term use of services was small enough to be manageable and indeed they were known to service providers. Initial meetings with stakeholders focussed on what was working well and where improvements could be sought.

Early in the development of KPP, a number of features of good service arose out of consultation with consumers and their families/whanau. These became referred to as “Ten Key Features”. Five relate to individuals and five to the system providing service. They were as follows-

Personal-

- Guaranteed access - and recognition on re-entry

- The provision of health advice specific to the needs of individual clients

- Social support in connection with work, housing, education

- Anticipating crisis- making crisis services alert and responsive to the specific needs of individual clients

- Clients would be reviewed regularly

System-

- A system focussed on personal growth and self management

- Accountability by a defined team

- Coordination point for health and social support

- Contact maintained come what may

- Evaluation, learning from experience and involving clients in making improvements to service

For individual case workers, KPP was about the above. It provided a method whereby the needs of individual clients could be managed in association with them. However, KPP is more than this.

Identifying and meeting needs

Health planning generally and health needs analysis in particular have traditionally relied on surveys based on samples. An underlying assumption here is that the actual population of interest¹ is too large to survey and that the needs within the population are too numerous to enumerate. The resulting information provides general estimates of potential need. KPP is a method similar to the surgical waiting list: every need is listed and assigned to individual patients. This information guides action that has measurable results for actual patients. KPP is a census not a sample.

Staff satisfaction

I have attended workshops David and Barry have conducted with case workers and team leaders. What is apparent is that KPP provides this group of staff with the means of monitoring the effects of their work. This is the case because of the information base that is developed as part of KPP. Staff do know on a regular basis how well they are doing as they are provided with feedback. Those working with KPP can be expected to derive greater satisfaction from their work than those who do not operate with a client oriented information system.

Performance managing the service

KPP provides a means of *performance managing* a mental health service designed to meet the needs of clients who are long term users of service. It does this by providing information in areas of relevance to clients where goals and objectives have been set. When information is collected and collated according to the needs of the individuals who make up a service, it becomes possible to identify the extent to which a service is meeting the needs of these people. If for example, through KPP, it is established that there are a certain number of people with specific social needs in a locality or district, then progress can be measured over time.

Management development

Training in health organisations is wasteful when participants cannot make the linkage between the material under discussion and the specifics of the service they work in. A tradition in health circles is to blame funders for there being insufficient resources. Often, discussion will drift towards a consensus around the notion that services would improve if there was more money available. When training focuses on the needs of people using services and how these services can best be configured to meet these needs, it will have greater meaning to those providing service.

KPP's emphasis on identifying objectives according to client needs (which have been identified under the 10 key features) means that groups of staff from different locales can share experiences and develop as case workers and managers in the context of the specific types of services they are responsible for. I observed this taking place in a training session led by David who facilitated a meeting with heads of certain service from different districts. The participants discussed what they were seeking to achieve for clients in their services. They did this in the context of the underlying philosophy driving their services and the specific objectives they had worked out for their clients in association with them.

¹ In the case of KPP, it is people who make long term use of mental health services that are the population of interest

Summary

In the beginning, KPP's emphasis was on identifying the numbers of people using specific services. From the information boards were able to obtain for themselves, it became apparent that the number of people using service over the long term was small and manageable. From here an effective liaison was developed with clients, their families/whanau as well as caseworkers and team leaders which led to the features of effective service being able to be identified. This in turn has led to the model being able to provide a vehicle for performance management and on-going human resource development and training.

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Executive Summary

'Knowing the People Planning' (KPP) is a management system that utilises the experience of mental health service consumers to evaluate and plan services, and to improve and personalise individual care plans through identifying consumer needs. It began in 1999 with a field trial/pilot involving South Island District Health Boards (DHBs). Initially focusing on service users with enduring mental health needs, it is currently expanding both nationally and in terms of client groups.

Although variations in implementation exist, typically case managers are assumed to 'know the people' and to be able to identify, alongside clients and families, and other stakeholders, individual needs. These needs may be addressed through linking with other organisations or within the service. The information gathered from clients is aggregated and the resulting statistics used in future planning processes.

This evaluation sought to examine KPP on a number of key features, such as determining strengths and weaknesses, current progress and possibilities for future development. This was done through consulting with a range of stakeholders including DHB staff, family advisors, consumers, non-Government organisations (NGOs), and Ministry and KPP staff. In addition, a study of the feasibility of a financial analysis was conducted.

The results of the evaluation indicate that KPP is viewed very favourably by the majority of evaluation participants, although some weaknesses and areas for improvement were identified. Of particular note is the importance of the prior acceptance of the Recovery and Strengths models of practise, or other consumer-focused approaches. These approaches appear to combine well with KPP, providing a philosophical framework as well as an impetus to engage the KPP process (or another similar tool). However, at the same time, some participants noted that it is not possible to separate out the impact of KPP from the Recovery and Strength models. This also has implications for the feasibility of conducting a financial review of KPP.

Key findings include:

- KPP can provide information about service users' needs to guide service planning
- KPP works well in services that have a consumer-focus, providing a tool for effectively reviewing consumer needs, in particular with regard to the implementation of Recovery and Strengths principles via case management

- In services that are well-developed in respect of holistically identifying and addressing individual consumer needs and community facilitation, KPP may have little to add to the Recovery and Strengths models currently operating
- The initial collation of information for KPP is time-consuming and this may add to set up costs
- While KPP can provide a framework for action, addressing identified needs may be hindered by a lack of available resources
- There are likely to be financial implications for NGOs and government agencies as a result of consumer needs being identified
- KPP appears to be more readily practised in smaller communities with strong inter-sectoral and NGO links
- In the long term, KPP should reduce costs to mental health services through a reduction in acute admissions and readmissions, and through the development of clear care and crisis plans.

The evaluation concludes with a list of recommendations. These include:

1. Training materials should be reviewed, particularly in regards to the practical aspects of implementing KPP
2. Training should be tailored for staff at various levels and other stakeholders
3. Tools to assist in the gathering and collation of data should be further developed² and provided to services
4. KPP clearly is most readily implemented if a consumer focus (for example, using the Recovery and Strengths models) is accepted and well-established. Addressing the resistance to or lack of understanding of, consumer focus models would aid the adoption of KPP. However, KPP may have little additional value to services that have well-established consumer-focused processes
5. Consideration should be given to resourcing a staff member in each DHB to facilitate the implementation of KPP, including the initial data collection, ongoing maintenance of aggregated records, support of case managers in the KPP process and networking with other agencies
6. There is clear support for adapting KPP and promoting its use in other branches of mental health services. This development should include a thorough pilot and evaluation including information gathering and analysis tools such as service user questionnaires and spreadsheets.

² It is noted that a spreadsheet for the collation of data has recently been developed.

Finally, it should be noted that there was no criticism of KPP per se made by participants in this evaluation, despite areas for improvement and development being identified. Therefore, there is no hesitation in recommending that funding be continued (leaving aside the issues of costs versus benefits), particularly if the recommendations discussed in Section 5 are addressed.

1 Introduction

'Knowing the People Planning' (KPP) is a method of stock-taking services for long-term mental health clients, with the aim of determining whether the health and social requirements in individuals' care plans are being effectively delivered, in order for appropriate adjustments to be made. The programme arose in 1999 out of a Health Funding Authority project to examine services in the South Island.

KPP was developed by two key researchers, who have provided workshops and other training and support for mental health services, initially through the District Health Boards (DHBs) involved in a pilot³ in 1999/2000, and increasingly broadly since. These two key personnel continue to be the leaders of KPP, although their engagement is part-time. However, the impetus for KPP arose much earlier.

In the mid-1990s, one of the KPP personnel, who had been involved in management of the mental health service in the United Kingdom, decided to explore the reasons for the challenges to the care of long-term mental health clients and started by looking for answers to two questions:

- What are the key features of good quality care and support services?
- How to speed the adoption and practice of these key features so that services with them are the norm and not the rare exception?

KPP arose out of the search for answers to these questions. The aim of the project is to understand the needs of long-term clients and how best to meet them.

KPP's first use was with a sub-group of adult mental health service users – people with a major mental illness and long-term contact with secondary care for two or more years. The first task when implementing KPP was to identify the key features that consumers wanted of services. The next step was to ask services to compare what they set out to do (their policies and procedures) with these key features. A key question for service providers is "What is current consumer experience of your service?" On the basis of this information providers will have gathered information to inform decisions on what to do to improve service delivery. This year, the Ministry of Health requires all 22 New Zealand Health Boards to report on how their services are working for long-term clients.

³ Documentation supplied by KPP staff varies in the description of the early stages of development. For example, some documents refer to a field trial in 1999, others to a pilot; similarly the discussion of the level and exact timing of involvement of DHBs varies. In this introductory material an attempt has been made to synthesise the various documents with the accounts of stakeholders. Any resulting minor inaccuracies are regretted, but it is believed the key points given here are an accurate reflection of the available information.

KPP is suggested as a means of determining this, but is not obligatory. It should be noted that KPP is currently described (by KPP staff and others) as 'a work in progress'.

Currently, KPP is being adapted for use with other groups, such as young people with mental health needs and alcohol and other drug services. An initial assessment is made, usually by consultation between the individual clients and their case manager/key worker, although this information collection may also include needs assessors, NGO managers, acute unit managers and family representatives. Interviewees receive a questionnaire to prepare for the interview, to determine the effectiveness of service delivery and needs. This needs analysis goes beyond that which hospital-based services have traditionally undertaken, to encompass services provided by other agencies, such as Work and Income New Zealand (WINZ). This may be written into a care plan. This information is then collated. In the collated document, comments are quantified where possible, for example, that x people need better accommodation, y people are ready for paid jobs, or z key workers have only a hospital nursing qualification and would benefit from further training.

At this point the material may be used in two ways: to develop personalised individual care plans that may encompass areas such as housing, employment needs/desires, social relationships and crisis plans and also as a broader management tool that can be used for service planning and delivery. The potential outcome, then, is twofold:

- providing individuals with effective and appropriate care which should have an end result of reduced acute admissions and readmissions, as well as improved personal and social circumstances
- providing service deliverers with an audit of services and statistical information about the need for future services which may be used for funding and planning projections.

Additional background information on KPP, prepared by KPP staff, is available at the website: www.kpp.org.nz

2 Policy Background

The eventual development of KPP and similar tools can be linked back to the deinstitutionalisation movement and beyond. In 1969's *Review of hospital and related services* we can look back and see the foreshadowing of a need for protocols to ensure appropriate care of mental health service users following deinstitutionalisation:

“In the past there has been a tendency to divide medical care into watertight compartments – general practice...hospital care for the mentally ill and preventive medicine. We must now realise that ...care of the patient...should be such that the transition into hospital and out again is smooth and continuous” (Gauld, 2001, p. 60).

Over recent years, alongside an increased emphasis on community care, mental health philosophy has been underpinned by concepts of ‘recovery’ and ‘strengths’ compared to earlier deficit-based models. Key documents include the Ministry of Health’s *Looking Forward: Strategic Directions for the Mental Health Services* (1994) and *Moving Forward: The National Mental Health Plan - for More and Better Services* (1997). These documents outlined goals for the development of mental health services for the next 10 years. They include mental health services as well mental health promotion, prevention and primary health care with measurable targets relating to development, purchasing of services and funding. The plan is to achieve more and better services that work together and with other health and social agencies so that services meet the needs of consumers.

These documents provide a number of strategic directions for mental health services, including:

- Develop comprehensive community-based mental-health services
- Develop specific and appropriate mental health services for Maori
- Increase the quality of service delivery
- Maintain a balance between individual rights and public protection
- Establish the necessary infrastructure to enable further development of mental health services, including workforce development
- Develop promotion and prevention approaches, addressing stigma and discrimination

2.1 The 'Recovery' approach

Currently, the *Blueprint for mental health services in NZ: How things need to be* (Ministry of Health, 1998) is a key guiding document for mental health services. It focuses on a recovery approach, one definition being that "Recovery is the ability to live well in the presence or absence of one's mental illness" (Ministry of Health 1998; 2002, p.43). Each person with mental illness needs to define for themselves what 'living well' means to them. This approach requires mental health services to develop and draw on their own resources, but also to develop and draw on the resources of consumers and their communities. Recovery is said to happen when people with mental illness take an active role in improving their lives and when communities include people with mental illness.

The *Blueprint* acknowledges that mental illness may result from family issues, social injustice and traumatic events, as well as an organic illness. These factors need to be addressed in order to achieve and maintain good mental health. This involves (as stated in the *Blueprint*):

- Individual responsibility - learning from mistakes and building on successes
- Social responsibility - including families, communities, social agencies, local authorities.
- Empowering consumers and assuring their rights, increasing control and enabling participation
- Focusing on the 0.5% of the population who are severely affected by mental illness and who use services for more than 2 years.
- Innovative service delivery
- Accessible services, including general health and social services
- Continuing care
- Family support, acknowledging the expertise held by families

The *Blueprint* reiterates the principles contained in *Moving Forward* which discusses the importance of working inter-sectorally. This means providers of services such as accommodation, employment and education have a role to play with mental health service consumers. These can include national government departments, local authorities and community organisations.

The *Blueprint* states that "People working in mental health services must use a recovery approach in their work" (p. 16). The Mental Health Commission has prepared a document (2001) which discusses recovery competencies for mental health workers and provides performance indicators.

2.2 The 'Strengths' model

If the Recovery model is the guiding ethos for mental health service practise, the Strengths model is a step towards operationalising that ethos. *Building on Strengths: A new approach to promoting mental health in New Zealand/Aotearoa* (Ministry of Health, 2002), encourages practical implementation, particularly via health promotion. As may be expected, documents are written in positive terms, discussing the enhancement of mental health, rather than deficit-based analyses of mental illness. The Strengths model arose as an alternative to diagnosis-based approaches, which were criticised for categorising people according to symptoms or illnesses, ignoring environmental factors. The strengths model focuses on identifying individual, family and community strengths. This model has three key features:

- It recognises the individual's potential to change and adapt, and utilise their capabilities, resources and strengths
- It gives primacy to people and the community – trust in people's judgement about what is best for them, and the role of community cohesion and strength in improving overall health and wellbeing. Allowing people control over their lives and choices
- Acknowledgement of the importance of culture and society as determinants of well-being

There is an inherent acknowledgement of social and economic factors in mental health, and therefore, an ability to promote mental health. The goals of *Building on strengths* are:

- To reduce the inequalities in mental health that are experienced by some groups
- Create environments that are supportive of positive mental health
- Improve individual and community resiliency skills

The latter includes discussion of service users/consumers/tangata whaiora as contributing to planning, delivery and implementation of mental health promotion programmes. One way this is done is through national and district advisory groups, in which people with personal experience of mental illness work with mental health service providers and public health promoters.

In conclusion to this discussion of relevant mental health policy, KPP has developed against a background of increased emphasis on community care alongside deinstitutionalisation. The corollary of this emphasis has been a move to increased individual and community responsibility, with the latter taking the form of increased engagement with both government departments such as WINZ and Housing New Zealand, and with non-Government organisations (NGOs) providing services both specific to mental health service users and to the wider community. Mental health policy has changed in response to the emphasis on human rights, community participation and responsibility, anti-discrimination and social inclusion. But at the same time there are public concerns over the quality of care received and risk management. The KPP method is Recovery-focused, ideally seeking the contribution of consumers and families. Their

evaluation of current service assists staff to understand how their service delivery is experienced.

2.3 Purpose of the Evaluation

The purpose of the evaluation was to assess the effectiveness of KPP as a management tool in the mental health service arena. The evaluation was undertaken in two components. The first component consisted of a 'broad-brush' approach, using largely qualitative methods, to ascertain KPP's general effectiveness. The second component was a scoping exercise which included a financial review and cost-benefit analysis. The following key areas were examined in component one:

- Differences in implementation across the DHBs
- KPP's place among the range of planning techniques currently available
- KPP's usefulness to DHBs, including critical factors for success
- The potential for KPP to be applied to other mental health services such as Child & Youth, and Alcohol and Other Drugs
- The appropriateness of continued funding

The main body of this report comprises the first component of the evaluation. The financial scoping exercise is appended.

3 Method

The design for this evaluation consisted of a qualitative research: incorporating interviews and document analysis, as described below. In addition, the feasibility of conducting a financial cost-benefit analysis was conducted by Associate Professor Toni Ashton. The results of the scoping study are appended.

3.1 Qualitative data collection

Over recent years policy-related decision-making has increasingly been predicated upon 'evidence'. Evidence-based decision-making extends to the funding of programmes and services. This decision-making draws upon the results of (social) scientific research. This evidence can provide information about how, why, and under what conditions a service or programme works (or fails to work). It involves eliciting the attitudes and perceptions of a group of stakeholders who are able to provide in-depth answers to these questions.

Quantitative research is useful for conducting research where the key questions can be clearly defined, a large group of suitable respondents can be readily accessed and the parameters are well established. However, there are limits to this type of research, especially where evaluation of a programme or service is concerned.

Firstly, we wish to elicit information that often can not readily be reduced to 'yes/no' or 'agree/disagree' categorical answers. Secondly, in order for quantitative data to be meaningful, it must be collected from a large number of relevant stakeholders (usually at least several hundred); more than it is possible to access in an evaluation of this nature. In contrast to quantitative research, qualitative researchers seek answers beyond numbers – to understand the attitudes and beliefs of key stakeholders and to generate new or unanticipated information that can not be gathered using quantitative methods. This allows us to understand how a programme is understood and experienced; why it is successful (or not), and how it could be improved. While both quantitative and qualitative research may come from a basis of eliciting "peoples' opinions", qualitative research allows us to understand the responses in context, giving added weight to these attitudes and beliefs, and allowing us to know more about the experience that lead to the formation of these attitudes and beliefs.

The number of participants in a qualitative study is not usually predetermined. As data collection is conducted, new participants are included so that emerging themes (or topics of interest) can be explored. Data collection is concluded once data saturation is reached – that is, once no new information is gained by adding more participants. Because statistical analyses are not conducted, a specific sample size is less important than in quantitative studies. The data collected are not numerical but verbal explorations. The emphasis is on *what* participants

considered relevant or important rather than how many participants gave a certain answer. “Qualitative data are words rather than numbers. Words describe and explain...suggest[ing] new perspectives. The hallmark of qualitative research is that it goes beyond asking how much there is of something to tell us about its essential qualities.” (Linacre, 1995, 405).

For this evaluation, the primary data collection methods consisted of face-to-face and telephone interviews. Through using a variety of methods, as well as including a variety of stakeholders, it is likely that a diverse range of experiences have been captured. Further details on the research process used for this evaluation are given below.

3.1.1 Sample

As discussed above, KPP was initially piloted in the South Island during 1999/2000. As these DHB areas would therefore have the longest history with KPP, it was decided that they should be given priority for consultation, alongside Ministry and KPP staff. A number of methods were utilised to recruit the participants for the evaluation. Several key stakeholders were initially identified through discussion with the funder and KPP staff. Further contacts were made using the networks of the researcher in the mental health service. In addition, mental health resource facilities were utilised, as well as internet searches, to identify broader stake-holder groups such as non-government organisations and consumer advocates. Once this initial sample had been contacted, they were invited to either provide the contact details of others they thought would be interested in being involved in the evaluation, or to ask others to contact the researchers. Letters and/or emails informing potential participants of the evaluation and inviting them to participate were sent to over 120 individuals and organisations.

Thirty-two discussions were held, with a total of 47 participants. Of these, 21 were individual interviews and there were 11 group interviews or discussions. The majority of discussions were conducted in person, the remaining six by telephone. In addition, one person engaged in a dialogue with the researcher via electronic mail. The sample comprised current and former Ministry and DHB staff including managers, quality improvement staff, funders, consumer advisors, family advisors and case managers, NGO staff, consumers and families. In addition, KPP leaders and Ministry staff were consulted to provide background information. The work positions of participants were classified as follows:

Service management/senior staff	14
Case managers	9
Consumer representatives / family advisors	10
NGO staff	6

DHB staff	6
Other	2

While ideally a relatively large number of NGO representatives, consumers and families would have been involved, it quickly became apparent that knowledge of KPP was very limited, or non-existent, among many of these stakeholders. In addition (perhaps unsurprisingly), more people volunteered to take part in the evaluation from areas in which KPP is particularly well-developed.

It should be noted that there may be other people who would have wanted to be included in the evaluations. Attempts were made to contact a cross-section of stakeholders, and it is the belief of the researcher that the sample does contain a variety of participants with different positions in relation to KPP, and of sufficient size that the conclusions drawn are valid. This belief is further justified by the fact that data saturation was reached. That is, by the end of data collection no new themes were emerging; all issues raised were discussed by several people. Nonetheless, an apology is offered to any person who did not have an opportunity to discuss their perspectives and would have liked to do so.

3.1.2 Qualitative Data Collection Methods

A combination of qualitative interviewing methods were used: semi-structured interviews and group discussions. Interviews were guided by a set of interview themes to ensure key topics were discussed; these were adapted to suit the experience and knowledge of the participants. In addition, an open-ended, semi-structured method of interviewing was included in recognition that to attempt to fit the participants' varied experiences into a 'one size suits all' structure would risk losing the subtleties of their interpretations. It facilitates access to information the researcher could not have considered (Burns, 1994). In line with this approach, once the interview guiding themes had been addressed, the participants were encouraged to explore any additional issues they considered relevant. During this stage the researcher's role was largely one of encouraging the process of allowing a narrative to unfold, seeking clarification and elaboration as required.

In some cases several people attended a discussion; these discussions took an average of one hour. The length of single-participant interviews varied between 15 minutes and one hour, with 45 minutes being the approximate average.

Thematic analysis was conducted to draw out the major themes raised by participants. That is, responses were coded in relation to the salient topics such as "reasons for successful development" and then into sub-topics, for example "available resources: staff time" and "available resources: financial". These major themes are presented in the Results section.

3.2 Document Analysis

The researcher was provided with a number of documents for analysis. These included DHB's current draft plans, reports on the pilot (field trial), statistics on key indicators such as acute admissions, readmissions, unemployment rates among service users and average length of stay (ALOS), and Ministry of health publications. These documents provided quantitative data and context used both to inform the qualitative data collection process.

3.3 Limitations of the Research

Although some of the participants were identified by the research team or other participants and invited directly to take part in the evaluations, approximately half volunteered and contacted the research team themselves. A potential methodological issue with self-selected participants is that they may not be representative of the population in general. That is, they may volunteer because they feel particularly strongly about the topic, whereas the majority of the target population may have neutral views and therefore be less motivated to volunteer.

There was a suggestion that in one service DHB management may have had undue influence in determining which staff took part in the evaluation. However, the results of the data analysis indicate that the people who took part in the evaluation (including those from that one particular DHB) presented a range of viewpoints. While it is not possible to know whether their collective views represent those of all possible participants, both positive and negative views were given. If anything, it may be that the overall target population for each evaluation is more neutral in its opinions than the evaluations would suggest.

4 Results

4.1 Differences in implementation across the DHBs

Although all South Island DHBs⁴ were invited to take part in the 1999/2000 pilot/field trial, development of KPP since varies markedly. However, all participants, with the exception of KPP and some Ministry staff, came from South Island DHBs, and all South Island DHBs were represented in the evaluation. A number of reasons for this variation in development were identified by participants and are discussed in this section. In some cases these reasons are conflicting. Due to issues about identifying participants, the report does not identify specific services.

Overall impressions of KPP per se were largely positive. In particular, participants were enthusiastic about the way in which KPP assists with operationalising a consumer focus. However, there were clearly barriers to overcome if successful development is to be achieved. Reasons given for the lack of KPP development include:

4.1.1 Managerial/staff issues:

Issues about staff occurred at two levels: senior management and 'grass roots' staff.

In regards to management two types of issues were noted.

- Approximately half the staff (4) spoken to at one organisation mentioned that the management style was rather directive and autocratic, and this affected staff buy-in at the case manager level. This resulted in case managers seeing KPP as a 'burden', and 'more paper work'.
- It was also noted that the attitudes and personalities of one or two key staff, particularly at senior management or clinical level, could have a major impact on the successful implementation of KPP.

Clear support, enthusiasm and a commitment to resourcing, at least in terms of time, were considered essential factors, as was involving staff in a more open way, so that they see the value of KPP.

Results of discussions with some staff at the case manager/key worker level concurred with these findings, with participants saying that they felt KPP was something they 'had' to do but did not see the relevance or point of adding it to

⁴ The Hereford Centre in Christchurch, one of a number of community mental health teams in the city, took part in the field trial, rather than the whole Canterbury DHB.

their workload. However, it should be noted that this issue was fairly isolated, with most case managers spoken to expressing enthusiasm for KPP.

4.1.2 Initial presentation of KPP:

The presentation of the KPP method at initial meetings and workshops was discussed by many participants. Participants said that there was a lot of enthusiasm shown by presenters, which stimulated interest in attendees, and the background to the concept is discussed fully.

Specific points made included that the material delivered was unclear and/or lacked details. Evaluation participants reported that while it was frequently stated by the presenter that the method was not "rocket science" it was not made clear exactly what it was, particularly in regards to the 'nuts and bolts' of implementing KPP. Because people were told that "it's not rocket science" they tended not to feel comfortable in asking questions and also to wonder why they should bother with KPP. In addition, presentations have not always been tailored to suit the audience. One participant spoke of a session for clients and families that was "over their heads". A few participants said that the KPP team sometimes seemed to be "making it up as they went along" in relation to training but particularly to KPP overall.

"Some parts of the service don't fully understand how it will work, especially if they personally don't have good links to NGOs...they are afraid that they'll end up doing a lot of running around trying to get it organised"

"We might still be working through material [from a visit from KPP staff] and they go away and think about it and come back with a modified version. It's a bit confusing and they don't seem much clearer on how to do it than we are. We just get the hang of something and they want to add something on."

"There's a lack of information on how to interpret the project into clinical working concepts"

4.1.3 Resourcing:

The areas in which KPP has been most successfully implemented designated a particular staff member to undertake the initial collation of information. However, this has sometimes been highlighted as a burden or drain on resources. Participants expressed concern about the amount of time involved in the ongoing up-keep of records and acting on needs assessments.

Although in theory key workers/case managers should 'know the people' and therefore should be able to gather and provide the necessary information to set up KPP very readily, reports in the evaluation indicated that considerably more work is required to collate this information than anticipated. Some staff spoke

about the time involved in drawing up questionnaires and databases in order to gather information. They reported a lack of IT support (within services) and expertise to do this. It was noted that KPP staff have provided assistance with this and a spreadsheet has recently been made available and this was viewed positively. However, the work around this in the past had been something of a burden and contributed to a small number of participants feeling that KPP had developed in an ad hoc manner and that this developmental work should have been done before KPP was piloted, or at least before it was continued further.

4.1.4 Broader issues in the mental health arena

Staff at one DHB commented that KPP has taken a second place to more pressing issues about funding and resourcing, both current and dating back to earlier restructuring. It was noted that strategic goals include "...implement 'Knowing the People Planning'", but there is no action plan for this, just the statement of the goal.

4.1.5 Adherence to medical models

Adherence to medical models or deficits-based views of mental health were discussed by some participants. While medical models inform aspects of legislation, policy and treatment, it was noted that some clinical staff do not see it as their role to go beyond providing medication and therapy, to look at consumers' social and other needs. There is reluctance by some to deliver services consistent with the Strengths and Recovery models, and this in turn impacts upon the feasibility of effectively implementing KPP. In one case, this appears to be an issue at an institutional level (although there were conflicting views on this); while in other cases it has been the viewpoint of a small number of influential staff.

"Resistance is a result of attitude problems regarding dealing with social problems...not seeing it as our job"

"You can't afford to get offside with [senior staff] entrenched in the medical model"

4.1.6 Size of the community serviced:

This was given as a reason for KPP not developing as successfully as it could in areas with a larger population. As mentioned elsewhere, a dedicated staff member was required (on a part-time basis) to undertake the initial collation of information and the maintenance of records even in small services. This was emphasised by larger services as a barrier to KPP being utilised effectively.

On the other hand, small and rural communities had less access to resources, such as the range of inter-sectoral and NGO services available in larger communities.

4.1.7 General issues

In addition to the obstacles to effective development of the KPP tool as discussed above, it was apparent that understandings and the level of knowledge of KPP differed among stakeholders, including in areas where KPP is well-established. In particular, there was frequent conflation of KPP and the Recovery and Strengths models. Further, some participants suggested that potential stakeholders, although involved in KPP, would not recognise the name.

As discussed above, in some services there appeared to be a level of resistance to KPP and the Recovery and Strengths models (and/or the perceived increase in work entailed). This resistance was often not recognised or acknowledged by other staff spoken to.

Reasons for successful development:

4.1.8 Fit with current mode of practice

It was very clear that the services that have most successfully/thoroughly implemented KPP are those most committed to the Strengths and Recovery models:

“KPP complements what we were already doing with Strengths and made it easier to facilitate the Recovery approach...they all complement each other”

However, as noted by several participants, and discussed in the scoping study appended, this high level of integration with the Strengths and Recovery approaches means that it is not possible to determine whether changes in client outcomes are due to KPP, Strengths, Recovery, or a combination of the three.

4.1.9 Staff commitment

Staff and managerial issues were discussed above as potential barriers to the progress of KPP. The reverse of this is that commitment and enthusiasm from a small number of staff members can have a marked positive impact. In particular, participants from one service repeatedly mentioned the influence one key person had in ‘driving’ the implementation, encouraging and supporting others.

“You need a strong manager who will push it, but who can also motivate people from the bottom up...and deal with the backlash”

4.1.10 Service size and structure

The size of the DHB in terms of population was seen as both positive and negative. One of the underpinning concepts of KPP is that the target population, the three percent of people with severe and enduring mental health needs, is sufficiently small for service staff to know service users and therefore to readily implement the KPP method. This assumption is partially borne out by the results of the evaluation; some participants did acknowledge that case managers know their clients well. Therefore, they were able to conduct assessments and prepare care plans with relative ease in many cases, although this did not necessarily translate into an ability to readily collate data.

Additionally, smaller communities seemed to have stronger networks and more knowledge of individuals, and were better able to cope with work around the initial collation of information on clients and with upkeep of these records.

“It really helps if Funding and Planning and the provider arm all work together”

4.2 KPP's usefulness to DHBs, including critical factors for success

All participants agreed that KPP was potentially valuable. Positive comments about its usefulness included:

“It's a way to deliver the recovery model...and now that we've got the databases up and running they'll be really useful... we can work towards goals that have been high-lighted...You can look at what makes a difference to people and then allocate resources more appropriately and effectively”

“Creating links with GPs and getting shared care going would decrease our workload ...for some clients the only reasons they see us is medication”

Most participants were readily able to identify critical factors for the successful implementation of KPP, some of which have been mentioned above, such as staff 'buy-in', management support, a 'driver'. Other factors identified include:

“Seeing the service user as the central priority [is crucial]...acknowledging the importance of housing, jobs and income in recovery”

“Having good intersectoral links...it will challenge NGO's ability to respond...a redistribution of resources will probably be required, if not an increase”

“Being able to come together with the community and network effectively and having the resourcing to do that”

“It’s a simple concept, and people need to remember that”

“Success hinges on how it’s introduced to staff and clients”

“There needs to be an implementation infrastructure”

Some participants were unconvinced of the value of implementing KPP into a service that was seen as running effectively and using Recovery and Strengths approaches. A few participants, from two DHBs, felt that KPP had added little to their existing practise:

“We were already working using these philosophies, so it’s hard to separate out what KPP has meant. We were consumer-focused anyway, focusing on people’s strengths...and this was built into our quality management. We’d drafted a needs assessment form...and we were getting a lot of similar information from consumer surveys”

“We work from the same principles anyway – it’s just best practice marketed another way...although focusing intensively on case management with enduring clients can be difficult due to staff and resourcing issues”

Although they did not view KPP negatively in itself, they considered that it was of little benefit to current practice. Senior staff at one DHB mentioned that they were considering withdrawing from KPP for this reason.

Several suggestions were made for improving the uptake and development.

- Clarity of purpose and process from the outset (from KPP staff), including realistic timeframes for action, determining responsibilities and communication channels within mental health services as well as clear understandings across agencies
- Provision of tools, such as spreadsheets, assessment forms and questionnaires by KPP staff
- Incorporation of training on KPP into existing DHB staff training where possible, for example, including it in training around the Recovery model, instead of a separate ‘add on’; “a new thing they have to do”
- Emphasise the potential outcomes and benefits, to service users, management and staff: that initial investment will ultimately result in more effective care plans, which should reduce readmissions and acute admissions, and ensure more appropriate services, which may result in decreased workloads.
- One person within the service provider should be designated as the key ‘KPP facilitator’, who has a good understanding of the practicalities of implementation, is responsible for collating information and preparing reports, and who staff can consult.

Overall, opinions of the value of KPP were high. One interview conducted with a group of consumers and family advisors was particularly strong in their support of KPP:

“It has resulted in a complete change...looking at things differently...getting people working and happy. I’d recommend it to anyone”

4.3 Perceived Strengths of KPP

In what may be considered an overall comment on KPP, strengths were more readily identified than weaknesses. Many have been noted earlier. Quotes which address the most common points are reiterated here:

Planning solutions:

“[KPP] gives a more objective, analytical basis to planning”

“You can match client feedback with data and go to Funding and Planning with numbers and get what people really need”

“It focuses on real people, rather than demographics...it gives the ability to find solutions”

“Its biggest strength is in encouraging re-evaluation. These clients can be invisible, particularly if they’re just ‘ticking over’ quietly.”

Inclusivity:

“It includes all stakeholders, so people can take ownership and it celebrates achievements”

“It gives self-responsibility with guidance, doing it with people, not for them”

“It acknowledges the importance of family”

Combining approaches:

“It gives a more balanced view to challenge the dominant medical model”

“It enhances the Recovery approach - it’s more about fixing the problem”

“It encourages thinking about what works well, what the gaps are and what the strengths are”

“The combination of Strengths and KPP works well - you’re not just a number. They complement each other. [But] it’s hard to know if KPP would work without Strengths, they’re so meshed together”

“It helps find a pathway between clinical, evidence-based practice and the reality of living life in the community”

4.4 Perceived Weaknesses of KPP

A number of weaknesses of the KPP method were identified. The most common concerns were about resources, an underlying framework or philosophy to support KPP, and mismatches between service users needs and expectations to what is possible. The following quotes were chosen to illustrate these weaknesses:

Resources:

“It’s only as good as the [service providers’] ability to action it. It’s a framework for identifying needs, but it doesn’t solve anything. It comes back to resources, whether that’s within the service or within the community...someone, somewhere, has to actually do the work of helping people get jobs or whatever it is.”

“The financial implications for NGOs must be acknowledged and addressed. If people’s needs are being addressed, and those needs are out in the community, then the community services need to be there”

“NGOs are competing with each other about money so there isn’t a lot of information-sharing”

“How do you do both - keep contact with people and address their social factors without taking money away from the treatment end of it? Maybe ultimately we can swap staff around - less acute care but more community care - but that’s not possible yet. There needs to be extra funding in place while there’s the overlap period between putting [KPP] in place and seeing the effects”

“Few GPs have the time or commitment [to increase involvement with mental health service users]. They [clients] don’t fit into 10 minute appointments a lot of the time, so there’s a funding issue...Who has the on-going responsibility for dealing with people who stop taking meds?”

“There are clients who don’t fit the definition [to be included in KPP assessment] but take up a lot of work and time and that gives a false statistical impression.”

“There was some initial confusion about who should be included. There are some people who are really high needs who would really benefit, but they haven’t been with us for two years. And there are others who we only see for meds who are included”

Underlying ideologies:

“As with Strengths it struggles a bit here because we’re still so medicalised...some medical staff are reluctant to share their power”

“KPP can’t really stand alone; it needs a framework to wrap around, like Strengths”

Client issues:

“Some people won’t admit they have an issue so care plans don’t work or they can feel stigmatised and not want to get involved with community services...they don’t want to draw attention to themselves”

“There is potential for labelling people as having an ‘enduring mental illness’ to become a self-fulfilling prophecy”

“There can be a mismatch between what the service user sees as something really important to them and what’s actually possible...you need to be clear about limitations to what can be done”

“There’s the potential for a ‘pass the parcel’ approach to emerge...who takes ongoing responsibility if someone is discharged from the service because they’ve ‘recovered’?...Recovery might not mean the same things with those with recurring episodes”

4.5 KPP’s place among the range of planning techniques currently available

Very few participants were able to comment on how KPP compared to other needs assessment or service management tools. The only instrument mentioned more than once was the ‘Camberwell Assessment of Needs’, with participants noting that it provides similar information on clients’ status, but this is done in isolation of a treatment philosophy, whereas KPP assists in identifying ways to meet needs. There was a general sense that KPP probably has an advantage over other techniques as it has been developed in New Zealand.

Several participants mentioned that they would have liked more information on how KPP compared to other tools at the outset. This would have assisted with staff buy-in, as well as simply knowing that it was an effective, evidence-based initiative.

“Presumably [the KPP key staff] reviewed other tools and strategies and used these in their development of KPP. It would have been nice to know more about this process.”

4.6 The potential for KPP to be applied to other mental health services such as Child & Youth, and Alcohol and Other Drugs

There was wide-spread support around the potential for KPP principles to be applied more broadly, within mental health services, but also health services accessed by people with enduring physical health problems. There would clearly need to be adaptation, for example:

- Child and adolescent services will require more focus on educational needs and family/whanau input
- Alcohol and Drug services may require more consideration of issues around crime and parenting

4.7 Areas for improvement/development

The majority of participants were satisfied with the current format of KPP, although issues around training delivery and the ongoing process of development were identified, and have been discussed elsewhere. However, there were some additional areas for improvement discussed by a small number of participants. These include:

4.6.1 Culture

A small number of participants brought up the issue of the cultural needs of clients, stating that this appears to have been given little explicit consideration. On reviewing the data, it is apparent that there are a number of outcomes or potential community linkages discussed repeatedly, such as GP Link, addressing housing, education and employment needs, linking with community groups providing leisure activities and so forth. However, there is almost no discussion of linking with cultural groups such as iwi organisations. This may in part be due to the relatively homogeneous nature of the South Island population which may have resulted in the majority of clients involved in KPP being Pakeha, and an implicit assumption that networking with family and community agencies will provide for Pakeha cultural needs. However, Maori access mental health services at a higher rate than other ethnicities (Mental Health Commission, 2004), and given the Ministry's commitment to ensuring appropriate services for Maori and other ethnicities, including cultural dimensions in needs assessments seems appropriate.

Please note that it would be inappropriate to assume that KPP is not culturally safe; rather this is an area that could benefit from further consideration or more explicit discussion. Assurances have been provided by KPP staff that "Maori are very supportive of the concept across [the] board as it fits with their world view".

4.6.2 Information technology

A small number of participants discussed a need for better information technology – both from KPP and within the mental health services they are part of, in order to effectively manage data collected in the course of KPP (and other) work.

4.6.3 Information-sharing between DHBs

Some participants mentioned hearing about the work other DHBs are doing around KPP, and expressed an interest in knowing more. This would assist in knowing what is working well, and the reasons for this, as well as helping to avoid potential problems. It was suggested that regular networking opportunities should be further developed to facilitate the exchange of information, ideas and inspiration.

4.8 Financial implications

A full financial analysis of KPP was outside the scope of this evaluation; please see the appendix for further information on this. However, participants did comment on their perceived financial implications of KPP. All agreed that KPP has had minimal financial impact on their services, as far as they were aware. However, it must be noted that a need for increased resources, including financial, was frequently discussed, and was given as a reason for the lack of progress with KPP in some areas. Concerns regarding financial resourcing revolved around the following areas:

- The initial collation of data. It appears that this has often been a greater burden than perhaps was anticipated and is a hindrance to establishment and a possible barrier to implementation in other districts
- Ongoing maintenance of aggregated records. While this may not be an issue in small services if a regular routine is implemented and a staff member is given responsibility, it is a concern in larger services
- Networking time and associated costs. Collaboration with NGOs is a key factor for KPP's success in terms of client outcomes, but will entail the reallocation of staff time to engage in networking activities and resources to cover associated administrative and other costs.
- Funding of NGOs and increased time involvement from other agencies. It is assumed that if needs outside the mental health service are identified and are to be addressed, additional time and financial resourcing will be required. This will involve government agencies such as Workbridge and Housing New Zealand and community organisations such as specialist mental health support services, for example, Richmond Fellowship and Supporting Families (formerly Schizophrenia Fellowship).
- Some participants noted that clients cannot afford to see a general practitioner, and so use mental health service staff, although this is not necessarily the most appropriate service for those needs. In addition,

there is a lack of access to GPs in some rural areas. Although outside the mental health service, this is an issue to be addressed.

5. Conclusions and Recommendations

'Knowing the People Planning' has clear potential to improve mental health services, through ensuring the needs of mental health service users are clearly identified and met where practicable. KPP is able to provide a platform for developing personalised care plans, networking inter-sectorally and providing evidence to be used for funding and planning purposes.

KPP is working very well in a number of areas in which it was piloted, with very positive feedback received in the course of this evaluation. It is clear, however, that KPP has not completely fulfilled its potential as rapidly and effectively as possible in all areas; this difficulty with progress was mentioned by numerous participants at the senior staff level. Reasons for this include:

- A lack of clarity about the practicalities of implementation
- A lack of commitment to consumer-focused approaches to mental health services among some staff
- Time constraints related to collating initial data
- Issues around staff buy-in
- A lack of resources (time and financial) for networking

The reverse of these issues may be considered as factors that could assist implementation (for example, commitment to and integration with the Recovery and Strengths models). Other key factors for the successful implementation, and areas for development include:

- A key 'driver' for KPP within service providers, who is able to make clear the benefits of KPP to staff and to support individual staff members in the process
- Resourcing for this driver, and/or a person responsible for the initial collation and maintenance of records, particularly in larger DHBs. It is expected that once KPP is set up, this cost would be relatively small compared to potential gains
- The encouragement of community cohesion via, for example, a newsletter to relevant parties and regular meetings
- The provision of tools such as assessment questionnaires and spreadsheets
- National networking facilities, to celebrate successes and share information

Of particular note is the potential for integration with the Strengths and Recovery models.

5.1 Recommendations

It is noteworthy that there was no criticism of KPP per se made by stakeholders in this evaluation, although areas for improvement and development were identified. Therefore, there is no hesitation in recommending that funding be continued (leaving aside the issues of costs versus benefits). It is, however, strongly recommended that the suggestions for improvement and development in sections 4.2 and 4.6 be implemented. Of particular importance:

1. Training materials should be reviewed, paying particular attention to the practical aspects of implementing KPP
2. Training should include, and be tailored for, staff at various levels of the mental health service and encourage avenues for inter-sectoral and other stakeholder networking
3. Tools to assist in the gathering and collation of data should be further developed⁵ and provided to services.

In addition to recommendations aimed at KPP staff, it must be acknowledged that for KPP to be implemented as successfully as possible service providers may need to reallocate some resources to the collation and maintenance of records and community networking. There may also be implications that can only be addressed at Ministry level, such as the resourcing of NGOs and other stakeholders. This may be eventually offset by decreased demands on DHB mental health services.

There has been some discussion of making KPP mandatory. As a result of careful consideration of the data, it is recommended that this not be done at this point, for the following reasons:

4. KPP clearly is most readily implemented if the Recovery and Strengths models are accepted. It is clear that there is a level of resistance to these, and consumer-focused models in general, among some staff. This resistance, or lack of understanding, should be addressed before KPP can be most effectively progressed.

⁵ It is noted that a spreadsheet for the collation of data has recently been developed.

5. Conversely, it is apparent that KPP may have little additional value to services that have well-established processes that fit with the Recovery and Strengths models. Implementing KPP would entail staff training and possible changes to consumer assessment and data collection processes for little or no gain.

Finally, there is clear support for adapting KPP and promoting its use in other branches of mental health services and possibly also other health services. As part of this development, however, it is recommended that a thorough pilot and evaluation be undertaken, including information gathering and analysis tools such as service user questionnaires and spreadsheets. This will allow a well-planned process for the practical implementation of KPP into these services to be devised before roll-out continues.

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7 Appendix: A scoping study of the costs and benefits of

'Knowing the People Planning' (KPP)

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Introduction

Knowing the People Planning (KPP) is a tool for improving the planning and management of services for high needs mental health patients. The purpose of this scoping study is to determine whether or not it would be feasible to undertake an economic evaluation of KPP. The scoping study was undertaken in association with the 'Knowing the People Planning' Evaluation study, undertaken by the Survey Research Unit, University of Auckland.

An economic evaluation of any health intervention basically addresses the question: Are the additional benefits associated with an intervention worth the additional costs? The specific purpose of an economic evaluation of KPP would be to determine whether or not expenditure on KPP provides value for money compared with expenditure on other health interventions.

The type, depth and accuracy of economic evaluations can vary considerably. However all studies require:

- (a) A comparator against which the incremental benefits and costs of the intervention can be assessed.
- (b) Some evidence of the effectiveness of the intervention, including evidence on any costs avoided.
- (c) Sufficient information to measure, or at least to make a good estimate, of the resource costs associated with the intervention

In the case of KPP, the comparator is obviously the management of mental health services *without* KPP. An economic evaluation would then systematically (i) identify (ii) measure, and (iii) value the *incremental* benefits and costs associated with introducing KPP.

The following sections consider each of these three steps in turn in respect of KPP.

Identifying the costs and benefits

Identification of the potential benefits and costs of KPP would not be a difficult exercise. Many of these have already emerged during the interview process, and from the available documents. However, to undertake a full economic evaluation, a more systematic process would be required to ensure that the list of benefits and costs is complete. While the types of costs associated with implementing KPP are fairly common across all DHBs, the types of benefits associated with KPP may vary considerably, depending upon the perceived needs of the long-term clients, the priority that the DHB gives to these needs, the way in which KPP is implemented as a means of addressing these needs, the organisational structure of the DHB, and so on.

Benefits and costs that were identified during our preliminary investigations were:

Benefits

For the clients

- Improved quality of life
- A return to employment
- Avoidance of imprisonment
- Continuity of care with a GP and other service providers
- Ability to access services in a crisis
- Improved case management

For families and carers

- Greater empowerment as a result of greater input into the development of client action plans
- More positive relationship with staff

For DHBs, NGOs and other providers

- Higher productivity through better case loads and better use of crisis teams
- Reduced admissions for long term clients
- Better coordination of staff members within the organisation and with other stakeholders
- Satisfaction associated with improved outcomes for clients

For the Ministry of Health

- Better data on the numbers of clients and their needs for the purposes of strategic planning

Costs

The costs of KPP comprise the direct costs of the programme itself, plus any indirect costs associated with reorienting management practices and implementing the programme.

Costs of the KPP contract

The direct costs of the KPP contract are the

- the costs to the Ministry of negotiating and monitoring the contract
- the costs of the KPP contract (currently NZ \$190,000 per annum) for training and assisting managers to reorient their management practices and to collect the data that is required to identify and manage long term clients

Other costs:

In addition to the direct costs associated with the KPP contract, additional costs will be incurred by the Ministry, DHBs, NGOs, and possibly other organisations as a result of implementing KPP. These indirect costs include:

- travel, staff time and other costs associated with attendance at workshops and other training
- costs of setting up and maintaining a register of high needs clients
- costs of developing plans for clients
- costs of reviewing the experiences of clients
- reorienting services to respond to the identified needs of high needs clients
- additional services provided by NGOs (such as community housing)

As noted above, these lists are indicative only. If an economic evaluation were to be undertaken, it would be necessary to identify the benefits and costs more systematically, possibly through a survey of the relevant organisations together with the collection of data over a defined time period.

Measuring the costs and benefits

Many of the costs and benefits listed above are common to both a “with” and “without” KPP scenario. Therefore it would be important to separate out the *incremental* benefits and costs that can be attributed to KPP. However KPP is not

an intervention as such, but a tool for changing the way that long-term clients are managed, or for ensuring that interventions or processes are completed. This makes it very difficult to attribute any changes in many of the costs and outcomes identified above directly to the introduction of KPP. As an example, a DHB may find that a number of high need clients need to be placed in more appropriate accommodation. A measure of effectiveness of this policy would be the number of targeted clients who find appropriate accommodation. But some – and possibly all – of these clients may have been placed into more appropriate accommodation in the absence of KPP. A higher rate of placements could be due to factors such as the general economic environment or the availability of housing rather than to the implementation of KPP.

A number of concomitant changes have occurred in the health sector during the period that KPP has been implemented. In particular, most DHBs that have worked with KPP have also pursued the use of the ‘strengths’ model in caring for their long-term clients. It is therefore difficult to separate out the influence of KPP on clients from the effects of the ‘strengths’ model, or from the shift towards a recovery ethos more generally. Similarly, changes in client outcomes may be associated with organisational changes, staff turnover, funding levels, internal contractual arrangements, organisational leadership and so on.

To measure the incremental benefits and costs of KPP with any degree of accuracy it would be necessary to have some counterfactual (i.e. comparator) which effectively provides a baseline line against which any differences in the costs and benefits of the intervention can be assessed. There are two possible approaches. One would be to take a before-and-after approach for individual DHBs (or possibly even for individual clients) in which a selection of indicators would be compared before and after the introduction of KPP. A second approach would be to compare the costs and benefits of DHBs which have introduced KPP with the costs and benefits of those which have not. A combination of the two could also be done, with trends in KPP DHBs being compared with trends in non-KPP DHBs over time.

A preliminary analysis has been undertaken which compares acute admission rates, readmission rates and length of stay for 5 DHBs with KPP with the rates for other DHBs. For the year from 2002/03 to 2003/04, acute admissions fell by 9% in the KPP boards compared with 3% the other DHBs while the rates of 3 or more repeat admissions declined by 28% in the KPP boards compared with a 1% increase across other DHBs. While these results are interesting (and may be worthy of more in-depth examination) any changes in outcomes and costs cannot be attributed to KPP from this type of “with” and “without” analysis for a number of reasons.

First, because KPP is a tool for improving planning and management, or for ensuring that interventions are completed, rather than an intervention in itself, any changes in service provision generally occur incrementally, with different strategies being pursued over different periods of time depending upon the changing needs of patients. This means that the distinction between “before” and “after”, or between “with” and “without”, is blurred.

A second problem is that the degree of “buy-in” into KPP differs considerably across DHBs. Whereas some DHBs are very committed to the concept and are working very actively towards implementing the 10 key features, some staff in other DHBs are not even aware of the concept. This means that it is not simply a question of whether or not KPP has been introduced, but to what degree it has been implemented and maintained.

Thirdly, the very essence of KPP is the identification of high needs clients. Any benefits of KPP are therefore likely to accrue primarily to these clients. But boards without KPP do not usually have a comprehensive list of these clients and their needs. Therefore, no direct comparisons can be made of the outcomes for those very clients who are expected to receive the greatest benefit from the programme.

In theory, any confounding influences on costs and outcomes (including changes in funding levels) could be controlled for by including a large number of DHBs in a comparative study over a number of years. But even 21 DHBs would not provide a large enough sample size to control for the many other factors that might influence both costs and outcomes, except, possibly, over a very long period of time. If individual clients were selected as the unit of analysis, rather than DHBs, again a very large sample size would be required because the incidence of some of the outcomes (imprisonment, for example) is relatively rare.

All of these points mean that no clear distinction can be made between a “with” or “without” KPP situation, making accurate measurement of costs and benefits impossible, at least in the short term. Even so, there may be some value in examining any existing data on the various potential benefits listed above to determine whether or not there are any *apparent* differences in outcomes between the two sets of DHBs. To account for the uncertainty that surrounds the size of any benefits associated with KPP, a sensitivity analysis should be undertaken in which the size of the benefits are estimated within a range – a sort of best and worst scenario.

A final point to note is that direct attribution of benefits to a programme or intervention is always difficult in social science research. This does not mean

that the programme is not worthwhile. But it does mean that any quantitative analysis, such as an economic evaluation, will be subject to a very high degree of uncertainty. It is for this reason that economic evaluations are not usually undertaken in these types of circumstances.

Valuing the costs and benefits

The Ministry of Health is interested in the financial implications of their investment in KPP. This means that, ideally, as many of the benefits and costs as possible that are associated with KPP would be quantified in dollar terms. However, accurate valuation first requires accurate measurement. Therefore, only those benefits and costs which can be directly attributed to KPP can be valued with any accuracy.

If the measurement problems discussed above could be overcome, so that the size of the benefits (and also the costs) could be estimated with some degree of accuracy, then it would certainly be possible to place a dollar value on many of the benefits of KPP from existing financial data. For example, it would be possible to estimate the value of admissions avoided, of changes in the use of other health services by clients, of imprisonments avoided, and of additional productivity from increased employment. But in the absence of good measures of the size of any changes that are attributable to KPP (for all of the reasons discussed above) such quantification remains purely hypothetical.

From the list of benefits above, it is also clear that many of the benefits of KPP (such as the satisfaction for clients of being in employment, or improved coordination of staff members) fall into the category of what economists call "intangibles" because they do not involve any change in resource use. The standard method for valuing these types of benefits (called contingent valuation) uses surveys to measure people's willingness to pay for a desired change in outcome. Contingent valuation is highly controversial because it is fraught with conceptual and methodological problems, not the least of which is the fact that it measures hypothetical willingness-to-pay rather than the individuals' true willingness to pay. These problems mean that in practice, any intangible benefits are often omitted from the valuation process. This in turn means that the total benefit of the programme will be under-estimated. Circumstances where the intangible benefits are significant have therefore been identified in the literature as one of the circumstances where an economic evaluation should *not* be undertaken.

Other issues

Adequacy of KPP funding

KPP is a relatively low cost programme. However some interviewees noted that there is a need for better upfront resourcing of KPP during the implementation phase. This phase can be resource intensive, with considerable time needing to be spent on the initial compilation of data. By the same token, one DHB noted that much of this information is already available. Moreover, investing in better client information may be worthwhile with or without KPP, because the information is useful as a general client management tool.

Longer term funding of KPP

One consideration for the Ministry of Health is the question of whether longer term funding of KPP would be a more efficient method of funding the programme. Longer term funding would allow longer term planning which may in turn secure greater net benefits. For example, some of the initiatives associated with KPP are likely to have longer term resource implications for other organisations; for example, community housing or organisations that provide supported employment.

Our investigations suggested that longer term funding would probably not significantly enhance the programme because most of the direct costs of KPP are the annual costs associated with the provision of workshops and support in the implementation of KPP. That is, the programme does not involve any significant fixed investment which would require a long term funding stream. Rather, most of the costs incurred are recurring annual costs. Enhancing the provision of services on a longer term basis requires certainty in funding the services themselves, rather than certainly in KPP funding.

Cost of an economic evaluation

In considering whether or not to undertake an economic evaluation of KPP, the cost of the evaluation itself needs to be considered. It would be a relatively easy – and hence relatively low cost– to make some estimates of the financial implications of changes in some of the trend data (such as client contacts or admission rates). But again, it is emphasised that such information is not very meaningful unless these changes can be attributed directly to KPP, which is clearly not the case at present. As noted above, a more meaningful analysis of the benefits and costs of KPP would require the systematic collection of data over a number of years. A study such as this would be very costly and would certainly exceed the current annual cost of the KPP contract to the Ministry.

Conclusion

KPP does not lend itself well to a formal economic evaluation for the following reasons:

- KPP is a method of planning and managing service delivery, rather than a clearly defined change in the way that services are delivered.
- Those DHBs which have implemented KPP to date have done so at very different levels of commitment and investment.
- It is impossible to determine whether changes in health service use and patient outcomes are due to KPP or other influences, such as the use of the 'strengths' model in caring for clients.
- The potential benefits of KPP depend upon the particular needs of high cost clients in each DHB rather than on the fact that KPP is being practised. The benefits therefore vary from one DHB to another and from one time period to another, making inter-DHB comparisons difficult.
- It is difficult to separate out many of the costs of KPP from the usual costs of managing a service.
- The intangible benefits of KPP are significant and may outweigh those benefits that have the potential to secure some net savings.
- The costs to the Ministry of Health of undertaking an economic evaluation would be high (given the diversity of potential outcomes of KPP) in comparison to its annual investment in the programme.

For all of these reasons, it is concluded that a formal economic evaluation of the benefits and costs associated with KPP would not itself provide the Ministry of Health with value for money.