# KNOWING THE PEOPLE PLANNING (KPP)

A NEW, PRACTICAL METHOD TO ASSESS THE NEEDS OF PEOPLE WITH ENDURING MENTAL ILLNESS AND MEASURE THE RESULTS

David King & Barry Welsh

The Nuffield Trust
FOR RESEARCH AND POLICY
STUDIES IN HEALTH SERVICES

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# FOREWORD

Specialist services bring added value to patients, the rarer the disease is but may do harm if overprovided (Baicker and Chandra, 2004). Specialist medical services are expensive and almost always more expensive than primary, generalist, health services. These two facts make it essential that specialist services are appropriately deployed.

Knowing the People (KPP) is a project developed by Mr David King and colleagues, first in New Zealand, and later in the UK. It offers an approach to rationalizing the use of secondary services in mental health. It works by focusing secondary team care on the small, but important, group of the population who have used specialist services repeatedly and then following them up rigorously to ensure medical and social support is delivered systematically.

The numbers involved usually turn out to be smaller than expected and so are more manageable than some had feared. The results have proved encouraging.

Whilst this project has operated in the field of mental health, in the Anglo-American world similar approaches of intensive community based care has more often been developed for physical diseases, like heart failure, for example, by Evercare and now the NHS.

All over the world, these and other developments can be seen as variations on a single theme: the need to focus health and medical services in the community rather than in hospitals, so emphasising the importance of continuing, individualized care.

The Nuffield Trust has been pleased to support this project and to host two seminars to develop and disseminate the ideas.

Sir Denis Pereira Gray, OBE, HonDSc, FRCGP, FMedSci
*Chairman of the Trustees*

The Nuffield Trust
April 2006

**Reference**
Baicker K and Chandra A (2004) Medicare spending, the physician workforce, and beneficiaries' quality of care Health Affairs web 4 184.

# 1. HOW WELL DO MENTAL HEALTH SERVICES MEET THE NEEDS OF THE MOST NEEDY?

*Abstract: KPP is a practical approach for evaluating health and social services. Its first application is a method for measuring the needs of long-term mental health clients: whether their needs are being met and if prescribed action is having the intended results. This application helps providers improve the effectiveness and efficiency of recovery-based casework. It is of value for planning and performance management.*

## Care in the community: a failure?

Have you ever met anyone with a good word to say for community mental health services?

It's not that people are unsympathetic. They usually agree that care in the community is a good idea, but the media tell them it is a shambles: swamped by demand and hopelessly under-resourced. Hardly surprising, when they hear that one in every five of us will have a mental health problem during our lives and that the available resources can only cater for the 3% of people in greatest need.

The most worrying concern is that in the move from the old mental hospitals to the community, the people in greatest need may well have been overlooked. Since services have become available in the community, they have been exposed to increased demand from people who previously would not have set foot in the old hospitals.

In the melee for thinly-spread resources, have the losers been those in greatest need but the least vocal - the former hospital patients (and others like them, too young to have been admitted to the old hospitals)?

## The project and the authors

In 1999 and with this in mind, the Authority responsible for funding mental health services in the South Island of New Zealand commissioned a study to examine how well service providers were catering for such clients, who they described as people with "high needs".

Although we had not met or worked together before, the authors became the Joint Project Managers. The project and partnership has continued since.

We discovered a mutual interest in analysing and explaining the work, in order to define the features of good mental health services and how they can be applied everywhere.

Each of the authors had been pursuing these interests for some time: one in England and in New Zealand, after a long experience of managing mental health services in both countries; the other, in New Zealand, with experience of management in the agricultural industry and personal use of mental health services. Both share a keen interest to discover the answers to their questions and a desire to see the results implemented.

The research methods used involve 'Delphi groups' and 'appreciative inquiry'. Above all, KPP is intended to provide practical management tools to aid the improvement of performance.

## What is KPP?

The KPP approach and its mental health application have been major outcomes of the project. The aim of the KPP approach is practicality and utility by describing the work undertaken for the client group being studied and looking at the results for all clients, not just a sample of them. The KPP method uses data that services routinely collect and only adds a small amount.

The object is to provide D-I-Y applications that service providers and others can easily use themselves in order to evaluate their performance.

This first application is a practical way to record, for every client, and aggregate for the entire local caseload that their needs are being met and that services are having the intended results.

With a clear statement of what the service provides, it is possible to ask if everything ordered been delivered. Is it having the intended effects? Answering such questions allows service providers to give account of themselves, to celebrate what they do well, and to decide what they must do to improve performance.

Services that use this KPP application have done so without adding to costs. They find it practical, straightforward and useful. No special expertise or training is required. The data can be quickly obtained and easily adapted to local information requirements.

The information obtained throws light on the requisite service organisation, staff training needs and performance management, as well as assessing met and unmet client needs.

Though designed for long-term mental health clients, the KPP approach can be used for any health or social service clientele. A start has been made on applications for addiction services.

## Relationship with our clients

The Mental Health Directorate of the Ministry of Health in New Zealand funds the work and supports it wholeheartedly.

Participating District Health Boards (DHBs) in New Zealand, do so voluntarily. Support has come from all stakeholders: clinicians, clients, Maori, managers and family members because they think it is down-to-earth, makes sense and assists their work and its outcomes for clients.

The relationship is interactive. The evidence collected and the views of the participants strongly influence the development of KPP.

## The English trial

Important elements of the groundwork on which KPP is based, arose from work carried out in England between 1992 and 1997 by one of this report's authors. Recently, a number of Mental Health Trusts in England have adopted the KPP mental health application through a project ably facilitated by Tony Day, a freelance policy analyst, who specialises in mental health. The participants are volunteers who find the method of value and their participation shows that KPP is relevant and adaptable to services internationally.

## KPP and the Nuffield Trust

We are indebted to Denis Pereira Gray, chair of the Nuffield Trust, for his support for the project. The Nuffield Trust has sponsored two seminars for the English participants and this report is at his suggestion as a general description and discussion of the concept, its use and usefulness.

# 2. THE KPP MENTAL HEALTH LONG-TERM CLIENT APPLICATION

*Abstract: The defining characteristic of the clientele is their long-term contact with services. Using the Delphi method, a comprehensive set of service requirements was compiled to meet long-term clients' needs. These are known as the 'Ten Key Features'.*

## 'High needs' or 'long-term' clients?

The people whose needs we were originally commissioned to examine in the South Island were those with enduring mental illness: schizophrenia, bi-polar disorder, personality disorder and persistent depressive disorder. However, diagnosis alone does not provide the key to 'high needs'. Many people with these conditions are able to lead ordinary lives without the constant support of secondary care services.

The matter of defining the clientele was resolved by adopting a classification that had been used for a client register in Wandsworth, London during the 1990s: it was based on clients who had first contacted secondary care services two or more years previously. It seemed apparent that people's needs must be high to require long-term use of secondary care services. Consequently, we used 'long term' as synonymous with, and as a proxy for, 'high needs'.

## Their needs

We could find no comprehensive list of needs so we set about compiling one. Aware of the dangers of too much detail and over-elaboration, our aim was a basic, but comprehensive framework of needs. We chose to do this by talking to as many stakeholders (consumers, their families, Maori, clinicians and managers) as we could. We learnt from them and made a number of return visits so as to check and confirm their information. We began in June 1999 and the exercise took 20 months to complete.

Time was needed for relaxed conversation with as many stakeholders as possible. The method chosen was a programme of 'neighbourly visits' in which teams of stakeholders

drawn from parts of the South Island examined each of the local services. The visits took two or three days and a report was written with no more than five recommendations for improvement and included a list of things the visiting panel considered good practice. After a period, there was a follow-up visit to assess the action taken.

## Ten key features

The outcome of the neighbourly visits and subsequent rounds of stakeholder consultation resulted in a list of service requirements that became known as the 'Ten Key Features'. They are a basic set of service requirements, which were defined as necessary to meet the needs of long-term clients by those we consulted. Four relate to individuals and six to the system meeting such needs.

### Personal

1.  Care plans regularly reviewed and updated

2.  Anticipating crisis - relapse prevention plans accepted and used by the Community Mental Health Team (CMHT), the Crisis Team and the Acute Unit

3.  Health advice for mental health and physical health conditions.

4.  Social support, where needed; work, housing, education, and social contact.

### System

5.  A focus on personal growth and self-management: practicing the Recovery Approach.

6.  Guaranteed access and recognition on re-entry.

7.  Accountability - a comprehensive service with common aims.

8.  Coordination point for all health and social support.

9.  Contact maintained come what may – or assertive outreach

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

Stakeholders gave unanimous approval to this basic set of requirements and new participants in England and New Zealand have accepted these requirements. This is a very important point, for it means an agreement on what clients want and what clinical services say they should, and more importantly, can and would provide. This transforms the 'Ten Key Features' from a client 'wish-list', to a specified service product.

Having defined the 'Ten Key Features', the next step was to discover how each of the six services in the South Island measured up to them. We adopted a format for self-assessment by services that had been used in a set of National Mental Health Standards issued by the NZ Ministry of Health in 1997. Self –assessment has also been used in England to measure progress with implementation of the Mental Health National Service Framework since 1999.

The response was prompt and excellent in the sense of its completeness; every service submitted a return. A problem emerged: the replies were based upon policy intentions and not an account of how things were actually working – how it felt on the street.

## The birth and development of KPP

What we needed was a snapshot of daily experience. Since, in their caseloads a CMHT caseworker had between one and 20 long-term clients, it seemed possible to obtain a picture by interviewing the caseworkers. They knew the people and both their met and unmet needs. Caseworkers would be able to tell us what they found easy to provide and where they might need assistance from management to make things happen.

Plans are about knowing where you are in relation to where you want to be and devising a means of getting there. The usual practice is to apply some norm or template devised by central planners. With KPP it is possible to have real information based on a census of client experience: information based not on norms or other proxy 'top down' measures but from knowledge of client needs – a 'bottom-up' approach.

In 2001, we were close to the end of a contract period and time was against us, but we recruited three small localities to give the idea a trial. In three sites we conducted the interviews, and an assertive outreach team in an inner city carried out its own assessment. The trial started in Westport, a town on the West Coast of the South Island, which was the first to volunteer.

Caseworkers and CMHTs are accustomed to individual case conferences, but this was the first time that they had the opportunity to review the results for all their clients. They found it revealing and useful. The resulting reports were well received and a decision made to offer KPP to any DHBs who wanted to use it.

Relying on interviews alone is a slow process and difficult to ensure that each and every client is included. Consequently, a spreadsheet was designed, and is being developed. Data is recorded, aggregated and then analysed on the spreadsheet.

This makes it possible to not only know the amount of unmet need, but also whose individual needs they are. This is invaluable for measuring results that are meaningful to clients and clinicians. Caseworker interviews remain an essential component of the process and, in preparation for them, participants can see the analysis of spreadsheet data for their personal caseload.

Currently, the spreadsheet comprises 15 items. In New Zealand, items 1 – 8 can be downloaded automatically from existing Patient Management Systems.

| |
|---|
| 1. Name |
| 2. Number |
| 3. Gender |
| 4. Year of birth |
| 5. Ethnicity |
| 6. Admissions in previous 12 months |
| 7. Length of contact |
| 8. Caseworker |

Items 9 – 15 are completed by the caseworker. To do this, for example in item 9, calls for the entry of one of three numbers: (1) – a care plan, but not recently revised in accordance with local policy; (2) – an up to date care plan; (9) – no care plan. Data entry for caseworkers is neither time-consuming nor burdensome and, if they use laptops, any changes can be recorded at the end of a meeting with each client. Many of the items change little from month to month. However, they provide a useful summary for caseworkers of what they have achieved, and what needs to be done.

| 9. Care plan |
| 10. Relapse Prevention Plan |
| 11. Medications |
| 12. GP contact |
| 13. Housing |
| 14. Occupation |
| 15. Leisure and social contact |

The data can be verified in two ways: by audit (comparing what is recorded on the spreadsheet with the client file); and from participation in the local planning process. If results differ markedly from the impressions gained by consumer representatives from their peers' comments, the matter can be re-examined.

The data that comes from the spreadsheet and caseworker interviews is analysed. A summary report is produced and is used by the local stakeholder committee to prepare the annual plan. Objectives and therefore results relate to actual people. For example, six clients want a change of accommodation and the results are that the six identified people have or have not benefited from the change they were seeking.

Representatives of 10 DHBs at a KPP Workshop in October 2005 requested a KPP Tool Kit to include all components, advice and instruction to make KPP a completely D-I-Y process. At the time of writing, this is in preparation.

# 3. RESULTS: THE PEOPLE – WHO THEY ARE AND HOW MANY

*Abstract:* *Some people make regular and long-term use of mental health services and are well known to service providers. The number is small, about 0.6% of the adult population, with a low turnover of constituents.*

## How many long-term clients?

Our studies reveal the following information:

- numbers are in the order of 0.6% of the local adult population;

- for a DHB serving an adult population of 275,000, the number of clients will be in the order of 1650, a number comparable to the student roll of many schools;

- the majority of clients have been in contact with services for longer than five years;

- there are equal numbers of men and women,

The results are similar in England and New Zealand: the number is small, the people are around for a long time and they are well known to providers. The evidence does not support the impression that is sometimes given: of teeming numbers and a flood of new clients.

Perhaps the most important result of the finding is that there is no impending crisis. There is, therefore, time to research numbers and characteristics in far greater detail and refinement. Pending these further researches, the compilation of the numbers of long-term clients has given several fascinating insights that call for more immediate inquiry and action.

## Are 'long term' and 'high needs' synonymous?

Our initial assumption that all clients remaining in long contact with secondary mental health services have high needs has not been sustained by the evidence so far.

While it is true that there are those who need a long-term casework approach, there are many who either remain or are retained on caseloads for reasons other than their personal high needs.

- In a few instances this was the first case review for some time and, though the names remained, the people had been discharged.

- Quite large numbers of clients have been revealed who are called in for routine 'check ups' by consultant psychiatrists. Given the shortage of doctors and the pressure on their time, the value of this use of their scarce skills calls for further examination.

- In New Zealand, where there is a co-payment system for General Practice, clients may be retained on secondary care caseloads to receive free medication. This may also sometimes occur in England to avoid primary care prescription charges.

- Others are retained because there is a requirement for regular blood tests in order to use certain medications.

- There is another group who do not currently have 'high needs' but prefer the 'insurance' of remaining in contact with secondary services. They are concerned that, once discharged, they cannot easily re-enter the system without demonstrating 'high need' as an access requirement, or may have to face the delays of referral and assessment procedures.

- There are those who have to be on the caseload in order to be eligible to retain social support.

An interesting feature of most of these examples is that there are often neighbouring DHBs where the clinical staff have found solutions enabling clients to be discharged without the feeling of being 'abandoned'.

The resulting impression is that the small caseload of long-term clients is itself larger than it would be if current 'high needs' were the single criterion for inclusion.

## Is everyone included?

In 1999, we shared a common view that many people went untreated because services were unable to meet demand or reach out to them. Epidemiological evidence indicates that 2.5% of the adult population experience chronic, serious mental illness, yet the caseloads we have examined only reveal 0.6%. Does this support the argument that many needy people are unable to access treatment?

In the localities we have studied, this seems unlikely for two reasons. Firstly, not everyone with an enduring mental illness requires secondary care for effective treatment and support. Many people with chronic conditions are treated by GPs, or transferred to GP care after a short period of secondary care.

Secondly, we have been working in a number of places in New Zealand for six years and we know all the local stakeholders, including client and family groups. Although they may sometimes criticise local services, we have never been told of people with serious mental illnesses who are unable to access treatment (as opposed to delays on access or re-access).

Exclusion from treatment has never been claimed, but if there were concerns of this kind, the information could be quickly discovered by local surveys of family doctors, consumer and family organisations.

## How many and is the number increasing?

The answer is that the number of long-term clients is small and does not appear to be increasing.

In the caseloads we have analysed there is no indication that numbers will increase or are being replaced at the same level: the majority (about 70%) of clients are over 40 years old.

## Is there an over-representation of Maori people?

The South Island has a small population of Maori people.  In three North Island DHBs, where the percentage of Maori people in the population is in the order of 20% or more, the numbers of long-term clients are of comparable magnitude. We have not found evidence of over-representation.

## Is the clientele changing?

When the old mental hospitals closed there was a sudden influx into the community of clients with little experience of looking after themselves. CMHT caseloads increased with numbers of clients for whom housing and social support were significant priorities. Subsequent growth in numbers has been small and providing for their needs is not a major logistical challenge.

## The impact of this information

When we began the project there was little or no locally available information about numbers, though it existed on central statistical databases. This has now changed. The information gleaned from central databases and local inquiry can be made readily available to managers and practitioners on the ground.

We now know that for New Zealand's adult population (over age 20) of three million, there are about 15,000 people who are long-term mental health clients. Even the largest Boards have long-term caseloads of no more than 1500, and therefore it is possible to 'Know the People'. The same is true of our findings in England, with small numbers of clients, who are well known to service providers.

The paradox of all these findings is that clinical staff know the small number of people who make the greatest use of mental health services, but planning and management processes seem not to be aware.

Planning methods to assess demand and design service models commonly use norms; models of care and case mix information. Yet planning and management can be based on the experience of the actual, small number of known clients and their individual needs. It was for this reason we call our method 'Knowing the People Planning'.

# 4. RESULTS: PERSONAL NEEDS

*Resume: There are gaps in the provision of personal needs. However, none are of any magnitude that requires major financial investment. The unfulfilled needs of a few individual clients can be achieved by purposeful and attentive casework. The two areas requiring the greatest attention and improvement are relapse prevention and employment.*

*The first four of the Ten Key Features listed in Chapter 2 are personal needs that can be recorded for every client on a spreadsheet.*

The examples given are drawn from analyses of data recently compiled by four DHBs. The total number of clients across these four DHBs is 1414. They are referred to as the sample DHBs.

## 1. An up to date care plan

The evidence is, as might be expected, that the great majority of clients have care plans. Not all of them are up to date, however, and the record varies between caseworkers and between DHBs. In the sample DHBs, the percentage of long-term clients with care plans updated in accordance with local policy ranges from 24% to 75%. Since a care plan is the bedrock of casework, the status of care plans should be a matter of concern and certainly that is the consensus of clinicians who have received the information.

## 2. A relapse prevention plan

In the sample DHBs, the proportion of long-term clients admitted to the acute unit in the course of 12 months ranges from 23% to 48%. The percentage of those admitted three or more times in the space of 12 months ranges from 5% to 20%.

From interview information, it appears that some caseworkers regard admission as inevitable, yet there is growing evidence that when attention is given to reducing avoidable admissions improvement can be achieved.

Many clients are admitted, even though they have relapse prevention plans, and there is a

need to examine the reasons. In a study of admission rates in the South Island of New Zealand in 1998, we found a variation between districts of 200%. Clinicians concluded that this had more to do with differing local practice rather than differing geographical rates of acuity.

There is also agreement that the plans must be current if crisis teams and acute units are to be convinced of their authority and take note of them when called out by clients or their families. Without this, they inevitably have to exercise caution, reduce risk and admit clients.

The consequences of avoidable admission include the blight they have on employment opportunity as well as the possibility of losing a home and social networks.

## 3. Health advice
The two items included in the current spreadsheet have particular relevance to the New Zealand health care system but have relevance in England also, according to clinicians in that country.

### Medications
Before they are generally available for free prescription by secondary care services in New Zealand, medications have to be approved by Pharmac, a central funding authority. DHBs can opt to fund them themselves. This matter arose a few years ago when a new medication appeared that had not been approved. After examining their long-term client register, the DHB concerned found that there were no more than five clients who might benefit from the new medication. They were able to cost and approve themselves and did not need to lobby the central body.

Since that time, Pharmac has approved the medication concerned, but the matter could recur with newly introduced medications. This is an example of a general finding from the KPP experience: that the numbers of people in need for change under any of the needs explored is usually few and the task of catering for them, manageable and affordable.

The second aspect of medication is the number of clients on routine depot injections. Although there has been a programme promoting the newer medications, its impact can only be assessed with data for the total client group. In the sample DHBs, the range of clients on standard depot medication varies from 9% to 38%.

In Bristol, England, the clinicians were pleased to learn how many of their clients regularly take their medications: the received wisdom is that these were people unlikely to do so.

### Primary care
The other matter of attention is the number of long-term clients who use GPs. In New Zealand, there is a co-payment system that is thought to deter clients from accessing primary care services. The evidence is that the majority of clients do have, and use, GPs and many also say they are on good terms with their GP. In any case, there are funding methods for overcoming the co-payment trap. DHBs can now assess exactly how many of their clients they need to make these arrangements for. Once again, it routinely turns out to be small numbers of people and is an achievable task.

In this instance, comparable information is available for three of the sample DHBs, and the number of long-term clients is 538. The range is 81% to 93% of clients with a GP, and 36% to 80% who are said to have a good, supportive relationship with their GP.

Although GP services are free in England, it is nevertheless important to know that clients are registered and have access to a family doctor.

## 4. Social support

*Housing*

When the old hospitals closed, there was a sudden exodus of large numbers to the community. Finding appropriate homes for them was a major challenge. With stable numbers of clients in the community, housing no longer appears to be the problem it once was. However, for some individual clients at a stage in their lives, finding accommodation can be difficult. The point is that the scale of the problem is small and there is no apparent need for a major increase in the provision of supported accommodation.

In the New Zealand analyses, there are always a few clients seeking better accommodation, but they are in sufficiently small numbers so as to make this achievable. The English experience is similar.

Here is the analysis for one DHB with 252 long-term clients.

| | |
|---|---|
| 34 clients | Level 4 (24hr staffed) |
| 11 clients | Level 3 (staffed hostel) |
| 202 clients | Independent (64 with home help) |
| 5 clients | Data missing |
| 19 clients | Seeking change |

Only 18% of the clients are in staffed hostel accommodation. The majority either rent, or in some cases own, their homes. 25% receive domestic support. The need for hostel accommodation appears to be decreasing, with clients preferring to have their own accommodation.

*Occupation*

This is the area of greatest unmet need. The percentage of clients with no recorded daytime activity or employment across the sample DHBs ranges from 38% to 72%. It is interesting to note that the DHB with the lowest percentage of clients with no occupation has the highest percentage, 30%, with either full or part-time paid employment.

As with all the preceding analyses, the result is an indicator to show where attention should be given to make improvement. Clients and clinicians say that the best indicator of recovery is for a person to be in regular paid employment where possible. This should be the goal. Individual caseworkers need support to help their clients achieve this, especially when the expertise to find jobs is in another agency.

From interview information, there appears to be an acceptance among many caseworkers that people with enduring mental illness are unlikely to find employment. Job agencies are said to be equally pessimistic. The picture can change, however, when these agencies and prospective employers, know they have back-up from CMHTs for a finite number of long-term clients looking for jobs.

The difference in the number of long-term clients in employment between DHBs is worth examining to find out what makes it possible in some but not others.

### Leisure

One DHB added a column to the spreadsheet to record the number of social outings per week for clients to throw light on the extent of social isolation. This is to be included in future revisions of the standard sheet available.

## Value of the spreadsheet

The spreadsheet was intended as part of a planning system. Clinicians are developing it as a useful *aide memoire* for caseworkers and team leaders to show that the basic building blocks for recovery are in place: a care plan aimed at recovery, appropriate medication, relationship with a GP, a home, a job, social company and a relapse prevention plan to avoid unnecessary hospitalisation and prompt access to assistance should it be needed after discharge from the CMHT.

Clinicians say that the aggregated information assists them gain a balanced view of their work and that without it, their concerns over a few challenging problems can easily cast misleading gloom over all their work.

# 5. RESULTS: WHAT CLIENTS NEED FROM THE SYSTEM

**Abstract:** *Long-term clients seek a consistency from their local service, which they say they seldom experience. This is because three or four teams comprise a comprehensive local service. The most frequent contact is with the CMHT, but this is usually a 40-hour a week service. At other times, needs are met by crisis and acute services that have a different approach other than that offered by the CMHT. It is a practical possibility, however, to improve cooperation to achieve greater consistency of approach.*

## Service system requirements

Information on the remaining six of the Ten Key Features is derived from both the spreadsheet and caseworker interviews. Meetings with client and family representatives also throw light on just how effectively services are working.

The interviews enable caseworkers to contribute to the planning process by saying what they find easy and difficult to provide for their clients and their experience of how effectively the local service components are working together. Talking about the work is also an opportunity to assess training needs.

## 1. Focus on recovery

Although everyone claims to subscribe to the Recovery Approach, this is not always borne out by evidence from caseworker interviews. There is often low expectation that clients can learn to manage a crisis, hold a job or take good care of themselves.

On the other hand, there are caseworkers and CMHTs who go to considerable lengths to find alternatives to hospitalisation, who do find jobs and GPs for clients. Regular evaluation of service performance can demonstrate caseworker training needs and what to look for when recruiting them.

## 2. Guaranteed access and recognition

Clients, their families, and caseworkers speak of difficulties and delays experienced in getting back into service after discharge or accessing different parts of the local service even when they are in care. Because of the nature of their illness, a principal need is prompt attention at the onset of a crisis to avert it deepening. They talk of crisis teams which will not accept the call for help from a family member, and of multiple assessments to qualify for attention. They also speak of delays in re-engaging with the CMHTs after discharge from the acute unit when their confidence after recovery from an acute episode is at its most frail. Clients say that in having to join queues and having to qualify for admission to services makes them feel like 'cases', and not the people in long-term contact who are known to all the staff. To lessen these problems, clients are reluctant to be discharged in the first place – and clinicians are reluctant to discharge them.

Some local services overcome these difficulties by recognising the problem, having the will to find a remedy, and making simple organisational arrangements to achieve it and keeping an account to ensure the arrangements work effectively.

## 3. Accountability

Good co-ordination, at both team management and service management levels, is essential for effective performance.

On occasion, however, there are team leaders who do not seem to be aware of the caseloads of individual team members. Sometimes, there are service managers and clinical directors who only seem to become engaged in service performance at times of crisis.  On such occasions, meetings may be held to develop new co-operative procedures, but these are not always followed through to see that they work as intended.

Service management has tended to focus on resource acquisition and management: an emphasis on process and not performance.

When "performance" is measured, it is measured in terms of counting activity and inputs, or occasionally outputs. Results for clients, or even the quality of the outputs, are hardly ever measured.

It is long-term clients who suffer most from this lack of accountability and the fragmentation of services. Ensuring the effective co-ordination of the elements of service is where the management contribution is most needed.  Yet it would appear that nothing particularly complicated is called for.  For example, even in the largest DHBs, acute unit discharges average only two or three a day, it would seem easy enough to check there is good communication between the Unit and CMHT by requiring team leaders to jointly sign off thereby confirming that there has been consultation on every discharge for a period.

## 4. Co-ordination of health and social needs

There has long been recognition that recovery depends upon a successful combination of health and social factors. There is a need for the CMHT to be a 'one-stop shop' that attends to both aspects. This is a particular matter in some parts of the South Island of New Zealand where health and social needs are separately assessed by staff working

independently of each other. It is a practice based on models used in the disability fields. Usually, staff overcome this by working closely together, but not always. It may not assist client recovery (the treatment objective) if social needs are assessed on the basis of disability entitlement, which may foster dependency.

The professional training of caseworkers may include very little on meeting social needs and in interviews, some caseworkers express concern at the time they spend on this when their interest is the clinical side.

## 5. Contact come what may

All the CMHTs we have worked with practice assertive outreach. If clients do not turn up for appointments the staff go out to find them and to engage with them. There are a few specialist assertive outreach teams but, for the majority of DHBs, this work appears to be best done when the outreach workers are embedded in the CMHT. They can then accept and return clients to their colleagues as client need indicates, rather than have to make a referral with all that entails. It is also the experience in many rural English districts that a separate assertive outreach team is not required.

In the services we have examined, the number of clients who self-discharge is negligible; they usually turn up somewhere else and contact is made between services in the new and former locations. At grass roots level there is good communication and nobody seems to get lost, though this may be a feature of a small country like New Zealand. There is little evident need to increase assertive outreach services.

## 6. Service evaluation and planning

The whole thrust of KPP is to provide information for action.

Information is gathered about current clients, in order to identify effective aspects of the work as well as to find ways to improve outcomes for them that can be measured by changes for known people.

For so long planning has been associated with bidding for new resources, devising new services and facilities, writing and considering reports. The result is that these old habits are hard to break.

KPP calls for the critical evaluation of the way local services respond to client need and, for this reason, it is far trickier territory. Everyone locally can join forces in the bid for more funds from the distant Ministry: it is a far different matter when it comes to a critical examination of local performance. The encouraging news is that some are willing to make the change and are making progress.

KPP planning reports are short, five sides of A4 paper are usually enough. Questions to ask may include:

● Should so many clients still be on depot injections?

● What can be done to reduce the numbers admitted three times or more?

● Is it appropriate for respite care to be provided in the acute unit?

- What can we do to help the 18 clients find the courses and jobs that they want?

The plan should record success and examples include:

- 30% of the clients are in full or part time employment;
- Three of the four most challenging clients have remained in their current accommodation for six months, which is a record;
- Clients now have confidence in their relapse prevention plans, which has allowed 15 of them to be discharged and to get on with their lives.

Such achievements are worth celebrating: something that is rarely done.

# 6. CURRENT CONCLUSIONS

## The effects of KPP

In its short life, KPP is having a variety of effects, which need to be put in context through a brief reminder of the process. Three major components emerge:

● Definition of a service product. The Ten Key Features define the needs of people with serious and recurring mental illnesses. They also define what recovery-based casework is designed to provide.

● Small numbers. Recognition that a small number of people with such conditions call upon the support of secondary care services for long periods of time or at occasional times of crisis.

● A practical method to assess the performance and quality of recovery-based casework

## KPP and quality improvement

Needs-based planning has always been regarded as the ideal, but it is an ideal that is unobtainable to many, because of the high cost of the expertise required.

The most significant change which KPP has made is the development of a needs-based planning method that is practical, because it entails little or no cost and only a small time commitment from clinicians. The data can be compiled and analysed by grassroots professionals to achieve better results for their clients.

In using the method we have come to realise that KPP is more than a 'client-needs' assessment tool. It is also a method that allows teams to monitor their own performance. With it, they can keep score of their work and the results for their clients. KPP enables them to give an account of themselves and also to assess the quality of what they do, rather than having to rely only upon external accreditation, certification or performance statistics.

In the early days of KPP a common grumble by CMHTs was that, although planning should be needs-based, nobody 'higher up' would take any notice. By using KPP, CMHTs have found that, with the evidence from their clients' experience, the team is empowered and

can make significant and measurable change, whether or not notice is taken elsewhere. They can also give an account of their performance.

Leadership for the use of KPP best comes when all levels of management and clinical staff are in agreement. This is an ideal but not a necessary condition, for staff at junior levels of their organisation lead a number of the KPP developments that we are engaged in.

KPP is a measure of service effectiveness and efficiency. It is an educative process in itself and there is still much to learn and develop from its use.

## No major lack of resources

The gaps in resource (including staff numbers) which we thought would result in shopping lists of things to buy for clients' unmet needs have not eventuated. The gaps our inquiries have revealed are small, manageable and affordable. This is a major change in thinking.

These are gaps that good casework can fill, such as finding a sympathetic GP. There are also gaps which better cooperation of the teams that provide a comprehensive local service will solve for example, discharge from the acute unit without CMHT consultation.

From the very first inquiry (into the service in Westport on the West Coast of New Zealand's South Island) and all those since, we have discovered a common problem, that when services fall short, it is not through lack of resources so much as poor organisation and cooperation, especially, not having all the elements working to a common purpose for clients.

The remedies for this do not call for major service reorganisation, but practical step-by-step improvement.

There are two major unmet needs that frequently occur:

● lack of prevention relapse plans to anticipate crises and give better alternatives to acute hospital admission,

● lack of occupation and especially jobs for those seeking employment.

## Some changes

There are some more tangible indications of KPP's impact.

### Reduced use of acute beds

Unpublished Information from the NZ Ministry of Health (June 2005) on bed day use by long-term clients between 2002/03 and 2004/05, shows that in the three DHBs using KPP over a period of three years, there has been an average reduction of 51%. In eight DHBs using KPP for a shorter period, the average reduction is 10%. In the 10 DHBs with no KPP process there has been an average increase of 20%.

### The possible benefits of effective relapse prevention plans

There appears to be some evidence that those DHBs with more clients who have relapse prevention plans, also have both fewer hospital admissions and more long-term clients in paid employment.

There is no proof that these changes have been caused by KPP, but the indications are that the use of KPP does seem to have an effect. At this stage no greater claim can be made, but in the course of the next few years, the considerable body of research data being collected will be published.

## Some challenges

### How is recovery registered?

Our assumption that 'long-term' contact is an indicator of 'high needs' has not been supported by the evidence. There are considerable numbers of clients who are kept in contact with secondary care for other reasons than their high needs. This raises the question: who should be in contact with secondary care and for how long?

'Recovery' is now the watchword, but what does it mean? How and when do I register recovery? When it happens, what are the changes for me? Is long-term care in the community a necessity or should the aim be for it to come to an end empowering me to get on with an ordinary life?

It is difficult to have confidence in one's recovery if it means being under constant surveillance rather than knowing that, should assistance be required at any time, it is readily accessible. Discharge alone, without that guarantee, is not a solution, because this can lead to the old concept of the 'revolving door patient'.

Discharge should be the aim, but discharge when basic needs are met and that includes a plan enabling clients to get prompt and reliable assistance should acute symptoms recur. This would give timescale to care plans. What purpose is served by a plan that only contains targets and not estimations of time for their achievement and an achievable end?

The benefits of the Recovery Approach could also be supported by measuring the numbers of long-term clients discharged'.

### A challenge to think more about the roles of those engaged in the work

In the course of our inquiries we work with staff at all levels: caseworkers, team leaders and service managers. There seems to be no agreed work requirements at any of these levels. People we think do their job well are not always held in regard by the system. There are excellent people at all levels, but they come and go by chance and there seem to be only broad notions about how the jobs should best be done.

Perhaps the need is for greater definition of the work and some specific training for it.

## Is care in the community a failure?

We return to this question posed at the beginning of this report. In 1999, when the project began, we expected to find serious service weaknesses.

We have not. From all the evidence we have gathered, mental health services in New Zealand, and those we have looked at in England, do a good job. The next time we meet anyone who has not a good word to say about mental health services, we will correct that

mistaken impression. Although there have been criticisms throughout this report they are suggestions for improvement and are not fundamental condemnations.

For services to remain good and make improvement, they must adapt just as the environment in which they operate changes. They always need to review the work they do to find where change is required. In KPP they have a practical means of doing this.

## Coda

In that seminal work, *'Effectiveness and Efficiency'*, Archie Cochrane writes:

"Having chosen two indices, 'Effectiveness' and 'Efficiency'… I soon discovered they were applicable to a part of the NHS. I see the NHS, rather crudely, as supplying on the one hand therapy, and on the other; board and lodging and tender, loving, care. My two indices are very relevant to the former, but only to a limited extent to the latter."

In 1971, when he wrote those words, the mental health service was part of the care side of the NHS. It still is. We hope that KPP does something to extend Cochrane's concepts and inspiration into mental health services, thereby enabling the people who work in and use them to show what they do well and how they can do better.