



Te Kaitātake Oranga
MentalHealth
COMMISSION

November

2010

Mental Health and Addiction Funding

Mechanisms to Support Recovery

Acknowledgements

LECG appreciates and would like to acknowledge the valuable contributions from survey and interview participants, and from its key contacts.

Prepared for the Mental Health Commission by LECG

November 2010
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PO Box 12479, Thorndon, Wellington 6144, New Zealand

ISBN 978-0-478-29206-0

This document is available on the Mental Health Commission's website:
www.mhc.govt.nz



Commissioner's Foreword

One of the functions of the Mental Health Commission as listed in the Mental Health Commission Amendment Act 2007 is to monitor and report to the Minister of Health on the implementation of the national mental health strategy.¹ Key to the implementation of the strategy are the funding mechanisms for services. This report reviews DHB funding of mental health and addiction services in meeting the challenges set out in *Te Tāhuhu*.

The Commission is aware that the National Health Board is helping to facilitate DHB regional service planning and funding. This report does not directly address regionalisation although many of the principles and practices described are relevant.

The report presents case studies of innovative funding initiatives. There are other examples not included in this report, and the Commission is always interested in hearing from providers about innovative ways to fund and deliver services effectively and efficiently. This report is focused on mental health but we believe that the principles also apply to addiction services. This information is intended to be a resource for people working in the development of policy, and planning and funding related to the provision of mental health and addiction services within New Zealand. It will also be of interest to service providers, service users and families who are interested in innovative approaches to the provision of services. We have made the assumption that the reader will be familiar with the terms and language.

The survey described in this report indicated that there is minimal funding allocated to online therapy services and to providing service users with budgets to buy services. We believe both are options to be considered. When the Commission wrote the *Blueprint*² 12 years ago, online therapy options were not available so were not included, respondents said this now causes restrictions. Such restrictions are part of the reason the Commission is collaborating with the Ministry of Health on revising the *Blueprint* to develop the Mental Health and Addiction Service Development Plan.

There is ambivalence in this report around the ring fence for mental health and addiction funding. The Commission is of the view that the ring fence is important and without it mental health and addiction services would struggle to compete for funding. However, we are also keen to see flexibility, in particular to support the development of primary mental health care.

Finally we support the vision in the *New Horizons* publication (see Appendix 1) that physical health and mental health are regarded on an equal footing. We hope this report is useful and we welcome feedback info@mhc.govt.nz.

Ray Watson
Acting Chair Commissioner

¹ The current mental health strategy is *Te Tāhuhu – Improving Mental Health 2001-2015: The second New Zealand mental health and addiction plan*. Published in 2005 by the Ministry of Health.

² Mental Health Commission, 1998. *Blueprint for Mental Health Services in New Zealand: How things need to be*. Wellington: Mental Health Commission.

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Executive Summary

*Te Tāhuhu*³ challenges the mental health and addiction sector to “develop and implement funding mechanisms for mental health and addiction that support recovery, advance best practice and enable collaboration”.

This report describes current funding mechanisms at a district health board (DHB) level, looks at some of the theoretical and real problems that led to the challenge in *Te Tāhuhu*, and identifies case studies of innovative funding arrangements that can be used to provide examples to others in the sector.

A survey was sent to mental health funding and planning portfolio managers, covering 26 DHBs and shared services agencies, and 21 responded.

Respondents identified the following barriers to achieving ‘new funding mechanisms to support recovery’:

- conservative/risk-averse culture
- ring fence (siloeed funding)/patch protection/system doesn’t encourage shared funding
- focus on inputs or outputs rather than measuring outcomes/effectiveness
- need for unbundling of current resources/contracts locked/rigidity of system
- lack of sustainability/fragmented services/small providers/poor service capability.

Funders identified a set of current innovative approaches to funding mental health services in their agencies, including: devolution of clinical services to NGOs (non-government organisations); having needs assessments and service co-ordination sit inside planning and funding services; collaborative initiatives; peer-led initiatives; and flexi funding/packages of care approaches.

Survey responses reflected a mixed set of views among funders, with some supporting the continuation of the *Blueprint* and mental health ring fence, and others calling for a new paradigm that is more connected to recent developments in primary mental health and is more outcomes oriented.

It was noted that the interaction between the *Blueprint* and the DHB population-based funding formula (PBFF) created some unintended consequences. DHBs that are funded at 100% or more of the PBFF may be reluctant to receive additional mental health *Blueprint* funding, because it will reduce the amount of funding they receive for other services. The mental health ring fence also creates difficulties with deficit DHBs – which may decide that they should reduce spending on mental health services along with other services. Current rules forbid this, even if the DHBs spend more on mental health than the *Blueprint* advises.

Innovative funding mechanisms imply, and are usually designed to support, an innovative service delivery programme. The two are linked, with innovative funding being one aspect of innovative programme design and delivery. Hence it is useful to

³ *Te Tāhuhu* is the second New Zealand mental health and addiction plan 2005-2015.

understand the practical service delivery implications of a funding arrangement, as well as its theoretical strengths or weaknesses.

The table below summarises the key *Te Tāhuhu*'s objectives, the problems addressed by each potential funding mechanism to address these, and the illustrative case studies described in this paper.

Table 1: Case studies and funding mechanisms that address *Te Tāhuhu* objectives

<i>Te Tāhuhu</i> objectives	Problems addressed	Potential funding mechanisms	Case studies
Promote seamless delivery	Fragmentation amongst providers Transaction costs Barriers to social inclusion	Incentivising collaboration between service providers Optimising number of NGOs Combining clinical and non-clinical services within a single provider Pooling funds across health and social sectors	CHAMP (Counties Manukau Health and Addictions Partnership)
Foster learning and evaluation/advance best practice	Scarcity of outcomes evaluation and data	Collect and benchmark service outcome data to monitor effectiveness (these can be used for quality improvement as well as potentially for funding services)	CLS (Community Living Services) benchmarking services – Counties Manukau
Enable providers to adapt the services they provide to better meet the needs of service users	Monocultural services	Unbundling of services out of DHBs – transfer services to providers with best capability to provide appropriate care	Devolution of clinical services to Māori providers – Hawke's Bay
	Lack of flexibility to meet individual (and fluctuating) needs	Flexible individual needs-based funding programmes	Flexible packages of care: Hawke's Bay Waitemata
Enable provider development	Low provider capacity, capability, critical mass issues	Pooling funds across health and social sectors – especially in relation to Māori providers	Tui Ora – Taranaki
Remove incentives that can keep service users tied to certain services	Funding tied to secondary mental health clinical services Service specification rigidity makes early intervention difficult	Primary mental health Brief interventions	Focus on primary mental health funding: South Canterbury Capital Primary Health Organisation ProCare

Some funders are clearly moving to more collaborative and flexible solutions within the current operating parameters. Innovations such as cluster agreements, consumer-run

services, 'whatever-it-takes' approaches, packages of care and 'friendly landlord' arrangements are becoming more common. However, evidence for effectiveness and outcomes is often lacking, resulting in funding being based on outputs, inputs and qualitative information, rather than evidence of effectiveness. There did not appear to be any funding arrangements where providers' payments were contingent in any way on achieving outcomes, or where contractual incentives for better outcomes existed.

DHBs and the Ministry of Health could consider:

- how the routine collection of needs assessment and outcome data might be used to inform mental health funding arrangements
- whether alliance-style contracts might be a way of binding providers to improve system efficiency and effectiveness collectively.

The case studies cannot in themselves provide proof that one way of delivering services is better than another. But they do serve to illustrate what is possible and to demonstrate the importance of continual innovation in improving service user outcomes and promoting the best use of resources. Innovative programmes require innovative and flexible funding arrangements to support them, and monitoring of outcomes to evaluate them.

1 Introduction

1.1 Purpose

New Zealand has a population of 4.3 million and, based on the New Zealand Mental Health Survey, 4.7% of people will experience severe mental health or addiction problems requiring district health board (DHB) and/or non-government organisation (NGO) services in any one year (Oakley-Browne et al, 2006). DHBs and the Ministry of Health combined spent \$1.2 billion in 2008/2009 on publicly funded mental health services.⁴ How effectively these funds are allocated is an important determinant of the quality and quantity of mental health services in New Zealand.

This report provides an overview of current funding mechanisms at a DHB level, looks at some of the theoretical and real-world problems that led to the challenge in *Te Tāhuhu* and identifies case studies of innovative funding arrangements that can be used as exemplars for others in the sector. Innovative funding mechanisms imply, and are usually designed to support, an innovative service delivery programme. As such it is useful to understand both the funding mechanism and the associated service delivery arrangements.

1.2 Structure of this report

The report is structured into six sections as follows:

- Section 1: Introduction – the purpose of the report and the method
- Section 2: The *Te Tāhuhu* challenge and its background
- Section 3: Responding to the challenge part 1: funder survey
- Section 4: Responding to the challenge part 2: case studies
- Section 5: Alternative funding models – reviewing alternative funding models, looking at other possibilities not well explored in New Zealand
- Section 6: Concluding remarks.

The appendix provides a brief summary of recent directions in mental health funding in England and Scotland.

1.3 Method

Survey

An electronic survey was sent to all 26 identified funders, including all 21 DHBs and three shared services agencies (SSAs) in May 2010. The purpose of the survey was to obtain a general understanding of current funding mechanisms at a DHB level by gathering information on:

⁴ Information received from Ministry of Health, 2010.

- how decisions are made about funding allocation within the budget for mental health and addiction services
- alignment with *Te Tāhuhu*
- innovative funding approaches
- funder views on the usefulness of the mental health funding ring fence
- funder views on the usefulness of the mental health *Blueprint*.

The survey results are summarised in Section 3.

Case identification

Case studies of innovative recovery-oriented funding mechanisms were identified through key sector informants. The case studies aim to illustrate the possibilities for funding arrangements that meet the *Te Tāhuhu* challenge.

The case studies identified are:

- **Counties Manukau Mental Health and Addictions Partnership (CHAMP)** – as an example of incentivising collaboration between service providers
- **Flexi funds (Hawke’s Bay)** and **packages of care (Waitemata)** – as examples of needs-based individual funding
- **Tui Ora Māori development organisation (Taranaki)** – as an example of pooling funds across health and social sectors
- **Community Living Services (CLS) benchmarking services (Counties Manukau)** – as an example of collecting and benchmarking service outcome data to monitor effectiveness
- **Devolution of clinical services to Māori providers (Hawke’s Bay)** – as an example of combining clinical and non-clinical services within the same provider
- **Funding upstream (South Canterbury), Primary Solutions (Capital Primary Health Organisation) and ProCare (Auckland, Waitemata and Counties Manukau)** – as examples of focusing on primary mental health and early and brief intervention funding.

Case study data gathering

In each of the selected case studies, the lead funders and planners were interviewed to obtain an overview of the programme and a funder view of the rationale for the innovation, and the underpinning principles. Relevant providers and service user groups were interviewed to obtain their perspectives on the particular initiatives.

The interview questions included the following key themes:

- the target population
- underlying principles
- funding
- what value funders felt they were getting for their funding

- what worked well about the programme
- what did not work well about the programme
- what sorts of barrier were encountered when implementing the initiatives
- what sorts of barrier were currently encountered
- their views on the sustainability of the programme
- whether there had been any evaluation/monitoring
- whether there had been identifiable differences in outcomes since the initiative started
- how providers would like to see funding allocations for mental health and addiction services look in an 'ideal world' without existing constraints.

The survey and the interviews were complemented by a brief review of international directions in mental health funding. These are summarised in the appendix.

Limitations

The information provided by survey and case study respondents has not been independently verified. In some cases different respondents had divergent views about the same programme. There has been an attempt to reflect the divergent views where known, but the veracity of any information supplied cannot be guaranteed.

2 The *Te Tāhuhu* Challenge

Te Tāhuhu, the second national mental health and addictions plan, set out in 2005 10 challenges for the mental health sector. The *Te Tāhuhu* challenge, ‘funding mechanisms for recovery’, is set out in Figure 1 below.

Figure 1: *Te Tāhuhu*: funding mechanisms for recovery

Develop and implement funding mechanisms for mental health and addiction that support recovery, advance best practice and enable collaboration.

With immediate emphasis on establishing funding models, contracting processes and service frameworks that:

foster learning and evaluation

promote the seamless delivery of services between providers and across boundaries

remove incentives that can keep some service users tied to certain services and enable providers to adapt the services they provide to better meet the needs of service users

enable the development of provider capability.

Te Tāhuhu explicitly recognises that funding mechanisms are instrumental in shaping mental health and addiction services. *Te Tāhuhu* goes on to state that:

“Innovative and pioneering funding mechanisms will be needed, within the life of this plan, to balance demands and shift the basis upon which services are funded to better enable seamless delivery of services for people” (Minister of Health 2005, p.16).

2.1 Background to the challenge

The idea of funding mechanisms that support recovery and the accompanying call for innovation are best understood within the historical context of mental health services in New Zealand. This section provides a very truncated summary of the relevant trends of the past 50 years.

Out of hospital

From the mid-20th century, the availability of antipsychotic drugs, together with changes in views of mental illness and compulsory treatment legislation, led to the deinstitutionalisation of most of the large psychiatric hospitals in New Zealand and throughout the Western world. In the 1960s psychiatric institutions encompassed some 10,000 beds in New Zealand – most of which have now been closed (Brunton, 2003).

But not part of the community

Community-based services require much more complex sets of relationships between service users, social service providers, communities and clinical services than institutional approaches to care. People have argued that some mental health staff retain ‘institutional’ attitudes and that this, together with lack of support and community attitudes, has resulted in many people with serious mental illness living in the community but not participating fully in community life.

Vulnerable to funding cuts

A further issue has been the vulnerability of spending on mental health services, and the ease with which health funders and providers have been able to reduce spending on community mental health services. Highly visible service failures led to a number of reviews that called for increases in the provision of mental health services in the 1980s and early 1990s.

First national mental health plan, *Blueprint* and ring fence

Looking Forward: Strategic directions for the mental health services (Ministry of Health, 1994), the *National Mental Health Strategy* (1994), *Moving Forward: The national mental health plan for more and better services* (Ministry of Health, 1997) and the *Blueprint for Mental Health Services in New Zealand* (Mental Health Commission, 1998) can be seen as responses to these issues – forcing a focus on mental health services for those with serious mental illness, driving higher community-based service expectations and providing funding increases to enable them. The *Blueprint* estimated the needed resources based mainly on an input (full-time equivalents [FTEs] and beds) perspective. At the same time the mental health ring fence rules in the DHB Operational Policy Framework (OPF) forced DHBs to spend mental health funding only on mental health services, effectively creating a Vote: mental health by proxy.

The rise of the NGO

As additional community-based funding became available, New Zealand's funder–provider split led to increased interest in the NGO provision of community-based services. NGOs were often able to provide services at a lower cost, and were seen as more flexible, better connected to communities and more likely to take a holistic approach to recovery rather than a clinical approach (Platform, 2010). NGO spending has increased from under 3% of spending in 1990 to over 30% of current total mental health spending. The rise of NGO services created more options but also increased service fragmentation, required additional monitoring and made it difficult to hold any one entity responsible for service outcomes.

Primary mental health

Government funding for community mental health services has been focused until recently on the severe end of the spectrum, although mild to moderate mental health disorders are more prevalent. A MaGPIe Research Group study (2003) found that surveyed general practitioners (GPs) often identified mental disorders (half of their patients have been diagnosed with some type of mental health disorder in the past year). Out of these, 2% were considered to have severe illness, 9% moderate and 11% mild. In 2005, the Ministry of Health dedicated funding to primary mental health care through piloting 26 initiatives across 41 primary health organisations (PHOs), targeting mild to moderate mental health and substance misuse disorders. The pilots were aimed at increasing patients' access to talking therapies and other psychosocial interventions. The evaluation suggested the outcomes of these initiatives were very positive and the programme has now been rolled out to all of the 80 PHOs. This is a step forward; however, the proportion of funding spent on primary mental health is still relatively small compared with that on other areas.

2.2 The DHB role

DHBs are responsible for providing, or funding the provision of, health and disability services in their districts. There were 21⁵ DHBs established in New Zealand in January 2001. Contracting of mental health and addiction services is mainly done through the planning and funding arms of DHBs, although the Ministry of Health retains some residual funding responsibilities for national programmes, and PHOs are also emerging as important funding bodies for mental health services.

DHBs are required by their Crown Funding Agreements to operate within the OPF for DHBs, which contains a set of requirements approved by Cabinet or the Minister of Health. Important provisions in the OPF about mental health include:

- DHBs are required to give effect to the mental health ring fence provisions in their planning documents
- DHBs are required to use the Nationwide Service Framework (NSF), including:
 - service specifications published on the NSF Library website
 - common service agreement forms and documentation
 - established business rules, such as wash-ups, inter-district protocols and risk management
 - existing monitoring processes
 - Sector Services (formerly known as HealthPAC)
 - Common Counting Group and Costing Group Standards.

The national service specifications use a predominantly input-based approach to purchasing mental health services, with most community-based services purchased on the basis of FTEs and most residential and inpatient services purchased on the basis of available or used 'beds'.

A national price book is available, which DHBs must use for inter-DHB charging (except by mutual agreement), but which is optional for local funding decisions.

⁵ On 1 May 2010, Otago DHB and Southland DHB merged into Southern DHB, so there are now 20 DHBs.

Figure 2: Common DHB funding flows

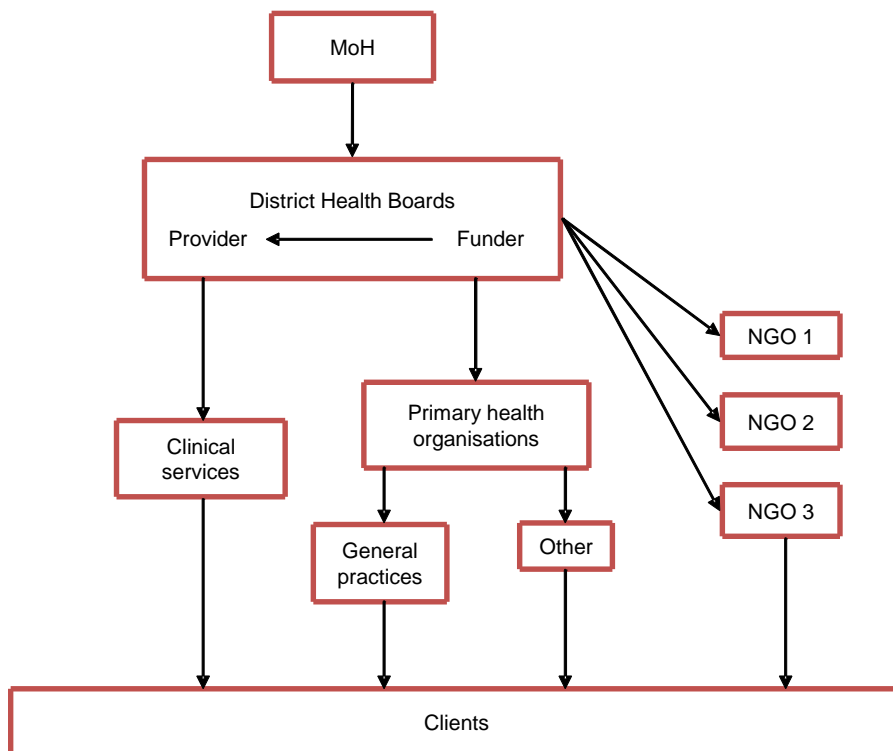


Figure 2 shows the usual arrangement for funding flows in DHBs in New Zealand. DHBs usually contract with their provider arms for specialist clinical services, including community mental health teams and acute inpatient units, with PHOs for primary mental health services and with NGOs for a range of community-based recovery services. Iwi providers often provide a range of both NGO and primary care services.

2.3 Issues arising from the current model

A recent review by Platform (2009) of the NGO–DHB contracting environment revealed the following significant issues in the current environment from an NGO perspective:

- the blurring of DHB funder and provider roles creates a conflict of interest, with funding influenced by provider arm interests rather than the evidence of outcomes and best practice service delivery
- relationships between funders and community organisations are not always mutually respectful
- RFPs (Requests for Proposals) are routinely used to allocate new funds, but create considerable compliance costs for NGOs
- the multiplicity of reporting to the Programme for the Integration of Mental Health Data (PRIMHD), to HealthPAC and to individual DHBs creates high compliance costs for NGOs
- monitoring and evaluation could usefully be consolidated for larger providers that hold a number of contracts across various DHBs – for instance, by the identification

of expert auditors, and a system for sharing the audit results with all of the DHBs and the Ministry of Health.

The overall picture painted by respondents in a Platform survey is one of an environment with inconsistent application of purchasing models, and models that are not conducive to sustainable service delivery.

The 2010 Platform report also notes that “the highly prescriptive nature (of contracts) and rigid purchase models have inhibited innovation”.

Platform suggests that:

- contracts need to be less prescriptive and more flexible, allowing services to focus on current needs and be innovative rather than constrained by detailed specifications
- there needs to be greater use of packages of care as a method of contracting, and outcomes reporting
- longer-term contracts (eg, five years) would reduce administrative impact and create a better strategic environment for planning, innovation and growth
- there may be advantages to regional planning and funding as the locality model has created silos, strained DHB funder arm capacity by duplicating functions 21 times, and resulted in funding decisions that are not always transparent.

2.4 Theoretical context: principal–agent theory

From an economics perspective, contract design is about overcoming issues in the principal–agent relationship.⁶

In this case, the principals (DHBs) wish to contract with agents (mental health service providers) to provide services (mental health care and referral to other services) to their enrolled populations. Because the principals (DHBs) are reliant on the agents (providers) to make decisions on their behalf, they want to ensure that the agents’ decisions are aligned with their own. Delegating decision-making to agents becomes problematic when two conditions exist between the parties:

- there are incongruent objectives
- asymmetries of information exist (Mannion and Davies, 2008).

Asymmetries of information exist where the principal is not able to observe perfectly the actions of the agent.

⁶ In the health sector context there are also insurance issues to consider, including problems of cream skimming, adverse selection and moral hazard.

Incongruent objectives mean that without monitoring, the agent would potentially take decisions that do not best achieve the principal's objective. For instance, the agent might decide to accept only referrals of clients with relatively low levels of need into a residential programme, whereas the principal would prefer that only those patients meeting certain higher need criteria were accepted. Agents are incentivised to do this because the fee for service (eg, per bed day) is the same regardless of client need, and the cost of not accepting a referral is borne by someone else (eg, the acute unit provider or the client).⁷

If asymmetric information problems can be overcome, then in theory, monitoring alone may be used to ensure the agent behaves in the interests of the principal. As this is usually not possible, the challenge for the principal is to design the contractual relationship between the principal and agent in such a way as to incentivise the agent to act on its behalf. Incentives may be financial and/or non-financial, eg, reputation, autonomy, ability to provide a wider range of services for one's clients.

In the New Zealand mental health context a chain of principal-agent relationships exists: the Ministry is an agent for the Government, the DHBs are agents for the Ministry/government, and contracted providers are the agents for the DHBs. Restrictions are placed on flexibility by the principals (eg, requirement to use the NSF) because the agent is not necessarily trusted to have congruent objectives and the principal does not have perfect access to information.

Internal DHB funding arrangements

The majority of mental health services are provided by DHB provider arm services, under an internal funder-provider agreement. The problems of disparate objectives or asymmetrical information do not usually apply to the internal funder-provider relationship. However, the relatively weak internal accountability and performance incentives can create another set of problems in that:

- DHB provider arms may receive funding for services 'as of right' and not have incentives to innovate or find more efficient delivery options
- mental health funding may be used to prop up inefficient provider arm services to ensure the DHB deficit as a whole is reduced.

A further issue is that the multiplicity of providers in the DHB environment creates transaction costs for service users, funders and providers, as each must understand the complexities of the overall set of services available and who provides what, and where.

⁷ There may be disincentives to a provider 'cream skimming' because this practice may lead to poor reputation and a lack of credibility in the funder's eyes.

3 Responding to the Challenge

Part 1: Funder Survey Results

A survey was sent to 37 mental health funding and planning portfolio managers, covering 26 DHBs and SSAs. From these, 21 responses were received – this represents an 81% response rate from the identified funding agencies – although not all responded to every question. This section provides a summary of the replies received – giving an overview of funder perspectives on mental health funding.

3.1 Allocating funds

Table 2 shows responses to the question: how does your funding agency allocate mental health funds?

Table 2: Funding allocation methods

Allocation methods	Proportion of funder responses			
	Almost never used	Sometimes used	Used most of the time	Nearly always used
Use of evidence of effectiveness to reprioritise services and allocate funds	11%	37%	37%	16%
Rollover of historical contract with minor adjustments	21%	32%	47%	0%
Purchasing services from service user-run organisations	21%	63%	11%	5%
Purchasing of clinical services from alternative providers, such as primary care, NGOs and iwi	26%	53%	21%	0%
Contestable purchasing of residential and support services	26%	53%	16%	5%
Funding packages of care for individuals	26%	53%	21%	0%
Mechanisms to combine different funding streams for a more holistic approach (eg, mental health and social services)	26%	68%	5%	0%
Contracting with lead/umbrella organisation to co-ordinate services across organisations	42%	42%	11%	5%
System outcome gain/risk sharing with providers (eg, for acute bed days)	47%	37%	16%	0%
Capitated funding approach	47%	42%	5%	5%
Giving service users or their agents real or nominal budgets to buy services	68%	21%	5%	5%
Funding online therapy services	68%	21%	11%	0%

Key points

The following approaches come through as often used:

- rollover of historical contracts with minor adjustments

- evidence of effectiveness to reprioritise services and allocate funds.

The following approaches come through as seldom used:

- giving service users or their agents real or nominal budgets to buy services
- funding online therapy services.
- system outcome gain/risk sharing with providers (eg, acute bed days)
- a capitated funding approach.

Many respondents ticked ‘sometimes used’ for most categories – making it more difficult to interpret these responses.

3.2 Barriers to achieving Te Tāhuhu

Funders were asked:

“One of the 10 directions in Te Tāhuhu is ‘new funding mechanisms to support recovery’. What do you see as the barriers to achieving this?”

Responses included the following themes:

- conservative/risk averse culture (six respondents)

“There needs to be confidence that if a flexible funding approach is adopted, that the outcomes are better than under traditional models, and will warrant the work it takes to set them up”
- ring fence (siloes funding)/patch protection/system doesn’t encourage shared funding (five respondents)

“Patch protection that leads to silos and duplication – some providers are more interested in the growth of their own organisation than in development of an integrated, cohesive system that can flex to meet the needs of consumers”
- focus on inputs or outputs rather than measuring outcomes/effectiveness (four respondents)

“The difficulty is determining effectiveness measures for contracts in order to get an idea, beyond numbers of people attending or utilising a service, if the service is doing what it should be”
- need to unbundle current resources/contracts locked/rigidity of system (three respondents)

“Unbundling the current resources: once the money is spent it is very difficult to make changes. We just seem to work around the edges”
- lack of sustainability/fragmented/small providers/service capability (five respondents)

“Sustainability – there are too many small, fragile providers. As a DHB we value the service/function provided by these organisations but cannot continue contracting with potentially unsustainable organisations. We require financial statements/accounts as part of contract review and are actively supporting organisations to merge.”

Other items mentioned as barriers were the economic environment, issues with the interface between primary and secondary care, and Blueprint requirements.

3.3 Innovative funding arrangements

Funders were asked to:

“describe the most innovative approach to funding mental health services in your agency”.

Themes that emerged from the responses received are summarised below along with respondent quotes.

- Devolution of clinical services to NGOs/community providers (two respondents)
“In October 2008 kaupapa Māori clinical mental health and addiction services (23 FTEs at approximately \$2.1 million) were transferred to management of two NGO services. There is joint clinical governance.”
- Having NASC (needs assessment and service co-ordination) sit within planning and funding/single point of entry to services/cluster agreements between provider divisions and NGOs with regard to delivery services (three respondents)
“The most innovative approach to funding mental health services is having a NASC service that sits within Planning & Funding and is the single point of entry to support services. They also provide business cases for high and complex service users.”
“In May last year we introduced cluster agreements between the provider division and NGOs with regard to the delivery of child and youth services. These agreements see a group of providers in a geographical area working together through one point of entry and shared clinical governance to provide child and youth mental health services.”
- Joint arrangements for providing care in the community/collaborative initiatives (two respondents)
“We introduced cluster agreements between [the] provider division and NGOs ... a group of providers in a geographical area work together through one point of entry and [there is] shared clinical governance.”
- Flexibility in approach to utilising budget/allowing NGO providers to move resources around to best meet needs/flexi funding (five respondents)
“We have services that have personalised approaches with people, allowing for flexibility; using flexi funding to purchase any specific services/items that will enhance personal recovery.”
- Peer-led initiatives (two respondents)
“We have purchased services by a peer organisation for wellness training of various types, to be delivered by peers and have increased our peer workforce in the NGO and DHB settings.”
- Performance-based contracts/introduction of targets and performance indicators/ assessing impact of NGO services on acute inpatient services/data repository and benchmarking outcomes (two respondents)
“For these services, the development of a data collection repository for the purpose of benchmarking the outcomes between services has been very useful.”

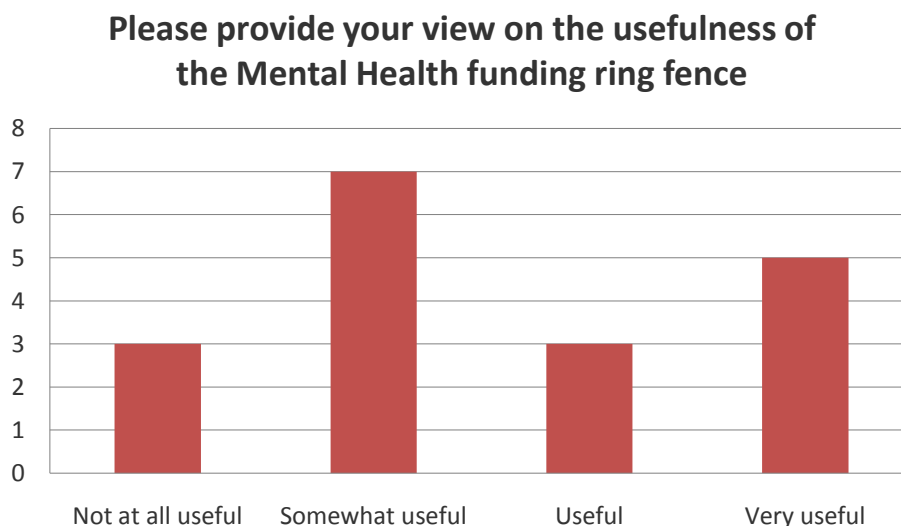
- Identify and fund whatever it takes to support recovery (two respondents)

“Friendly Landlord’ is a small fund of \$108,000 per annum to support low-cost housing options and has resulted in private landlords renting to people with long-term mental health issues. It supports 30–40 people per year. The people (who are) supported change as they become independent and live in the community with less support.”

3.4 Mental health funding ring fence

Funders were asked to rate the usefulness of the mental health funding ring fence.

Figure 3: Views on the mental health funding ring fence



Respondents were divided on the continuing usefulness of the mental health ring fence. One common view was that the ring fence has protected mental health funding and led to a progressive increase in services.

“I think it is useful because it is dedicated for the use of mental health – not other services within an organisation. It can be tracked and reported on. The ring fence allows mental health and addiction services to continue to develop up to expected levels. If it is removed before those levels are reached, they will probably not be reached.”

“I think it’s been a really useful tool to ‘encourage’ the development of mental health and addiction services over the past years. On the other hand, it has also led to some complacency among providers and can protect poorer quality providers in so far as exiting a contract as a result of poor outcomes goes. The DHB provider arm is probably one of the biggest offenders of this!”

“We have seen a significant amount of service gains being achieved and particularly one-off workforce development initiatives from reinvestment of the underspent dollars. As the health dollar is becoming tighter – each mental health and addiction service is being asked to carry vacancies ... (This) reduces the level of service that is available to clients and family. The interpretation of the ring fence is being eroded by creative accounting. It is my belief that the ring fence should remain and that rather than look at the rats and mice dollars a more in-depth review should be

undertaken to reduce the number of DHBs and duplication of back room support roles, particularly in the smaller DHBs who have little population increase.”

“Even more so in this economic environment it protects expenditure for mental health and addictions. If the ring fence goes, it is likely that specialist mental health expenditure will reduce. Not so bad if it’s reinvested in primary mental health.”

A common reservation is that it directs funds away from early intervention:

“With a greater emphasis on primary care and flexible approaches to care it can act as a barrier to funding following the needs of clients.”

“The ring fence protects funds for people with the most severe need but it can be difficult to utilise it to move towards those with less acute needs, an early intervention approach.”

“The ring fence is about utilising funding for secondary mental health – we have taken the approach that prevention and early intervention reduces the number of people needing to access secondary services. The ongoing wellness of mental health clients is greatly supported by having access to appropriate primary health services and mental health services [and] are [a] part of the provision of health services.”

A view often cited is that the ring fence has been of some value in past years but that this has reduced in recent times.

“The world has moved on since the introduction of the ring fence and the Blueprint has become dated and not kept up to date with the paradigm changes, for example, the developments in primary care, etc.”

“Several years ago ring fence funding was a way of ensuring mental health and addiction funds did not get siphoned off to provide other non-mental health and addiction services. I believe that these days it’s not as important, as a more integrated ‘whole of health’ approach should be taken of which mental health and addiction is one part only. This approach is more holistic and in the long term better. However, there is the danger that mental health and addiction funding could slip under the radar and be given less importance than, eg, more visual and emotive things like cancer treatment, or cardiac surgery. Therefore there are important caveats to making any moves to change the ring fence process.”

Others had broader organisational concerns:

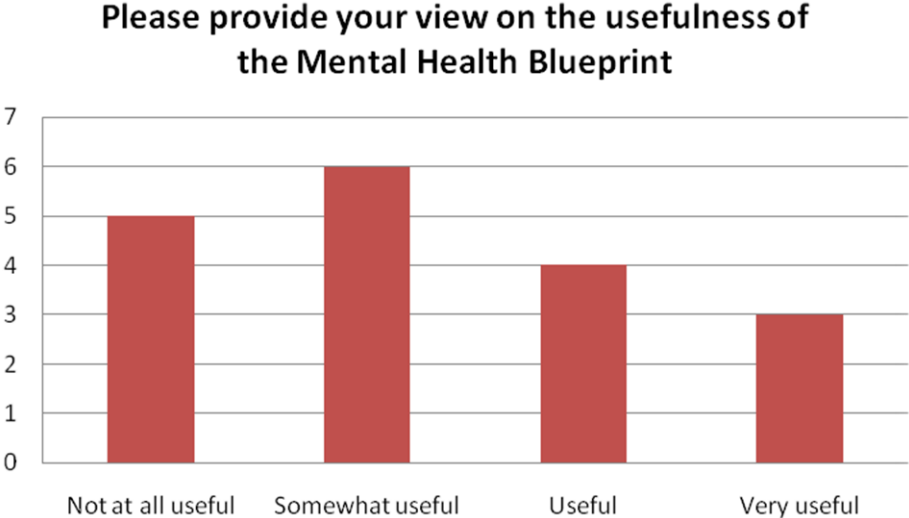
“If a ring fence is to be continued there must be a level of leeway (ie, within 5% of ring fence total before carry forward requirements are applied).”

“(The ring fence) is a barrier as ... it does perpetuate a funding silo and approach to meeting peoples’ needs. Impacts to the detriment of the wider organisation in financial terms...”

3.5 The *Blueprint*

Funders were asked to rate the usefulness of the *Blueprint*.

Figure 4: Views on the *Blueprint*



Funders were split on the usefulness of the *Blueprint*, although many respondents considered that the *Blueprint* was valuable because it set specific standards and expectations about capacity in mental health:

“It is useful because it gives us capacity to build or deliver new services and fill gaps as they are identified.”

“The Blueprint was a useful document in that it set standards for what could be expected for services for those with the highest needs for mental health and addiction services. A review is helpful at this point to articulate what is still a priority but also to ‘join up’ services – secondary through to primary.”

“The Blueprint served an excellent purpose for the time of development that mental health services were at. It now seems to be time to take a fresh approach and for it to look at the models of care that are developing now.”

“It has been a great mechanism to improve overall staffing numbers and develop services.”

“This is an extremely good process to ensure regular funds are received to increase services to meet the necessary health targets – Blueprint targets.”

Others considered that the *Blueprint* has had its day and should be reviewed or replaced:

“The integration of services to primary health will require a very open approach; how specialist services work, what their roles and workloads will be, should in theory change considerably. The Blueprint, while we are still reporting on access rates only to secondary services, and linking this to levels of service provision, etc, will need to be reviewed fairly promptly.”

“With new innovative and different recovery focused services it is necessary that these Blueprint targets are reviewed and updated to meet current changing needs.”

“Needs review based on current issues, eg, methamphetamine.”

“In its day the Blueprint was a very useful document that provided sound benchmarking for service development and delivery. The document is now dated, as demand for different services have evolved, and the principles of population-based funding has changed how needs are viewed.”

“My DHB is not that keen on the Blueprint because of implications on out years funding”.

“Blueprint information has been somewhat useful in acting as a base for benchmarking however this is reasonably limited and aspects of this are now so dated it is possibly no longer useful. If this is to be updated careful consideration should be given in relation to how this can be applied by DHBs for benchmarking purposes and the manner in which services are allocated to different groupings.”

“It carves up funding too much, used for lobbying only, doesn’t demonstrate effectiveness, performance etc; range of services limited – ie, no online services; creates expectations of specialty carve out – ie, maternal, eating disorders, etc.”

“The Blueprint was a useful tool when introduced to return focus and attention to mental health services for people with serious mental health conditions which was needed and appropriate in the late 1990s. However, a more holistic approach to health and changing environment mean that models of mental health services have evolved and the Blueprint has the risk of indicating either too much or too little funding is being allocated to secondary mental health services – more appropriately the model of recovery and the overall health services along with the outcomes for clients with mental health diagnosis should be considered.”

“The world has moved on since the introduction of the ring fence and Blueprint has become dated and not kept up to date with the paradigm changes for example the developments in Primary Care and National Service Framework.”

3.6 Survey summary

Some funders are clearly moving to more collaborative and flexible solutions within the current operating parameters. Innovations such as cluster agreements, consumer-run services, whatever-it-takes approaches, packages of care and ‘friendly landlord’ arrangements are becoming more common. However, evidence for effectiveness and outcomes is often lacking, resulting in funding often being based on outputs and inputs rather than evidence of effectiveness.

Survey responses reflected a mixed set of views among funders, with some supporting the continuation of the *Blueprint* and mental health ring fence, and others calling for a new paradigm that is more connected to recent developments in primary mental health and is more outcomes oriented.

More than one respondent noted that the interaction between the *Blueprint* and a DHB population-based funding formula (PBFF) created some unintended consequences. DHBs that are funded at 100% or more of PBFF may be reluctant to receive additional mental health *Blueprint* funding, because it will reduce the amount of funding they receive for other services.

The mental health ring fence also creates difficulties with deficit DHBs – which may decide that they should reduce spending on mental health services along with other

services. Current rules forbid this, even if the DHBs spend more on mental health than the *Blueprint* advises.

4 Responding to the Challenge

Part 2: Case Studies in Funding Innovations

4.1 What is innovation?

In this report, innovative funding mechanisms mean practices that, in response to constraints posed by the current system, present a different way of doing things, with the purpose of supporting recovery and using resources more efficiently.

Specific funding programmes are described, which illustrate recent innovations in funding practice and appear to have had positive outcomes. The exploratory nature of this investigation means that:

- this is not a comprehensive list of current funding innovations
- verifiable evidence of positive outcomes has not been sought.

Innovative funding mechanisms imply, and are usually designed to support, an innovative service delivery programme. The two are linked, with innovative funding being one aspect of innovative programme design and delivery. Hence it is useful to understand the practical service delivery implications of a funding arrangement, as well as its theoretical strengths or weaknesses.

Case studies have been grouped according to the funding mechanisms involved as:

- incentivising collaboration between providers
- flexible individual needs-based funding programmes
- pooling funds across health and social sectors
- collecting and benchmarking service outcomes data to monitor effectiveness
- combining clinical and non-clinical services within a single provider/unbundling DHB services
- focusing on primary mental health/early and brief intervention funding.

These mechanisms have in turn been linked with the objectives in *Te Tāhuhu*, as shown in Table 3.

Table 3: Case studies and funding mechanisms that address *Te Tāhuhu* objectives

Te Tāhuhu objectives	Problems addressed	Potential funding mechanisms	Case studies
Promote seamless delivery	Fragmentation amongst providers Transaction costs Barriers to social inclusion	Incentivising collaboration between service providers Optimising numbers of NGOs Combining clinical and non-clinical services within a single provider Pooling funds across health and social sectors	CHAMP (Counties Manukau Health and Addictions Partnership)
Foster learning and evaluation/advance best practice	Scarcity of outcomes evaluation and data	Collect and benchmark service outcome data to monitor effectiveness (these can be used for quality improvement as well as potentially for funding services)	CLS (Community Living Services) benchmarking services – Counties Manukau
Enable providers to adapt the services they provide to better meet the needs of service users	Monocultural services	Unbundling of services out of DHBs – transfer services to providers with best capability to provide appropriate care	Devolution of clinical services to Māori providers – Hawke's Bay
	Lack of flexibility to meet individual (and fluctuating) needs	Flexible individual needs-based funding programmes	Flexible packages of care: Hawke's Bay Waitemata
Enable provider development	Low provider capacity, capability, critical mass issues	Pooling funds across health and social sectors – especially in relation to Māori providers	Tui Ora – Taranaki
Remove incentives that can keep service users tied to certain services	Funding tied to secondary mental health clinical services Service specification rigidity makes early intervention difficult	Primary mental health Brief interventions	Focus on primary mental health funding: South Canterbury Capital PHO ProCare

4.2 Incentivising collaboration between service providers

Rationale

Service providers, even if they are not-for-profit entities, are effectively competing for service funding and other resources. This can lead to fragmentation and to sub-optimal levels of communication, liaison and information sharing. We describe below a case study of a funding mechanism intended to address these problems by incentivising collaboration between providers in the interests of service users.

We note that more than one DHB has sought to consolidate the number of NGOs through contestable purchasing (eg, Wairarapa, Tairāwhiti).

Case study 1: Counties Manukau Mental Health and Addictions Partnership

Overview

The Counties Manukau Health and Addictions Partnership (CHAMP) was established in 2003 to represent all providers in Counties Manukau in partnership with the DHB, as a collective of organisations with interests centred on the provision of mental health and addiction services to the district. It was intended to encourage NGOs to work collaboratively.

In order to do this, Counties Manukau DHB (CMDHB) allocated one-off seed funding to providers with the aim of incentivising collaboration in establishing initiatives that would support efficiencies, improve services and enhance consumer outcomes. The pool of funding is allocated to specific initiatives by the collective based on what it views as priorities, with input from the DHB. Although it was initially intended to be one-off seed funding, the DHB is considering making it a permanent feature, based on the perceived success of the initiative.

Examples of specific initiatives that have been funded through CHAMP include:

- the Infrastructure and Procurement Group (InPro) – a work group that seeks efficiencies through shared purchasing and the provision of operational support services
- the Interim Housing Initiative for Community Living Services – a pilot study involving the provision of temporary accommodation for people exiting hospital-based services
- the Innovation Awards – a celebration of innovation and excellence in mental health and addiction services.

The CHAMP partnership is open to all providers that contract with CMDHB to deliver mental health and addiction services within the Counties Manukau district (including both NGOs and the CMDHB provider arm). There are currently 14 organisations represented in the partnership.

The membership has developed a Collaborative Agreement and Terms of Reference. Participation in the partnership is based on a non-legal and non-binding agreement to collaborate.

Underlying principles and rationale

The collaboration aims to:

- promote more co-ordinated, effective and efficient delivery of mental health services
- promote collaborative work between providers in the best interests of service users
- improve the interface between the DHB, NGOs and the wider community
- consider whole/across-system issues, such as welfare, disability and clinical NGO activity that affect and impact on service user outcomes
- share intelligence to ensure responsiveness to community need

- manage the resources and funding allocated to specific agreed activities
- promote innovative practices.

Overcoming barriers to implementation

Informants noted that the barriers to implementation included the need to build trust and to take difficult funding allocation decisions. They indicated that the following helped to break through these barriers:

- formal structures and careful planning
- taking time to build trust
- seed funding/investment
- strong leadership
- strong service user involvement and voice
- having a clear rationale for action.

Participant views

Key informants interviewed stated that they strongly supported the CHAMP initiative and that:

- there is a feeling of commitment to working together and sharing based on trusting relationships that have been built over the years under CHAMP
- if funding from CHAMP ceased, there is a risk that NGOs would return to operating in independent silos and in a fragmented way. This is because they still operate in a competitive funding environment and having an extra resource available can be an incentive to keep some engaged

Members of CHAMP are in the process of determining alternative sources of funding through grants and other funding, such as government funding for workforce development. “I believe the collaborative will get stronger if our infrastructure and operational framework is solid (we continue to work on that and have formalised it via our work plan). We have the view that we must actively seek alternative funding sources and be very mindful of how we utilise our current resource. Like all other enterprises the shape of the collaborative would undoubtedly change should funding be no longer available” (provider respondent).

Evaluation

A formal evaluation of this initiative is being planned.

Alignment with *Te Tāhuhu*

The CHAMP initiative aims to promote the *Te Tāhuhu* objective for seamless delivery of services.

Comment

Clear strengths of the CHAMP initiative are the commitment to collaborative endeavour that has been built up between the parties, and the ability to gain a systems view of the mental health sector.

This could be strengthened in future through a more formal alliance-type contract approach (see Section 5).

A potential weakness is the risk that the forum would become a high-transaction, time-intensive exercise with a focus on process rather than outcomes. However, interviews with participants indicated that they do not see the initiative in that light at present.

4.3 Needs-based individual funding

Rationale

Flexible packages of care are responsive support interventions tailored to meet an individual's need for a period of time. They are an example of enabling providers to adapt their services to meet the needs of specific service users. They can also be considered an example of needs-based funding or of an ad hoc type of case-mix-adjusted funding.

Flexible use of DHB funds means that service providers can:

- supply a one-off mix of services required by a particular client or client cohort
- combine funding from a number of distinct output groups to deliver a responsive or integrated service for clients
- roll up funding attached to related activities within an output group to deliver a responsive or integrated service for a particular client group.

Two case studies of flexible packages of care funding illustrate how the arrangements work: one in Hawke's Bay and one in Waitemata. A number of other DHBs have partial or full packages of care programmes.

Case study 2: Flexi funds (Hawke's Bay)

Overview

The Hawke's Bay DHB (HBDHB) packages of care programme was brought in as a response to claims that more flexibility was needed in services.

The initiative began in 2006 when Whatever-it-Takes (WIT), a peer-led service, approached the DHB for support in providing personalised care to a particular individual. The DHB offered to fund one staff member for five hours a week. This initiative was successful, and the pilot of funding packages of care was extended to cover a few high-needs service users then to more individuals residing in psychiatric units and in residential services. Contracts were then developed with other service providers. WIT remains a significant provider.

At the time this report was commissioned, there were 195 clients supported through flexi funding. The current funding for flexi services, including packages of care, is around \$1.3 million per annum and contracts are reviewed every three years.

Access is based on a needs assessment. A package of care is developed by the HBDHB NASC in conjunction with the provider and the service user.

The NASC maintains a spreadsheet database that is used to track and authorise all packages of care. This allows the DHB to run monthly reports and pinpoint areas where services are being provided, who the lead providers are, the average number of support hours that are being utilised, etc. It is not currently linked to any other regional or national database.

Packages of care are a combination of bulk funding through FTEs and some flexible funding. Funding for the programme comes mainly from the Ministry of Health PBFF, but there is also a memorandum of understanding with the Ministry of Social Development to provide subsidies for housing. This allows people to live in places that they could not have otherwise afforded.

Monthly meetings are held with NASC, Mental Health and Addiction Services, Disability Support and Aged Care. Joint funding arrangements and assignments of responsibility for achieving the set targets are all agreed in these meetings.

Other than packages of care, flexi funding has also allowed the piloting and implementation of the 'friendly landlord' scheme, independent living skills and a medication run scheme.

Underlying principles and rationale

- Increase flexibility and allow funding to follow the individual.

"When resources are planned according to client need, integration into the community is sped up, which translates into more effective recovery for the individual as well as potential savings from less utilisation of acute services. The difference in utilisation of services and savings can be seen as early as six to 12 months."

- Provide seamless movement for a person through the continuum of care available throughout the services.
- Prevent providers from working in isolation.
- Foster innovation.

Overcoming barriers to implementation

Respondents noted the following barriers to implementation:

- smaller organisations that do not have the necessary infrastructure in place have a hard time exploring innovative services
- clinical resistance presents a barrier to innovation

- discrimination and community resistance are barriers to providing care in the community.

Providers also pointed out that a difficulty in implementing packages of care in the initial stages is that employing staff according to flexible needs can sometimes be challenging – since they may have no certainty of employment. This can be overcome in part by having a larger volume of packages and a mix of permanent and casual staff.

Respondents indicated that providers need more support in getting new projects started. A provider suggestion was a business development unit that could be attached to NGOs.

Participant views

Respondents noted that:

“The change in funding approaches is aligned not only with Te Tāhuhu principles but also with the current economic environment, as it emphasises the need not for more, but for better services.”

“A lot of this is evolutionary, sometimes revolutionary, but mostly common sense.”

“When too much importance is placed on where funding comes from, this may become a barrier for the care of the client. The starting point for funding should be needs-based and funding is planned around that, so that funding may come from mental health, housing, social services, and wherever necessary.”

Evaluation

The flexible packages of care approach is regularly evaluated internally by WIT. Overall, Hawke’s Bay has had a significant decrease in inpatient bed usage, as noted by the DHB.

The premise for the ‘friendly landlord’ scheme was that good, stable accommodation would improve health outcomes. An internal evaluation by WIT that compared inpatient bed nights among consumers prior to and one year after joining the scheme found there was a reduction from 800 bed nights to 321 bed nights per year.

Alignment with Te Tāhuhu

The service is aligned with the *Te Tāhuhu* objective:

- Enable providers to adapt the services they provide to better meet the needs of service users.

The service also removes incentives that can keep service users tied to certain services.

Comment

Hawke's Bay was one of New Zealand's leaders in developing packages of care tailored to individual service users' needs. This shift in direction has driven significant changes in the way services are delivered.

There is room for debate about whether the needs assessment should sit within the providers (NGOs) or within the funders (DHBs). If DHBs devolved needs assessments to NGOs, there would be a more seamless delivery of care, yet accountability to service users would perhaps be hindered.

Case study 3: Waitemata – packages of care

Overview

The packages of care service was set up in Waitemata in 2002/2003 to provide intensive support (and if necessary accommodation) for mental health service users with high and complex psychiatric needs. Services and support needs were to be directed at those for whom existing services had not proven sufficient and who might normally remain in a hospital setting if such services were not available.

The funding available for packages of care was \$235,000 across seven providers in 2009/2010. Flexi funds attached to the other services provided under contract included:

- home-based treatments: \$20,000
- family, whānau support agreements: \$63,000
- kaupapa Māori day programmes \$30,000.

The funded amounts will change slightly in the near future.

The general requirements of the packages are outlined in broad terms in the contracts but are not prescriptive. Each provider is given flexibility to tailor a package of care to their client's unique needs and each interprets the guidelines differently. This lack of clarity in the current system is due to the fact there has never been a particular formula for allocating flexi funding and it is therefore not particularly equitable across providers. The current system involves 'clawing back' or retrieving unspent funds at the end of each month, which is time consuming and leads to some perverse incentives (ie, spending funds on low-value services).

As a result, Waitemata is currently developing an allocation and administration system that will allow the process to become more consistent and more equitable as it will be based on utilisation of services. The new funding approach will use a formula to allocate a set amount of funding to FTEs working under the flexi funding programme.

The new funding approach will also take into account an extensive list of services to be funded on a fee-for-service basis. Funding for items outside the list will require specific funder agreement.

Underlying principles and rationale

- Quality improvement by providing enough flexibility to enable innovation and risk taking.
- Improving service user outcomes.
- Decreasing utilisation of inpatient services, reduced length of stay and decreasing use of respite services.

Overcoming barriers to implementation

A barrier identified during the packages of care initiative is the need for clinical services as well as NGOs to view recovery as more than just the provision of mental health services.

“Getting providers to think beyond the traditional responses can be difficult; there is some risk aversion on the providers’ part, because they want to do a good job.”

There tend to be concerns around allocating set amounts of funding to providers, which provides more flexibility but potentially less accountability. However, Waitemata DHB notes that based on experience thus far, providers’ flexi fund budgets are rarely exceeded; what is left over is returned to the DHB and is then reallocated.

“Providers ultimately want to deliver a successful service and are therefore eager to monitor themselves, in some cases more closely than the DHB would monitor them.”

It is difficult to obtain clinicians’ buy-in initially, as there tend to be concerns around the effectiveness of packages. This is becoming less of a difficulty as more evidence is collected around the country regarding positive outcomes of packages. Informants highlighted that co-operation from senior levels of management eases the change management process.

An issue that needs constant monitoring and communication is the clarity of the criteria regarding what flexi funding is being used for. It is intended to be non-recurring funding for things that cannot be accessed from other streams of funding. However, when there is lack of clarity and communication, it is sometimes the case that things are bought under flexi funding that could have been bought with mainstream funding. Waitemata is addressing this problem by developing the new allocation and administration system for funding.

Participant views

“System outcomes are not usually picked up in evaluations, but what we have picked up is that there has been less of a drive for more beds.”

“We need flexible responses to meet needs. The previous environment wasn’t responding to needs. It’s about thinking outside the square and supporting innovation.”

A key informant commented on barriers to entry to packages of care as being an area where there is room for improvement. Currently the only way into a package of care is

through a co-ordinator and if a client after a period of time of not requiring support from the packages of care suddenly needs it again, it may take some time to get them back into the programme. An initiative similar to south Canterbury's 'Green Card'⁸ may be useful in these cases in order to ensure continuity and seamless delivery of care.

A good example of the benefits of having flexibility in funding is the Care for Caregivers service:

"The flexi fund is an essential component, as often the families won't come if they don't have transport, babysitter, etc. The service provides support and education for families that care for people with mental health conditions. It goes hand in hand with packages of care, as it allows the families to support patients better and therefore to improve the health outcomes."

Evaluation

This programme was evaluated in April 2004 and is currently being re-evaluated.

Alignment with Te Tāhuhu

Waitemata's flexible packages of care aligns with the *Te Tāhuhu* objective:

- Enable providers to adapt the services they provide to better meet the needs of service users.

Comment

Flexi funds in Waitemata are an example of providers being able to adapt their services to meet the needs of specific clients and adapt services to changing needs.

The changes underway illustrate a general tension between flexibility and innovation on the one hand (linked to a desire to do whatever it takes) and concerns about probity, accountability and equitable treatment between individuals on the other. Waitemata appears to be seeking to codify flexi funding to a greater extent – making more types of support available automatically without requiring special agreement.

4.4 Pooling funds across health and social sectors

Rationale

Mental health outcomes are attributable to a wide range of influences outside health and disability services. People's access to welfare services, education, employment and affordable and sustainable housing has a direct impact on the quality of their recovery. The resources to achieve this lie with a number of national and local government sectors. Therefore a co-ordinated and integrated cross-sectoral approach to service delivery is an important part of addressing the broader human needs of consumers, and reducing inequalities.

⁸ The Green Card is described in section 4.7.

Many Māori organisations, in order to build critical mass in caring for their own whānau, seek to provide a range of health and social services. This not only enables a more seamless delivery of care, but also spreads corporate service overheads across a wider base and makes the services more sustainable.

The next case study describes a Māori umbrella entity that is funded to address a number of the *Te Tāhuhu* objectives, and has an intersectoral perspective.

Case study 4: Tui Ora Māori development organisation

Overview

Tui Ora was formally constituted as an entity in 1998. Tui Ora is a Māori development organisation that operates as a 'lead contractor' with a 'for Māori by Māori' focus on the specific needs of Māori in Taranaki. Since 1998 it has been an umbrella organisation for Māori health and social service providers, providing support in contract negotiations with funders and Māori workforce development. Along with developing best practice methods and monitoring Māori provider services, the primary objective of Tui Ora is to improve Māori health status in Taranaki through the provision of health and social services, as well as economic and health promotion programmes.

Tui Ora receives funding from the Accident Compensation Corporation (ACC), DHBs, the Ministry of Social Development, the Ministry of Health and Te Puni Kōkiri. Most funding is through the DHB or Ministry of Health directly. Funding is around \$8 million per annum. Services and programmes are delivered through a network of affiliated service providers, with each provider having strong linkages to the communities it serves.

Te Rau Pani, a pilot programme that started in 2002, is one affiliated service aimed at improving access to co-ordinated specialist kaupapa Māori mental health services. Soon after it was established, a further pilot was undertaken aimed at getting people who experience mental health difficulties back into the paid workforce. The DHB provider arm mental health services has a governance role and Te Rau Pani employs most of the staff, a multidisciplinary team consisting of a psychiatrist, social worker and management; nurses are employed by the DHB and seconded to Te Rau Pani. The idea is to bring specialist services into a kaupapa Māori community setting.

Tui Ora itself funds service by FTEs; the contracts work in the same way as contracts a DHB provider arm would have with its funder.

From the late 1990s to early 2000, Tui Ora rapidly expanded from working with eight to 26 providers. From 2000, the organisation started moving towards consolidating providers by clustering them into groups – *“not pressuring them, but rather encouraging collaboration”*. Focusing on the financial sustainability of individual providers and improving integration of services where duplication or overlap was identified achieved this. Around 2005/2006, the number of providers went from 26 to 13. Also during this period, turnover increased and the number of services was extended, despite there being fewer providers.

Tui Ora Trust is a 50% owner of Hauora Taranaki PHO in partnership with Taranaki Primary Health Provider Inc, a network of general practitioners. The partnership provides opportunities to improve access to services for Māori and high-need populations through the delivery of a wide range of health services and programmes. Direction has shifted towards services that improve the wellbeing of Taranaki Māori, rather than just focusing on illness services.

As part of the Better, Sooner, More Convenient Primary Care Strategy, and to get more resources to the front line, Tui Ora is considering further integration with wider primary care networks, and greater integration of the community services with primary care.

Underlying principles and rationale

The rationale behind Tui Ora is to take a more coherent Māori development approach across the sector, as well as looking at the broader determinants of health.

Tui Ora, like other Māori development organisations and Māori organisations, believes that linking health, housing, employment, education, justice and other social services together in an organised and well planned manner will achieve health and wellbeing for all people.

Overcoming barriers to implementation

Initial barriers to Tui Ora included difficulties in building credibility by demonstrating the ability to manage providers and monitor their performance; and gaining the funders' confidence in Tui Ora's ability to deliver. These were overcome by establishing a track record in delivery and focusing on quality.

Asking providers to collaborate, to give up some autonomy, to reallocate funding to other providers, or even to merge with other entities, requires strong leadership and delicate change management. An interviewee described the process as follows:

"In the initial stages of the innovation, every provider was asked to describe their focus. A number of workshops were carried out to determine what the true focus of each provider was. Providers were encouraged to focus on the services they were best equipped to provide rather than following the areas where they anticipated funds would be directed. This required strong leadership and compromise on the providers' part. It was an important process, as it facilitated decisions regarding funding allocation based on needs as well as geographical areas. Areas were divided geographically to ensure every community and particular populations were covered.

Thanks to the collaborative process of identifying each provider's exact services and needs, providers are able to identify themselves who is most appropriate to deliver the service and accordingly, where new funding should be allocated. When providers offer similar services, there is a consultation process where the options are discussed between Tui Ora management and the relevant providers and the solution is agreed through a clear negotiation process. Tui Ora also provides management support services for most providers (financial services, HR services, IT, etc).

Initially there was an internal RFP process, but with time it was agreed that tendering internally led to wasted resources and that internal competition was hard to manage.”

There are four key elements to Tui Ora’s success:

- good governance throughout the organisation (there were professional directors from the beginning of the initiative)
- investing resources into developing leaders, careful selection of them and not being afraid to address performance if necessary
- investing heavily in workforce development
- dedicated project management resources.

Participant views

Key informants interviewed noted:

“Something that has changed since Tui Ora’s inception is that there used to be a perception that we focused on contract and on compliance. That was not the intention, but it is how the approach came across to providers. In response to that, Tui Ora shifted the focus in 2005 to a strong client focus and emphasising the importance of relationships. A contractual component still remains, but the idea is to try to read the signs of problems as early as possible and work them out in collaboration with providers, encouraging change.”

“One of the reasons Tui Ora has continued to grow is that it continues to adapt to change and to use a quality model, reviewing functions when necessary and creating the structures around need.”

Evaluation

No formal evaluation has yet been conducted of this initiative.

Alignment with *Te Tāhuhu*

This initiative is aligned to the following *Te Tāhuhu* objectives:

- enable provider development
- promote seamless delivery of services.

Comment

Tui Ora is one example of funding via an umbrella organisation that:

- is closer to the actual delivery of services than a funder
- can monitor issues on a real-time basis
- develops provider competence
- provides shared corporate services
- avoids the fragmentation that occurs with many small providers.

A critical element in a funding mechanism such as this is ensuring that the umbrella entity truly adds value, and does not become another management layer or service overhead.

4.5 Collecting and benchmarking service outcomes data to monitor effectiveness

Health services are generally funded based on inputs (eg, FTEs) or outputs (eg, visits). Not often can outcomes be attributed solely and clearly to a single provider such as to enable funding to be based on the value generated to the consumer (ie, consumer outcomes). However, at least in theory, knowing the different outcomes between providers would allow a funder (and consumers) to make rational resource allocation decisions that improve value overall. Similarly, service providers obtaining poorer outcomes would be incentivised to make the necessary changes in service delivery or organisational culture to improve.

The following case study is an initiative to obtain and share benchmark data on outcomes.

Case study 5: Community Living Services benchmarking services (Counties Manukau)

Overview

Community Living Services (CLS) was established in 2004 as an innovative approach to community support provision. CLS aims to provide for more flexible models of care that will assist service users to achieve and maintain full and independent lives in the community. The service was jointly designed by NGOs and the DHB with the purpose of improving social inclusion for those with highest levels of need. Specifically CLS helps service users to move into housing of their choice, to increase their employment opportunities, to imagine better lives and to achieve this drawing on community resources. Evaluation subsequently showed that people using CLS had decreased utilisation of other mental health services such as inpatient services, residential rehabilitation and respite services.

In implementing this new service, CMDHB decided to ensure that there was sufficient information reported to: a) set up an opportunity for providers to use information in order to benchmark and improve their performance; and b) properly evaluate the impact of the service. This element of the programme is a significant point of difference; it is uncommon to find programmes that incorporate the standardised collection of outcome data or that support benchmarking activities.

In order to enable evaluation and benchmarking of CLS performance, CMDHB requires reporting of outcomes and activities by NHI (National Health Index) number. A database to link this information with the DHB's own information about service use was set up, which enables the DHB to generate reports to track performance and describe:

- who uses the services
- what services are received

- how long the services are used for
- the impacts on the use of other services, including acute services
- the housing and employment outcomes.

Each month providers receive reports to track their own performance, and every three months a benchmark report is produced with data from all providers and all teams. This serves to compare performance and share learning.

Underlying principles and rationale

- Enabling funders and providers to make rational resource-allocation decisions to improve service users' outcomes.
- Information sharing and quality improvement of services.
- Improving communication and collaboration between clinical teams and their NGO partners.
- Enabling the sharing of workload and encouraging clinical and CLS staff to view services as complementary.
- Illustrating principles of a strengths-based, recovery-oriented service.
- Decreasing utilisation of inpatient services and residential rehabilitation.

Overcoming barriers to implementation

The CLS benchmarking approach results in quantitative data only as good as the quality of monthly data supplied by providers to the DHB. In order to promote best practice in reporting outcomes, to support providers to share information openly and learn from one another, and to encourage the use of information to improve services, the funder agreed to an amnesty period during which benchmarking information would not be used for funding decisions but rather as an exercise for quality improvement practices.

Even though the single national data collection for mental health and addiction (PRIMHD) is active, it still has not compiled data to the same level of detail that CMDHB is currently collecting. Therefore the initiative is not seen as duplication.

Although reporting and evaluative practices such as these do increase workload for providers, ultimately people invest time in practices they consider to be of value, and the strong uptake and commitment to this benchmarking approach suggests that it is perceived by participating providers as being of value.

Evaluation

The first results of a quantitative analysis were reported to all CLS providers in March 2005. A second quantitative analysis covering service activity from January 2006 to December 2006 was combined with two qualitative surveys conducted by the CMDHB Research Evaluation and Audit team in Mental Health Services in October and November 2006.

The results of the evaluations were reported to show that CLS has to a large extent achieved its objectives in that providers are making a valuable and positive contribution to service users. This is illustrated by improved outcomes, including consumers moving into accommodation of their choice, learning skills to live independently, requiring less hospital-based mental health services, and having a better quality of life.

Participant views

Informants interviewed felt that evaluating all services is a sustainable practice as there is an increasing emphasis on evidence-based decision-making; it is expected the practice will become standard at some point. It also enables funders and providers to identify whether a service is sustainable at an early stage.

Alignment with *Te Tāhuhu*

The Counties Manukau CLS benchmarking service aligns with the *Te Tāhuhu* objectives to foster learning and evaluation and advance best practice.

Comment

Collecting robust data and evaluating services provide an excellent opportunity to advance best practice. The more widespread these efforts become, and the more they are shared, the more possible it will be to base funding on evidence and outcomes.

4.6 Combining clinical and non-clinical services within a single provider/unbundling DHB services

Rationale

Deciding who to buy services from is a key funder prerogative and an important element in optimising service outcomes. However, it is unusual for DHBs to purchase clinical services from NGOs.

In the following case study this has occurred recently, and the obvious barriers appear to have been successfully overcome.

Case study 6: Devolution of clinical services to Māori providers (Hawke's Bay)

Overview

In 2008, after an RFP process, HBDHB contracted for the provision of kaupapa Māori mental health and addiction services to be operated by Māori NGOs. Services to around 150 people with high needs are now provided by Te Taiwhenua o Heretaunga Trust and Te Whatuiapiti Trust. Te Taiwhenua provides adult mental health services and Te Whatuiapiti provides addiction services. The interests of the other Māori entities in the region are provided for through a joint governance group. Considerable support for the devolvement of kaupapa Māori services came from Ngāti Kahungunu, who had expressed its vision for kaupapa services to be in the community from its inception, and from the leadership of HBDHB.

Total funding for the services is around \$2.1 million. The initiative is funded on an FTE basis. NGO FTE rates in the contract were initially comparable with DHB rates, which made the transition easier for hired staff. A gap has since grown as national price increases have not been consistently passed on to the NGO provider, and staff are reportedly sometimes lost to the DHB owing to the higher wage rates of the DHB (which are paid at a higher FTE rate).

The psychiatrists employed by the NGOs are part of the HBDHB clinical team for clinical governance purposes (credentialling, Continuing Medical Education, quality review, etc) and take a turn on the acute roster.

The initiative is PRIMHD compliant, and the clinical information system is integrated with the DHB clinical information system – meaning that staff working in the NGO service are working from the same clinical record and electronic patient management system as the DHB provider arm, with each being able to access the other's files.

Underlying principles and rationale

The initiative was set up to deliver better health outcomes through increased accessibility, cultural governance and management. Objectives include:

- delivering services more effectively
- aligning resources to fit clients' needs
- observing the participation and partnership principles in the Treaty of Waitangi
- balancing the need to offer choice with providing high standards of care
- creating an environment where it is acceptable to move clinical services from the provider arm to NGOs.

Overcoming barriers to implementation

Barriers to the initiative included:

- resistance from the existing DHB clinical team
- the importance of not disturbing client relationships or jeopardising client recovery
- the risks of isolated clinical roles (especially psychiatrist)
- the impact on the DHB acute roster.

Respondents indicated the following were important success factors in overcoming these barriers:

- joint clinical governance – including secondment of an HBDHB psychiatrist to the NGO to cover the psychiatry role: this made the transition smoother
- selective recruitment of staff – only those staff who were suited to work in a kaupapa Māori community environment were offered roles in the new service
- the skill mix of the transition project team – which included a tangata whaiora consultant, clinical expertise, systems expertise and kaupapa Māori expertise
- time – shifting services out of the provider arm without upsetting clients took nine months

- establishing two lead providers to avoid fragmentation, but with collaboration from/relationships with smaller providers.

In terms of barriers to accessing community support services, one participant pointed out:

“The point of devolvement is to be more responsive with community; this can become more efficient if we have our own needs assessment co-ordinator. We need delegated authority to carry out assessments.”

Participant views

Participants commented that the move into an NGO brought to light considerable unmet needs.

“We need a kaupapa Māori child and youth service. At the moment we only have a mainstream service, but a lot of people see us as the mental health service and also bring the young people. We need a whānau approach.”

“The stigma and concerns about NGOs providing services out of the community were all put to rest once the services were devolved. The staff employed cannot believe the difference.”

“The initiative enabled us to build the workforce and assist other providers to deliver services to help with their capacity and capability.”

Evaluation

Te Taiwhenua has had internal performance reviews carried out. The service also completes HONOS (Health of the Nation Outcome Scales) assessments regularly and enters outcomes data into the mainstream database with the DHB. Anecdotally, respondents reported that there have been reduced inpatient admissions.

Te Whatuiapiti carries out internal evaluations and has recently commissioned an external evaluation by Kahui Tautoko. This evaluation was in the process of being finalised at the time of writing this report.

Alignment with *Te Tāhuhu*:

This initiative is aligned with the following *Te Tāhuhu* objectives:

- enable providers to adapt services they provide to better meet the needs of service users
- enable provider development
- promote seamless delivery of services
- remove incentives that can keep service users tied to certain services and enable providers to adapt the services they provide to better meet the needs of service users.

Comment

This case study illustrates how clinical services can be successfully devolved to NGOs. It is not a 'one size fits all' case, but it does highlight the value of providing flexibility and trying new configurations of service delivery in order to meet clients' needs in the most effective way. The arrangement for joint clinical governance with the DHB provider arm also provides a neat solution to the issues of professional isolation and critical mass in a small service.

The initiative provides a useful exemplar for by Māori for Māori services that span both clinical and non-clinical aspects of service delivery – hence providing the opportunity for a more coherent total package for consumers.

4.7 Focusing on primary mental health/early and brief intervention funding

Rationale

The first national mental health plan focused on the small percentage of people with serious mental illness. This together with the traditional reluctance to purchase clinical services other than from DHB provider arms has made it difficult to move services 'upstream' – to provide earlier and briefer interventions. However, more recently national primary mental health service developments have illustrated the potential success of primary-care-focused service delivery at an earlier stage.

Three brief examples of this approach are presented. Primary mental health service delivery has been described and evaluated more comprehensively by the Ministry of Health (www.primarymentalhealth.org.nz).

Case study 7: Funding upstream (south Canterbury)

Overview

South Canterbury District Health Board (SCDHB) serves about 55,000 people. SCDHB is interesting in that it has a funding gap in terms of meeting *Blueprint* guidelines on spending; it spent only 64% of its PBFF share last year. However, an internal needs assessment indicates the DHB has sufficient funding to meet all local needs, and outcomes indicate that services are being delivered effectively. In addition, waiting times for services are low. The Ministry of Health employed Australian consultants to undertake a review of mental health secondary services in south Canterbury. No significant concerns were raised by the review and the recommendations were implemented without increasing expenditure.

This case study explores how SCDHB manages its budget, spending less by focusing on primary care service delivery, and how this element fits within the overall approach to care.

Primary care model

In 2003/2004 SCDHB began developing and funding primary mental health services, including brief interventions and early interventions to avoid service users needing

secondary services (when the Ministry of Health later started funding primary mental health, SCDHB was initially ineligible for this funding as it was already funding the service).

The DHB decided to fund brief interventions for adults in primary care. These are limited to four sessions with extensions if justified. Brief interventions are delivered in general practice and were developed in collaboration with nurses and GPs. From brief interventions, clients are referred to a range of services, including secondary services, if necessary. Subsequently the DHB has funded brief interventions for adolescents provided by another mental health provider.

The rationale behind this model is not only to improve patient outcomes. Other advantages are that waiting lists for hospital care are bypassed, the service doesn't have the stigma sometimes attached to formal mental health providers and institutions, and accessibility is enhanced because the service is provided locally and people do not have to travel to larger institutions.

The programme works as follows: a person with mental health issues goes to their GP; the GP asks the person whether they would like to see brief intervention staff; the GP sends an electronic referral to South Link Health; and the GP is phoned back by a primary mental health clinician the next working day. South Link Health staff aim to meet the person face to face at the primary care centre. It is then decided whether it is the best agency or whether there are other organisations that would be better suited to treat the person.

The adult service receives an average of 90 referrals a month. It only employs registered health professionals with mental health backgrounds. The service is expected to provide services at every GP clinic weekly.

The service is funded per FTE, not per actual brief intervention. If more services are needed that cannot be provided by FTEs, the service user is supported in finding further services or applying for a disability benefit.

The service has been very successful and it won an innovation award in 2007. Because the service is well regarded and is increasingly known, GPs are finding that people ask about it, rather than the GP having to introduce the service to the person. Since the start of the initiative, staffing has increased from two to 4.6 FTEs to meet this increase in demand.

The SCDHB invests approximately \$1.6 million in primary mental health services, including addiction services (of which about \$300,000 comes directly from the Ministry of Health and is utilised to increase the existing services). Services are funded on a traditional FTE basis including:

- 4.8 FTEs for adult care (Health Link South) – brief interventions
- seven FTEs for child and adolescent (Adventure Development Trust) adventure therapy, mental health assessments, brief intervention services, and alcohol and other drug services for youth
- one FTE from Plunket – education and early intervention – postnatal depression

- one Māori non-clinical support worker – Māori health provider
- 1.6 Māori clinical workers – Māori health provider.

Broader context

The DHB has placed a considerable focus on determining need by using a Knowing the People Planning (KPP) process and strengths-based models. It has developed a range of individual packages of care for people who cannot be provided with appropriate care in any of the contracted settings and/or within current contracted services. Individual care planning is shared between all providers and forms the basis for service delivery.

Since 2003, the 'Green Card' has also been funded. With this initiative, any service user who is part of the KPP programme and who has a serious mental health diagnosis can immediately access secondary services without referral or delay; in effect it is a ticket to rapid re-entry into clinical services. Anecdotally the Green Card initiative has led to savings from reduced acute bed nights.

There is also a strong focus on interagency collaboration. All mental health agencies meet once a month. At the meeting all services are discussed and lessons are shared.

SCDHB psychiatrists have regular meetings with GPs and each has a relationship with a specific set of primary care practices.

SCDHB also funds flexible packages of care as a key component of the service.

Packages of care are based on the 'whatever it takes' model to regain independence and integrate into the community. The NASC co-ordinates service funding and delivery, on instruction from the service user's key worker.

Underlying principles and rationale

The service philosophy is:

- by way of prevention and early intervention to prevent service users needing secondary services, which are more complex and more expensive
- working with the strengths-based model and ensuring that all funded mental health services have all staff trained in the strengths-based recovery model and all providers are contracted to use the model; flexible funding based on needs
- co-ordinated care.

Barriers to implementation

Respondents noted that some GPs were initially concerned about the brief intervention programme:

"[They were] sceptical it would involve a lot of paperwork and were not confident it would actually work. With time they realised all they have to do is give the person's name and number and South Link Health gets notes electronically. Also because

South Link Health is based out of GPs' offices, BI [brief intervention] staff build a good relationship with GPs."

Another respondent noted that the fact that the DHB spends much less than the *Blueprint* guidelines has led to tension with the Ministry of Health:

"One of the Ministry of Health's key performance indicators is access to secondary services. In reality DHBs should be aiming at a reduction of the need to access secondary services."

Prior to the early 1990s, south Canterbury had no community mental health teams, only an acute inpatient unit and outpatient psychiatry services. As a result, the DHB had no historical precedents in relation to funding mechanisms as other DHBs had. This allowed for more flexibility in devising a south Canterbury-specific approach.

Strong clinical leadership facilitated the shift in focus to primary mental health away from secondary mental health.

Small scale has also apparently assisted in the transition – for instance all secondary services except child and adolescent services are based in the same building. This facilitates referrals and the speed with which services are accessed.

Participant views

SCDHB is small and there is a close relationship with the community, which facilitates access to services. But informants suggested that:

"There is no excuse for large DHBs not to do the same because it is a matter of working together and knowing who is doing what out there."

Clinical provider views:

"I've been doing it for five years and it hasn't burnt me out. It's challenging to entice people out of secondary service into primary services. Some people think work is boring or worry they have to take a pay cut, but when you are working in this environment, pay is not the main motivator. Workforce retention is not an issue."

"Feedback from GPs is that they don't refer as often to secondary services. They first refer to BIs. Those at significant risk are referred to secondary services (only about one referral a month)."

"Some of the providers in the community are considered to be providing secondary level services for clients."

Evaluation

There have been two audits by South Island Shared Service Agency Ltd of the brief intervention service, both of them with positive results. A full programme evaluation has not occurred.

Alignment with Te Tāhuhu

The SCDHB approach is aligned with many of the *Te Tāhuhu* objectives, including:

- remove incentives that can keep service users tied to certain services
- enable providers to adapt the services they provide to better meet the needs of service users
- promote seamless delivery
- advance best practice.

Comment

The SCDHB service is based on early intervention, the premise being that at least some clients can avoid a costly and disruptive level of specialist care through brief interventions. The brief intervention programme is only one element in an overall set of mental health services that appears to meet community needs at a lower cost than equivalent clinical services in other DHBs.

Case study 8: Primary Solutions (Capital PHO)

Overview

The Primary Solutions initiative covers Kapiti PHO, Porirua – Tumai mo te Iwi PHO, Wellington – Capital PHO, and To Be Heard in Wairarapa Community PHO. Compass Health submitted an original pilot proposal to the Ministry of Health in 2005, when the Ministry first made dedicated funding available for primary mental health care. This enabled 26 different primary mental health initiatives to be established across 41 PHOs. The initiatives were targeted at people with mild to moderate mental health and/or substance use disorders. A key aim of the initiatives was to increase patients' access to talking therapies and other psychosocial interventions.

Capital PHO's funding currently is around \$600,000 per annum, for an enrolled population of approximately 155,000. Under that budget the PHO with the support of Compass Health provides clinical co-ordinators in each PHO, mental health clinical leadership, non-clinical co-ordination and operating expenses. What remains of the budget after those initial expenses is then allocated to packages of care; this determines how many packages of care are available each year, taking into consideration referral rates, client need and the workloads of clinicians.

The programme is available for all Māori, Pacific and youth and those for whom finance is a barrier to accessing services.

Services that can be accessed through Primary Solutions are:

- full needs assessment
- extended GP consultations or nurse brief interventions
- referral to other services
- referral to psychological services
- service co-ordination
- packages of care (may include brief interventions or group counselling).

Providers claim back to the PHO for the services they have delivered. Bimonthly, the non-clinical co-ordinator makes a report to compare the funding committed with the services for which the providers have actually claimed. There is also a consultation/reconciliation process between the service user (how much more/less does the service user need) and the clinical co-ordinator. Strict criteria apply to the services that can be claimed for, however the PHO tries to provide flexibility. Capital PHO has begun to explore bulk funding of providers (eg, youth services based within secondary schools).

The mental health teams are co-located in each PHO locality team. This enables the co-ordinators to work with and have direct access to the wider PHO team, including health promotion, outreach nursing, diabetes nurse specialists, immunisation co-ordinator, etc. The management infrastructure across Compass Health also provides a direct relationship with clinical governance and quality control. The PHO outreach nursing team has direct linkages to many NGOs providing social services. This enables a collaborative multidisciplinary approach between the primary care team, the specialist mental health service within the PHO and wider PHO services, and direct linkages to the community.

Underlying principles and rationale

- Improve health outcomes for those with mild to moderate disorders.
- Remove barriers/improve access.
- Fund individualised packages of care.
- Carry out client-centred needs assessments.
- Provide an integrated model of care: PHO services, contracted providers.

Overcoming barriers to implementation

Capital PHO has a mental health advisory group that meets quarterly and monitors Primary Solutions (among other things) and looks at what else should be delivered. This serves for monitoring and improving quality, as well as enabling a sharing of knowledge and expertise. Reports go through the PHO and clinical quality boards, and mitigation papers are prepared in order to ensure any potential problems or barriers are being addressed promptly and appropriately.

As a result of budget constraints during the pilot phase of the programme, where all pilot programmes received the same amount of funding regardless of their size (funding is now population based), the PHO began building stronger links and enhancing collaboration with providers. The PHO has also co-ordinated a resource for practices so that everyone knows what services are available in the community, outside Primary Solutions.

Capital PHO has a steady and growing referral rate for youth and is exploring new service delivery options specifically for youth.

Participant views

The PHO expressed the view that:

“A potential improvement to the service model would be to change funding models for psychiatrists so they can support patients in a primary care setting and encourage more partnership.”

Regarding psychiatrists supporting patients in a primary care setting, the current FTE funding model does not constitute a barrier; barriers may be more related to historical precedents, culture, attitudes and training of psychiatrists.

It was also pointed out that:

“Currently outcomes are not compared. Realistically people who go through Primary Solutions would not have gone through secondary solutions, so it is difficult to tell if the initiative has reduced service utilisation. There is opportunity to look at outcomes reporting and potentially linking into community outcomes reporting, eg, youth service uptake and reduced incidence of violence.”

Participants noted the historical separation of reporting from migrant and refugee services from mainstream services reporting, and the increasing importance of keeping track of new populations using mental health services to inform funding decisions.

Participants also highlighted the importance of bridging the perceived divide between physical and mental health.

Evaluation

The Otago School of Medicine has completed a national evaluation of the programme. The PHO has been involved in this evaluation and responded to the recommendations from its report.

Alignment with *Te Tāhuhu*

Primary Solutions aligns with the *Te Tāhuhu* objectives to remove incentives that can keep service users tied to certain services, and to support best practice.

Comment

Focusing on primary care initially increases demand for services from the community. This means there is an immediate need to respond with more services and increased capacity. In the long term however, focusing on primary care may reduce the population's demand for mental health services through earlier, effective intervention.

Case study 9: ProCare (Auckland, Waitemata and Counties Manukau)

Overview

ProCare began developing a primary mental health programme in 2001. Limited funding from ProCare's pool of 'referred services' savings was made available to fund this programme, in particular to fund access to care for people who would otherwise be

unable to fund their own care. As new streams of funding came into primary care as a result of the primary care strategy, through PHOs, access to funded primary mental health care was gradually expanded, based on level of need and lack of ability to self-fund care.

The programme is currently funded through a number of separate funding streams:

- Ministry of Health 'Services to Improve Access' (SIA) funding (in the past three or four years) focused on improved access for population groups with identified poorer health status and lower levels of access to primary care
- Ministry of Health 'Primary Mental Health Innovations and Initiatives' funding – all three ProCare PHOs were successful in proposals submitted to access this funding. This funding stream has now been replaced by dedicated primary mental health funding
- Work and Income PATHS (Providing Access to Health Services) pilot funding
- ACC funding

Services include extended GP consultations, nurse phone support/follow-up, linkages to community health co-ordinators to address cultural and psychosocial issues, and packages of care including brief talking therapies (most often cognitive behavioural therapy).

There are currently more than 15,000 people accessing extended GP consultations, and 2,375 people annually who access packages of care, through ProCare.

ProCare data show that over the lifespan of the programme since 2001, the number of people accessing funded mental health consultations has increased significantly, but that ProCare GPs have considerably reduced the number of people they refer to specialist mental health services.

In this period, efforts have also been put into upskilling GPs and practice nurses on mental health issues, so that they are now able to deliver better support.

Underlying principles and rationale

- Applying evidence – evidence-based funding is a stepping stone to outcomes-based funding (both system outcomes and individual outcomes).
- Early recognition and intervention can only occur in primary care, and are key to improved population (mental) health.
- Evidence that having psychiatrists working in/with primary care teams increases the capacity of the primary care team, and can reduce referral rates to secondary mental health services – including by improving the ability of the GP to meet the person with mental health needs.
- Earlier intervention in a primary care setting will be more cost effective.

Overcoming barriers to implementation

Barriers identified by respondents included:

- attitudes – *“the bricks and mortar of the institutions are long gone, but specialist mental health services remain institutionalised in practice”*.

Participants acknowledged attitudes are slowly changing, partly as a result of increasing confidence in the primary care workforce, and partly as more positive outcomes become visible

- workforce skill base, in particular:

GPs/practice nurses – have historically been deskilled by lack of support from specialist services – this is slowly being addressed via the workforce development occurring through primary mental health programmes

mental health nurses – can become deskilled by spending too much time on generic ‘case management’. Those who are trained in value-added interventions (cognitive behaviour therapy, medication adherence interventions, etc) struggle to find the time to apply these skills.

Participant views

PHO-based programme informants expressed the strong view that primary care-based interventions of this type are much more cost effective than specialist mental health services. DHB-based informants were less convinced by the cost effectiveness arguments and stressed that the PHO primary care services were seeing individuals with much milder and less complex forms of mental illness, hence cost comparisons were not valid.

PHO participants also expressed a view that output- or case-based funding would be preferable to input-based funding.

“We should fund mental health services not by FTEs, but more aligned by how other health services are funded: by the number of cognitive behaviour therapies, certain number of psychiatric interventions, etc.”

“Having a population focus is necessary, segmenting services by need (episodic versus enduring).”

“Currently in most DHBs there is no functioning mechanism for shared cross-sector leadership, planning, prioritisation of new resources, and monitoring of service quality. When such approaches to sector-wide leadership and planning are attempted, often they too easily get bogged down in dynamics related to ‘who’s in control’, and/or ‘who’s getting the funding’.”

Evaluation

There have been some external evaluations carried out (funded by CMDHB). There has also been a primary mental health initiatives evaluation by the University of Otago School of Medicine.

The programme has ongoing measurement of performance indicator data, which is used in individual and service quality improvement, as well as for professional development.

Alignment with *Te Tāhuhu*

ProCare is aligned with *Te Tāhuhu's* principles to remove incentives that can keep service users tied to certain services, and to advance best practice and enable the development of provider capacity.

Comment

Easy access to primary mental health may be a more cost-effective way of providing mental health services. Primary mental health services such as these may prevent some people with mild to moderate mental health disorders from moving on to more severe mental health disorders. However, evidence around the proportion of people with mild to moderate mental health disorders who progress on to more severe disorders is still scarce. This makes it difficult to determine the cost effectiveness of therapy services for people in the mild to moderate group.

5 Alternative Funding Models

5.1 Advantages and disadvantages of different arrangements

The table below provides a summary of the advantages and disadvantages of different funding models in a mental health context.

Table 4: Comparison of mental health funding models

Models	Examples	Advantages	Disadvantages
Client based	Case funding, client-held budgets, packages of care	Funding can be adapted to meet individual client needs	Substantial needs assessment, co-ordination, brokerage and review costs. Funding may be idiosyncratic and inequitable
Inputs based	FTEs, beds	Simple; reflects costs of providing the service	Does not reward investment in local skills development, IT or better systems and processes. Does not reflect outcomes
Population	Capitation-based	Spreads funding according to the most important indicator of aggregate need; encourages lower-cost interventions	May not reflect small population requirements. Can be 'fee for no service' – incentivises under-servicing
Outputs	Fees-for-service visits, bed days	Incentivises provision of services to meet demand; incentivises efficient provision	Can lead to over-servicing and supplier-induced demand. Reduces ability to meet needs in innovative ways (eg, e-consults) if these are not counted as outputs
Outcomes Pay for performance, payment by results, gain sharing	System outcomes	Aligns provider incentives with funder/population health incentives	Difficult to attribute outcomes to any one provider
	Process outcomes	Promotes best practice, eg service user seen within 24 hours of discharge	Focuses on the small number of processes that can be measured – ignoring quality issues that are not measured
	Consumer-reported outcomes	Reflects service user experience and service user goals	Can be 'satisfaction' measures that are not necessarily related to objective service outcomes
Combination of service user based, inputs, outputs and outcomes	Programme funding/blended funding, alliance contracting	Can provide a balanced set of incentives	Bulk funding can result in low incentive to innovate. Alliance contracts pricing can be complicated to calculate

Many of the potential funding mechanisms are illustrated in the case studies in this report. In this section we review two opportunities for innovative funding that have not been a strong feature of the New Zealand funding environment in mental health to date:

- performance/outcomes-based payment

- alliance contracting.

5.2 Performance/outcomes-based payment

Contracting for outcomes aims to align the interests of the agent and the principal by making the payment to the provider partially dependent on achieving expected outcomes. Such contracts raise a set of issues, including:

- problems with attribution and windfall gains – what if efforts by someone else actually led to the change in mental health status?
- measurement – what tools are used to measure outcomes, and are they service-user-rated outcomes or clinician assessed?
- sustainability – if a provider cannot achieve the outcomes, will they receive sufficient funding to maintain services?
- ‘cream skimming’ – will a provider who works with a more at-risk population receive less funding because targets are higher to achieve?

On the other hand, contracting for outcomes can result in a focus on what really matters to service users: quality and effectiveness.

An example of outcomes-based payment in New Zealand is the PHO performance programme, which pays small incremental amounts to PHOs according to their achievement of a set of quality measures. The United Kingdom has a similar but much more significant programme, the quality outcomes framework, which incentivises GPs to increase their incomes by up to 30% by meeting quality targets. These types of contract are also termed pay-for-performance contracts.

Pay-for-performance arrangements are becoming ubiquitous in the United States and the United Kingdom. The evidence for the effectiveness of this form of remuneration is growing, but is not yet overwhelming. Pay-for-performance programmes require agreement from all contractual parties on three basic elements:

1. a set of quantitative outcome measures
2. an algorithm for converting individual measure scores into composite quality scores
3. a method for linking these composite quality scores to reimbursement incentives.

Pay for performance also requires information systems that can store the relevant information, aggregate it and report baseline and progress updates to providers.

The introduction of pay for performance is often preceded by a ‘pay for reporting’ arrangement, whereby quality measures are collected and baseline performance compared across providers.

A New Zealand outcomes framework for mental health might include the following components:

- specifying a set of standard outcome measures for different services

- benchmarking performance to establish needs-adjusted norms for different service types (acute inpatient, residential rehabilitation, vocational support, etc)
- carving off a proportion of the service price (eg, 5%) to be paid according to absolute or relative improvements in performance towards evidence-based targets.

Service user and clinical involvement in such a process would be vital. It would also be important to understand the differences in needs and likely outcomes between different service user cohorts (ie, distinguish those with mild to moderate problems from those with high and complex problems). The *New Zealand Mental Health Classification and Outcomes Study* (Gaines et al, 2003) provided some data that might inform such an approach.

5.3 Alliance contracting

Alliance contracting is a term usually used in commercial capital projects (eg, bridge building) to refer to arrangements between parties based on shared objectives, shared risks and high trust. Alliance contracting is generally recommended in a high-complexity, high-uncertainty environment as a way of reducing information asymmetry and aligning incentives between different entities that wish to collaborate in pursuit of a mutual goal.

The Australian State of Victoria (2006) published a detailed guide to project alliancing that, while focused on major capital projects, contains useful guidance for public entities on alliance contracting in general.

The guide identifies the following as key features of the alliance contract approach:

“All participants win, or all participants lose, depending on the outcomes actually achieved.

The participants have a peer relationship where each has an equal say in decision making for the project.

Risks and responsibilities are shared and managed collectively, rather than allocated to individual participants.

Risks and rewards are shared equitably among the participants.

All participants provide best in class resources.

The participants are committed to developing a culture that promotes and drives innovation and outstanding performance.

All transactions are fully open book.

Communication between participants is open, straight and honest.

Important decisions are made on a best for project basis according to the agreed principles and not on the basis of organisational positions.”

Alliance versus traditional contracts

Traditional contracts normally focus on the delivery of agreed services/products to agreed standards for agreed prices. Within the traditional framework each party pursues their own interests and manages their own risks. In many situations the interests of the

contracting parties may not be aligned and information may be asymmetrical, resulting in one party taking advantage of the other or overall outcomes not being optimised. Alliance contracts are generally set up so that information is shared openly, objectives are shared and rewards are distributed based on actual outcomes.

Remuneration in an alliance contract is normally made up of three elements:

- direct time and materials costs (usually based on actual or benchmarks)
- accepted overheads (including agreed profit margin)
- gain/pain sharing based on actual outcomes.

Remuneration is underpinned by open book accounting for all costs associated with the project. The remuneration approach is intended to support the financial alignment of objectives.

The potential advantages of alliance contracting in a mental health setting are that:

- it could provide an open-book, high-trust environment for funders and providers
- it could be used to incentivise NGO providers to work on system goals, such as reduce acute inpatient admissions, by providing an environment in which sector performance information is openly shared and in which the gains and risks of acute admissions are shared.

For instance, a DHB concerned at a high number of acute admissions and re-admissions could enter into an alliance contract with a group of NGOs and primary care providers, with each provided with real-time information on occupancy issues and with the sharing of any gains associated with managing occupancy down.

Alliancing is linked to outcome-based contracting in that it involves the specification of desired and mutually agreed objectives, with incentives structured to support collaborative activity to attain the objectives.

6 Concluding remarks

DHBs have made significant progress in diversifying from the purely input-based funding regimes of the early part of this decade. Innovative arrangements are in place in many districts piloting flexible packages of care, ‘friendly landlord’ services and other client-specific funding mechanisms. However, these arrangements tend to be at the margin; most services are still funded on FTEs and beds, with limited measurements of effectiveness.

This survey did not identify any funding arrangements where the provider’s payment was contingent on achieving outcomes, or where contractual incentives for better outcomes existed.

Provider informants made a plea for longer-term contracts (eg, five years) to reduce the administrative burden and create a better strategic environment for planning, innovation and growth.

There is room for debate around where the needs assessment should sit when developing and approving packages of care, whether within the provider as proposed by a number of informants, or independently as is usual practice. Provider-based assessments are more likely to be timely and responsive and to reduce the impacts on consumers. Funder-based or independent needs assessments provide greater accountability and consistency.

DHB funders are divided on the continuing usefulness of the mental health *Blueprint* and the mental health ring fence. The arguments in favour of retention included: the opportunity to protect mental health funding at a time of vulnerability; the *Blueprint’s* usefulness as a benchmark for service development; and the utility of population-based funding in helping to move DHBs towards equity. However, there was also a view that the *Blueprint* was too focused on inputs and specialist services, and mitigated against the opportunity to fund earlier interventions in primary care settings.

The effectiveness of primary mental health care in reducing the need for more expensive and complex specialised services is still a point of debate. On the one hand, people presenting in primary care will not necessarily progress to the more severe end of the spectrum and will not necessarily access secondary services. On the other hand, key informants involved in the delivery of primary mental health presented strong arguments that early interventions could reduce the need for secondary services. It would be worthwhile conducting a formal study in a New Zealand context to explore the cost effectiveness of primary mental health care initiatives.

DHBs and the Ministry of Health may wish to consider:

- how the routine collection of needs assessment and outcome data might be used to inform mental health funding arrangements
- whether alliance-style contracts might be a way of binding providers to improve system efficiency and effectiveness collectively.

The case studies cannot in themselves provide proof that one way of delivering services is better than another. But they do serve to illustrate what is possible and to demonstrate the importance of continual innovation in improving consumer outcomes and promoting the best use of resources. Innovative programmes require innovative and flexible funding arrangements to support them, and monitoring of outcomes to evaluate them.

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Appendix 1: Funding directions in mental health in England and Scotland

This annex provides, for interest, a brief summary of current directions in mental health funding in England and Scotland, relating particularly to outcomes-based funding and collaborative agreements.

England

The *New Horizons* (HM Government, 2009) document outlined the vision set by the Government, key initiatives and next steps in improving mental health services. Main themes arising from this document include:

- the need for partnerships encompassing central and local government as well as the sector and the professions
- a 'whole of government' approach
- recognition that physical health and mental health are now to be regarded on an equal footing.

The National Health Service established a Mental Health Ministerial Board to oversee high-level progress of the 'New Horizons' (NH) agenda, and an NH Ministerial Advisory Group for Inequalities and Mental Health to advise on implementation and monitor the progress of its mental health strategies.

In England, the Government is actively encouraging a cross-sectoral approach to mental health, through publications, policy frameworks, impact assessments, public consultation sessions and performance indicators such as public service agreements (PSAs) and local area agreements (LAAs). Local governments are the key to developing 'value for money' cross-sectoral services in this environment.

In alignment with this new framework, the Government will introduce a 'payment by results' (PbR) funding system by 2011 that will be based on case-mix-adjusted activity. Administered by primary care trusts and their mental health services trusts, the incentives for sector co-operation and collaboration will be financial rather than structural. The PbR project objectives are:

- to develop national currencies that can be used as the basis for contracting and paying for mental health services in England
- to produce a more transparent funding system for mental health services, with clarity as to what care is being provided, how it is paid for and what outcomes are delivered
- to ensure that funding reforms support mental health policy objectives
- to identify good practice in needs-based packages of care
- to cost up both good and existing practice
- to ensure that an amended mental health minimum data set is fit for the purpose of mental health PbR
- to achieve agreement on a standard needs assessment tool

- to develop necessary software to allow grouping of service users into clusters
- to successfully pilot local approaches to PbR for mental health and extract the nationally applicable learning
- to specify the necessary changes to support the operation of a mental health PbR type system (HM Government, 2009).

The Future Vision Coalition (FVC), a coalition of 11 leading mental health organisations, strongly highlighted the need for a ‘whole-of-government’ approach. ‘Quality of life’ packages are to be offered to people with ongoing and severe mental health problems. Based upon personal health budgets, these packages would give people the flexibility to choose from a range of services that allows them to achieve recovery on their own terms. This is comparable with New Zealand’s flexible packages of care.

The FVC agreed with the strategies laid out in *New Horizons* but also encouraged a more vigorous approach than that laid out by the Government. The coalition recommended that a Cabinet Minister post be created specifically to champion mental health and wellbeing, as well as oversee all government activities with a view to determining their impact on mental health. The FVC also recommended that an Interdepartmental Co-ordinating Committee be established to support linked policies and integrated services across government. This is based upon the recognition that a prerequisite for system transformation is the elimination of ministerial and departmental silos.

In addition, the FVC advocated for a new PSA for mental health and wellbeing that would specify expected actions and outcomes at the local level. The new PSA would incentivise the collaborative efforts of local health and social care agencies. As well, the FVC suggested that funding for local health and social services be pooled to permit flexible determinations of resources across a range of services. The FVC sees local decision-making and flexible resource allocations as important in the delivery of holistic, effective mental health services (FVC, 2009).

Scotland

In recent years the Government in Scotland has been moving towards a more outcomes-based approach to public sector accountability. The Scottish Public Health Observatory (a collaboration of key national organisations involved in public health intelligence in Scotland) will report annually on national mental health wellbeing outcomes using indicators to track progress and measure achievements. The indicators have been developed within the context of the National Performance Framework. (Scottish Government, 2009).

The Government also funds the Scottish Recovery Network (SRN), an organisation established to promote recovery-based service delivery. The SRN provides training and learning materials for the workforce as well as for people with mental illness, and supports the development of peer and employee support networks. The Government also supports ‘Voices of Experience’, a user-led, volunteer organisation that is dedicated to ensuring user involvement in service development and actions to create positive environments for those with mental illness.

Scotland's plan outlines strategies to support communities in their efforts to help people look after their own mental wellbeing through a combination of cross-governmental activity, policy and programme collaboration in poverty reduction, anti-discrimination projects, equality and equity initiatives, economic regeneration, education and early years development.

Appendix 2: Interviewees

Table 5: Interviewees who participated in this project

Interviewees	Job titles
David Codyre	Clinical Director, Consultant Psychiatrist, ProCare
Robert Ford	Manager Mental Health, ADHB
Bruce Arroll	ProCare doctor
Berni Marra	Manager, Capital PHO
Rachel Harrison	Health Promotion Co-ordinator, Capital PHO
Sue Hallwright	Manager, Mental Health Development Team, CMDHB
Frank Tracey	CEO Affinity Services
Paul Ingle	Pathways Trust
Marion Blake	CEO Platform
Mary Wills	Portfolio Manager Funding and Planning, HBDHB
Bruce Green	NASC Co-ordinator, Hawke's Bay
Doug Banks	General Manager Community Organisation, WIT
Patrick LeGeyt	Manager of Te Taiwhenua o Heretaunga Trust
Brenda Kupa-White	CEO Te Whatuiapiti Trust
Margaret Hill	General Manager of Planning and Funding, South Canterbury
Mandy Shelker	Consumer advisor SF (Supporting Families) Aoraki
Michelle Baldwin	South Link Health Manager Timaru-South Canterbury
Diane Black	Consumer representative of provider arm, south Canterbury
Hayden Wano	CE Tui Ora
Hinemoerangi Ngatai-Tangirua	General Manager Te Rau Pani
Philip Grady	Group Funding & Primary Care Manager, Waitemata
Naomi Cowan	CEO Equip

Table 6: Other sources of information

Name	Organisation
Joan Mirkin	Ministry of Health
Nemu Lallu	
Memo Musa	
Bevan Sloan	
Peter Kennerley	
Rawiri Evans	
Robyn Shearer	
Andrea Bunn	Whanganui DHB

