Youth Horizons
Productivity Commission Submission

Better Social Services 2014

Overview

This Youth Horizons submission is from its perspective as a national NGO providing specialist treatment services for children and young people with serious conduct problems. The conduct disorder population is at risk of a range of poor life course outcomes such as criminal offending, teen pregnancy, unemployment, and poor health. Long term offenders generate significant costs to the state including the adult criminal justice system, welfare receipts and health services. It is our submission that funding for specialist social services for this population is most effectively utilised when an investment approach is taken, concentrating funds in evidence based programmes which are carefully integrated into the New Zealand cultural context. There is good evidence from the Washington State Institute of Public Policy that investment in early interventions which research has demonstrated lead to improved outcomes, leads in turn to reduced costs to the state over time and safer communities. For example, for every dollar spent on Functional Family Therapy for young offenders, there is an estimated net benefit to the Washington State of US$8.88 (http://www.wsipp.wa.gov/benefitcost).

The success or failure of agencies delivering these models also depends on being sufficiently resourced to implement the models with strong clinical and operational governance to ensure professionals are well supported. These agencies also need outcome measurement systems which ensure continuous quality improvement.

This submission addresses the following Productivity Commission questions: Q36, Q44, Q45, and Q48 – Q53.

Section 1 has a focus on the features of evidence based services and the importance of data gathering and the political and funding systems which either support or impede such services.

Section 2 discusses the challenges of knowledge transfer.

Section 3 discusses the challenges of building data gathering capability within an agency.

Section 4 outlines the tensions between supporting local innovation and benefitting from international learning.

Section 5 discusses the risks of a data informed approach.

Section 6 outlines the benefits of investing in a small number of agencies to deliver specialist services rather than spreading available funding over a wide range of providers.

CHALLENGES OF EVIDENCE DRIVEN SERVICE DEVELOPMENT AND POSSIBLE SOLUTIONS:

1. Data driven service development time frames vs. political time frames and trial by media:

Our organisation strongly supports the use of data to inform service provision as this is the only way to make informed decisions about the best way forward.

There are many examples of services that were perceived by authorities, users and providers to meet an important need and be very helpful, but did not in fact result in any benefit and may in fact have been harmful. The wide scale provision of critical incident debriefing being one example (http://www.thecochranelibrary.com/userfiles/ccoch/file/CD000560.pdf for the Cochrane review and http://www.portlandtraumatreatment.com/cisd-references.htm for a list of references in relation to this).

There are also lessons to be learnt from health and public health initiatives.

As governments increasingly seek to obtain the best value for their populations and look for the evidence to guide this work, various approaches have evolved to provided helpful evidence. There is a wide range of relevant evidence including:

- broad **population wide prevalence, demographic and other census information**,
- systematically collected **longitudinal research**
- **randomised controlled trails**, where confounding variables are relatively well understood and controlled,
- sustained programmes of work to develop **evidence based interventions** for particular applications,
- **Implementation science** which examines how to replicate and then roll these out evidence based interventions and practices on a larger scale
- well-coordinated **independent evaluations** of programmes or initiatives
- service **providers own evaluation** of their programmes to demonstrate value added and inform quality improvement
- **narratives and informal client feedback**

At each level there are also a range of measures and indicators, with varying degrees of validity, reliability and accuracy. Often data that is easiest or least costly to obtain is also unfortunately most subject to bias or error. This data may also have the greatest popular appeal.

Effective work requires a **sustained, intentional, explicit and systematic approach**, where there is attention to **evaluation** at every stage and this is fed back into the system as programmes are rolled allowing **continuous quality improvement**, with attention to **sustainability** and good **implementation** processes so that evidence based service provision can be replicated on a larger scale. This latter generally requires skill in implementing **system wide change**.

It is also true that society is constantly changing.

It is not surprising therefor that a data driven approach is not without its pitfalls. Some of these are discussed below;

An evidence driven approach needs most broadly to link to well developed and sustainable policy development based on analysis of existing data.

To do this policy makers need to be familiar with knowledge gained for local and international research and longitudinal studies and integrate this with input from sector experts, including service providers, census data, evaluations of initiatives as these occur, as well as input from communities and cultural knowledge holders about how understandings fit in the local context.

This policy driven approach also ensures that variables outside the direct control of social service providers and developers, such as socio-economic adversity, low employment, and health factors, or housing problems, to mention a few, can be integrated into a broad evidence based approach at government level.

While conceptually everyone is clear that preventative work may well save both economic costs, and human costs, demonstrating this requires a broad approach to data, and a need to learn from many sources of information to assess whether benefits are realised over time.

A sustained programme of social service improvement takes long periods of time. There may be some challenges for administrations, who need to demonstrate they are making a difference in relation to important issues. Easily understood and headline grabbing findins may not always represent a sustained long term view.

Possible Solution: Policy makers also need to work to give clear guidance to the sector, and empower Ministers with information needed to promote the benefits of sustainable change to voters and ratepayers. A more responsible and informed media, driven by a commitment to building public understanding, rather than creation of headlines is a helpful tool in this area. Initiatives such as this enquiry assists knowledge holders in the sector to inform government.

2. Difficulties with knowledge translation

Researches tend to be acutely, and many would say rightly, aware of the possibility for error in data.

This includes factors like the complexity of social contexts, where there are many confounding variables which may produce both the appearance of false "positive" outcomes and hide real benefits and the limitations of the generalizability of the information from studies.

Analysis tends to be done carefully over time, with peer review, and reporting is often technical. This presents barriers to information being fed into policy and service development.

Possible Solutions: Closer partnerships between government agencies, universities which hold expertise and capacity for research, and service providers, and the development of skill in knowledge translation - that is experts able to understand research and interpret it in ways that are accessible to providers and policy makers (http://en.wikipedia.org/wiki/Knowledge_translation).

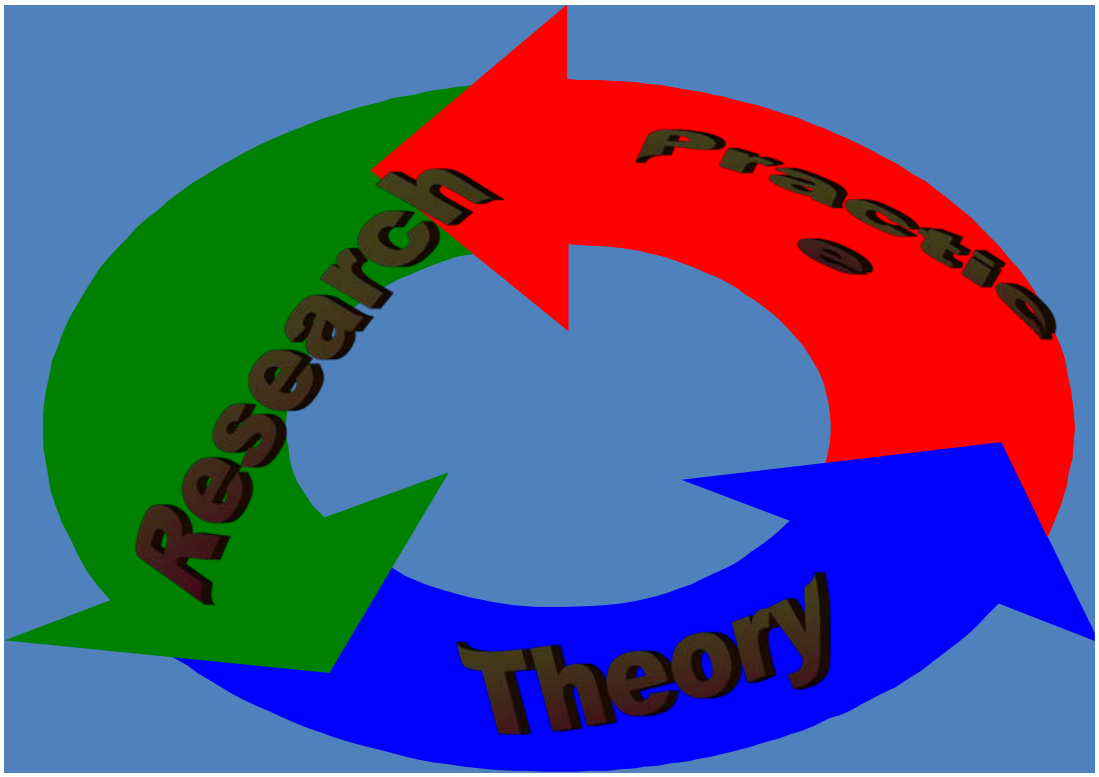
Evaluation can fall subject to the same kinds of errors as research, unless carefully done. As many parts of the social service sector are not accustomed to investing in evaluation this area may be underfunded. Particularly in the early phase of implementation of a service, longer term benefits cannot yet be realised. Initial set up and implementation cost need to be borne. There is a real risk

that poorly done independent studies, may lead to the scrapping of promising programmes, after the bulk of set-up costs are already sunk, but benefits have not yet been realised.

Evaluation by service providers or government funding agencies themselves, or by both working in partnership, is likely to ensure better understanding of the service involved and a greater stake in demonstrating the value added. However this work needs to be sustainably funded. Services must be willing to both report and respond to less optimal outcomes and abandon services that consistently show no benefit.

Possible Solutions: The current Investing in Service Outcome Trials represent a good attempt by the Ministry of Social Development working with service providers to learn from experience without too much pressure to produce only positive outcomes. However to succeed on a broader scale, this work needs to transition to longer running more sustainably resourced initiatives, that will require some level of funding for both the Ministry and Providers. A cost which should ideally be recovered through improved outcomes. Ideally the approach needs to be one where data is used both to demonstrate value added and contribute to learning and improvement

This is represented by the feedback loop used by social learning theory approaches to developing evidence based interventions. The process should be iterative, so that knowledge is built up and fed back into service development.



3. The costs of resourcing data collection and gaps in data availability

There are costs at multiple levels in relation to using data. There is client time taken to complete client measures (e.g. behaviour scales, questionnaires etc.). There is the cost of practitioner/evaluator time in gaining consent and collecting data, data entry costs, data analysis costs and the cost of skilful interpreting data to accurately inform service development. As data collection is not the focus of most practitioner's, time and effort is required to promote an evaluation culture and checks to promote compliance with data collection.

These costs need to be weighed up against the reliability, validity and meaningfulness of the data. That is is the data "worth" the effort required to not only collect but interpret and use it.

If data collection is to be efficient, avoid duplication and be meaningful, evaluation and research into programme effectiveness requires a number of skills and resources. Knowledge of psychometric tools and other metrics is needed to select measures. Ideally evaluators should identify measures already used clinically, or readily available, that can also be used for evaluation. Currently most contracts held by our agency focus on "how much" is done. Audits cover basic requirements of service provision, but not necessarily attention as to the quality of evidence behind interventions used. In some contracts data from clients about service outcomes (such as the Strengths and Difficulties Questionnaire for example) are collected, but not necessarily analysed or shared.

Introducing the use of data requires skill if the implementation is to succeed. Data analysis skills need to be combined with clinical knowledge of the area to correctly interpret results. While a comparison of well-chosen metrics at intake and discharge can give an indication of the impact of a programme, ideally there should be a control group to establish whether the same outcomes would not have been obtained just due to the passage of time, services as usual, or on the other hand

whether a small improvement actually represents great effectiveness, and a comparison group would have shown deterioration over time. For example statistics suggest that youth who begin offending in early adolescence go on to more serious and frequent offending as they get older. To avoid confounding effects of selection, assignment to intervention or non-intervention conditions should be randomised. This presents a number of challenges, including ethical concerns. Difficulties are particularly marked in small populations, particularly for specialised interventions. Using a control group also requires identifying, gaining consent from and funding evaluations of the control group. This may not be something most service providers are able to do, and would require government to be actively involved.

Ideally evaluation of effectiveness should include follow up over time. Our experience has been that particularly with high needs and transient populations, obtaining follow up data is time consuming and a lot of families are lost to the study, making it difficult to interpret the data. In addition these follow up results can be difficult to interpret in the absence of a control.

Possible Solutions:

Use of interagency data:

One way to reduce the burden of data collection and increase the number of service users that can be followed up, particularly over time, is to utilise interagency data, such as youth offending data pre, post and at follow up, police involvement, school enrolment and attendance and other key indicators. While there are promising moves towards making this kind of anonymised programme wide data available for evaluation, this has not yet been successful. We were unable to obtain this data for our FFT study. We are currently awaiting an application to access youth offending data, as this is a key area we aim to address through our interventions.

Given that this data is held by government agencies they are best placed to work in this area to access information to inform their decisions and assist service providers in evaluating their outcomes. The Investing in Service Outcomes Trials are likely to provide an indication of the challenges in doing so.

The MSD Youth Service contracts for youth people not in education, employment or training on Youth Payment or Young Parent Payments are an example of a government Ministry working with service providers in this way, providing outcome data as part of the process of assessing the impact of the service.

Building an evaluation culture across the sector:

The use of data driven evaluation and evidence based approach to service provision is not strongly or consistently developed across the sector.

While service providers should ideally be building an evaluation and quality improvement culture, and utilising data to improve the effectiveness of services, evaluation and data analysis are specialist skills.

***Sustainable funding*:** It would be in government interests to build evaluation capacity in the sector in a way that is sustainable and not dependent on project funding and pilots as is currently the case.

***Role modelling*:** State providers such as Child and Adolescent Mental Health services, Child Youth and Family and Youth Justice Services should also lead the way in terms of evaluating services they deliver. This will build capacity in the sector, and model a commitment to assessing what is effective. This happens, but not consistently, and tends to occur more frequently for projects or trials than for work as usual.

The Ministry of Education follow up of its Incredible Years Roll out is an example of a Ministry working with NGO providers to evaluate implementation of an evidence based model over time.

The recent work by the office of the Chief Social Worker on social worker caseloads is a good example of a courageous and systematic look at data to inform decision making and service development.

***Learning for other countries*:**
There is much fairly accessible information and much to be learnt from such approaches in other countries, such as Australia, the United States, the United Kingdom and Scandinavian countries (see for example the recent 2nd Biennial Australian Implementation conference, which brought together researchers, practitioners and policy makers from numerous countries with a commitment to an evidence driven approach http://www.ausimplementationconference.net.au/. Particularly the keynote speech by Bryan Samuels**,** Executive Director of Chapin Hall, one of the US's leading research and policy centres focused on improving the well-being of children and youth, families, and their communities)

Good policy work should enable government to develop clarity about which issues need to be addressed, what outcomes are desirable for children, young people and families, and also what kinds of interventions are most likely to achieve these in a cost effective manner.

Non-governmental organisations who are part or wholly funded by government need to focus both on best practice in their areas of expertise, but also, in our experience, expend a great deal of resource trying to understand government initiatives and direction. Currently there are a number of approaches being explores (Social Sector Trials, Investing in Service Outcome Trials and Children's teams to name a few). This can cause confusion for providers.

The experiences of other countries suggest that providers pay great attention to the ways in which funding is allocated. Therefore and investment approach that targets incentive funding to key outcomes and withdraws funding from services that consistently and over time have no evidence of efficacy is likely to be an important part of an evidence driven strategy to improve outcomes. However this needs to be done carefully so that service providers are not placed under so much pressure that they are not able to maintain a skilled workforce and the infrastructure to support evidence based service development and quality service provision. There needs to be enough stability of funding to allow for sustained development.

***Clear policy and careful use of funding incentives*:**
Easily available, clearly reported population wide data, broken down by area with clear indications of service gaps, is essential to an outcomes based investment approach. Also important is an understanding of the complexities of data in social services, where social change is sometimes happening more quickly than data can be collected and analysed.

However clear policy it is essential if government is to give providers a clear indication of where investment is needed and also what the trajectory for young people and families appear to be where there are no services in place, providing a baseline against which outcomes can be compared.

A clear understanding of what factors drive good outcomes for families and children is also needed.

Accessing data on effective intervention: Information is also needed as to which approaches have proved effective in achieving these outcomes, and what the best/likely impact of such approaches are. For example for high risk populations such as young people with conduct problems, even with international best practice programmes, transitions to a lower level of care may be achieved for the majority, but not for all young people, that is the intervention is not equally effective in all cases, but the savings and impact are still significant. .

Increasingly data on evidence based interventions, that clearly define and weigh up evidence, as well as present cost benefits analyses are more readily available (for example the California Evidence Based Clearing House http://www.cebc4cw.org/., Blueprints is hosted by the Center for the Study and Prevention of Violence (CSPV), at the Institute of Behaviour Science, University of Colorado Boulder, http://www.blueprintsconference.com/; or the cost benefit work of the Washington State Institute for Public Policy http://www.njjn.org/uploads/digital-library/resource_590.pdf; The Centre for Evidence-Based Intervention (CEBI) at Oxford university http://www.cebi.ox.ac.uk/about-us.html also work by our own SuPERU http://www.familiescommission.org.nz/news/2013/superu-provides-hub-for-longitudinal-study and Australia's Parenting Research Centre http://www.parentingrc.org.au/).

The costs of service provision relative to alternatives needs to be weighed up. For example for young people with severe conduct problems the cost of placing the young person in a high cost evidence based Teaching Family Home or treatment foster care programme, needs to be weighed up against the cost of likely alternatives such as residential or secure residential care or multiple failed placements utilising social work resource, as well as future cost savings if programmes are able reduce future mental health difficulties or time in prison.

The use of technology: The RealTime Feedback project being run by the Health and Disability Commission is an example of using technology to obtain data (in this case on client satisfaction) in a way that is engaging for clients, automates data entry and draws on centralised skills in analysing and feeding back data in real time. There are projects in other areas utilising this approach to collect client assessment data in this way that are showing promise particularly for youth (http://www.youngandwellcrc.org.au/research/user-driven-and/interactive-online-e-tool-assessment/). This area shows promise, but is also specialised and development work can be costly. This may be an area in which government could well add value.

4. Tensions between supporting local innovation and benefitting from international learning

The above discussion touches on the complexities of developing and disseminating evidence based services.

Even with good measures in place, in the absence of randomised controls, it can be difficult to interpret results. Data is not the same as valid evidence. Poorly run evaluations or research can actually be misleading, and lead to the abandonment of promising programmes. Where use of evidence is inconsistent, pioneering service providers who look at their evidence may be penalised, whereas less able providers may be doing no better, but simply not have measured their outcomes. Similarly a high cost service, showing promising results, may not be doing any better than services as usual unless a comparison is done. Unless assignment to the comparison or intervention is random, selection factors may mask results.

Nevertheless, over the last three to four decades, internationally a data driven approach to service delivery has been utilised to develop **evidence based models/interventions** with considerable success.

Generally evidence from previous research is used to inform practice, which if shown to be promising by initial evaluation is then manualised, so it is explicit what is being evaluated, and this is then assessed in randomised controlled trials to establish good evidence about effectiveness. The intervention then needs to then be independently replicated and again shown to be effective compared to a randomised control. This will result in a strong evidence base and a body of knowledge about how to deliver the service.

However future implementations of the programme need to ensure they are targeting a similar population, doing the same thing (fidelity) and also use data to show outcomes are actually achieved.

The development of evidence based interventions is a slow process. **Using existing evidence based models**, carefully matched to the needs to a service, and that allow, as most good models do, for individualisation to accommodate client culture and local needs, can allow social services to piggy back off decades of good data use.

This has to be weighed up against the value of **developing innovative and local approaches**. However where this is done there needs to be a sustained commitment to development over time.

More complex and specialised services, where standard approaches have been unsuccessful, probably would do better with the evidence based intervention approach.

In our own field of work, young people with severe conduct difficulties, traditional services were particularly ineffective. In recent decades sustained programmes of work have yielded effective approaches such as Multisystemic Therapy, Functional Family Therapy, Multidimensional Treatment Foster Care and Triple P.

By working diligently in partnership with model developers who have developed expertise in disseminating their model, this approach has assisted Youth Horizons to be able to build capacity in a field where expertise is scare. This has however taken sustained work over more than a decade and development is on-going. We were lucky enough to be able to present some of this work and learn from the experience of others through the recent sector conference He Tai Pari (http://hetaipari.co.nz/presentations/).

There have however been concerns raised as to what the importation of international models of practice mean for the development of local approaches.

Possible solutions:
Implement carefully chosen Evidence Based Interventions, with fidelity and evaluate locally:
As noted our agency's current approach is wherever possible to utilise evidence based interventions (EBIs) that have already been demonstrated to be effective in randomised controlled trials and have been effectively replicated in another setting and again demonstrated effectiveness.

Countries with large populations are able to randomly assign whole districts to a treatment or control condition. Well-established evidence based models/interventions (for example Functional Family Therapy, Multisystemic Therapy, Triple P and Safe Care), have also often shown effectiveness across a range of populations. In implementing these models we initially focus on how effective we

are in replicating those aspects of the programme that are associated with effective outcomes, that is the drivers of meaningful change. This is referred to as programme fidelity. One of the advantages of EBI's is that both the service developer and the funder have clearly defined fidelity measures that indicate how well the service is doing what it is intended to do, allowing for quality improvement early on. As these are the aspects of the service that drive positive change, they are also a good proxy measure for how well the service is performing. If a well evidenced model is being implemented with fidelity, there is a high likelihood that the outcomes will be replicated. Fidelity data are often available earlier on than outcome measures. It takes time for practitioners and services as a whole to develop proficiency. Evaluating a service too early on may mean poor outcomes indicate the service is still in the development phase. For well-established EBI's fidelity measures provide a good indicator of when a programme is ready for more rigorous evaluation research.

Once fidelity is achieved it is important to also demonstrate whether outcomes are been replicated, that is not only showing we are doing what has been shown to be effective, but that it is effective in the current application.

While we have not been able to arrange randomised controls, or even controls of any kind, pre, post and follow up data in this context can provide meaningful evidence, when added to the existing data base. We will shortly be publishing the results of our research into Functional Family Therapy. Multisystemic Therapy has a growing body of evidence in the New Zealand, as does Triple P. Our study into Multi-Dimensional Treatment Foster Care is under way.

The advantage of an evidence based model is not only does the intervention have an existing evidence base, but working with a model, with inbuilt checks on fidelity, means that evaluation can compare delivery across sites and even providers, where a fairly consistent service is being evaluated.

As research into EBI's tends to be on-going studies from other implementations provide some form of benchmarking for current implementations in the absence of randomised controls (this is not without possibility of error, but does give an indicator)

Cultural due diligence:

Our experience so far has been that well developed clinical models in this field are designed to allow for sensitivity to cultural differences. In addition careful due diligence involving cultural knowledge holders and on-going support to ensure that accommodations are made which allow culturally safe and relevant practice, without violating model fidelity increase local acceptance and relevance of the work. The commitment to evaluation built into these approaches means that data is also available on the cultural acceptability of these models to first people's and diverse populations and outcomes for these groups relative to others. Studies involving EBI's like Safe Care [1], Parent Child Interaction Therapy[2], CBT[3], MST[4] Research and international work on FFT[5] and initial local research into

[1] **Chaffin, M., Bard, D., Bigfoot, D. S., & Maher, E. J. (2012).** Is a structured, manualized, evidence-based treatment protocol culturally competent and equivalently effective among American Indian parents in child welfare? Child Maltreatment, 17(3), 242-252. doi: 10.1177/1077559512457239

[2] **Matos, M., Torres, R., Santiago, R., Jurado, M., & Rodriguez, I. (2006).** Adaptation of Parent-Child Interaction Therapy for Puerto Rican families: A preliminary study. *Family Process, 45*, 205-222. **McCabe, K. M., & Yeh, M. (2009).** Parent-Child Interaction Therapy for Mexican Americans: A randomized clinical trial. *Journal of Clinical Child & Adolescent Psychology, 38*, 753-759

Function Family Therapy in New Zealand shortly to be published and work on Triple P[6] all show promising results. Implementing and evidence based model, does not need to mean that the implementation is not responsive to local needs.

Focus on clearly defined outcomes:
Evidence Based Models are not the only approach. Where existing good practice is evaluated this provides evidence of the difference the programme is making. However the challenge can be to then replicate this practice in other sites, or if key staff move on. Ideally practice should be manualised. Evidence based interventions have the advantage of already being manualised. This does not mean they are mechanistic, but that the key elements that drive positive change are well articulated in such a way that the intervention can be replicated. This process in itself requires skill and knowledge, and the work of NIRN (http://nirn.fpg.unc.edu/about-nirn) and others on implementation science is a resource that should be more widely used.

There are examples where existing services (for example home visiting programmes for families at risk), could be improved by implementing well researched evidence based models (for example SAFE CARE or Nurse Family Partnerships (See footnote 1 above).

In other cases where the services required are quite widely available and the target outcomes clearly understood and definable the focus can be on allowing a range of providers to work towards achieving the outcomes. This approach appears to be showing promise in the Youth Service for Young People Not in Education, Employment and Training and the YP and YPP payments.

5. Narrowing service delivery, perverse incentives and choosing the wrong outcome variables

The very act of measuring something results in change. Where measures are too narrow, or incentives too narrowly linked to measures that do not truly capture the breadth of the required intervention or outcomes, this can result in perverse effects or unintended negative consequences. For example if the only focus in number of interventions for cost, there is a risk that quality of intervention will be compromised.

In particular too narrow a focus on particular measures can result in providers narrowing the focus of their work. Perhaps the best example of this kind of concern is the risk of a focus on standardised testing in education narrowing the focus of teachers to "teaching to the test", rather than provision of a rich broad, but effective education (http://en.wikipedia.org/wiki/Teaching_to_the_test).

Because many social variables are difficult to measure proxy measures may be utilised. For example parent satisfaction with a service may be used as a proxy for measuring the extent to which parents are assisted with the demands of parenting challenging children, but if this measure is too highly valued or seen in isolation, practitioners may not challenge parents as much for fear of "scoring poorly" and consequently not bring about changes in parenting practice which might actually make a difference.

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[3] **Pina, A. A., Silverman, W. K., Fuentes, R. M., Kurtines, W. M., & Weems, C. F. (2003).** Exposure-Based Cognitive Behavioral Therapy Treatment for phobic and anxiety disorders: Treatment effects and maintenance for Hispanic/Latino relative to European-American youths. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*, 1179-1187

[4] http://hetaipari.co.nz/wp-content/uploads/2014/08/MultiSystemic-Therapy-MST-Life-Without-Barriers2.pdf

[5] http://www.blueprintsprograms.com/evaluationAbstracts.php?pid=0a57cb53ba59c46fc4b692527a38a87c78d84028

[6] http://www.triplep.net/glo-en/the-triple-p-system-at-work/evidence-based/key-research-findings/

Possible Solutions: It should be clear at this point that we favour an iterative process to build up evidence and knowledge on which service development is based. Evidence from a variety of sources should be collected and fed back to improve services, and decisions based on a number of sources of data carefully considered.

The outcomes chosen, the way they are measured and the way in which services are incentivised to achieve them, all need to be constantly evaluated, and emerging evidence used to improve the process.

For our own organisation the use of evidence based interventions has given us a head start in doing what is likely to work. Combined with good cultural due diligence, and a strong commitment to engaging fully with the Tamariki, Rangatahi and Whānau, this has delivered rich practice. We have a longstanding commitment to research and quality improvement, and are increasingly seeking to evaluate what we do. This involves challenges in terms of sustainably resourcing this piece of work, but it is a challenge we are committed to.

6. **What are the most important benefits of provider diversity? For which services is provider diversity greatest of most limited? What the implications for the quality and effectiveness of services?**

In the domain of specialist services for high need children and young people with serious or complex mental health, disability, or conduct problems, our view is that it is better for the country to have a *small* number of national or regional agencies which are sufficiently resourced to compete on an equal footing to deliver highly specialist treatment services. Our view is that when funding for specialised interventions is diluted across too many agencies, these agencies find it difficult to build the critical mass of expertise or to have the focused commitment needed to build efficient high quality services.

The small population size of New Zealand provides a natural limit to the number of providers with sufficient scale to afford the clinical, cultural and operational support and expert governance that is needed to deliver sustainable, high quality, evidence-based interventions. An agency needs to invest in the systems needed to optimise success such as outcome evaluation measures, model fidelity measures, incident monitoring and response, and systems to loop evaluations measures back into practice improvements.

These evidence based interventions are a net benefit to the country as they are more likely than non-evidence based services to produce a financial and social return on investment via reduced costs of crime, welfare and healthcare.

The benefits of a investing in a small number of specialist agencies include:

- They are less likely to be distracted by non-core business priorities. Their effort is concentrated on doing a few things well.
- They can contest RFP's for new business in the specialist domain on a relatively equal footing with the small group of competitors – which drives competitive improvement in the sector
- They become repositories of expertise and information which is useful to Government agencies in the development of Government policy or service specifications pertaining to their specialist domain

Funding approaches which dilute specialist service development

By contrast, we are familiar with bidding for RFP opportunities where there is a government agency determined funding model which corresponds to a certain number of bednight payments or a certain number of interventions per annum for children or young people with conduct problems. In some cases the funding is set at a level where it is technically feasible to deliver an evidence-based intervention, but only by running the service at a loss, or by compromising on model fidelity, or by compromising on volume attainment.

In these scenarios the specialist provider will typically compete with multiple other agencies. The non-evidence-based providers have the advantage of not having the costs associated with an evidence based model (e.g., extensive training, ongoing model fidelity measurement and outcome measurement). They can contest these tenders, confident of a reasonable margin. The service specifications do not require an evidence based model to be used, therefore it is not an agreed determining factor for panels to judge the relative merits of proposals.

The strength of our evidence-based model expertise means our organisation is well placed to compete for contracts of this type but because such services are not funded for the cost of delivering our models of practice, we have at times taken on contracts that barely cover direct costs. An organisation like ours can carry some low margin or deficit services, but only to a certain limit. We have walked away from specialist service funding opportunities which were financially unsustainable.

Possible Solutions:

Funding approaches which support specialist service development

In some instances our main funder, MSD, has worked in partnership with us to develop new service specifications, which we believe is an effective procurement strategy. Be it via a competitive tender process or direct procurement, the design consultation has enabled us to positively influence service specifications in a way that best supports the implementation of evidenced based interventions. In our case, interventions such as Multisystemic Therapy, Functional Family Therapy and Multidimensional Treatment Fostercare have been shown to reduce the long term cost to the state relative to no treatment or treatment as usual. They require sufficient resourcing for the agency to afford professional staff, training, supervision and clinical oversight.

A benefit of this partnership approach at the design stage is that it leads to a tender process which favours agencies that have proven capability in delivering specialist services using the best international evidence. Moreover, our experience has been that these contracts are more likely to be funded at a level to support these complex interventions.

Summary

In the scenario where government funding for specialist services is distributed across a large number of agencies who are either small specialists or large non-specialists, the result is a proliferation of non-evidence based services operating at lower cost and, in the case of small specialist providers, a set of agencies that are unlikely to be financially sustainable.

Our view is that for target populations which have complex and hard to treat conditions the country should invest in a small number of providers which can scale up evidence-based interventions, implemented with high model fidelity, and with the capacity to build ongoing data collection and quality improvement systems. We recommend that government agencies make a strategic decision to take a targeted investment approach on the basis that this will create the conditions which facilitate strong organisations delivering interventions which yield strong investment returns via reduced costs of crime and other social harms to the state and private sectors.