MULTI ANNUAL POLICY PLAN

2016 – 2018

FORECASTED BUDGET 2016

Standing on cross roads

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0 Management summary

The Mental Health Foundation (MHF) provides mental health care to clients on St. Maarten and the BES Islands Saba and St. Eustatius. In these areas, it positions its self as a care provider that takes health care very seriously and acknowledges the importance of close cooperation with other stakeholders.

The lifetime of the multi annual policy plan 2013-2015 '*From growth to professionalism'* has come to an end and new avenues need to be explored. In fact the MHF is standing on cross roads; no more subsidy from Government, outdate laws and regulations, uncertainty about tariffs and new markets that draw the attention. Except from continue to build upon the developments in the last three years, new topics will need to be addressed. The main topics are the need for/to:

- intensified ambulant care by introducing FACT and increase the amount of AVBZ clients, which will influence the amount of crises interventions and admissions
- further intensify and professionalize the Faraja (day care, short/ long stay) programs and increase the amount of clients
- further increase the volume of clinical care (counseling and consultation) especially amongst children and youth
- explore new was of prevention and information interventions in conjunction with partner organizations
- to address the developments in the market with regards to the needs of child- and youth psychiatry and forensic psychiatry
- further intensify and consolidate the cooperation with key stakeholders in the different markets to ensure continuous care in the care chains
- up-to-date legislation and regulations on health care in general and on mental health care in particular
- strengthening the internal organization and governance structure
- a further professionalization of the whole staff through training and education, development of protocols/ manuals, quality management, team building, personal development plans and staff satisfactory assessments
- continue the usage of ICT solutions to improve the quality of care and to increase the efficiency of the institution, which includes paperless offices, up-grading of relevant reports and more intensive and accurate usage of SQLapius and other relevant soft-ware applications
- further preparations of output financing, which requires up-to-date tariffs that will cover the costs, an accurate internal reporting system on production, productivity and outcomes, other key - parameters and on cash flow
- preparation of new facilities in Madame Estate and Cay Hill that meet the standards of a modern futuristic psychiatric facility to replace the existing facility
- re-branding of the MHF services after being 10 years in the market with the aim of further reducing stigma, increase accessibility and become more contemporary in its corporate identity and image
- networking at a national, regional and international level for support generation, joint planning, partnership and cooperation at various levels

- doing research in close cooperation with the government to identify the prevalence of psychiatric illnesses of the population in general and specifically amongst youth. This information will be valuable for future policy planning and evaluating health care effects

The abovementioned changes give rise to some drastic policy changes. Of course in the period 2016 - 2018 MHF will also continue to develop as a secondary provider as well as a primary care provider (Ambulant Care) and strengthen and preserve its position in the current markets (including Sint Maarten, Saba and Sint Eustatius).

Driving "quality improvement" is at the heart of our strategy, to improve patient satisfaction and safety, mental health care outcomes and patient and care giver experiences. Therefore the strategic goals are delivering patient centered and collaborative care enhancing operational excellence, being at the forefront of a healthcare system that is fit for meeting the health and social care needs of psychiatric patients and their families.

MHF hopes to consolidate the assortment of care products in conjunction with a steady growth in the volume and the number of employees. The number of full time equivalents will increase to 47.50 in 2016 and 50.50 in 2017. MHF will achieve its goals by involving staff in more efficient and effective working methods and integrate patient oriented care on all levels of its care products. Innovative treatments will be adopted through closer working relationships with partner institutions in Sint Maarten, the BES region, the Caribbean and The Netherlands and by providing transparent and accessible information on St. Maarten for patients, care givers, government and other stakeholders.

The foundation is very positive and hopeful about the future and of the wisdom of policy and decision makers, key stakeholders and the community at large in supporting the MHF to address all mental health needs in St. Maarten, Saba and Sint Eustatius.

Drs. P.D. Lucas

Director

Dr. F. Holiday	Mr. J. Challenger
President	Secretary

1 Introduction

1.1 Historic context

MHF was legally established in 2001 and became operational for patients in 2006. It started with a clinic, crisis interventions, a day care treatment program in 2007 and a handful of employees in a very small facility. Since then MHF has grown considerably as an institution and positioned itself in the health care market.

In 2011 the MHF was able to upscale its staff, both in quality and quantity, to 40 members. MHF employs two resident psychiatrists. In addition the foundation completed the renovation of a new building that can house all departments, which were formerly spread over two buildings. Moreover with a capacity of 9 beds and a separation room, patients who previously had to be sent to Curacao for admission can be admitted and treated at the MHF. Apart from treating patients in their own community these strategic actions have contributed to a decreased number of relapses of patients

With reference to, the WHO (Geneva, 4 October 2001) one in four people in the world will be affected by mental or neurological disorders at some point in their lives. Around 450 million people currently suffer from such conditions, placing mental disorders among the leading causes of ill health and disability worldwide. Within the 10 years of existence the Foundation has emerged into the main player in the mental health care system on the island. Based this world wide indicator that 25% of a population suffers from mental health challenges on Sint Maarten with 40.000 inhabitants the amount of patients presently in care is 1,600 registered, which covers 15 % of the potential needs for psychiatric health care. MHF offers a full range of care products consisting of:

- clinical care
- ambulant care
- crises interventions
- admissions
- day care
- short/ long stay
- prevention, information and knowledge center

MHF employs approximately 40 employees who cover 35.1 FTE positions and 15 call-up workers. The foundation is aware that there is still a huge job ahead in order to cover the actual need for mental health care on St. Maarten. AS already mentioned in 2016 the MHF is standing on cross roads how to deal with this; the adagio is ‘more of the same and new avenues to be explored’.

1.2 Goals of this multi annual policy plan

The goal of the multi annual policy plan is twofold. First, it gives direction and uniformity to the actions of the staff, management and board of the MHF. On the other hand, it aims to inform stakeholders about the organization of the MHF, the objectives it pursues and the vision from which it acts.

This multi annual policy plan defines the vision, mission, direction, methods and activities of the MHF for the years 2016 – 2018. It will be further prepared, detailed and implemented by means of task forces with clear objectives and time-frames.

1.3 Methodology

This multi annual policy plan 2016 – 2018 is executed by performing desk review of documentation provided by MHF as well as INK management model[1] and multi annual policy planning literature. To arrive at a sound multi annual plan, interviews were initially held with the director, human resource manager and the finance administrator. The framework for this multi annual policy plan was then reviewed and discussed with, the psychiatrists, psychologist, and the human resource manager and department coordinators. Feedback was received from all mentioned above including the new director and added to the document. Finally the supervisory board approved the document.

The National Mental Health Policy Plan of the Island Government is an integral part of this document, since no Multi annual policy plan is available from the Government the Foundation assumes to have chosen the right path with the integration of this plan.

The strategic choices made by management based on the analysis of the external developments (contemporary legislation, realistic tariffs, transparent care chains and clear public relations) and the internal developments (continuous improvement of care products, increased professionalization, monthly/ quarterly reporting, intensified usage of ICT solutions) are described together with the financial impact of the plan for the budget 2016.

The current care products, which are delivered, are described in chapter 2. Chapter 3 focuses on the vision, mission, and principles. In chapter 4 the strategic objectives of the foundation are described. This is followed by a review of the key issues that affect the implementation of the multi annual policy plan.

The quality management approach of MHF is described by elaborating on the following domains:

- Management of processes (Chapter 5)
- Management of employees (Chapter 6)
- Performance areas (Chapter 7)
- Management of finance (Chapter 8
- Special projects and activities (Chapter 9)
- The budget 2016 (Chapter 10)

With reference to 4.1.11. no financial projections for the years 2017 and 2018 are included in this multi annual policy plan as yet. In 2016 – after the new tariffs are in place - the plan will be amended and these projections will be added.

[1] INK means Institute Dutch Quality. INK management model is a model used to self-evaluate the growth stage of an organization

2 Care products

The adherence population of MHF is estimated at approximately 45.000 people. The WHO publishers of adolescent mental health care established in 2012 that 10 - 20% of a population is estimated to experience mental health problems. The WHO also predicts that by 2020 depression will be the 2nd highest cause of disabilities worldwide.

In the past years with improved access to services results are a continued growth in demand for health and social care services on St. Maarten, particularly inpatient, ambulant and intermediate care to support adolescents, youth population or people living with long-term multiple illnesses and forensic care.

Within the 10 years of existence the foundation has emerged into the main player in the mental health care system on the island. The care products delivered by the Mental Health Foundation can be divided into:

- clinical care
- ambulant care
- crises interventions
- admissions
- day care
- short/ long stay
- prevention, information and knowledge center

2.1. Clinical care

A team of two psychiatrists, two psychologists (as of April 1, 2016: 3) and five psychiatric care nurses/ case managers is responsible for consultation and counseling, psycho education and family counseling. The figures below show the number of patients, new patients and consultations from 2010 to 2015 (January to December).

	2010	2011	2012	2013	2014	2015
Consultations	*	4,301	5,409	5,156	6,115	7,946
Patients	235	412	428	575	658	886
New patients	77	276	311	309	430	420

As a result of the increased awareness and the reduction of stigma perceived in the past years, a substantial further increase in the number of consultations and counseling is expected.

2.2. Ambulant care

Psychiatric community care provides care to the community as an outreach measure to provide at home/ site treatment to clients who are physically or mentally unable to leave their home. Social psychiatric nurses and registered nurses (RN), certified in psychiatric/mental health nursing, give support to those who need specialized nursing. The service is offered at the client's home or at site. The goal is to maintain the client's independence and avoid relapse and (re)-hospitalization.

During the period of this multi annual policy plan MHF intends to implement the FACT (Flexible Assertive Community Treatment) model on St. Maarten, Saba and St. Eustatius, in collaboration with SVP-CN, who has implemented FACT method on Bonaire. Assertive Community Treatment (ACT) is an evidence-based practice model designed to provide treatment, rehabilitation and

support services to individuals who are diagnosed with a severe mental illness (SMI) and whose needs have not been well met by more traditional mental health services.

Stein, Test and Marx (Test and Stein, 1978) in the United States introduced assertive community treatment (ACT) in the 1970s. In ACT a multidisciplinary team consisting of 10 FTE cares for about 100 clients with a shared caseload, so that all the members of the team know all the clients. The approach focuses on outreach and on providing persistent and very intensive care and treatment. ACT is indicated for the most severely ill, in particular hard-to-engage patients at risk of hospitalization, homelessness or neglect. Broad impact research has been carried out and fidelity scales have been developed. ACT is internationally recognized as an EBM (Evidence-Based Medicine) intervention.

What can the FACT (Flexible Assertive Community Treatment) model developed in The Netherlands add to such a widely acclaimed model? The reason is that FACT contains beneficial innovations. These innovations first become apparent at the team level, in the daily operation of FACT teams. However, the FACT model also creates opportunities for innovation in a broader field, namely the organization of community mental health care services for SMI individuals in the community.

MHF is aware that it is an extremely ambitious plan but with the experiences of the past year and with the support of stakeholders believes that there is a future for this care method and to ultimately get accredited for it as has happened on Bonaire in 2014.

	2010	2011	2012	2013	2014	2015
Ambulant patients	11	16	20	27	19	113
In % with 2010 as reference	100	145	182	245	173	1,027[2]

2.3. Crisis intervention

Crisis intervention provides 24/7 emergency care to patients that are a potential danger to themselves and/or others, in accordance with the applicable (KZ-) legislation 1922 and 2010. If necessary the MHF facility has one separation room available for treatment/ stabilization.

The table below shows the number of crisis patients from 2010 to 2015 (January to December).

	2010	2011	2012	2013	2014	2015
Crisis patients	55	47	96	110	49	114
KZ	18	12	57	14	15	27

Noticeable is that there is a distinction between voluntary admissions and involuntary admissions of client. The voluntary admissions are based on article 16 of the KZ-Ordinance and the involuntary admissions are based on the articles 13, 14 and 15 of the KZ-ordinance. The MHF has a very strict protocol for the handling of crises intervention under the KZ-ordinance, which is in compliance with the requirements set by the department of public health and the inspectorate of public health of the Ministry of Public Health, Social Development and Labor. The MHF has a KZ – license until December 2016 and will request expansion for the years after.

[2] In 2015 in preparation of the introduction of FACT an assessment of the workload with regards to all known clients has been conducted, with as a result that 1,027 clients are still active in the ambulant system.

Also noticeable is the fact that the MHF with only one separation room does not have sufficient flexibility to deal with the needs. As from 2016 other alternatives will be explored.

2.4. Admission

The inpatient wing has a capacity of 9 beds and provides admission- and 24-hour treatment services to patients with psychiatric illnesses. There are three modes of admission:

- Voluntary admission following a crisis
- Involuntary admission following a crisis as defined by legislation (KZ procedure)
- Voluntary admission

The goal of the admission service is to provide quality evidence-based care on a 24-hour basis to resolve or stabilize a crisis situation or assess and manage the clients' psychiatric illnesses in the shortest possible time. The MHF strives to facilitate a smooth transition into the community.

	2010	2011	2012	2013	2014	2015
Admitted patients MHF	*	17	30	33	61	97
KZ admissions Curacao	21	12	N.A.	N.A	N.A.	N.A.

* Indicates no admissions, care was available as of October 2011
N.A. means not applicable, since patients are now treated on the island

Since the commencement of care products crisis intervention and admission by MHF no patient has been flown abroad for care. A decrease in relapses of patients is now noticeable at MHF because of family involvement from the onset. Care- givers call the foundation at an early stage when they observe changes in behavior of their relative.

2.4. Faraja Treatment Centre

On weekdays the Faraja *day treatment centre* provides therapeutic sessions, psycho-education, enhancement, re-socialization, job training, recreation and entertainment. The objective of the Faraja treatment centre is "to guide and motivate patients with a psychiatric illness to achieve the self-confidence they need to actively participate in society, regardless of their personal challenges." Each client is assigned to a personal mentor who provides encouragement and a suitable care plan that coincides with their mental health, their history and the programs offered. This care plan is filled with teaching various skills, therapeutic activities and training which include: computer skills (computer lab), arts & crafts, candle production, sports, home economics (cooking and cleaning) and job training. A bus transports the patients from and to their home and takes them to outdoor activities. On a daily basis the average number of patients visiting the Faraja Treatment Centre is 31 (20 AVBZ patients, 5 admission patients and 6 patients from the short and long stay). The Faraja Center can facilitate a maximum of 40 patients per day. The following table describes the amount of daycare hours provided for from 2010 to 2015 (January to December).

	2010	2011	2012	2013	2014	2015
Day-treatment hours	24,075	33,784	17,934	17,406	17,056	28,563
In % with 2010 as reference	100	140	74	72	71	119

MHF has entered into an MOU with the Department of Social Services and of Labor Affairs for job placement of clients. This will require adaptation of the offered activities presently keeping clients occupied and an educational facility focused on training clients for the labor market. For the implementation of the MOU the MHF teamed up with the AUC.

2.5. Short and long stay program

The short and long stay that replaced the guided living in 2014 is a re-socialization program. In this program clients acquire the necessary essentials for functional independent living. The program provides one-on-one residential services to those experiencing mental challenges. Through an in-depth and professional assessment process by the case manager and psychiatrist candidates may qualify to participate in the short & long stay program. Once accepted by the AVBZ clients are appointed a mentor who will guide the client through the program based on the agreed care plan. The short and long stay facility can accommodate 6 patients. It is already experienced that this current capacity is insufficient and can become a major bottleneck with regards to re-integrating clients into the community. It has also been identified that there is a need for a night asylum for homeless and persons who live on the streets for other reasons.

2.6. Prevention, information and knowledge center

The MHF works closely together with a variety of local, regional and international media outlets. Information is usually distributed through health updates in the local newspapers, re-occurring workshops and lectures, internal presentations as well as community based presentations, radio and television interviews, website updates, target group focused events and the MHF newsletter. Through these activities the prevention, information and knowledge centre contributes to creating awareness and eradicate stigma and discrimination of persons suffering from mental illnesses in the community.

In 2015 MHF took the initiative of a health care prevention platform. As from 2016 this platform will become a legal entity with a focus on coordinated prevention based on the mission “strong coordinated prevention reduces the increase of cure/ admission/ institutionalization.

3 Organizational references

3.1 Mission

MHF's mission is:

> *'To enable holistic qualitative psychiatric care which is based on agreed budgets and tariffs, by establishing patient's diagnosis, psycho, social and educational needs and by providing for adequate treatment, therapy and re-integration.'*

The foundation hopes to prevent acute and unsafe situations for patients and families both by bringing alternative lifestyles to individuals and families and by monitoring their related progressions.

3.2 Vision

The vision of MHF is to take an integral approach towards guaranteeing continuity and consistency in preventative and quality care, including all aspects of psychiatry, improving quality treatments and care to patients/clients and focusing on re-integration of patients/ clients in the society.

3.3 Organizational structure

The MHF is governed by a board and a general director (with delegated responsibilities). The board comprises of a president, a vice president, a treasurer, a secretary and two (2) general board members. However the St. Maarten Corporate Governance Code and the Ordinance Healthcare Institutions dictate a two tier organization structure consisting of a board and a supervisory board. MHF will implement this supervisory board model in 2016. Consequently the MHF will deploy the following organizational structure.

The supervisory board
In this model the supervisory board has three types of responsibilities, being 1) to render advice to the board, 2) to perform the supervision regarding the implementation of approved plans by the board and 3) a number of specific authorities which are regulated in the laws of the foundation.

The supervisory board will be represented in three committees;

- The financial committee
- The patients council
- The complaints committee

The board
The board will be responsible for managing the foundation in accordance with the articles of incorporation, the Corporate Governance Code of St. Maarten and the foundations articles. The board will comprise of a general director.

As a consequence of the ambition to implement the supervisory board model the articles of incorporation has been amended. The articles of incorporation include rules concerning the duties of the board and the supervisory board and the supervision within the facility, directed to the functioning of the foundation in line with the objectives. Additionally regulations are developed for the board as well as the supervisory board in accordance with the Ordinance Health Care Institutions.

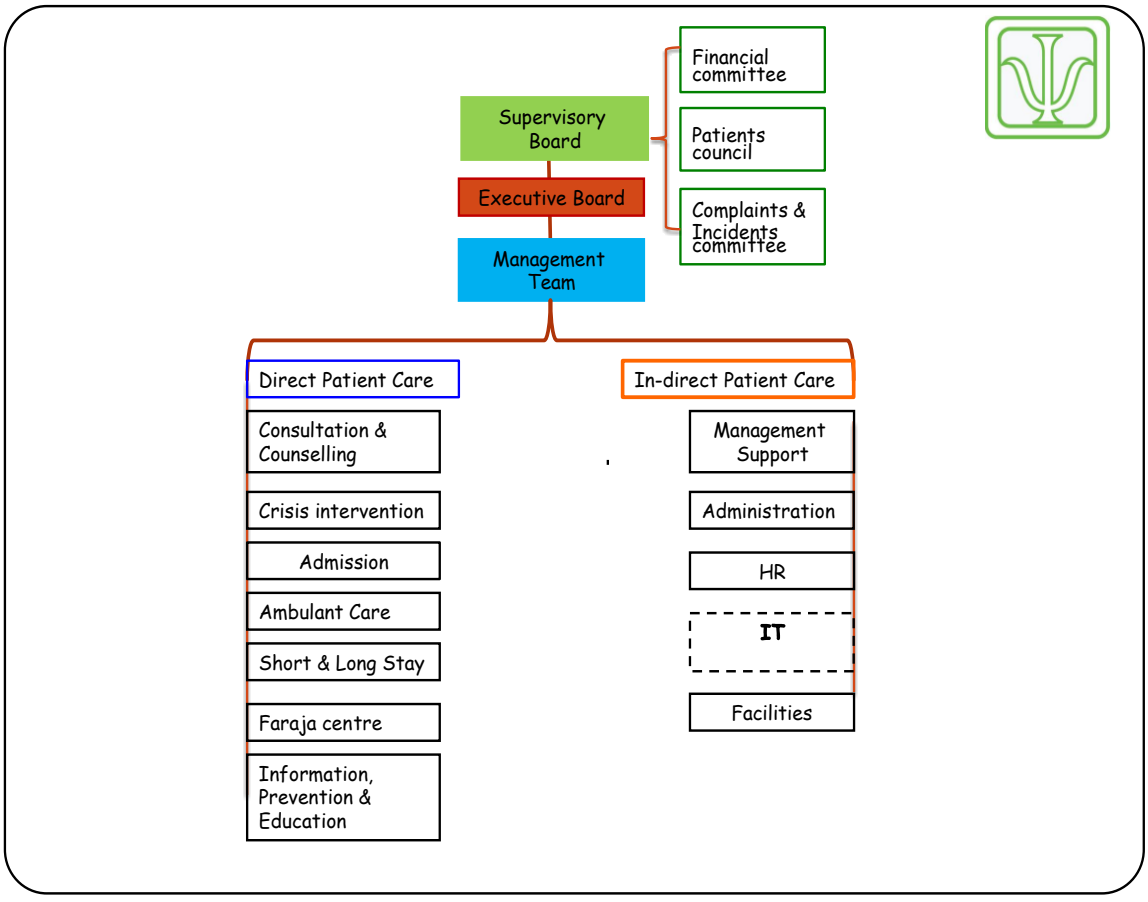
This structure describes the new corporate governance structure, whereby the executive board - comprising of one person - is supported by a management team.

The role of the management team is twofold;

- Direct patient care, with the medical care cordinators/pscyhiatrists and psychologist as important players regarding the medical policies, management of quality care and treatment developments
- Indirect patient care is all that is required in support of providing care to the patients, e.g. financial administration, human resource management, ICT and facilities

The total care coordination is managed by the executive board/ the general director of the foundation.

Organizational Structure as of 2016



The tow medical care coordinators are final responsible for the medical care within the seven care products. The general director if final responsible for all non-medical care aspects within the care products. The administrator and the human resource manager are responsible for their 'own' domains and report directly to the general director.

3.4 Committees

As stated by the Ordinance Health Care Institutions the MHF must have one or more committees with the following tasks:

- The registration of incidents, which are considered undesirable events or a series of undesirable events, whether or not corrected in time, which led, or could lead to undesirable consequences such as death, injury, unnecessary breach of privacy, illness or damage to or loss of equipment or property
- Advising on the supply and distribution of medications on the advice of a pharmacist
- Advising on maintaining optimal hygienic conditions
- Taking care of the development of uniform medical and nursing protocols regarding treatments

In addition the MHF is required to have a protocol in place for the independent handling of complaints about the conduct of the healthcare institution or that of the persons working in the healthcare institution working towards a patient and clients.

In March 2011 the incident and complaint committee (INCOM) was installed. The objectives of the committee are based on the belief that:

- Client safety is central to quality health care as reflected in the Hippocratic Oath: "Above All, Do No Harm"
- Prevention of client injury, early and appropriate response to evident and potential risks, is the key to client safety
- Continuous improvement in client safety is attainable only through establishing a culture of trust, honesty, integrity and open communication
- Client involvement and constant communication between caregivers and clients, by catering to their needs, wishes, and abilities

The committee meets quarterly and reviews all incoming incidents and complaints. The INCOM consists of the following members:

- One representative of management
- One representative of the clients
- One representative of the independent doctors
- Two representatives of the staff members (one from admissions and one from ambulant care)
- A secretary

MHF is also a member of the Islands wide complaints committee since its inception in 2014.

In 2015 the MHF commenced with a committee responsible for the development of protocols, work instructions and processes. The committee started with an inventory and based on that (re) describing the most critical care protocols and processes. As from 2016 this process will continue within the framework of ISO 9001 ‘quality management’.

As indicated by the Inspectorate of the Ministry of Public Health, Social Development and Labor, given the current limited setting the importance of an infection prevention committee and a medication committee is to be considered. However the MHF is planning to develop an infection prevention policy and a medication safety policy and related protocols between internal and external experts.

4 Strategy and policy

4.1 Strategic objectives 2016 - 2018

Since its start in 2006 the Mental Health Foundation has developed significantly and implemented all care products as determined by Government, as established the articles of the foundation in 2001 (Article 2). In the coming years the focus will be on:

- intensified ambulant care by introducing FACT and increase the amount of AVBZ clients, which will influence the amount of crises interventions and admissions
- further intensify and professionalize the Faraja (day care, short/ long stay) programs and increase the amount of clients
- further increase the volume of clinical care (counseling and consultation) especially amongst children and youth
- explore new ways of prevention and information interventions in conjunction with partner organizations
- to address the developments in the market with regards to the needs of child- and youth psychiatry and forensic psychiatry
- further intensify and consolidate the cooperation with key stakeholders in the different markets to ensure continuous care in the care chains
- up-to-date legislation and regulations on health care in general and on mental health care in particular
- strengthening the internal organization and governance structure
- a further professionalization of the whole staff through training and education, development of protocols/ manuals, quality management, team building, personal development plans and staff satisfactory assessments
- continue the usage of ICT solutions to improve the quality of care and to increase the efficiency of the institution, which includes paperless offices, up-grading of relevant reports and more intensive and accurate usage of SQLapius and other relevant soft-ware applications
- further preparations of output financing, which requires up-to-date tariffs that will cover the costs, an accurate internal reporting system on production, productivity and outcomes, other key - parameters and on cash flow
- preparation of new facilities in Madame Estate and Cay Hill that meet the standards of a modern futuristic psychiatric facility to replace the existing facility
- re-branding of the MHF services after being 10 years in the market with the aim of further reducing stigma, increase accessibility and become more contemporary in its corporate identity and image
- networking at a national, regional and international level for support generation, joint planning, partnership and cooperation at various levels
- doing research in close cooperation with the government to identify the prevalence of psychiatric illnesses of the population in general and specifically amongst youth. This information will be valuable for future policy planning and evaluating health care effects

4.1.1. Implementation of FACT

In 2015 a position paper has been drafted with regards to the implementation of FACT. The followings steps will be taken in 2016 and 2017:

Steps to be taken:	*Actor(s)*	*Explanation:*
Decide on the implementation of FACT	MT	MHF chooses to implement FACT with the objective to improve care delivery and reduce admissions and crises
Analyses workload and sharing workload	SG + case managers	Inventory has been done
Discussion paper and start document	SG	The paper outlines FACT and the way FACT should be implemented/ function with a brief action plan
concept approval in MT	MT	
Presentation of FACT in MEM meeting	SG	To get internal commitment with FACT and the implementation of FACT involvement and commitment is key
Introduction of daily FACT meetings	SG + case managers	Monthly meeting will be cancelled and instead a daily 30/45' meeting will take place
Quick scan of MHF ambulant care based on the checklist CCAF	SG + case managers/ CCAF	The outcomes will give a clear view of what needs to be done and what is there already
Development of an action plan based on the quick scan	SG + case managers	The action plan will give direction on all actions that need to be taken and by whom and functions as a guideline
Training FACT team and FACT chair	PL	'Stichting Certficering Fact en ACT' (CCAF) will be asked to deliver training and discuss the criteria
Internal or external appointment of a project leader/ coach	PL/ SG/ MT	The experiences on Bonaire show that this can be very helpful to support the implementation of FACT
Development of FACT packages covering financial costs and care delivery (tariffs)	PL/ SZV/ SVP-CN/ VSA/ SZV	Instead of the present tariff structure new packages should be developed reflecting the FACT approach
Adjustments to the Fact board in SQ	SG/ GC/ IT	Set - up of digi-board in SQLapius
Selection of space/ location for FACT meetings and arrangements of facilities (f.i. beamer)	SG	To start the multi-purpose room will be used and a beamer will be made available
Familiarity with the Assessment instruments	FACT team/ trainers	FACT team needs to get accustomed with the required tools
Test accreditation by CCAF	CCAF	The test accreditation is like a zero base measurement to identify the developments of MHF related to the final requirements of CCAF
Adjustment of the action plan based on the test accreditation	SG + case managers	With the information of the test the existing action plan can be fine-tuned and improved
Start a pilot to assess how it goes	FACT team/ trainers	Trial and error with close monitoring, evaluation and redirecting
Discussion about extra personnel MHF such as social worker and job trainer	PL/ SG/ SVP-CN/ CPS	A sound discussion should be held between the options of in house or outsourced or a combination of both
Discussion about cross organization FACT	PL/ SG/ SCP-CN/ VSA	MHF might need input from other institutions to be able to execute FACT in its full performance
Request for accreditation of MHF by CCAF	MT/ CCAF	The final objective should be clear in terms of required criteria and an action plan how to reach and when
Accreditation CCAF FACT	CCAF	All aspects of the checklist should be prepared well and in place

The adjustment of the action plan based on the test accreditation will be the last activity in 2016.

4.1.2. Intensify and further professionalize Faraja

In 2015 the process to intensify and further professionalize Faraja (day care/ short/ long stay) started with an evaluation of the program. Also a first step was made to get frequent reports about the complete situation/ status of all clients in care. This allows staff members to have insight in the situation and condition of each client and makes client related meeting easier to handle. Using ICT – solutions this process will be continued to allow Faraja to intensify the care delivery and to further professionalize staff.

Looking at the capacity and the present volume, the amount of AVBZ clients can be increased to 25 in 2016 and 30 in 2017. Negotiations with SZV are on their way.

4.1.3. Increase of clinical care

On yearly bases the amount of new clients is still increasing (see chapter 2). Based on all efforts of MHF in the area of promotion, information, but also P.R. and marketing the general practitioners are more eager to refer their patients to the MHF. Also the awareness of the population at large is a driving force in this development. Standard operational procedure is that the MHF conducts a psychiatric intake first followed by a nursing intake. After the both intakes the decision will be taken, what the treatment shall entail or if any supporting assessment by a psychologist is needed.

A target group that will certainly address more intensive is the group of children and youth (until 18 years). The MHF will be building upon the experiences of program's like 'Zippy's Friends' and 'anti bullying'. Most efforts will have school behavior as a first reference. Related target groups are teachers and parents, who, where possible and useful, will be included in the clinical approaches.

4.1.4. Explore new ways of prevention

First of all prevention and information should be an integrated part of each care product. In 2015 a knowledge center has been added to information and prevention as a sort of internal focal point for information about psychiatry, psychiatric developments, conferences and training opportunities.

Also in 2015 the initiative was taken by the MHF and CPS/ Government to establish an island wide prevention platform for health care providers in Sint Maarten. The year 2015 has been used as a pilot and as from 2016 the platform will be formalized and fully activated. The platform is cooperation between health care providers who believe in the intensification of prevention effort by sharing experiences and information and by teaming up where possible.

4.1.5. New developments in the market

In 2015 three new markets were identified as fast growing markets with a lot of needs; children and youth and forensic cases and the employee assistance program (EAP).

Since the start of the children and youth psychologist MHF has more intensified contact with children and youth. In 2015 it has been concluded that the supply cannot match with the demand anymore and MHF decided to increase its capacity with a second child and youth psychologist. One of the reasons for the increase in demand is the fact that almost all systems reduced their non-teaching staff and start referring to SSSD, a supporting agency of Government. Due to the lack of psychiatric services within SSSD, schools, teachers and parents have also found their way to the MHF. Considering the complexity at primary and secondary schools with regards to behavior, social and learning challenges that the schools are faced with, MHF expects a big increase in the amount of referrals of children and youth. With this in mind a sustainable partnership with children and youth psychiatrists is considered. The MHF will also start to explore the possibilities to hire a child- and youth psychiatrist.

In 2015 MHF established the continuation and further intensification of the relation with the Point Blanche Prison (crises interventions and treatment) with a renewal of the existing contract. In 2015 also a new relation has been established with the Miss Lalie Centre (youth 12 – 18) in terms of a contract and with the public prosecutor's office (forensic reports). Also the relation with the Court of

Guardianship (referrals) has been continued. In general this means that four agencies from the ministry of justice are or became corporate partners. Looking at the forensic part of these partnerships it can be concluded that the volume of requests is still increasing and intensifying. It regards crises interventions, consultations and counseling, assessments, short and long forensic reports and sometimes on-call services. It also regards non existing facilities like TBS and FOBA (Forensisch observatie en behandel afdeling). The MHF is willing to work along with the Point Blanche Prison and the Justice Department to further discuss and develop plans for such entities to allow detainee's with a psychiatric condition to be treated apart from prison. For this the MHF embraces the initiative of the prosecutor's office to establish a forensic platform. MHF hopes that this new way overdue challenge will have full support of all parties involved. From the end of the MHF the possibilities of having a forensic psychiatrist will be explored.

In 2015 MHF started to explore the possibilities to establish an EAP (employee assistance program). During a meeting of the HR –platform it was concluded that there is a need for such a care product. This product would cater towards the business community and Government owned companies. The objective of the program is to help employees that are dealing with mental health challenges or addiction problems and for that are not able to function properly. The EAP can help employees and with that their employers to guide and treat these employees so they can become a productive participant in the work force again. As from 2016 the further exploration of the ins- and- outs of this program will continue, to prepare the launching of this new care product.

4.1.6. Cooperation with key stakeholders

First of all MHF continues to strengthen the ties with its clients/ patients, their families and caretakers (MHCPA). This will be done through informative meetings, recreation activities and direct contacts. In this also the general public will be involved on a regular base by means of an open house. In all cases the MHF will ensure that relevant and practical information will be shared with the objectives of capacity building and reducing of stigma.

As a natural partner and in line with developments in other places of the world, the cooperation with Turning Point could be further explored. The MOU that has been signed in 2016 sets the guidelines for such cooperation in general and more specific in the area of ambulant care and the B-smart program. Other areas of development are the issue of continuous on-call availability of psychiatric services on Sint Maarten and the sharing of separation rooms.

Also the White Yellow Cross Care Foundation (WYC) and the Sint Maarten Medical Centre (SMMC) are natural partners. With WYC the cooperation with regards to psychiatric services and dietitian should be continued and further explored. With SMMC the cooperation with regards to facilities should be continued and if possible in the area of psychiatric on-call. The MHF is also willing to participate in the development of a new hospital facility with regards to a psychiatric ward (PAAZ). Last but not least the kick – off of the Health Care Federation is projected to take place in 2016 and will have its challenges as of then.

Another important corporate partner is SVP-CN. The MHF has become an important hub for psychiatric services to the population of Saba and Sint Eustatius. This allows the MHF to also deal with clients that full under the jurisdiction of The Netherlands, which come with the challenge to comply with related rules and regulations.

The Ministry of Public Health, Social Development and Labor is another important key stakeholder. The MHF is willing to participate in amendments to existing laws and regulations with relation to health care, such as: the KZ-ordinance (up-date), the AVBZ ordinance (addiction) and the Ordinance for Health Care Institutions and Medical Equipment (Hospital requirements). Also participation and decision making from the Ministry is required with regards to the establishment of new tariffs related to mental health care. Last but not least a position needs to be taken on the financing of: uninsured; prevention and information; crises interventions (KZ); mortgage. The discussion about these subjects relates also with SZV.

The Ministry of Justice is also another important key stakeholder. In paragraph 1.4.5. the importance has already been elaborated upon.

SZV and NAGICO, ENNIA and the Guardian group (Fatum) are also key players when it comes to mental health care. In fact they create the financial framework for the execution and delivery of care. In the coming years the following developments are expected to happen: a new tariff structure for mental health care; further digitalization of the billing and payment structure; including new care products/ packages in the insurance package; a clear understanding about the dealing with uninsured (emergency fund).

In general MHF does not want to be or remain a stand-alone institution; MHF is seeking for partnerships with relevant organization and institutions to enhance the care delivery to its clients/ patients and to develop new care products and/ or approaches for new markets and target groups.

4.1.7. Up-date legislation

In paragraph 4.1.6. this objective already has been addressed. MHF realizes that changes in laws take time and by time can meet some resistance. The MHF will spearhead the most importance changes in terms of developing white papers as a starting point of the process.

4.1.8. Strengthening the internal organization and governance structure

In the past policy period a set of measures has been initiated to upgrade the organization to a level that fits the number of employees and that is in compliance with the law “Wet op de Zorginstellingen en medische apparatuur”. Some examples are the recognition as a hospital, corporate governance code, organization structure, streamlining of the archiving system, digitalization, development of care and non – care protocols and in-house workshops for employees.

Moreover MHF hopes to continue improving the effectiveness, productivity, satisfaction and safety of our employees. Our efforts will be geared to setting up and improving the data collection and processing systems, using affordable IT technology. Aspects, like evidence-based interventions, early recognition and treatment of mental disorders, quality performance indicators will be incorporated in our information and prevention programs as described in chapter 5.

The former Island Council of St. Maarten enacted the Corporate Governance Code in 2009 obliging the MHF to comply with the rules and requirements of the code. As indicated in the financial statements the foundation is too small to comply with all the rules and requirements of the code; however management and board are committed to maintaining good practices in the

area of good governance and continue to work on the integrity and sustainability of the foundation.

In the coming three years management will strive to close the gap on compliance to the code on the following rules and requirements:

- Draw up a financial statement and report within 5 months of year closing
- Appoint a maximum of 7 board members at any time and fill in vacancies within a short period of time
- Establish an internal audit department. As soon as the financial position of the foundation is stable management will hire an internal auditor or contract internal auditing services. This is forecasted for the year 2017
- Align the organizational and communication structure

4.1.9. Professionalization

The MHF supports the vision of the continuous learning process, based on the principle that the only certainty in life is that there will always be change. In 2015 the MHF took the initiative to link a knowledge center to the care product information and prevention. This knowledge center became the focal point for the selection of education and training requests and needs. The center started to make a calendar of all scheduled activities such as internal workshops, workshops with external experts, conferences and training courses.

Another area of concern is quality management. In 2015 the MHF started a process of inventory and develop protocols/ manuals using ISO 9001 'quality management' as a reference. Where possible and feasible the development of new and the evaluation of existing protocols and manuals will be executed in conjunction with the Inspectorate of Public Health and the financial auditors. The protocols and manuals will be used as standard operational procedures (SOP) and will become guidance for the delivery of treatment and services. This process will be continued in the coming years.

Last but not least on a very personal, individual level the professionalization will be guided and supported by efforts in the areas of: performance based management evaluation; team building, personal development plans and staff satisfactory assessments.

To support all these efforts the budget 2016 has a special provision for both training and education and quality management. By doing this the MHF tries to prepare itself on external developments such as the introduction of the BIG and the quality requirements as stated in the law.

4.2.10. ICT solutions

In 2015 a campaign to optimize the usage of ICT – solutions has been started, with as a result: a secured triple back-up system; a double internet back-up system; a full Wifi coverage; soft-ware for asset management; fire-walls security throughout the building and a centralization of data with access authorizations.

In 2016 and beyond this process will continue with the usage of ICT solutions to improve the quality of care and to increase the efficiency of the institution, which includes paperless offices; standardization of hard-ware in terms of thin clients; stimulation of flex-work throughout the

building; up-grading of relevant reports and more intensive and accurate usage of SQLapius and other relevant soft-ware applications.

4.1.11. Output financing

In March 2015 it has been decided that the MHF will retroactively not receive any subsidy from Government anymore to cover its operations as per January 1, 2015. Even though there are still some area of discussion (paragraph 4.1.6.) it is clear that the MHF will further develop in the direction of output-financing covered mainly by health insurances. In 2016 an agreement should be reached with SZV and the Ministry of Public Health, Social Development and Labor about the new tariff structure (paragraph 4.1.6.), based on the cost price calculation of the different care products.

As a result of this output-financing system the MHF needs to change and adjust its internal reporting system on production to hold track on the progress of the revenues in relation to the costs. For this as from 2016 quarterly reports will be developed, presented, analyzed and discussed on: all care products, human resources, finances, ICT and facility management. These quarterly reports will function as a management tool within the frame-work of the output-financing system.

Last but not least within this new system the need for accurate monthly cash flow overviews becomes an important requirement, with projections on the months to come.

4.1.12. Enhancing and improving quality care

The quality of care is determined by the extent in which the input and the healthcare process meets the quality standards, as laid down in the legislation and what has been agreed upon in the sector. The basis for the Mental Health Foundation is primarily formed by, the ordinance healthcare institutions and medical equipment. The ‘ordinance healthcare institution’ is a framework law. That means that the law outlines the main themes that healthcare institutions must address. It is the responsibility of the healthcare institution itself to indicate the manner in which interpretation is given with respect to the requirements of the law.

According to Article 10 of the ordinance healthcare institutions, professionals and equipment every healthcare institution takes care of the systematic monitoring, control and improvement of the quality of care. To this end the health care institution ensures:

- The systematic collection and registration of data on the quality of care;
- Based on the data systematic reviewing to which extent the manner of implementation of the Ordinance regarding the quality of care leads to responsible care;
- On the basis of this review improving the quality of care if necessary;
- Ensuring formalized discussions between the management and the divisions or sections of the healthcare institution with reference to the quality of care.

The main activities to determine and control the quality of care will be described in chapter 5 till 7.

4.1.13. Professionalization by upgrading the capacities of the staff members and implementing personal development plans

MHF has at all times been aware of the pivotal role the employees play in the establishment of mental health care. From the onset job descriptions have been utilized and staff has been evaluated at least annually, regardless of the fact that the foundation did not have a HR department. In 2014 a quick scan was performed by FWG, which included recommendations for the implementation of a function appraisal system (chapter 6 & 7). An HRM department has been set up for the management of the function appraisal system. Staff can now be evaluated based the targets set and the progress made, at least three times per year. This system will provide, timely intervention if targets are not met and adjustments can be made if deemed necessary; the ultimate goal is job satisfaction.

The AVBZ-fund has now committed to an addition of 2% per salary of employees for education purposes; the foundation is hoping that SZV will follow the lead of the AVBZ-fund also for other funds in the new tariff system. If that is the case, MHF will be able to adequately plan education of staff to meet the needs of the foundation. This is a dire need for the foundation because qualified psychiatric health care workers are hard to come by and experience has learned that training local staff on the job supports continuity of care. Staff from abroad requires adjustment and are generally not persons who would like to stay on the island ling term.

4.1.14. Further improve information, prevention and mental health education

For years the foundation has been providing information and prevention with one employee, requests from schools for sessions about mental health have been turned down due to lack of time. Media sessions have been ongoing in many forms in an attempt to reduce stigma and encourage timely treatment attempting to prevent long-term chronic illness. With the extra financing for education an extra staff member is budgeted, to assist in, not only educating staff but also stakeholders and the public in general. The information and prevention activities will be ran through events organized by third parties and through own events. For this a year calendar 2016 has been developed. The year 2016 will also be used to celebrate the ten years of existence as an operational mental health provider.

4.1.15. Strengthening the financial position and structure of the foundation by improving marketing and outreach strategies

By consolidating the care products of the foundation and, as by implementing budgets per care products as per January 2015, the foundation is now in the position to create marketing and outreach strategies.

In 2015 the foundation scheduled the re-calculation of existing tariffs. The next step is to negotiate the tariffs with medical insurers and government. The SZV tariffs are bound by legislation and require permission from government.

Presently the SZV tariffs, which covers 60% of the clients seen, are extremely low and not all treatment options, developed in psychiatry over the years have tariffs, this is the reason for MHF to request subsidy. The foundations subsidy is based on the fact that the present tariffs do not cover the actual expenditures of the necessary treatments.

With an adequate tariff system in place, the foundation will be able to provide and account for:

- Quality care
- Continuity of care
- Improve marketing local as well as regional
- Create out-reach strategies lowering the threshold for persons seeking mental care on time and preventing serious chronic mental illness.

4.1.16. New facilities

The foundation purchased an old hotel adequately located near the SMMC in 2010. The committee of board and staff was well aware of the risks involved in renovating an old building with a low budget. So far however the facility has served a great purpose, creating admission possibilities including crisis which was previously not possible locally. MHF also adequately dealt with the backlog of psychiatric care and to date is still attempting to facilitate all needs of psychiatric patients.

More adequate data has become available (year reports MHF) to now be able to determine what the actual needs of patients and clients are. MHF has focused and is attempting to professionalize its ambulant care (FACT chapter 2). This method saves costs and prevents the need of institutionalizing patients; however there are at all times that some clients will need a form of guided and or protected living facilities.

The future plans are to build a new Mental Health Facility on the government land allocated to the foundation and the present location can be utilized for guided and protected living. The financing options are being studied and a project dossier is to be developed.

The project 'new housing facilities for MHF services' (Project.MHF.NHF.002 version 25062015) - that was started in the mid of 2015 - describes the present situation of the facilities of the Mental Health Foundation. Some of the conclusions of the project are that:

- The present building is not 100% suitable for mental health services
- The present building is not in a good condition
- The present building has become too small
- Some of the services should be split and divided over different locations (guided living)
- Inclusion of addiction rehabilitation and forensic services should be taken into consideration

The MHF is aiming at the preparation of new facilities in Madame Estate and Cay Hill that meet the standards of a modern futuristic psychiatric facility to replace the existing facility. The MHF is presently in the process of finalizing the request for proposal. The very optimistic objective is that the MHF will enter into a new building in the end of 2017.

4.1.17. Re-branding

In 2016 the MHF celebrates its 10 years of being operational. This is also an important moment to look back and evaluate. Based on feedback of some of the general practitioners the MHF should reconsider its name and image. The name Mental Health Foundation does not reflect what the institution is aiming at. For instance the wording mental health is a source of the creation of stigma and discrimination; it reflects more the problem than the solution. The word foundation is totally irrelevant for the market. Presently the MHF is busy to explore the possibilities to increase accessibility and become more contemporary in its corporate identity and image.

4.1.18. Networking at a national, regional and international level for support generation, joint planning, partnership and cooperation at various levels

As stated earlier in this multi annual policy plan The MHF continues to establish a working and sustainable cooperation with all stakeholders and will continue to do so in the future in order to achieve its objectives. The main stakeholders are:

- General Practitioners and their associations
- Ministry of Public Health, Social Development and Labor
- Ministry of Justice
- Turning Point Foundation
- White and Yellow Cross Care Foundation
- SMMC
- Specialists' Association
- SVP-CN (Stichting Verslavingszorg en Psychiatrie Caribisch Nederland)
- GGZ Curaçao
- Capriles Clinic
- Psychiatrisch Centrum Suriname
- InGeest
- Parnassia Group
- Novadic Kentron

As stated in the National Health Plan 2014 -2018 the Ministry of Public Health, Social Development and Labor is the responsible agency for developing, health policy plans and legislation in the country, acknowledges the need to foster formal specific collaborations between government departments and specific agencies on St. Maarten on mental health issues. Turning Point Foundation (addiction care center) is an important institute on St. Maarten considering that; worldwide addiction and psychiatry are related, in the sense that many patients have a dual diagnosis. MHF and TP do work together while a formal working relationship does not exist. The main challenge is that on St. Maarten addiction, by law is not seen as an illness. General Practitioners are also considered important partners because many patients continue care by their GP, MHF reports on a regular basis to the GP of the patient, regarding treatment.

Furthermore signed service agreements and agreed upon working relationships between St. Maarten and The Netherlands including the Dutch Caribbean Municipalities are prerequisites to formalize the relationship in the field of addiction care and psychiatry, with emphasis on the possibilities of intensive ambulatory care on Saba and St. Eustatius.

Locally MHF has a formal agreement with WYC whereby 10 hours of psychiatric care is purchased from MHF and MHF purchases 8 hours of diet care per month. Also a MOU has been signed between the MHF and Turning Point.

Another important partnership, that is in a developmental stage but which will be formalized within the period of this multi annual policy plan is with the St. Maarten Medical Center. For MHF patients with depression and for patients of SMMC that develop mental problems related to their somatic illness a so-called PAAZ is anticipated in the new building plans of the hospital.

4.1.19. Research

In close cooperation with government to identify the prevalence of psychiatric illnesses of the population in general and specifically amongst youth will be identified. This information will be valuable for future policy planning and evaluating the results of the treatments and care provided. Research is a tool to aid prevention and timely adjustment of mental health care policies.

5 Management of processes

5.1 Development of protocols and working instructions

To ensure the overall quality of care delivered, reduce practice variation and improve transparency, the MHF performs in compliance with protocols, manuals and work instructions. The purposes of the protocols, manuals and work instructions are to standardize the care, support caregivers in decision making and to evaluate treatment afterwards. The MHF has installed a protocols and quality management committee supervised by the director in 2015. The tasks of the committee are to develop, enforce and evaluate protocols, manuals and work instructions and to provide access to uniform medical and nursing protocols. The protocols will be revised at least every two years.

5.2 Description of key processes

All key processes will be described, approved and documented in a manual in order to optimize the internal control system, financially, human resource as well as with regards to production. Once implemented the inspectorate, accountant and other (quality) auditors can rely on the internal control system and together with the tiers of controls base their audit plans on this system. This will help to increase the efficiency and effectiveness of such audits, as well as the support of quality care and the management thereof.

5.3 Implementation of a document management system

The foundation intends to implement a document management system (DMS) in which all protocols, work instructions, process descriptions, etc. can be managed. Issues like version management, accessibility, authorization and security will be solved.

5.4 Controlling and monitoring processes through process indicators

In order to control, monitor and if necessary adjust processes the MHF has started implementing performance indicators per care product and service in 2015. Performance indicators will provide insight in the care and service process and assist with internal control and improvement (internal indicators). In addition performance indicators can be used to compare the performance of the MHF with similar institutions (benchmark). On a quarterly bases reports will be available that shows the performance of that quarter and can be compared with the same quarter in the year before and with other quarters in the same year.

Finally performance indicators will be implemented for rendering accountability to the Inspectorate of Public Health, the Social and Health Insurances (SZV) and the Ministry of Public Health, Social development and Labor (external indicators), when requested.

The health information systems (SQlapius) used within MHF should regularly collect and report data on mental health service delivery, which should be broken down, at a minimum, by gender, age, nationality, insurance, diagnosis and delivered care. These data should be used routinely for evaluation and should be reported to the relevant authorities, and used as a basis for improvement and expansion of services.

For this purpose the basic set of indicators that are suggested in the National Health Policy and Plan of Action (objective 4.1.1.2 in 2015) will be reviewed, for its adaptation and gradual implementation.

Some examples of performance indicators are[3]:

- The percentage of clients whereby the seriousness of the problem has been systematically measured
- The percentage of the treatments whereby the patient has expressed to experience the improvements and stabilization as a result of the provided treatment
- The percentage of patients that; after being discharged from admissions receives ambulant care within 2 weeks by the same organization and/or caregiver
- The percentage of clients that receives medication and that has an accurate record of the medication subscribed
- The percentage of clients that after treatment relapse
- A daily measurement of the improved functioning of the patient
- The level of satisfaction of the client with the services rendered

In 2015 the MHF developed a client satisfactory measurement tool. As per January 1, 2016 the MHF will start measuring with the usage of this tool.

5.5 Complaints procedure

The MHF strives to provide responsible and safe care. However, there may always be situations where the care does not meet the expectations of patients/clients and/or their families. For these situations, the MHF provides for a complaints procedure. As indicated earlier the INCOM committee executes the complaints procedure. The INCOM committee records all incoming complaints and mediates between the parties involved.

In general the MHF encourages patients/ clients and/or their families to file complaints when they feel they were not treated well. By doing this the MHF hopes to learn more about the quality of care delivery and of its staff and to move away from the complaint image of 'finger-pointing'. The goal is to evaluate the complaint and incident procedure at least once a year. This procedure will be benchmarked against that of partners. Subsequently potential improvements will be identified and implemented.

The MHF also encourages staff to report about all incidents that occur with clients/ patients and/ or their families. All incidents and complaints should primarily be dealt with in the organizations, however if the person complaining is not satisfied with the results in the organization, he or she can decide to report to the islands wide complaint committee.

5.6 Safely reporting incidents (SRI)

The foundation defines an incident as an event or circumstance that could have, or did, result in unintended or unnecessary harm to a person, unnecessary breach of privacy and/or loss or damage. The objective of SRI is to prevent and control risks in order to improve the quality and safety of the care. To report safely a safe culture is essential in which the focus is not on the failure of individuals but rather the absence or malfunctioning of procedures, arrangements and safety barriers. The conditions under which employees report incidents should be organized in a manner that incident reporting safeguards the individual.

Incidents can be reported by filling out an incident form from the MHF intranet and sending it to the secretary of the INCOM committee. The INCOM committee records all incoming incidents and submits proposals for improvement measures. The foundation acknowledges that, the staff does

[3] Basic set of risk-indicators psychiatric health care and addiction care 2013

not have sufficient acquaintance about the purpose of SRI and the situations in which an incident should be reported. Therefore the foundation will continue to put some extra effort in informing the employees and encouraging them to report incidents.

5.7 Outside-in

In accordance with the 'ordinance health care institutions' the MHF will involve her patients/clients and referrers in the quality policy. The MHCPA (mental health caregivers and patient association) will be encouraged to get involved with suggestions presented to the foundation to benefit patients and clients. Also the general practitioners will be approached about their experience with the MHF. In order to enable the care recipients and referrers the opportunity to share ideas, suggestions, contributing to plans or proposals for improvements, the foundation will conduct frequent research.

6. Management of employees

6.1 Personnel planning

The current number of Full Time Equivalent is 41.5 Based on the expected service level there will be an increase in personnel from 46,5 FTE in 2016 to 49,5 in 2017.

Personnel Planning 2015- 2018

	2015	2016	2017	2018
Indirect personnel	14,5	14,5	14,5	14,5
Direct personnel	27,0	32,0	35,0	35,0
Total FTE	41,5	46,5	49,5	49,5

6.2 Upgrading the capacities of the staff members

Improving quality strongly depends on the experience, knowledge, skills, behavior and attitude of the employee. Developing the competencies of the employee is therefore a determining factor and should play a key role in giving substance to the different HRM instruments.

To further professionalize the HRM aspects and to create more transparency and consistency within MHF it is imperative to ensure that the administrative elements provide a solid foundation to support a strategic HRM. In the chapters 4 and 5 measures are elaborated on in support of HRM.

From the onset MHF has utilized job descriptions and evaluation methods that are designed in consideration with the objective of function, rating systems and the organization's objectives and vision, providing a starting point for among others job evaluation, personnel planning, recruitment and selection. In order to align the HRM policies of MHF with the HRM policies of SMMC and WYC, it is a condition that all three organizations use the same function rating system. Introducing job descriptions based on the same rating system is therefore highly recommended. MHF will also start with the implementation of a performance based evaluation system, in which goals will be set for all employees at the beginning of the year, a progress evaluation will be held in the middle of the year and a final job evaluation will follow at the end of the year. The performances will coincide with this multi annual policy plan and year plan. In the case of good or excellent performance incentives will be considered.

Currently MHF does not have a formal salary structure; in 2015 the MHF has aligned its salary structure with the SMMC and WYC function appraisal salary scales system in 2015. As of 2016 a trajectory will start together with FWG to: evaluate and adjust the job descriptions; to rate/ appraise/ value the job descriptions; to develop a salary structure; to match the functions with the salary scales and to link this system to the performance management evaluation system.

With a limited labor market the focus will be placed on training and the development of the current staff, based on a personal development plan. This long-term focus and is crucial to improve quality. An overall education plan will be developed by the knowledge center to train staff in key competencies. This is a high priority aspect.

Securing funds to execute the education plan is a prerequisite. AVBZ has budgeted an additional 5% of the salary costs for the personnel attached to the care products financed by AVBZ. In this

multi annual policy plan MHF has forecasted this percentage for the total workforce. MHF is relying on the support of SZV to support this initiative from AVBZ and the other funds in order to be able to provide for an overall education plan for the entire team at MHF.

As stated in a HR Quick scan performed by the FWG, efforts should be made regarding the upgrading and development of the competencies in the organization.

Development and education	Role development Competency	Needed
Develop education plan	Establish competency deficiencies	- Require time and effort of staff HR staff - Funding once established
Personal development plan for each employee	Consider personal competencies	- Require time and effort of staff HR staff and supervisors - Internal support
Develop plan to incorporate short term employment with the education plan	Recruit persons who can help develop current staff	- Require time and effort of staff HR staff - Internal support
Streamline evaluation form	Consider competencies	- Time HR staff and department heads - Internal support
Separate job satisfaction survey	Neutral	- Time and effort HR staff
Evaluation and Incentive		
Develop an incentive system	Link reward to developed competency	Consider financial constraints
Salary raise	Link salary raise to level of developed competency	- Salary scale structure needs to first be is developed - Financial consequences reviewed

7 Result areas

The foundation will continuously monitor the evaluations by the employees, clients and other stakeholders. Direct measures are derived from the satisfaction polls, incidents and complaint reports, audit reports and inspection reports. Based on the results of the measurements the MHF will take the necessary measures for improvement.

7.1 Employees

The extent to which the MHF meets the needs and expectations of the employees will be measured based on:

- Performance based management system (direct)
- Employee satisfaction (direct)
- Personal development plans (direct)
- Sick leave (indirect)
- Productivity and turnover (indirect)

7.1.1 Performance based management system

This is a system of systematically evaluating staff performance based on 3 moments of measurement:

- At the beginning of the year
- After six months
- And at the end of the year based on the agreed performance indicator

7.1.2 Employee satisfaction

The MHF plans to execute a satisfaction survey amongst her employees in 2016. In the Employee Satisfaction Survey (ESS) the employees are asked to rate the personnel policy and the method in which this is implemented in practice. The ESS focuses on all aspects of the functioning of the employees within the MHF including:

- The pursued personnel policy
- Development opportunities
- Workload and work pressure
- Communication and coordination with management
- Working atmosphere

The results of the survey 2016 will be used as a baseline measurement to monitor the satisfaction of the employees. The intention is to repeat the ESS once a year.

7.1.3. Personal development plan

All employees will be invited to develop a personal development plan (PDP), with targets on knowledge, skills and attitude/ behavior. It also expresses the desirable career path within and outside MHF. The PDP will be one of the checklists during the performance based management system.

7.1.4 Sick leave

The following figure describes the sick leave percentages in 2012, 2013, 2014 and 2015 (January to December)

	2012	2013	2014	2015
Duration sick leave (days)	132	152.5	163.5	

Duration maternity leave (days)	60	30	60
Sick leave % (excl. maternity leave)	1.0%	1.5%	1.6%

Although sick leave data does not give direct information on the valuation by the employees they can give an indication that the employees are satisfied with the workload.

7.1.5 Productivity and turnover

MHF will incorporate the indicators about productivity and turnover in the periodic reporting and decision-making.

7.2 Customers

The MHF distinguishes two groups of customers being patients/clients (inpatient and outpatient), but also referrers GPs, SMMC, White Yellow Cross Care Foundation, etc. In order to identify the valuation of the customers the MHF will make use of the following instruments:

- Personal meetings and discussions with patients/ clients
- Patients/clients satisfaction (direct)
- Referrers satisfaction (direct)
- Complaints registration (indirect)
- Incidents registration (indirect)

7.2.1. Personal meetings

The MHF staff will as much as possible stay in touch with the wishes, feedback and suggestions of patients/ clients. This does not only give a personal touch to the care delivery, it also helps to increase confidence and it generates information about the care delivery.

7.2.2. Patients/clients satisfaction survey

The MHF introduced in 2016 yearly patients/clients satisfaction surveys. The satisfaction of the clients will be measured based on the following dimensions:

- Availability (physically as well as by phone)
- Openings hours
- Waiting time
- Information services;
- Accessibility
- Quality of care
- Client focus and expertise of the staff
- Privacy

7.2.3. Referrer's satisfaction survey

The MHF considers it essential to evaluate the satisfaction of and the cooperation with the key partners (referrers) as part of its quality system. In order to measure the satisfaction and cooperation the MHF intends to implement a satisfaction survey amongst the GP's, SMMC, White Yellow Cross Care Foundation, Turning Point Foundation, SVP-CN, the prison and the police.
The survey will be repeated once a year. The satisfaction of the referrers will be measured based on the following criteria:

- Quality of service
- Accessibility
- Availability during an emergency

- Availability for consultation
- Information service
- Knowledge exchange

7.2.4. Complaints and incidents registration

As indicated earlier the INCOM committee records all incoming complaints and incidents and mediates between the parties involved. The following table presents the amount of complaints and incidents handled by the INCOM committee in 2013, 2014 and 2015 (January to December).

	2013	2014	2015
Complaints	3	1	5
Incidents	8	4	11[4]

Based on the current procedures the system will be improved by re-defining what complaints and incidents are and introducing different risk categories and action protocols based on these categories.

7.3 Society

In this multi annual policy plan 2016 – 2018 the MHF focus is on making choices and improving the quality. Driving “Quality Improvement‟ is at the heart of our policy and will:

- Improve patient safety
- Contribute to mental health care outcomes and impacts
- Improve patient and care giver experience
- Decrease macro-economic, business and community losses
- Guarantee Corporate Social Responsibility (CSR)

[4] The increase of the amount of incidents and complaints is the result of an active campaign to file reports.

8. Future challenges

The following are considered the main issues, which may impact the realization of the multi annual policy plan.

8.1. Acknowledgement as a hospital

Until 2014 there were merger demands and plans in place between the MHF and SMMC. This would automatically allow the MHF to be acknowledged as a hospital. Based on a quick scan in 2014 and a report about the outcome of the quick scan in 2015 between SMMC and the MHF it has been concluded that cooperation could be interesting on certain domains but that a merger would not have an added value and would even be a risk for the continuation and quality of care. In 2015 the MHF has been advised by the Ministry of Public Health, Social development and Labor to start preparations to become acknowledged as a hospital facility. As from 2016 the MHF will start the process of becoming acknowledged as a hospital.

8.2. New building

MHF is encountering many problems in the present building because:

1. The basic construction is in poor condition requiring much upkeep, more than was anticipated
2. Renovating an old building does not mean that such a building is adequate for mental health patients. The admissions ward is dark and has no access to a garden where clients can walk around
3. Expansion, to facilitate the increasing care demands at the present location is not possible

The design and plans are available and MHF is now looking into the possibility of financing this new building and creating guided living apartments on the old location. Because of the great importance of this possible expansion we will continue communicating with all stakeholders to acquire the necessary permits and funding. If these plans materialize, we expect the new facility and additional apartments to be ready for use some time after 2017.

8.3. Collaboration agreements

From day one of its operation, the MHF has attempted professional cooperation with the other care providers on St. Maarten. Some progress has been made with respect to addiction patients together with Turning Point in terms of a MOU. There is also an agreement with WYC and an agreement with SMMC on facilities and possibly a PAAZ department and on call-assistance in the near future. With MLC a brand new agreement is on its way and the agreement with the Point Blanche prison has been amended and is also ready to sign off.

Both, board and management of the MHF will continue their attempts to cooperate with other care providers. This includes cooperation in St. Maarten, within the Caribbean, within the Kingdom, with Amsterdam through the Island government and with Suriname. This should be, amongst others on the following subjects: personnel exchange, training, internships, in house training, special projects, research and new methodologies.

MHF is of the opinion that especially cooperation within the Kingdom creates not only efficiency, but will also enhance the level of quality of mental health care.

8.4. Hiring of qualified staff

Another main challenge the foundation has been facing over the years is finding qualified staff. It cannot be assumed, that within the present legal framework, which requires quality standards and training-on–the-job that this can be done without qualified staff. In order to comply with the

legal standards a minimum of qualified staff must be available to deliver quality care products. MHF participated in the; 'Flinx recruitment expo Dutch Caribbean', in Rotterdam (FRED) in 2015 and increased the amount of St. Maarten professionals that were attracted. In 2016 the MHF will participate again together with SMMC and WYC.

8.5. National health policy/legislation

With regard to the government MHF strives to adhere to the National Mental Health Care Policy and Action Plan (launched in August 2014), in which the following building blocks for the future of mental health care are formulated, among others:

1) Prevention of and breaking with taboo (in progress)
2) Access to Mental Health Care (in progress)
3) Community – based and ambulatory care (FACT) (in progress)
4) Leadership's role of government
5) Quality, professionalism and research

MHF is pleased to work together with the Ministry of Public Health, Social Development and Labor on the modernization of legislation and tariffs in relation with mental health care and addiction related specific laws (e.g. KZ/ BOPZ/ AVBZ) and health care laws in general.

In general the strategic objectives of the MHF are in line with the national strategic objectives, although the interventions, performance indicators and timeframe to realize such objectives may differ.

8.6. Subsidy and break-even tariffs

As stated before, the current legal tariffs for the secondary psychiatric care are heavily outdated and of such a low level that no professional care can be given from only the revenues from tariffs alone. On the other hand the quality requirements have increased over the years with higher costs as a result. Also adjustments for costs of living and room for training and education or normalization of salaries with the market require sustainable financial coverage. As long as realistic tariffs, that cover the total costs, do not replace these tariffs, the MHF will remain dependent on substantial financial contributions from SZV and even from Government to assure the required level of quality care. This is not the exclusive problem of the MHF; the other care providers on St. Maarten also face this situation. Although MHF has done a few modest attempts, it can ascertain that it is not in its range of influence to change this financial situation. In case the budget cannot be increased MHF has to consider a fast downsizing of its operations and staff.

Of course the MHF has been pro-active in 2015 and has been working on internal cost price calculation for the seven care products, based on the principle of full coverage of costs. Hopefully in 2016 this will lead to an adjustment of the present tariffs, allowing the MHF to further continue its care delivery and develop in such a way that also new needs can be covered. The MHF is positive about this process and is looking forward for the years to come with a very positive mind.

9. Special projects and research

Last but not least in this chapter some important project are explained and addressed.

9.1. FACT

The implementation of FACT has been explained already in paragraph 4.1.1.

9.2. MOU

The execution of the MOU has already been explained in paragraph 2.4.

9.3. EAP

The development of the EAP has been explained in paragraph 4.1.5.

9.4. Zippy's Friends

MHF has allocated funds through the 'Cooperative funds" foundation from the Netherlands. This is a project that is coordinated by the psychologist. Zippy's friends is a youth project to create resilience in youngsters teaching them to deal with difficult situations and bullying. Psychology deals with many problems in schools whereby both teachers and student have problems with their coping skills. Many children require testing to establish their intelligence level, this is time consuming and one psychologist is no longer able to deal with the amount request coming in. The foundation hopes that with this program teachers will be able to better deal with problem children and reduce the amount of treatment requests. In 2016 the next phase of this project will be started, which includes the involvement of all primary schools.

9.5. Research

Research is another focus of the foundation for the coming years. It has not been budgeted in this plan. Hopefully with the support from Government, funding can be applied for. Without adequate data regarding the prevalent care needs on St. Maarten the future will be difficult to anticipate. Primarily research is to be geared towards patients' needs and quality care and the evaluation of care delivery.

9.6. Year MHF celebration

The MHF has been established in 2001 and became operational in 2006. This means that 2016 is the first lustrum of the institution. In 2015 the preparations started to prepare the celebrations during the whole year 2016 with its climax in the last part of 2016.

Budget 2016

10. Budget 2016

Forecasted annual budget 2016

The following table shows the forecasted annual budget 2016, both in terms of income and expenses. The budget 2016 has the actual expenses 2015 and 2014 as a reference. In the footnotes some trends that are included are explained. Further explanation is presented on the next pages.

	Actual	Actual	Budget
Operating income	**2014**	**2015**	**2016**
Consultations	452.7	545.2	851.7
AVBZ budget	1,514.0	1,514.0	1,611.1
AVBZ budget mortgage	185.8	185.8	185.8
Admission	601.3	517.8	847.4
Government Subsidy / SZV Supplement	1,605.5	1,605.5	1,835.0
Other Income	16.7	18.9	-
Total	**4,376.0**	**4,387.2**	**5,331.0**
Operating expenses			
Personnel and professional expenses	2,654.7	3,202.9	3,998.2
Administration expenses	484.6	502.0	643.2
Housing expenses	514.7	590.9	602.8
Medication and other activity expenses	68.3	82.8	87.0
Total	**3,722.3**	**4,378.6**	**5,331.0**
Operating profit/loss	**653.7**	**8.6**	**(0.0)**

* (all amounts in ANG 1,000)

1) Reference: draft strategic plan 2016-2018

2) Salaries adjusted to salary scales FWG

3) Training expenses of 2% of total gross salary

4) Yearly % of inflation: 2,5% during 2016 -2018

5) Yearly % of CLA effect on gross salary: 2.5%

6) One time FWG normalization of 2% of total gross salary

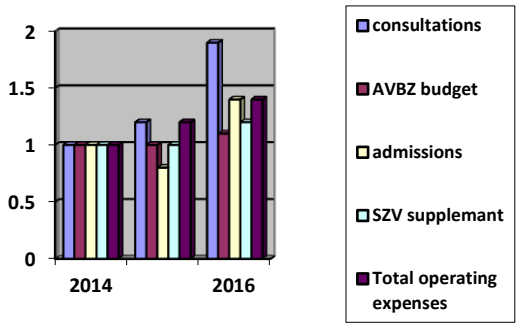
10.1. Explanatory notes forecasted budget 2016

Attached the budget 2016 of the Mental Health Foundation is presented. In this section some explanatory notes are presented.

1. The budget 2016 MHF has as a reference the strategic policy plan 2016 – 2018.
2. The actual 2014 is in accordance with the approved financial statements 2014.
3. The actual 2015 is in accordance with the reconciled figures of the first three quarters of 2015 with in addition a projection of the not as yet reconciled figures of the last quarter of 2015.
4. The budget 2016 is based on the agreements that were made between SZV, VSA and MHF on April 7, 2016: *'SZV will temporarily take over the payments after April 2015 based on the same level until new tariffs that cover the total operational costs of MHF will be agreed upon'.*
5. The new tariffs are not in place as yet; MHF expects to be able to present the cost prices of the different care products before April 1, 2016 to SZV and VSA.
6. The takeover of the payments after April 2015 and also the subsidy for the months January, February, March 2015 by Government are based on the subsidy level of 2014, which are based on the situation in 2013.
7. The budget 2016 is therefore based on projections of the year 2015, whereby 2013 and 2014 are used as a reference.
8. In 2016 the volume for consultations compared with 2015 is expected to increase with 57%, which results in an increase of revenues of 56% to the amount of ANG 851,700.00.
9. In 2016 the volume for AVBZ clients can compared with 2015 be increased with 25% by increasing the budget with 6.5% to the amount of ANG 1,611,100.00.
10. In 2016 the occupancy for admissions is compared with 2015 expected to increase with 1.5% which results in an increase of revenues of 64% to the amount of ANG 847,400.00.
11. To allow increases in consultations (56%), AVBZ (6.5%) and admissions (64%) the capacity (personnel and professional expenses) has been increased with 25% to the amount of ANG 3,998,200.00.
12. As an effect of the increase in personnel and professional expenses the administration expenses have been increased with 38% to the amount of ANG 691,200.00.
13. In total the expenses increase with 23% to the amount of ANG 5,379,000.00 to allow the increase in volume of patient/ client care.
14. As an investment and to secure future care an amount of ANG 120,000.00 is included in the administration expenses for the first part of the initial costs for a new building in 2016.
15. As an improvement and to improve the quality of care an amount of ANG 48,000.00 is included in the administration expenses to implement FACT.
16. To allow MHF to at least cover the operational costs (point 3) the SZV supplement needs compared with 2015 to be increased with 17% to the amount of ANG 1,883,000.00.
17. Part of this increase is due to the fact that the amount of admitted crisis days increased with 8% compared with 2015.
18. The level of the SZV supplement illustrates the need for (increased) new tariffs.
19. As soon as the new tariffs (point 3 and 4) are implemented the SZV supplement should be replaced by a 100% output financing system.
20. Charts will be added to illustrate the developments.

10.2. Explanation in graphs of the forecasted budget 2016

In the following graph the year 2014 has been taken as a reference for decrease and increase in the years 2015 and 2016. The graph shows that the increases of consultations, AVBZ – budget, admissions and SZV supplement together can cover the increase in the total expenses.



The conclusion is that the operating income increases, but needs to be supported by extra capacity. Even though the expenses are increasing they can be carried by the forecasted increase of the different sources of revenues.