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## **Evaluation of pilot project for the continuity of care**

### ***SUMMARY***

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## **Summary: evaluation of pilot project for the continuity of care**

On the instructions from the Research and Documentation Centre (WODC) of the Ministry of Security and Justice, the consultancy and research firm Significant carried out an evaluation of the pilot project on continuity of care in the De Schie location of the Rotterdam penal institution. This evaluation took place in the period from September 2012 to June 2013 inclusive.

### **Background and objective**

About half of all prisoners reoffend within two years. Psychiatric disorders and addiction are seen as key reasons for this. Given the prevalence among prisoners of psychiatric disorders (around half of all prisoners) and addiction (around a third), the provision of continuous care during and after detention is a crucial factor in preventing reoffending. However it seems to be difficult to arrange the provision of forensic care (meaning mental healthcare, addiction services and care for the mentally handicapped) in practice during and after the criminal sentence, in particular for the group of prisoners who are imprisoned for a short period (with prison sentences of less than four months or in preventive custody). They often spend too short a time in the penal institution for their care needs to be identified properly, and for appropriate care to be provided and agreements to be made with the regular care providers that would ensure continuity in their care. A complicating factor for prisoners detained in preventive custody is that it is not known at that point when they will be leaving the penal institution. That makes it more difficult to organize the transition to regular healthcare.

For these reasons, the municipality of Rotterdam, the Forensic Care Department of the Custodial Institutions Agency and a health insurer (Achmea) set up a pilot project aimed at fostering more continuity in the care provided before, during and after detention for prisoners with short prison sentences or in preventive custody and with a connection with Rotterdam. The 'continuity of care' pilot project consisted of two key elements: the deployment of a process controller from the Rotterdam Municipal Health Service, and joint procurement. The process controller was to be an important link in the screening process, providing information about the medical indication, organizing the right care and determining the specific care to be provided based on the prisoner's care needs. The process controller was also required to facilitate follow-up care following release from detention if that was agreed. The second focus of the pilot project was on joint procurement by the Custodial Institutions Agency's Forensic Care Department, the health insurer and the municipality.

The aim of this evaluation study was to reveal the extent to which the pilot project was executed as intended, to identify success factors and issues, and to determine the extent to which continuity of care was improved as a result of the pilot project.

### **Terminating the pilot project ahead of schedule**

The Forensic Care Department decided to terminate the pilot project in spring 2013, while this evaluation was being carried out. It should be noted here that the De Schie and Hoogvliet locations decided in consultation with the Municipal Health Service to let the Municipal Health Service's process controller continue her work. The pilot project was terminated for the following reasons:

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1. The target group turned out to be smaller than had been estimated beforehand on the basis of historical data.
2. The target group turned out to be known to the care providers to a greater extent than anticipated. Also, this (follow-up) care largely involved welfare services rather than (forensic) healthcare.
3. Finally, as researchers, we pointed out that it would be difficult or impossible to arrive at valid qualitative or quantitative conclusions about the effects of the pilot project, given the manner in which the pilot project had been implemented at De Schie.

In consultation with WODC and the Forensic Care Department, it was decided to terminate the evaluation in April 2013 and to report on that part of the evaluation that had been carried out up to that point. This means that only part of the study as set out in the approved research plan was actually executed. The evaluation was restricted to a description of the working procedures of the pilot project at one location (De Schie) compared with the intended working procedures.

The conclusions that follow are based on:

- a. A document study to give the background to the pilot project.
- b. A literature scan for the success factors in achieving continuity of care.
- c. Interviews with the De Schie project manager, the process controller (Rotterdam Municipal Health Service), staff at the Custodial Institutions Agency head office who were involved in the project, social workers at the penal institution, the chairman of the psychomedical forum and the follow-up care forum, three healthcare providers, the follow-up care coordinator for Rotterdam municipality and a member of the healthcare procurement department at the Custodial Institutions Agency.
- d. A limited quantitative analysis of the registration instrument used by the process controller. This allows statements to be made about the relationship between the intake in the pilot project and the expected intake, as well as the proportion of prisoners who were already receiving care prior to detention.

## **Success factors for the continuity of care based on a scan of the literature**

The table below shows the success factors identified in the literature for achieving continuity of care.

Stage in the process	Success factor
Screening on arrival in penal institution	<ul style="list-style-type: none"><li>• Routinely screening all prisoners for care needs (if necessary, followed by a more extensive diagnosis)</li><li>• Using recommended clinical assessment instruments</li><li>• Including both risk factors and protective factors in risk assessment</li><li>• Having one person or team responsible for the screening of all aspects to make sure comorbidity is identified</li><li>• The ex-prisoner has no serious problems in other areas of their life</li></ul>

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Drawing up a plan for follow-up care	<ul style="list-style-type: none"><li>• Starting work on drawing up the plan for follow-up care shortly after arrival in the penal institution</li><li>• Drawing up the plan for follow-up care together with the prisoner and their family</li><li>• Coordination between partners in the network about the allocation of tasks and responsibilities long before the prisoner is due to leave the penal institution</li><li>• Liaising with organizations in the prisoner's social environment to arrange supervision and accommodation during the first few days following release</li><li>• Appointing a case manager who monitors the process for the provision of care</li><li>• The case manager is thoroughly acquainted with the care offered by (local) care providers, is often present at the penal institution and offers intensive personal supervision following detention</li></ul>
Providing care during detention	<ul style="list-style-type: none"><li>• Providing care early, even while still in detention</li><li>• The healthcare professionals who will be providing care after detention contact the prisoner during detention</li><li>• Encouraging the prisoner to accept care</li><li>• Using family (or other prosocial individuals in the prisoner's social circle) to motivate the prisoner</li></ul>
Transfer to care institution	<ul style="list-style-type: none"><li>• On release, the prisoner has an appointment scheduled with the healthcare professional and has their contact details</li><li>• The penal institution and the ex-prisoner's family have also been notified of the appointment with the healthcare professional.</li><li>• If the ex-prisoner does not turn up to the appointment, the institution responsible tries to contact them immediately</li><li>• Monitor the results of the care provided</li><li>• The network partners have agreed on the allocation of tasks relating to monitoring</li></ul>
Forms of funding and needs assessment	<ul style="list-style-type: none"><li>• The penal institution has been made responsible for rearranging health insurance when the period of detention ends</li><li>• Healthcare insurers and the Ministry of Security and Justice purchase healthcare jointly</li><li>• Healthcare insurers, municipalities and the Ministry of Security and Justice are jointly responsible for the funding of the entire forensic healthcare network, including care prior to and during detention</li></ul>

## **The usual working procedures and the (intended) working procedures in the pilot project**

Consideration is already given to continuity in care in the usual working procedures at the De Schie location, albeit without the focus on the group with short sentences or in preventive custody. As part of the Entries, Screening and Selection procedure, all prisoners are screened by a social worker, the medical services and a member of the penal institution staff. If a need for forensic care is revealed by this screening, or later on during imprisonment, this care can be provided. In general, the medical indication is given by the psychomedical forum. Depending on the complexity of the problem, progress in the care is monitored by a social worker, member of the penal institution staff or the psychomedical forum. As regards follow-up care, there is a follow-up care forum in the penal institution that meets once a fortnight and discusses the follow-up care requirements of vulnerable prisoners. The follow-up care requirements of the other prisoners are covered in the Detention and Reintegration Plan. The Forensic Care Department has concluded contracts with various care providers for the care during detention and the penal institution makes use of these contracts. The care after release from detention falls under the Health Care Insurance Act; the procurement of this care is the responsibility of the health insurers.

The pilot project was aimed at improving the continuity of care for the group of prisoners with short sentences (up to four months) or in preventive custody and with a connection with Rotterdam. It aimed to achieve this by deploying a process controller and through joint procurement. The pilot project was thought necessary because it was assumed there was insufficient continuity in the care

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provided to prisoners with short sentences or in preventive custody. Their relatively short stay in De Schie makes it difficult to take the necessary steps to ensure continuity of care.

The action plan contains a general description of the problem. It is not always very specific about the implementation; the idea for most aspects is that the details should be filled in during the execution of the pilot project. The process controller has an important role to play according to the action plan. The person who takes on this role should preferably be a community psychiatric nurse and should regularly visit the penal institution. The process controller's responsibilities should include screening the care needs on arrival (preferably in a face-to-face interview), gathering information on the care history and having personal contact with the prisoner, as well as the care institution where applicable. In addition, the process controller should attend the relevant meetings in the penal institution, seek to prepare and motivate the prisoner for care following release from detention and ensure that the prisoner is picked up by a health-care professional following detention. Joint procurement was another component of the new approach: the Forensic Care Department, the municipality and the health insurer would purchase care jointly. The advantage of this is that a care programme could be defined at an early stage and that a new medical indication after release from detention may not be necessary any more.

The actual implementation of the pilot project was more limited in scope than envisaged in the action plan. A community psychiatric nurse was appointed as process controller for two days a week. The process controller focused on quickly obtaining all the relevant information concerning the care history of prisoners with short sentences and a connection with Rotterdam. For this purpose, she used the Evita registration system (operated by the Rotterdam Municipal Health Service) and SPAR (operated by the Rotterdam Security House, an alliance of organizations in the criminal justice, care and local government sectors). The process controller also established contact with the care provider prior to detention and made agreements about care following release from detention. The process controller only spoke to prisoners in exceptional cases; this happened a few times in 2012. Efforts were also made to extend the Evita registration system to enable progress in follow-up care to be tracked. There was no implementation of the plan for joint procurement. This decision was made following discussions between the Forensic Care Department and the health insurer as the conclusion was reached that there was not such a good case for joint procurement for prisoners with a short sentence. After all, this group barely starts receiving care during detention, so the Forensic Care Department only buys in very limited amounts of healthcare for this group.

## **Conclusions regarding the pilot project**

This study shows that the pilot project for continuity in care did not deliver what was expected of it. The intake numbers were (much) lower than anticipated; about 60 prisoners were covered by the pilot project in 2012 whereas several hundred had been expected. The lower intake numbers are largely due to factors that could have been foreseen. The criterion of a connection with Rotterdam meant that around 50% of the prisoners fall outside the scope of the pilot project. In addition, the pilot project was only implemented at one location when this study was carried out<sup>1</sup>. Most of the 60

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<sup>1</sup> The pilot project was also implemented at the second location (Hoogvliet) in February/March 2013. The project was not implemented at the Noordsingel location as it was in the process of closing.

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prisoners also turned out to be receiving care already, to which they returned after being released from detention. There were only one or two prisoners for whom a new care need was identified and care initiated as a result of the pilot project.

The pilot project appears to have been only a limited addition to the usual working procedures. Efforts were already being made at De Schie to foster continuity in care before the pilot, including for prisoners with a short sentence or in preventive custody. The added value delivered by the pilot project was therefore less than had been anticipated. In practice, the added value offered by the pilot project compared with the existing procedures was to be found in the following aspects:

1. The appointed process controller provides the social worker with factual information about care needs and the care history; in the existing situation, the social worker had to rely on the prisoner for this information.
2. The process of screening for care needs using registration systems (such as Evita and SPAR) is much quicker than in the past. The added value lies in the fact that this screening takes place immediately after arrival in the penal institution for prisoners with short sentences or in preventive custody. This can potentially reduce the number of prisoners with short sentences leaving the penal institution without arrangements for care after the release from detention.
3. It is easier for the process controller to make agreements with network partners, in particular healthcare professionals, thanks to the controller's familiarity with the local care offerings and the direct access to Evita.
4. Once the registration of follow-up care in Evita is in place, this will be a clear improvement on the current practice.

The action plan assumed there would be added value from a number of other elements. However these did not get off the ground sufficiently in the pilot project to deliver added value in practice.

This concerns the following elements:

1. Care during detention is provided where necessary and the pilot project did not really result in any changes here.
2. It turned out on closer examination that the implementation of joint healthcare procurement and funding was not necessary after all.

The follow-up care for prisoners with short sentences or in preventive custody at De Schie turned out to be largely unrelated to forensic care. In around 65% of the cases, follow-up care involved welfare services. It should be noted here that welfare services encompass more than just accommodation as they include benefits, income, daily activities and the person in question's physical and mental wellbeing.

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## **Possible reasons for the limited implementation of the pilot project**

Some possible reasons for the limited implementation of the pilot project are:

1. The establishment of continuity in care at De Schie is less of a problem than was thought: there was already consideration for continuity in care in the existing procedures. In addition, the numbers were less than expected. The pilot project was carried out at only one location and the criterion of a connection with Rotterdam meant that only half the prisoners with short sentences were covered by the pilot project.
2. The full potential of the pilot project was not exploited because of the way in which it was executed, including the preparation and management. There are a number of reasons for this:
  - a. In the preparation for the pilot project, not enough was done to establish the consequences of certain basic positions and the expected added value compared with the existing procedures were not established.
  - b. The action plan was not worked out in sufficient detail.
  - c. The action plan did not tie in sufficiently with the existing working procedures.
  - d. The management of the pilot project was unsatisfactory.
  - e. There was insufficient continuity in the staffing of the management task.
  - f. People inside and outside the penal institution were insufficiently aware of the pilot project.

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