Health Council of the Netherlands

Badly needed

The development of knowledge for public mental health care

Gezondheidsraad
Health Council of the Netherlands

To the Minister of Health, Welfare and Sport

Subject : Presentation of advisory report *Badly needed. The development of knowledge for public mental health care*
Your reference : -
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Dear Minister,

An estimated 150,000 people in the Netherlands cannot arrange their own means of existence, due to a combination of mental and other problems. Five times as many people are at risk of deteriorating into such a situation. These are only estimates, because no reliable information about the exact size of this group, the target group of public mental health care (PMHC), is available. There is, however, no doubt that the social impact is great. This is a group that sometimes causes serious nuisance. The discussion about the desirability of imposed help and about the scope of care providers' responsibility frequently raises deep concern, in the aftermath of serious incidents, for example.

Little information is available, not only about the size of the target group but also about the nature of the problems, the effectiveness and efficiency of interventions and the results of policy measures. This is due to the complexity of the issue, the multidisciplinary nature of the field and the awkward accessibility of the target group. The shortage of knowledge puts a brake on the professionalisation of PMHC and on innovation in the sector. Knowledge and a good knowledge infrastructure are vital for better care and effective policies.

The advisory report I hereby present to you describes what knowledge is necessary and what a suitable knowledge infrastructure for PMHC should look like. One of the recommendations is to build on and reinforce certain existing positive developments. There is a role here for universities, technical universities and other research institutions that are involved with PMHC. However, more is needed for a good PMHC infrastructure: a substantial long-term research programme is required, in which a number of substantive

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themes are worked through with the involvement of clients, municipalities, researchers, and judiciary and care and shelter institutions. In this process, a robust knowledge infrastructure will be created.

The Committee which drafted the advisory report recommends that the Netherlands Organisation for Health Research and Development (ZonMw) carry out a brief programming study, prior to deciding about the investment necessary for said programme. An assessment and analysis of all available epidemiological data should form an important part of this. The study should lead to a plan to set up the recommended PMHC programme and to an estimate of the sum necessary to implement it.

I am today also presenting this advisory report to your colleagues at the Ministries of Security and Justice, of Social Affairs and Employment, and of Interior and Kingdom Relations.

Yours sincerely,

(signed)
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President

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No. 2011/02E, The Hague, February 24, 2011

The Health Council of the Netherlands, established in 1902, is an independent scientific advisory body. Its remit is "to advise the government and Parliament on the current level of knowledge with respect to public health issues and health (services) research..." (Section 22, Health Act).

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Contents

Executive summary

An estimated 150,000 people in the Netherlands are unable to maintain control over their own existence, through a combination of mental and other problems. They languish, deteriorate, often in isolation, and sometimes cause social disturbances. Another five times as many people are at risk of ending up in such a situation.

In this advisory report, the Committee on Health Research of the Health Council of the Netherlands argues that public mental health care (PMHC), which deals with these groups, has an insufficient body of knowledge on which to base its practice. A substantial, long term investment in research is needed to create that necessary common body of knowledge. To achieve this existing research groups have to join forces and a programming study has to outline what research and what investment is required.

PMHC description

PMHC deals with the care and policy for people who have multiple problems in various areas of their life, and often psychiatric or addiction problems, or mental handicaps. They can no longer provide for their own means of existence or will end up in such a situation in the absence of the appropriate support. PMHC encompasses medical care, practical support, rehabilitation and shelter as well as the policy developed by the state and municipalities for these vulnerable citizens.

PMHC patients often cause problems in the public arena: they are often homeless, involved in petty crime, are a burden on police and the courts, create disturbances in the neighbourhood or evoke feelings of insecurity for neighbours. There are no precise data available about the number of patient in need of PMHC.

PMHC is a part of the policy area of the Ministries of Health, Welfare and Sport, Security and Justice, Social Affairs and Employment and the Interior. At the core of such policies always lies the question on how social functioning can be restored or maintained. The starting point remains the following question: What are people's possibilities, and how can their self-sufficiency and participation in society be advanced?

Knowledge development is necessary

PMHC has to deal with an enormous diversity of complex human problems and requires varying combinations of medical and social care. Systematic research to create an evidence base has not been undertaken, partly because of the complexity of problems, the multidisciplinarity of the research needed, and the difficult accessibility of the target group. However, an evidence base is necessary, to promote quality and efficiency of care and policy, and it could be built, considering foreign examples. The returns are many and varied: self-sufficiency and quality of life of the target group, and savings in regard to expenditures on care, social benefits and costs in the judicial field.

Research can lead to a new, demonstrably successful strategy

The long-term unemployed often suffer from physical, psychological and social problems. Research has shown that a programme of health promotion alone does not stimulate the resumption of work. This is why the city of Rotterdam developed a new approach wherein physical assistance, social support and guidance at work are offered as a combined intervention. A cost-effectiveness study demonstrated that this approach was cheaper and more successful than those often used in the past: More people went to work, and EUR 1.5 million was saved in social benefits payments. The four major cities in the Netherlands will be implementing this new approach.

Working towards a suitable research infrastructure

A first attempt at building a PMHC research infrastructure has been made – three academic work places are in progress as well as four university chairs, of which three are endowed but part time chairs. This progress is promising but still vulnerable. The interactions between research, practice and policy are weak. The field of study is fragmented; there is a lack of cohesion in the subjects of research and development, and studies are financed on a per project basis. The scale is small.

In order to ensure that a systematic knowledge building really gets going, a substantial, long term PMHC research and development programme is necessary in which a number of content-related topics are elaborated and in which a knowledge infrastructure to support the specific nature of PMHC research is gradually developed at the same time.

Recommendations

The Committee has decided on three recommendations:

1 Invest in a structured, top down managed PMHC research and development programme

According to the Committee, long-term and substantial investment is needed in a structured and top down managed PMHC research and development programme. The approach of the Health Research Funding Programme can be of good service:

- preparation and management by a committee of independent experts (usually the same as the subsequent programme committee)
- comprehensive orientation regarding the research area by means of consultation with experts and through workshops
- formulation of objectives, worked out afterwards into a strategic research programme
- focus on stimulating a limited number of the research groups expected to be most successful
- guidance of the programme's implementation by a programme committee.

The investment should be sufficient, over a period of 10 years, to bring about usable new knowledge, establish an adequate research infrastructure and ensure that there is continuity after the programme ends by means of financing from

regular PMHC and research funds. The Netherlands Organisation for Health Research and Development (ZonMw) could be able to support the preparation, implementation and evaluation of the programme as well as the embedment of the results.

The Committee believes that the investment will pay off in the form of greater self-sufficiency on the part of socially vulnerable groups due to an increase in effectiveness and efficiency of PMHC. Because the benefits of PMHC occur in various societal areas (health care costs, social benefits, costs in the judicial system), it seems obvious that the necessary resources should be provided by a number of ministries (Health, Welfare and Sport, Security and Justice, Social Affairs and Employment and the Interior).

2 Reinforce ongoing initiatives

In the short term it is important to develop and strengthen the existing initiatives that are associated with the universities. The embedding of PMHC research in universities can be improved by creating regular university chairs. Cooperation can be sought with universities of applied sciences that carry out practice-oriented PMHC research. Furthermore, there are opportunities for strengthening existing initiatives through better mutual cooperation, for example through the following:

- exchange of knowledge and research results
- combining data and research populations, among other things, in order to enable prospective research of sufficient scope
- forming networks of researchers in order to facilitate the bundling of research lines
- agreeing about who will tackle which research topics and the joint formulation of research proposals
- organising researchers' training.

By bundling strengths and optimally utilising synergy possibilities, current researchers – in cooperation with their partners in practice and policy – can demonstrate that a substantial investment in PMHC research is worthwhile.

3 Finance a PMHC programming study

The Committee recommends to the Minister of Health, Welfare and Sport that a modest programming study be permitted to prepare for a decision regarding a substantial, long term investment. Taking stock and analysing all relevant

epidemiological data that are collected in various contexts should make up an important contribution. This study should result in the outline of a strategic PMHC research and development programme, partly based on consultation with experts from practice, policy and research (including patients). It should also provide an estimate of the investment needed for the programme.

The Committee recommends that the task of conducting the study be given to The Netherlands Organisation for Health Research and Development (ZonMw). In the experience of ZonMw, such a study can be carried out over the course of two years for the amount of EUR 0.5 million.

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Chapter 1

Introduction

1.1 Motivation

In 2008, in a letter to the Ministry of Health, Welfare and Sport, the Netherlands Association for Psychiatry (NVvP) and Mental Health Care the Netherlands (GGZ Nederland) stated that the knowledge base of Public Mental Health Care (PMHC) is inadequate.

The social impact of PMHC is large, the letter's writers stated. The target group comprises people with various problems who seldom ask for help, but rather languish and sometimes cause serious nuisance. Increasingly, interventions take place under compulsion, and there is much discussion about the tasks and responsibilities of care providers, in the aftermath of serious incidents such as the death of the 'Meuse girl' (*'Maasmeisje'*) from Rotterdam.

This raises questions about the limits of tolerance and responsibilities, and also about possibilities for risk evaluation and effective working methods in PMHC. Knowledge about this is, in fact, absent; there are no evidence-based guidelines. For this reason, the NVvP and GGZ Nederland have argued for research into the PMHC issue and pleaded for investment in a knowledge infrastructure.[1] As early as 2006, the Association of Dutch Municipalities (VNG), the Association of Municipal Health Services (GGD), the Shelter Federation (Federatie Opvang) and GGZ Nederland have already asked for a PMHC knowledge infrastructure to be built up.[2]

The Ministry of Health, Welfare and Sport presented the letter from NVvP and GGZ Nederland to the Advisory Committee on Health Research (Raadscommissie voor Gezondheidsonderzoek, RGO) of the Health Council fo the Netherlands. As a consequence, the subject 'Research for PMHC' has been included in the Health Council's Working Programme for 2010, after which the RGO took the subject in hand.

1.2 Method

The RGO (hereafter referred to as 'the Committee', see Annex A) had a quickscan prepared in preparation of the advisory report, based on interviews with experts from different backgrounds.[3] This was introduced at an expert meeting held in February 2010, in which forty people participated (see Annex B). The results of this meeting were processed into a draft advisory report, which was presented for comment to around twenty-five experts, mostly participants in the expert meeting (see Annex C). The draft has also been evaluated by the Standing Committee on Public Health of the Health Council.

1.3 Structure

In Chapter 2, the Committee describes the characteristic features of PMHC and considers the extent and costs of the current problems. In Chapter 3, it establishes that there is a shortage of knowledge and formulates what knowledge is needed. Chapter 4 presents an overview of PMHC's current knowledge infrastructure and shows what a suitable infrastructure may look like. In Chapter 5, the outlines of a long-term PMHC Research and Development programme are sketched, which is necessary to build a proper knowledge infrastructure. In Chapter 6, the Committee sums up its recommendations.

Chapter 2

PMHC: specific nature, complex problems

In this chapter, the Committee defines Public Mental Health Care, and considers some of PMHC's characteristic features. The chapter concludes with an overview of what is known about the extent and costs of PMHC and about the savings PMHC yields elsewhere.

2.1 Description

The Committee takes PMHC to mean care provision and policy for people who have multiple problems in various areas of their lives, and often psychiatric or addiction problems or mental handicaps too, who can no longer provide for their own means of existence, or will end up in such a situation in the absence of the appropriate support.[1] PMHC encompasses medical care, practical support, rehabilitation and shelter as well as the policies developed by the State and municipalities for these vulnerable citizens.[2]

This description of PMHC is broader than the one generally used by municipalities and the Ministry of Health, Welfare and Sport. Pursuant to what is known as Performance Field 8 of the Social Support Act (*Wet maatschappelijke*

1 It concerns people on rungs two, three and four of what is known as the PMHC ladder (see Annex D).[4]

2 In this document, shelter is taken to mean: social shelter (shelter for the homeless and derelicts), women's refuges and shelter for street children.

ondersteuning), municipalities are responsible 'for the advancement of public mental health care'.[1] In implementing this, they mainly focus on people who have been so overwhelmed that they are unable to provide for their own means of existence. Less attention is paid to people who require suitable help to avoid such a situation. Similarly, the PMHC policy of the Ministry of Health, Welfare and Sport is primarily directed at groups such as care-avoiders, people who live in situations of squalor, (former) chronic psychiatric patients and addicts who have lost their grip on life, and homeless people and derelicts with various problems.[2]

The choice for a wider description of the PMHC target group in this advisory report follows from the desire to link up with the PMHC practice. PMHC staff are involved with people in wretched situations and people who manage to work their way out of these. At the same time, they are confronted with people who manage to hold on, but who, in the absence of adequate help, are at risk of entirely losing their self-sufficiency: people who are released from prison, young people who have been involved with the police or have become addicts, people with large debts who are evicted, and people with a (slight) mental limitation who are at risk of falling between two stools. To support the professionalisation and further development of the work of these professionals, a knowledge infrastructure is needed which is imbued with the same wide interpretation of who the target group consists of.

Considered in this way, PMHC is not only part of the policy area of the Ministry of Health, Welfare and Sport, but also of that of the Ministries of Security and Justice, of the Interior and Kingdom Relations, and of Social Affairs and Employment. The central aim of all PMHC policies is to restore or maintain social functioning, with the following question as a starting point: what are people's possibilities, and how can their self-sufficiency and participation in society be advanced?

2.2 Individual care provision and intersectoral policy

As mentioned above, PMHC ecompasses both care provision to socially vulnerable people and policy measures directed at these groups. Primarily,

1 The Social Support Act, performance field 8, takes the advancement of public mental health care to mean: identifying and controlling risk factors in the field of public mental health care, contacting and guidance of vulnerable people and risk groups, serving as a contact point for signals of crisis or threatening crisis among vulnerable people and risk groups, and reaching agreements among organisations involved about the implementation of public mental health care.

2 Within Health, Welfare and Sport, the Social Support department bears the primary responsibility for this policy, with further contributions from the departments of Public Health, Curative Care, Long-term Care and Nutrition, Health Protection and Prevention.

PMHC is individual care in the widest sense of the word: directed at problems concerning housing, financial affairs, daily activities and social network as well as at mental, psychiatric or addiction problems. Mental limitations may also be a factor.

Examples of individual care provision in PMHC

Debt assistance
Interventional care, assertive community treatment (ACT and the Dutch Functional ACT - not forensic ACT)
Safety net
Educational support
Help to victims and perpetrators of domestic violence
Admission to MHC institution
Practical and/or material support, such as arranging accommodation
Shelter for the homeless and derelict, refuge for women, shelter for homeless adolescents
Monitoring of medicine usage
Treatment and rehabilitation programmes

Secondly, PMHC is concerned with the development and implementation of (intersectoral) policy for the benefit of socially vulnerable groups. Annex E presents an overview of the policies of the State, municipalities, MHC and shelter institutions, as well as those of other bodies. Work is underway, for example, on connecting policies concerning housing, care and shelter, and on shared initiatives for broad, cohesive care. There are also links between care and the judicial domain. PMHC policies thus cover fields such as collective prevention, debt assistance, the police, welfare, work and the expertise and accessibility of care institutions and social institutions. On the one hand, this is done through legislation, on the other hand through policies developed by local administrative bodies or local parties for special target groups, such as victims and perpetrators of domestic violence, the homeless and derelicts, people with chronic psychiatric complaints and/or mental limitations who live independently or supervised, people released from detention, people with debts, and the long-term unemployed.

Policies are also needed to make individual help provisions possible. Examples are: organizing contact points for domestic violence, street teams and

local care networks by local Municipal Health Services (GGDs); reaching agreements among parties about, for instance, aftercare for detainees, prevention of eviction and the use of care advisory teams at schools; and developing and implementing reintegration and debt assistance programmes.

2.3 Medical and social

The care provision within PMHC includes prevention, identifying problems and recommending care, treatment, practical support, care and shelter, and recovery and reintegration. It is not the domain of a single sector, facility or paradigm – it is social support, medical care and practical work simultaneously.

In daily practice, however, integration of the medical and the societal paradigm has not yet got off the ground adequately. PMHC tends to fall between two cultures: that of health services (with its emphasis on evidence-based working and cure, with highly-educated professionals) and that of the shelter and welfare sector (with its less academic tradition, mainly aimed at relieving practical problems and recovery).[5] In order to improve care provision and increase effectiveness, it is essential that both perspectives become more integrated, both in the care practice and in the policies of municipalities and the State.

2.4 Public nature

Characteristic of PMHC is the public nature of the problems it is aimed at:

- Sometimes help is not requested, while bystanders consider that it is nonetheless necessary. In such cases, there must be good reasons to intervene, given people's right to self-determination (such as damage limitation by protecting a partner from a maltreating spouse).
- People with severe difficulties often cause problems in the public arena: they may be involved in petty crime, thus burdening the police and the courts, they may be homeless, they may create disturbances in the neighbourhood or they may make neighbours feel less safe.
- When such problems arise, societal pressures almost always play an important role, alongside individual characteristics and socio-economic circumstances.[6] Society requires that people participate, estimate risks and defend their own rights; policies emphasise the importance of the individual, personal responsibility and active citizenship. People who cannot meet these demands end up in difficulties.

Due to this close-knit relationship with society, problems are not stable.[7] New PMHC issues come up all the time. Examples are exploitation by loverboys, new addictions (internet, GHB) and serious social isolation.

Given the public nature, careful moral considerations are necessary in policy development and implementation, as well as in care provision.

2.5 Powerful and optimistic

The people who work in PMHC are highly motivated, with qualities such as altruism, compassion, loyalty and flexibility.[8] They are familiar with disordered circumstances and solve their clients' problems inventively. In PMHC, social functioning and the client's possibilities are the starting point for action. Support of recovery and reinforcement of self-sufficiency are key. Attention is paid to primary necessities of life (shelter, food, hygiene) and to what people want and can do. In addition, they receive aid, such as outpatient treatment, medicine, living assistance or motivational support. In all this, the search for a good balance between restricting autonomy and carrying out interventions that will hopefully result in a better situation for the client is central.

PMHC workers accept their client's initial situation. The quality of the relationship contributes to an important extent to the effectiveness of the care provision: for this reason it is important that they know how to establish contact with the client and build trust. Because self-sufficiency is key, the care calls upon the clients' own powers of recovery.

The validity of this optimistic assumption is verified by the experiences with the Social Shelter Plan of Action (*Plan van Aanpak Maatschappelijke Opvang*). Help to homeless people and to derelicts in the four major cities has resulted in almost all clients either living in a shelter, living entirely independently or living in some type of supervised accommodation. Some (how many is not known) have been able to re-establish social contacts and are actively working on their psychiatric or addiction problems, making use of the available assistance.

2.6 Network with many responsible parties

Municipal health services and social services carry out the municipalities' legal task in the context of the Social Support Act's performance field 8. The municipalities are also active in social shelter (performance field 7) and addiction care (performance field 9). Municipalities must manage all this and promote cohesion. At the same time, they implement the subsidy regulation 'PMHC initiatives' (2010 budget: 6.5 million Euros).

Various organisations are active in individual care provision: shelter institutions, Mental Health Care (MHC) institutions, with acute psychiatry and out-patient and intramural MHC, institutions for (out-patient) addiction care, Municipal Health Services (GGDs), housing associations, the police (policemen on the beat) and the judiciary (including exclusion orders, detention, rehabilitation), social services, welfare institutions and volunteer organisations, whether or not linked to church communities. If there are children involved in the situation, then education, child welfare and child health care are important partners in identifying problems and providing care. The Dutch Health Care Inspectorate (IGZ) supervises the entire care sector, including PMHC.

Police, rehabilitation services and the prison system are involved in PMHC because it sometimes concerns people who end up in the judicial domain.[9] A significant part of the prison population has psychiatric problems or mental limitations: 56.5 per cent of those detained in ordinary prison departments suffers from a psychiatric disorder.[10] Difficulties sometimes arise due to different ways of thinking and different approaches in the care sector and the disciplinary domains.[11] Recently, important steps were taken to better harmonise the two sectors.

All agents within PMHC work within their own legal frameworks and with their own funding sources and regimes, such as the Exceptional Medical Expenses Act (AWBZ), the Care Insurance Act (Zvw), the Psychiatric Hospitals (Special Admission) Act, the Housing Act, the Social Support Act (Wmo), the Work and Social Assistance Act, the Work and Income according to Labour Capacity Act, and various judicial regulations. It can be difficult, within such a subdivided field, to offer the integrated care that is necessary. That it is nonetheless possible to do so is apparent from initiatives by care insurers, care bureaus and municipalities to reach agreements about the provision of care, and from intitiatives by enterprising care providers who offer integrated care specifically for the target group.

2.7 Extent, costs, savings

Number of people in PMHC

The group requiring PMHC described in this advisory report is difficult to delineate. No epidemiological research based on clear definitions and well-defined practices is available. The figures that are available concern variously described groups. In 2004, the Health Council of the Netherlands estimated the number of people requiring acute psychiatric care at 24,000, around 0.2 per cent

of the population.[12] In 2007, the SGBO bureau calculated that nearly one per cent of the adult population belongs to the PMHC target group and four to five per cent to the PMHC risk groups.[13] In 2002, *Research voor Beleid* (Research for Policy) estimated the number of 'languishing and degenerate' at 0.3 to 0.9 per cent of the population (33,000 to 110,000 people).[14]

More recently, figures have become available from the Acute Psychiatric Service in The Hague: annually, 0.7 per cent of the population is in acute psychiatric need.[15] In a study by Midden-Holland Municipal Health Service, it was stated that over one per cent belongs to the PMHC group.[15] No data are available about the number of people in the target group who have a psychiatric disorder, addiction or a (slight) mental limitation.

Nature and incidence of problems

Little is known about the occurrence of different types of problems in the PMHC group. It is, however, clear that financial problems are common, often combined with psychosocial and behavioural problems,[16] although no reliable figures are available. Domestic violence in the family and maltreatment of the elderly also occur frequently. The guideline *Familiaal huiselijk geweld* (Familial domestic violence) mentions a study from 1992, which revealed that serious to very serious violence, repeated and with injury, befell one woman in nine. Another study found that 45 per cent of the population had confronted non-incidental domestic violence in their lives.[17] A study into maltreatment of the elderly in Amsterdam revealed that 5.6 per cent of the elderly are maltreated.[18]

Children

Children in families where the parents are socially vulnerable or have psychiatric problems or mental limitations are exposed to more risks, especially if the children themselves have mental limitations or mental or behavioural problems. At a recent conference on the health of Regional Education Centre (ROC) pupils, these figures were presented: 95 per cent of pupils at level 1 are overloaded with problems in the area of somatic health, mental wellbeing, addiction, accommodation and debts; 20 per cent of pupils at level 4 are overloaded.[19] The *Jeugdmonitor* (Youth Monitor) for pupils at the ROCs in Rotterdam indicates that 35 per cent of pupils feel themselves to be mentally unwell.[20] The *Federatie Opvang* (Shelter Federation) reports that annually around 7,000 children under 16 years old take refuge in a shelter with their mothers due to domestic violence. The Socio-cultural Planning Bureau (SCP) concludes that three per cent of

children aged 3-17 years are confronted with a combination of little social participation, material neglect and living in an unsafe or unpleasant neighbourhood. Social exclusion is caused by financial-economic factors (such as parents who cannot afford certain outgoings) and socio-cognitive factors (such as parents who show limited participation).[21] The Netherlands Court of Audit estimated the number of children living on the streets in 2007 at 6,000.[22]

Costs

Care for people in the group requiring PMHC is labour-intensive and relatively expensive. Further costs are incurred through the complex network organisation necessary in this field of work (such as transactional, regional, discussion and negotiation costs).

The size of the national expenditure on PMHC is, however, unknown. In the four major Dutch cities, in the period 2006-2009, 525 million Euros was spent on the Social Shelter Plan of Action, two thirds of which fell to the Exceptional Medical Expenses Act (AWBZ) and one third to the municipalities.[23] By this means, a large proportion of the 10,000 homeless and derelict people in Rotterdam, Amsterdam, Utrecht and The Hague were brought into an individual aid programme. The aid per person thus comes to a net sum of over 13,000 Euros a year.[24, 25]

In 2008, the Dutch Salvation Army spent 251 million Euros on care and aid for 36,244 people. This is an average of 6,925 Euros per person[26], with costs per person varying between 2,500 Euros for a debt assistance programme to 40,000 Euros a year for intramural accommodation (communication from *Federatie Opvang,* the Shelter Foundation). In comparison: the costs of health care in 2008 came to 4,809 Euros per inhabitant of the Netherlands (Statistics Netherlands, CBS).[27]

Savings

The use of resources from AWBZ, Social Support Act, Care Insurance Act (Zvw), and municipal and reintegration funds available through PMHC results in savings on, among other things, benefits, justice (including forensic-psychiatric care), maintaining order and combating nuisance. Savings are also made in the care domain, as problems are addressed at an earlier stage.

There is no information about the extent of the savings, but there are indications that they do occur. For example, the Social Shelter Plan of Action led to a substantial fall in the number of nuisance reports and evictions.[25] According

to Rotterdam municipality, the plan provided a cost saving (not further specified) to the police, justice system and damage insurers (verbal communication from Rotterdam-Rijnmond Municipal Health Service). In the report 'Cost-saving Projects', the Netherlands Organisation for Health Research and Development (ZonMw) calculated that increasing the self-sufficiency of clients in long-term MHC could lead to savings in labour costs.[28]

A little more is known about the cost-effectiveness of rehabilitation. Rehabilitation that makes use of so called 'supported employment methods' results in more people with mental problems obtaining and keeping a job.[29] A study showed that individual placement and support (IPS) often resulted in placement in a regular job, which was retained for a long time, and moreover in a reduction in the number of re-admissions.[30] Rotterdam municipality researched an integral strategy (out-patient MHC, social services, employers, social work) for the long-term unemployed regarding cost-effectiveness: 40 per cent of the unemployed found work, against 13 per cent in a comparable district with ordinary assistance. The average price per reintegration programme (1,974 Euros) was lower than the average price of an ordinary programme (2,900 Euros). The savings on benefits for the 111 clients who found a job came to nearly 1.5 million Euros in 2006-2007.[31]

Chapter 3

Knowledge necessary for PMHC

Knowledge is needed to adequately identify, approach and prevent the problems the group requiring PMHC has to deal with. Knowledge about the extent, nature, causes of and solutions to the problems is also vital for the development of proper PMHC policies. Knowledge of this kind is, however, not sufficiently available: PMHC is complex and policy-intensive, but knowledge-poor. What is needed to fill the existing gaps is described in section two of this chapter.

3.1 Complex and policy-intensive, but knowledge-poor

The great policy pressure in PMHC and the complexity of the issues are in stark contrast to the limited knowledge. The conceptual frameworks are hardly developed and the evidence-based way of thinking has not penetrated sufficiently into PMHC. There is too little knowledge about the extent and nature of the problems, about effective and efficient interventions and about the results of policies. There is also a lack of proper instruments for screening and identifying problems.

The causes of the absence of an adequate body of knowledge are:

- The absence of a tradition of knowledge development, accumulation and distribution. For instance, no university research tradition has developed. One of the reasons is that people requiring PMHC do not generally end up in university treatment centres. Also, it is not expected that PMHC research will

quickly lead to prestigious international scientific publications. A lack of substantial research programmes can, however, also be observed outside of the academic world. In policy development opportunities to do research are not taken up.

- The complexity of the research and the research setting. The target group is hard to delineate, it is difficult to get and keep people in research, routine outcome monitoring is tedious, the readiness to complete questionnaires and to participate in neuropsychological tests or neuro-imaging is low, comorbidity (somatic and mental) occurs, the practice features a high degree of flexibility, and many parties are involved.
- The involvement of many disciplines. No single professional group can be held accountable. In each of the groups, PMHC is only part of the field.

That it is indeed possible to build up systematic knowledge in PMHC fields is demonstrated by examples from Norway, Britain and Australia. Norway is combining policy measures and research in a single programme.[32] Britain has developed a long-term action programme to promote mental health and improve the quality of care.[33] The programme sees mental health as a major social task that demands effort from all departments. Intensification of research and innovation and the implementation of evidence-based interventions are action points in the programme. Australia supports the prevention of and the approach to combat homelessness with a 'Homelessness' research programme (epidemiology, care and effectiveness research, causes and risks).[34]

3.2 Knowledge development is needed

Developing knowledge for PMHC serves to get a better understanding of the problems, of what constitutes good and efficient prevention and care, and of effective policy development. Knowledge development also promotes the professionalisation of PMHC and is a condition for innovation that results in lasting improvement.

3.2.1 Process of knowledge development increases quality

The process of knowledge development itself contributes to a quality increase in care and policy. Active involvement of practice in research and of researchers in practice increases an organisation's self-critical power. Researchers are validated when their role requires them to pose questions about the effects and effectiveness of help or policies. This increases transparency, stimulates a

systematic approach and reinforces PMHC workers' professionalism. Moreover, practice is better prepared to participate in decisions about research methods. This important benefit of knowledge development processes for the quality of practice became apparent in ZonMw programmes such as the Fortitude, Revalidation and Mental Limitations (*Geestkracht, Revalidatie en Verstandelijke Beperkingen*) Academic Collaborative Centres. Another benefit of the research process is that it makes difficult questions or delicate matters more open to discussion.

3.2.2 Areas where knowledge is needed

Target groups and epidemiology

To start with, clear definitions and means of putting them into practice are needed. Comparisons between target groups are difficult, because there are no clear delineations and there is insufficient knowledge about them. Research is needed into the nature and extent of the problems (epidemiology and monitoring) and into the determinants of (the probability of) problems and solutions. Another relevant theme concerns the question of how, with whom and when problems will escalate.

Instruments and interventions

Much necessary research has already been done into certain promising interventions, such as Critical Time Intervention (CTI), Assertive Community Treatment (ACT and the Dutch version of FACT, Functional ACT – *not* Forensic ACT), and strength-oriented basic and rehabilitation methods, for example Individual Placement and Support (IPS). However, next to nothing is known about the effects of other activities, methods or interventions (directed at treatment, self-sufficiency, social recovery). Are they effective, what is the cost/benefit ratio, are there (damaging) side-effects?[35, 36] Nor is it known for what groups what interventions and methods may work and what predictors of progress there are. The steps from case finding, identification, problem analysis, diagnosis and indication to a suitable, integral approach are insufficiently supported by knowledge. The use of compulsion and duress is still an unexplored research field.[37] It is necessary to develop practical, valid and dependable measurement and risk evaluation instruments for identifying problems and screening, integral problem analysis, diagnostics, and for a determination of competency and risks.

Care research and interface with the judicial domain

Research into the accessibility and continuity of care, the effectiveness of management and collaboration processes, and the competencies and motivation of individual care providers is extra relevant to PMHC, because people who need help do not always seek or obtain it, or because what is on offer does not match the need. Research into the relevance of volunteer work also fits into this context: what is the extent, nature, implication and effectiveness of volunteer work as organised by (church) communities?

Knowledge is needed on the interface between PMHC and the judicial domain about how decision-making processes proceed, what the relationship is between recidivism and PMHC problems and how the care and justice chain can be optimised. Bundling and sharing of knowledge, for example about effective methods and risk evaluations, and interdisciplinary research into criminal behaviour (neurobiology and judicial interventions) benefit the quality and effectiveness of action in both domains.[9, 38-40]

Ethical reflection

The public nature of PMHC leads to moral questions and dilemmas. Examples are: intervening in good faith versus respect for autonomy, damage limitation, use of coercion and compulsion, adapting people to their environment or the environment to the people, normative postulates, processes of development and self-development, and stigmatisation and its relationship with nuisance. Reflection on and research into these ethical dilemmas are needed.

Knowledge for policy

Linking together the development of knowledge and policy helps in the development of efficient, evidence-based, sustainable and morally appropriate policies for PMHC. Efficient knowledge development is possible through linking research questions to the implementation of policy. The intake of clients into care may, for example, be linked to determinant research and to research into the nature and extent of their problems. It is also possible to couple *ex ante* or *ex post* evaluations to the implementation of policy measures. The comprehensive Social Shelter Plan of Action has had results, but has not adequately led to systematic, objective and transferable knowledge. In that sense, it has been a missed opportunity for effective knowledge development.

Client perspective

Clients' perspective is important in many of the subjects listed above in order to obtain a good impression of the questions and problems and their possible solutions. The client perspective can, moreover, open one's eyes to questions that can otherwise easily be missed. Why is it that people avoid care, and how does the motivation for recovery and participation arise? What possibilities and strategies for recovery, participation and empowerment do clients have, and how can clients and care providers cooperate? What are clients' needs and how can care best link up with these? What do they think of the rapport and cooperation among and with the care providers? What role can family members, friends and neighbours play in the cooperation between client and care providers?

Chapter 4

A knowledge infrastructure for PMHC

For the development of the necessary knowledge and its application in practice, a knowledge infrastructure is needed: an infrastructure that promotes the innovative power and professionalisation of Public Mental Health Care. Such a knowledge infrastructure is under construction within PMHC. Reinforcement is needed, however, in such a way that the knowledge infrastructure contributes as much as possible to the quality of care and policy.

4.1 Current knowledge infrastructure

The Committee understands knowledge infrastructure to mean the entirety of people, organisations, coordination mechanisms (forms of collaboration, decision-making processes, culture) and resources (expertise, databases, money, access to knowledge) contributing to the development and sharing of knowledge. In recent years a start has been made with the building of a PMHC knowledge infrastructure.

Three academic collaborative centres being created

The Netherlands Organisation for Health Research and Development (ZonMw) is financing a Public Health Academic Collaborative Centres programme (principal is Health, Welfare and Sport's Public Health Directorate). Some of these academic collaborative centres devote attention to PMHC in their projects.

In 2010, two promotional subsidies were provided specifically for the PMHC theme, for the Brabant Academic Collaborative Centre (part of Tranzo, Tilburg University) and the G4 Academic Collaborative Centre (Amsterdam, Rotterdam, Utrecht, The Hague), with Amsterdam Municipal Health Service as secretary. These two collaborative centres are forms of collaboration among municipalities (municipal health services), practical institutions and university researchers. The total investment comes to 2 million Euros for four years intended for constructing a (loose) coordination structure and four studies.

The third academic workplace, Shelter and PMHC (Dutch acronym OxO), in which twenty-four shelter institutions participate, is part of the Social Care Research Centre at the Radboud University Nijmegen Medical Centre. The participating institutions annually make a financial contribution available for activities. This collaborative centre does not form part of the ZonMw programme. The three academic centres collaborate in certain projects.

Four academic chairs

PMHC's complex and multidisciplinary nature and the medico-biological profiling of psychiatry have contributed to the disappearance from view of PMHC and the professors of social psychiatry linked to it at the universities in the 90s. PMHC no longer has any natural or structural framework in the medical-academic world. There are, however, four professors occupied in the field of PMHC, three of whom are special (i.e. not paid by the university) and one ordinary, at Leiden University Medical Centre (Prof. Bert van Hemert, Special Professor of the Epidemiology of Public Mental Health Care, psychiatrist), the Radboud University Nijmegen Medical Centre (Prof. Judith Wolf, Professor of Social Care, sociologist), the Erasmus Medical Centre (Prof. Niels Mulder, Special Professor of PMHC, psychiatrist) and the University Medical Centre Groningen (Rob Giel Research Centre, Prof. Durk Wiersma, Special Professor of the Clinical Epidemiology of Psychiatric Disorders, sociologist). The first three academic chairs are financed by the Parnassia Bavo Group. The Shelter Federation contributes financially to Professor Wolf's chair. Annex F contains a more detailed description of the chairs.

Other contributions to the PMHC knowledge infrastructure

Others besides those listed above are also developing research and development activities in the PMHC field. Annex G presents an overview of the commitment of technical universities (Hanze University of Applied Sciences, Utrecht

University of Applied Sciences *et al.*), universities (Tilburg University, AIAR), various expert centres (Verweij-Jonker Institute, IVO, the Trimbos Institute, MOVISIE), Municipal Health Services, ZonMw and Health, Welfare and Sport. These efforts are limited in extent and fragmented. NVAG, the scientific association of doctors in the field of policy, management and socio-medical research, has organised many training, refresher and further education courses in the PMHC sphere for Society and Health (M&G) doctors.

Promising yet vulnerable

The efforts of care and shelter institutions and the impetus of the ZonMw Academic Collaborative Centres programme have led to some promising initiatives. An infrastructure is under construction, which is however still very vulnerable.

The links between research and policy and between research and practice are weak and largely dependent on a few individuals. The research field is fragmented and is of limited scale. Studies are project-financed, lack the perspective of continuity and are mainly inspired by current events in the municipalities. There is no recognisable or coherent research programme to link together research and practice.

It is estimated that around 14 million Euros was spent on research in PMHC in the period 2000-2009 (the length of the Fortitude programme); this is an average of 1.4 million Euros a year. In relation to the size of PMHC costs this is a modest sum. Moreover, there is no prospect of continuing finance. Seen from a businesslike perspective: investment has been made in a development where insufficient consideration has been given to risks and yields from the investment and to guarantees of continuity. The resources available are fragmented and employed disjointedly. This causes a genuine risk that the investment ultimately yields less than hoped for and that what has been achieved with great effort evaporates in a short time.

4.2 Appropriate knowledge infrastructure

To ensure that what has been built up in past years can actually deliver usable knowledge that leads to better care and better policy, it is necessary to invest in an appropriate knowledge infrastructure in which the demands and needs of practice (care providers and clients) and of policy provide the direction. To enable practice and policy to fill this guiding role, the knowledge infrastructure must be one:

- that is harmonised with PMHC's specific nature
- that coordinates and connects
- in which the societal relevance of research is assessed for its value.

PMHC's specific nature

In order to be able to function properly, the PMHC infrastructure must fulfil the design requirements that result from the sector's characteristics, as described in Chapter 2:

- *Individual care provision and policy development:* the institutions (care, shelter, welfare), the clients and the municipalities must be involved in the knowledge infrastructure. The PMHC knowledge infrastructure is their common 'R&D division'.
- *Medical and social care:* broad multidisciplinary and interdisciplinary research. Isolated research from only a medical or only a societal paradigm delivers insufficiently coherent knowledge. The integration of these paradigms must be encouraged at all levels: on the workfloor (care providers and managers educated to secondary vocational (MBO), higher professional (HBO) and academic (WO) level), and in the research and policy (municipalities, internally at Health, Welfare and Sport and other ministries).
- *Public nature:* the knowledge infrastructure must be able to involve processes in society in the research. These processes may be the cause of the wretched situation under study, but they might also help to solve the problems. The subject thus no longer is the effectiveness of an individual intervention in care or shelter, but the effectiveness of strategies. For example, the effectiveness of a combined approach: work, behavioural training and debt assistance. Encouragement of the sector's innovative power is essential to be able to take advantage of developments in PMHC. Moreover, there must be space for reflection on the ethical issues that are associated with PMHC's public nature.
- *Optimistic and powerful:* thinking and acting on one's own initiative must be safeguarded in the knowledge infrastructure by, for example, involving clients in the formulation of research hypotheses and in the data collection.
- *Many responsible parties:* an open, communicative, networking knowledge infrastructure must be organised for the development and use of knowledge. Inspiration for this may be found in the concept of 'open care innovation'.[41]

PMHC's character and the nature of the necessary knowledge infrastructure

Public Mental Health Care characteristics	Knowledge infrastructure development requirements
individual help provision and intersectoral policy, jointly focused on prevention	involvement of municipalities, care, shelter and clients in the knowledge infrastructure
medical care and wider social care	broad multidisciplinary research
public nature	power to intervene rapidly in new social problems and attention to the moral dilemmas that arise from PMHC's public nature
power and optimism	structural dialogue between researchers and clients so that power and optimism are reflected back into the research
many responsible parties	open, communicative network

Cohesion

The knowledge infrastructure must create links among different disciplines, between research and practice and between research and policy. The cohesion with practice and policy is vital in all phases of the research. The aim is that a dialogue is started and that the parties involved develop shared research; in this way, a culture can grow in which the 'not invented here' syndrome is overcome and knowledge sharing is automatic. This cooperation costs time and requires support at a management level. An example may be found in Rotterdam, where the municipal board has appointed a chief science officer and has agreed on an 'academic coalition' with the university's board.

In the meantime, ZonMw has gained experience in promoting collaboration between disciplines, between researchers and practice and between researchers and policy. This is brought about, for example, by setting up academic collaborative centres, and also via expert meetings and extra bonuses for interdisciplinary collaboration, and by imposing conditions on finance and financing coordination activities. In the 'Fortitude' (*Geestkracht*) programme, it was revealed that the 'Educating Researchers in MHC' section (OOG) was a good instrument to encourage collaboration between practice and research, as was the double appointment of researchers. It is important to facilitate care and shelter workers and their clients, so that they obtain the practical opportunities to collaborate and to participate in research. They must have the time and feel themselves empowered to ask: does what we do work, can it be improved, and if so how? Subsequently, the answers to these questions should be translated into research hypotheses. Making funding available for the development of research

proposals supports the professionalisation of the sector, because PMHC workers can then cooperate on a grant application.

In the education, including further and refresher education, of staff - psychiatrists, GPs, Society and Health (M&G) doctors, Health (Gz) Psychologists, care providers educated to secondary vocational (MBO) and higher professional (HBO) level (such as social work, social educational care provision, nursing) and police and justice staff – explicit attention is needed for the PMHC group: what does responsible care for socially vulnerable people entail in practice? Structural attention to the PMHC field of endeavour is of great importance, particularly in the Society and Health (M&G) Doctor course (Paediatrician and Policy and Management doctor profiles).

Appreciation of social relevance

An important criterion in the decision-making about research is its relevance to society.[42] This insight is of crucial importance to researchers in a new research field like PMHC, which is not yet scientifically mature, yet is most relevant from a social viewpoint. In this context, it is hopeful that the Evaluating Research in Context (ERiC) platform, in which the Netherlands Association of Universities of Applied Sciences, the Royal Netherlands Academy of Arts and Sciences, the Netherlands Organisation for Scientific Research, the Association of Universities in the Netherlands and the Rathenau Institute participate, has developed a method to assess the societal relevance of research.[43]

Chapter 5

A PMHC Research and Development Programme

In order to get a good knowledge infrastructure off the ground, a substantial, long-term Public Mental Health Care research and development programme is necessary in which a number of substantive topics are elaborated and during which the PMHC knowledge infrastructure is expanded. In this chapter, the Committee sketches out some of this programme's outlines. The precise realisation must be done step by step. This process demands strong management and involvement of clients, municipalities, researchers, the judiciary, and care and shelter institutions.

5.1 Study population

It is important to achieve consistency regarding the conceptual and operational definition of the group or groups of people at which the programme is directed. The Council recommends that specific target groups should be selected during the further detailing. Examples of target groups with specific problems are:

- *The young:* there is a group of young people who do not succeed in building up an independent life on their own and with the support of social networks and parents. The street children belong to this group. They need help to become self-sufficient and to participate in society.
- *Families:* in the case of family problems – such as (the threat of) domestic violence, financial problems, parents who cannot cope with the care of their children due to their own psychiatric or addiction problems, criminality and

children with learning or behavioural problems – by definition several people are involved, and a transfer of problems and (damaging) behaviour from one generation to the next may occur.
- *The elderly:* the social network shrinks as age increases, mobility decreases, and the complexity of society and institutions becomes harder to cope with. This can lead to 'silent suffering': it is hidden and society has very little nuisance from it. There may also be maltreatment of the elderly by children, family or carers.

5.2 Outcome measures

Sensible outcome measures for PMHC interventions are: reinforcement of self-sufficiency, personal recovery, achievement of a stable situation, recovery of social functioning and improvement in social participation and quality of life. Outcome measures for preventive measures may be: reduction or control of risk factors, reinforcement of protective factors, improved observation and referral. It is recommended to involve the perspective of clients, workers in practice and funders in the definition of outcome measures.

5.3 Study designs

The programme must provide space for qualitative as well as experimental and non-experimental quantitative research methods. Because so much is still unknown about the nature and extent of the problems, there is a need for epidemiological research. Descriptive research is needed to map out the characteristics of the (context of the) target groups and of existing practices. Various forms of quantitative research could map out the experiences of clients and the practical knowledge of PMHC workers. For research into the effectiveness of interventions, randomised controlled trials (RCTs) and quasi-experimental study designs may be used. To evaluate policy measures, different methods will usually have to be combined.

5.4 Research themes

The Committee is of the view that some broad research themes should be selected to give the research and development programme direction. Possible themes, which link up with the fields requiring knowledge identified in Chapter 3, are for example:
- nature and extent of the problems, determinants, risk and protective factors

- instrument development: development and evaluation of instruments for risk assessment, identification and referral, as well as for broad problem analysis in the social field (for example the risk of domestic violence, child neglect , injury) and the medical-psychiatric field (somatic, psychiatric, mental)
- prevention: development and evaluation of possibilities for prevention, early intervention and prevention of escalation of problems (for example: what requirements should the support system and switching points in linked care fulfil in order to prevent escalation?)
- interventions: development and evaluation of combinations of interventions, of 'strategies', rather than separate interventions from a single perspective (what works?)
- help providers: their roles, competencies, experience (who works?)
- cost-effectiveness: analyses of costs and (social) benefits of interventions and policy measures, business cases
- policy evaluation, *ex ante* and *ex post*
- ethical aspects: research into ethical aspects of coercion, compulsion and assertive care, autonomy and social inclusion and exclusion and into encouragement, stigma and meaningful use of time.

Chapter 6

Recommendations

In the aforegoing chapters, the Committee established that Public Mental Health Care is a complex and dynamic area of endeavour of great societal importance, in which the development of knowledge is lagging far behind what is required for the necessary professionalisation and modernisation. The Committee is of the view that a long-term and substantial investment in an authoritatively managed PMHC Research and Development programme is necessary to get the urgently required knowledge development in PMHC under way.

Because such a programme cannot come into existence all at once, the Committee concludes its advisory report with two recommendations for the short term that are intended to enable a proper start to this substantial programme over the next couple of years. Firstly, a recommendation to the institutions and people who are already active in the PMHC research field: the Committee's advise to them is to reinforce and coordinate the initiatives already taken and thus show potential funders that an investment in a PMHC programme has prospects. Secondly, a recommendation to the Minister of Health, Welfare and Sport: to make possible the carrying out of a modest programming study, in preparation for a long-term research and development programme.

6.1 Invest in a well-managed PMHC Research and Development programme

According to the Committee, a long-term and substantial PMHC Research and Development programme is needed, as sketched out in the previous chapter. The way in which this programme is managed is crucial. The Health Research Funding Programme (SGO)'s top-down approach offers a good guideline.[1] Important elements of this approach were:

- preparation and management by a committee of independent experts (usually the same as the subsequent programme committee)
- comprehensive orientation regarding the research field by means of consultation with experts and by holding workshops
- formulation of objectives, elaborated afterwards into a strategic research programme
- focus on stimulating a limited number of the research groups: those expected to be most successful
- guidance of the programme's implementation by a programme committee.

The Committee considers this approach to be most suitable for bringing both the PMHC research and the PMHC knowledge infrastructure to fruition. The progress made in the programme should be assessed by an external committee after two, six and ten years. Embedment of the initiatives developed in the programme's context into the existing structures and funding streams should be an important focus of attention through the entire duration of the programme, and particularly in the final years. ZonMw should be able to support the preparation, implementation and evaluation of the programme as well as the embedment of the results.

The investment should be sufficient, over a period of 10 years, to yield usable new knowledge, establish an adequate research infrastructure and ensure that there is continuity after the programme ends by means of financing from regular PMHC and research funding streams.

1 The SGO, carried out between 1986 and 1997, stimulated health research in fields where a relatively underdeveloped scientific position and a clear societal importance occurred in combination. Thanks to the SGO, a research tradition has developed in fields such as revalidation medicine and rheumatology, which has generated valuable, practically useful knowledge and has contributed much to guidelines for medical treatment.[44,45]

The Committee believes that the investment will pay off generously in the form of greater self-sufficiency on the part of socially vulnerable groups due to an increase in effectiveness and efficiency of PMHC, and in savings in the labour costs of aid providers, benefit payments to (potential) clients and costs in the judicial domain. Because the benefits of PMHC occur in various social areas, it seems obvious that the necessary resources should be provided by a number of ministries (those of Health, Welfare and Sport, of Security and Justice, of Social Affairs and Employment and of the Interior and Kingdom Relations).

6.2 Reinforce ongoing initiatives

In the short term the Committee recommends expanding and reinforcing the existing initiatives at the universities – the three academic collaborative centres, the Health Research Committees (RGOs), and the four academic chairs. The professions represented (psychiatry, social care and shelter, epidemiology, sociology) are essential to PMHC, practice and policy are involved, they have relevant collaborative relationships with bodies, including expert centres and Municipal Health Services, and they are of a size that compares favourably to those of the other contributions to the PMHC knowledge infrastructure.

The universities involved (Amsterdam, Nijmegen, Leiden, Rotterdam, Groningen, Tilburg) can investigate whether the university framework of the PMHC research can be further improved. This might be through establishing one or more (shared) ordinary PMHC or social psychiatry chairs, integrating the medical and societal approach through structural cooperation with, for example, sociology, business administration or psychology faculties. Because many staff in PMHC are educated to higher or secondary professional levels, it is of great importance to seek collaboration with the technical universities that carry out practically oriented PMHC research. Consideration should be given to instituting a PMHC Master's course.

The Committee further considers that there are opportunities for strengthening existing initiatives through better mutual cooperation. It has no ready-made recipe for this: the institutions and people themselves will have to give form to their collaboration. But it is clear that there are many opportunities, for example in:

- exchange of knowledge and research results
- combining data and research populations in order, among other things, to make prospective research of sufficient scope possible
- forming networks of researchers in order to facilitate the bundling of research lines

- agreeing about who will tackle which research topics and the joint formulation of research proposals
- organising researchers' training.

By bundling strengths and optimally utilising synergy opportunities, current researchers – in cooperation with their partners in practice and policy – can demonstrate that a sustainable and substantial investment in PMHC research is worthwhile.

6.3 Provide a PMHC programming subsidy

The Committee recommends the Minister of Health, Welfare and Sport to make possible a modest programming study to prepare for the decision-making regarding a substantial, long-term investment. Such a programming study fits into the Health Research Funding Programme approach described in 6.1 and is necessary to realise the outlines of the PMHC Research and Development programme sketched out by the Committee.

The programming study ought initially to include an evaluation and analysis of the available epidemiological data – whether or not published. Much relevant information has already been assembled at the local level in various PMHC monitors and health memoranda for the purposes of policy. Information has also been collected in specific projects, including ZonMw's Social Shelter and PMHC Academic Collaborative Centres programmes, and in studies financed directly by Health, Welfare and Sport. In the context of the programming study, it should be investigated to what extent it is possible to produce an overview of the PMHC target group at a national level and of the different sub-groups that may be distinguished therein, through harmonisation and combination of the available files. Such an overview is an important reference point when developing ideas for setting up the PMHC programme, not least where the efforts necessary to allow for a better description of the target group or groups are concerned.

The study should further include a description of the knowledge available, an inventory of the working methods, instruments and policy measures used in practice, an overview of the existing knowledge infrastructure, including the way in which this has been funded until now, and an overview of the research and development activities underway and the way in which these are funded.

Based on all this, and on consultation with experts from practice, policy and research (including clients), the committee of independent experts to be set up for the programming study should be able to present the outline of a strategic

PMHC Research and Development programme, and an estimate of the investment needed to implement the programme.

The Committee recommends that the task of conducting the study be given to ZonMw. ZonMw's experience teaches us that such a study can be carried out over the course of two years at a cost of 0.5 million Euros. If the potential funders could indeed decide on a substantial investment based on the programming study, the strategic programme in outline could be elaborated into a detailed PMHC Research and Development programme.

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Annexes

Annex **A**

Advisory Committee on Health Research

- Prof. L.J. Gunning-Schepers, *President*
  President of the Health Council of the Netherlands, The Hague
- Prof. W.J.J. Assendelft
  Professor of General Practice Medicine, Leiden University Medical Centre
- Prof. J.M. Bensing, *Vice President*
  Professor of Health Psychology, Utrecht University Medical Centre
- Dr. A. Boer
  Board Member, Dutch Health Care Insurance Board, Diemen
- Prof. P.P. Groenewegen
  Professor of Spatial and Social Aspects of Health and Health Care, Utrecht University; Director of NIVEL (Netherlands Health Care Research Institute), Utrecht
- Prof. J.M.W. Hazes
  Professor of Rheumatology, Erasmus Medical Centre, Rotterdam
- Dr. J.W. Hofstraat
  Vice President of Philips Research, Eindhoven
- M.W. Horning, *observer*
  NL Agency, Ministry of Economic Affairs, Agriculture and Innovation, The Hague
- Prof. J. Kievit
  Professor of Medical Decision Theory, Leiden University Medical Centre

- Prof. P.L. Meurs, *advisor*
  Chairman of the Netherlands Organisation for Health Research and Development, The Hague
- Dr. R. van Olden
  Medical Director of GlaxoSmithKline, Zeist
- Prof. J.J. Polder
  Special Professor of Economic Aspects of Health and Care, Tilburg University; Centre for Public Health Status and Forecasts, Netherlands National Institute for Public Health and the Environment, Bilthoven
- Prof. S.A. Reijneveld
  Professor of Social Health, University Medical Centre Groningen
- Dr. J.W.A. Ridder-Numan, *observer*
  Research and Science Policy Directorate, Ministry of Education, Culture and Science, The Hague
- H.J. Smid, *advisor*
  Director of the Netherlands Organisation for Health Research and Development, The Hague
- Prof. H.A. Smit
  Professor of Public Health, Julius Clinical Research Centre / First-line Health Care, Utrecht University Medical Centre
- Dr. C. Smit
  Patients' and Consumers' Representative, Hoofddorp
- Prof. A.E.M. Speckens
  Professor of Psychiatry, Radboud University Nijmegen Medical Centre
- Dr .M.J. Trappenburg
  Politicologist, Special Professor of Sociopolitical Aspects of the Care State, University of Amsterdam
- Dr. C.M. Vos, *observer*
  Macro-economic Issues and Working Conditions Directorate, Ministry of Health, Welfare and Sport, The Hague
- Prof. R. Vos
  Professor of Health Ethics and Philosophy, Maastricht University
- Prof. E.G.E. de Vries, *advisor*
  President of the Netherlands Council for Medical Sciences, Amsterdam
- Dr. J.N.D. de Neeling, *scientific secretary*
  Health Council of the Netherlands, The Hague

The Health Council and interests

Members of Health Council Committees are appointed in a personal capacity because of their special expertise in the matters to be addressed. Nonetheless, it is precisely because of this expertise that they may also have interests. This in itself does not necessarily present an obstacle for membership of a Health Council Committee. Transparency regarding possible conflicts of interest is nonetheless important, both for the chairperson and members of a Committee and for the President of the Health Council. On being invited to join a Committee, members are asked to submit a form detailing the functions they hold and any other material and immaterial interests which could be relevant for the Committee's work. It is the responsibility of the President of the Health Council to assess whether the interests indicated constitute grounds for non-appointment. An advisorship will then sometimes make it possible to exploit the expertise of the specialist involved. During the inaugural meeting the declarations issued are discussed, so that all members of the Committee are aware of each other's possible interests.

Annex **B**

Expert meeting

An expert meeting was held on 11 February 2010, prepared for by a working group comprising:

- Prof. Anne Speckens, member of the Council Committee for Health Research and Professor of Psychiatry, Radboud University Nijmegen Medical Centre, *Chair*
- Prof. Niels Mulder, Professor of PMHC, Erasmus Medical Centre
- Prof. Judith Wolf, Professor of Social Care, Radboud University Nijmegen Medical Centre
- Ms Caroline de Pater, Health Council of the Netherlands, *Secretary*

During the meeting, under the chairmanship of the former Health Research Committee chairman Prof. Paul van der Maas, introductions were presented by:

- Prof. Marianne Donker, Chief Science Officer, Rotterdam municipality and Professor of Public Health Care, Erasmus Medical Centre
- Prof. Bert van Hemert, Professor of the Epidemiology of PMHC, Leiden UMC
- Prof. Eduard Klasen, Board of Directors, Leiden UMC
- Prof. Chijs van Nieuwenhuizen, Professor of Forensic Mental Health Care, Tilburg University

The following took part in the meeting:

- M. Barth, GGZ Nederland

- C. Beers, Federatie Opvang
- J. Bouwens, ZonMw
- G. van Brussel, GGD Amsterdam
- H. Buijze, IGZ
- J. Crasborn, AGIS
- M. Donker, gemeente Rotterdam
- I. Doorten, RVZ
- K. van Duijvenbooden, Ministerie van Justitie
- A. Elling, ZonMw
- U. Gangaram, ZonMw
- J. Hannik, Ypsilon
- A. den Hoed, Ministerie van VWS
- J. Hoogteijling, Leger des Heils
- M. Huijben, RVZ
- D. Kaasjager
- E. Klasen, LUMC
- H. Kroon, Trimbos-instituut
- M. Lansen, Anoiksis
- P. van der Maas, RGO
- H. van de Mheen, IVO
- M. Mootz, ZonMw
- C. Mulder, Erasmus MC
- N. de Neeling, RGO
- Ch. Van Nieuwenhuizen, UvT
- C. de Pater, RGO
- C. Pollmann, Ministerie van VWS
- E. Reitsma, Landelijk Platform GGZ
- A. Rijkschroeff, RVZ
- C. van Schie, GGD Flevoland
- R. Schoevers, UMC Groningen
- G. Schout, Hanzehogeschool
- A. Speckens, UMC St. Radboud
- T. Stikker, GGZ Nederland
- W. van Tilburg
- J. Timmermann, Divosa
- C. Urbanus, Divosa
- R. van Veldhuizen, GGZ Noord-Holland Noord
- C. Vos, Ministerie van VWS
- J. van Weeghel, Kenniscentrum Phrenos

- D. Wiersma, UMC Groningen
- M. de Wit, GGD Amsterdam
- J. Wolf, UMC St. Radboud
- J. Zoeteman, Mentrum

Annex C

Comments received

The Committee received commentary on the draft advisory report from:

- C. Beers, Federatie Opvang
- J. Bouwens, ZonMw
- M. Donker, gemeente Rotterdam
- A. Elling, ZonMw
- U. Gangaram, ZonMw
- H. Garretsen, UvT
- E. de Haan, GGZ Nederland
- J. Hannik, Ypsilon
- M. Huijben, RVZ
- D. Kaasjager
- H. Kroon, Trimbos-instituut
- M. Lansen, Anoiksis
- F. Leeuw, WODC
- M. Mootz, ZonMw
- P. Peerenboom, NVAG
- D. Reinking, GGD Utrecht
- G. Schout, Hanzehogeschool
- W. van Tilburg
- C. Urbanus, Divosa
- M. Vesters, ZonMw
- J. van Weeghel, Kenniscentrum Phrenos

- D. Wiersma, UMC Groningen
- M. de Wit, GGD Amsterdam

Annex **D**

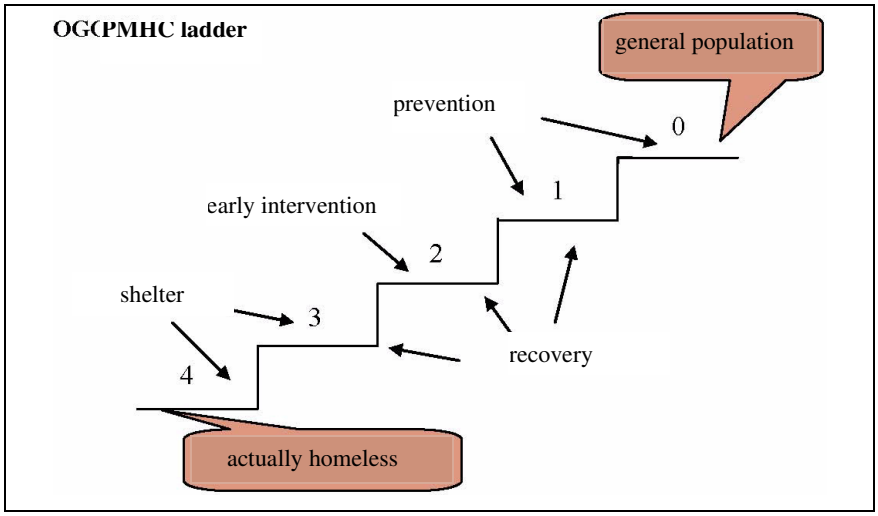
The PMHC ladder

The Public Mental Health Care ladder (Wolf, 2006) is engrafted on to the process of social inclusion and exclusion of vulnerable citizens and comprises five rungs. On each rung of the ladder, two dimensions come together, namely those of:

- the seriousness, complexity and duration of problems, expressible in a risk profile
- the desired and necessary support and shelter during the different phases of inclusion and exclusion.

Rung zero (the ground) represents the local population of municipalities. At this level, there is generally an adequate interaction between individual and environment, relatively good health and active social participation. Self-sufficiency and voluntary and family care suffice, also during and after a setback. Interventions at this level (collective prevention) include instruction and health promotion.

The first rung represents varied risk groups with a stagnating interaction between individual and environment, unstable self-sufficiency and reduced welfare. Nonetheless, the problems (still) remain within bounds, often due, at least in part, to support from the surroundings. Preventive activities, also targeted at the individual, can help prevent further deterioration.



On the second rung, we find people whose problems are increasing in seriousness and gravity. The problems extend over more and more areas of life and persist longer. Support from the environment comes under increasing pressure and may disappear in time. The quality of life decreases. Situations may escalate from time to time, due to problems piling up, far-reaching life events and (chronic) stress. This rung also represents vulnerable people who have been referred to institutional care due to their multiple problems and who are now trying to recover and once again get involved. Crisis intervention and long-term help at home are necessary to prevent collapse and relapse.

The third rung comes into sight when vulnerable people are referred to institutional care (refuge, psychiatric hospital, prison) due to various, often multiple problems. Their stay is often intended to be temporary, but may also be long-term.

On the fourth rung, vulnerable people have reached the very bottom of existence. They cannot provide their own shelter, but equally cannot or will not make use of shelter provisions. These people, referred to as effectively homeless, sleep on the street, find temporary shelter with friends or family, or end up in the night shelter. Here, care on the street is of importance.

On the top rung of the ladder, the main correlation is with Social Support Act (Wmo) performance fields one to four (the promotion of social cohesion and liveability, prevention-targeted support of young people with growing-up problems and of parents with problems with nurture, providing information, advice and client support, and supporting volunteer and informal carers). On rungs one and two, overlap occurs with performance fields five and six (the promotion of participation in social intercourse and of the self-sufficient functioning of people with a handicap or a chronic mental problem or a psychosocial problem, and the provision of facilities to these groups). Performance field seven, social shelter, currently corresponds roughly with rungs three and four. Conversely, the policy to combat domestic violence may also be localised on the upper rungs of the ladder. There is also cohesion, particularly on the lower rungs, with addiction policy (ninth performance field).

Annex **E**

Policy

Cohesion in living, care and shelter

Through the focus of the Cabinet and municipal councils on safety and combating nuisance-causing situations, there is political attention for people with psychiatric and other problems that reveal themselves in public.

The spinoff from the Social Shelter Plan of Action for the working field of Public Mental Health Care is significant. Work is underway on new forms of guidance, accommodation and living, identification of problems and referral. Shelter is no longer restricted to bed, hygiene and food, and guidance of clients. Early intervention activities, recovery and social activation now are part of the task package. Institutions that did not previously collaborate currently work together on building up a properly functioning network of care and guidance for individuals; due to the various funding streams and legislation this is a complex and time-consuming task. New recording systems for rapid information interchange are in development. Methodical working is also in development, but there is still too little knowledge available to put this into action dynamically.

The Social Support Plan of Action, phase 2 was initiated in 2010. This phase is targeted at preventing homelessness.

Municipalities, care bureaus and care insurers are together developing initiatives for broad, integrated care for groups of vulnerable citizens. The Experimental Public Housing Steering Group (SEV) is developing innovative answers to societal issues on accommodation.

The shelter sector is busy improving quality and transparency; it is actively seeking scientific support for methodical action and is working on professionalisation. For this, the sector is collaborating with Radboud University Nijmegen Medical Centre, in the Shelter & PMHC Academic Collaborative Centre (OxO).

Contribution of MHC to social functioning

Mental Health Care institutions are becoming ever more conscious of the role they have in issues of assertive care, rehabilitation, recovery and social participation: referred to as the socialisation of care. Psychiatry's rather inwardly-directed gaze of recent decades is shifting towards inclusive forms of care (including rehabilitation) that contribute to the quality of life and citizenship: recovery as the key principle in care.[46] Attention to the meaning of factors such as 'work' and 'living' for health and welfare is increasing.

Guidelines and quality

Guidelines regularly appear with the aim of promoting the quality of care provision in mental health care. Of importance to PMHC are the Guideline 'Decision-making compulsion: admission and treatment' (*Besluitvorming dwang: opname en behandeling*) and the three multidisciplinary guidelines 'Familial Domestic Violence', 'Suicide' and 'Schizophrenia'. The Committees that are developing these guidelines are all struggling with the problem of missing knowledge. The guidelines therefore provide – in addition to recommendations on care – recommendations on knowledge development.

Besides this, the institutions are in other ways actively engaged in the quality of care. An example of this is the MHC the Netherlands (GGZ Nederland) project, 'Reducing compulsion and coercion' (*Terugbrengen dwang en drang*). There are various initiatives, besides the Care Sector Quality Assessment Foundation (HKZ) measurement, in order to, primarily, assess the content and organisation of care. The ACT and FACT Certification Centre Foundation (CCAF) certifies ACT and FACT teams; these teams offer continuous help to people with psychiatric complaints who live outside institutions. The teams fill an important role in the care network and contribute to the prevention of PMHC problems. Radboud University Nijmegen Medical Centre (Social Care Research Centre) is occupied in the certification of strength-oriented basic methodology and critical time intervention. The Top Clinical MHC Foundation (TOPGGz) awards its hallmark to institutions that comply with the criteria, which include

research, development and innovation. Knowledge that is developed within TOPGGz departments may be relevant to the treatment and prevention of (worsening of) mental problems, including those of PMHC clients.

The Netherlands Health Care Inspectorate (IGZ) is intensifying supervision of institutions that are involved in the care of vulnerable families, in other words, families with limited social self-sufficiency. The Inspectorate names three prior conditions for responsible care of vulnerable groups: 1) offer active care and support as early as possible 2) care and support are needed long-term but of variable nature and intensity and 3) responsible care is only possible if institutions cooperate. IGZ collaborates here with other Inspectorates, including the Child Care and the Work and Incomes Inspectorates; the focus of the supervision lies on the collaboration among the institutions.[47]

Care insurers are campaigning for the introduction of Routine Outcome Monitoring (ROM) to follow the effects of treatments and care, and for the development of care purchasing policy – with the important focus points of clinical utility, quality and price.

The Justice Behavioural Interventions Recognition Committee was instituted in 2005 by the Minister of Justice. It has the task, based on ten internationally recommended quality criteria (What works criteria), of evaluating whether the behavioural interventions and training courses that are offered in a criminal law context may contribute to reducing recidivism. The Research and Documentation Centre (WODC) guides the recognised interventions through process evaluation. The Committee is expanding its working field to the custodial (TBS) institutions and forensic psychiatry.

Collaboration between Ministries of Health, Welfare and Sport and of Security and Justice

The Psychiatric Hospitals (Compulsory Admission) Act (Bopz) has been evaluated: the Cabinet decided to replace this (admission) act with a new treatment act. The new act (Compulsory MHC) makes it possible for non-voluntary help to be provided, more than is the case under the present Bopz Act. Besides this, the Cabinet is working on the Forensic Care Act (*Wet forensische zorg*). This act must make it possible to provide mental health care in a criminal law context. The two ministries involved, Health, Welfare and Sport, and Security and Justice, are working closely together in the preparation of both draft acts. The ministries are also collaborating on the approach to domestic violence, for example on instituting an exclusion order and on shelter for victims and perpetrators.

One of the Ministry of Security and Justice's priorities is to combat recidivism. One of the means to this end is to give the logic of medical treatment improved entry into the penalty domain, for example by offering care to detainees with mental problems and through the provision of behavioural interventions and effective treatment programmes.

A proper link among care before, during and after detention is essential for the person involved and his environment; specifically, this is about combating recidivism and reducing social nuisance. The municipalities and Justice have made agreements about aftercare for ex-detainees in the areas of accommodation, income, debts, care and the possession of an identity document. The Inspectorates involved (Health Care Inspectorate and Sanction Imposition Inspectorate) encourage an integral approach for this target group.[47]

Justice's Research and Development Documentation Centre (WODC) has major research programmes underway in the field of treatments and implementation practices in detention (TBS) institutions.

Position of clients

Finally, it also applies to PMHC, in particular where the shelter institutions are concerned, that the clients' position is reinforced so that they can exercise influence on the nature, content and quality of care. They can participate in recommending advice from care bureaus and care insurers via their representative organisations. They can also make their voice heard in the implementation of the Social Support Act (Wmo). In its evaluation of the Wmo, the Socio-cultural Planning Bureau (SCP) concludes that people with a mental limitation or chronic mental problems, the PMHC group, are less well represented in the Wmo councils. In order to improve this participation, it is therefore of the greatest importance that the empowering of client organisations provides for this role.

Annex F

Academic chairs

There are four university chairs in the field of PMHC:

- Leiden University Medical Centre: Prof. Bert van Hemert, Epidemiology of Public Mental Health Care; special professor, psychiatrist.
  This chair (0.2 FTE) is part of the Public Health of Northern Zuid-Holland Academic Collaborative Centre (PMHC thematic group), in which activities include collaboration with local Municipal Health Services. The research is in the field of the extent and nature of the problems, accessibility of care, client follow-up systems and referral methodology. There are three PhD students in the PMHC field.
- Radboud University Nijmegen Medical Centre: Prof. Judith Wolf, Professor of Social Care; ordinary professor, sociologist.
  The Social Care Research Centre directs itself at the creation and dissemination of scientific knowledge about the extent and profile of (groups of) socially vulnerable people, processes of social inclusion and exclusion, homelessness and domestic violence, and the development and evaluation of effective, efficient and appropriate interventions. Activities include carrying out effect studies (RCTs), a cohort study of homeless people in the four large municipalities (together with the IVO research centre) and a predictive study on eviction. There are seven PhD students. The research centre collaborates intensively with actors in practice and policy (shelter institutions, municipalities, client groups etc.). There is a collaborative agreement with

Utrecht municipality in the context of the G4 Academic Collaborative Centre.

- Erasmus Medical Centre: Prof. Niels Mulder, PMHC; special professor, psychiatrist.
  This chair is linked with the O3 Research centre, a collaboration among the MHC institutions in Rijnmond, the Rotterdam-Rijnmond Municipal Health Service and the Erasmus Medical Centre. Research is taking place into matters including compulsion and duress, the development of PMHC monitoring and evaluation of interventions. There are eight PhD students in the PMHC field. The Rotterdam municipality and the Erasmus Medical Centre have an academic coalition. Improvement in living conditions and increasing the chance of work in deprived districts is one of the three spearheads.
- University Medical Centre Groningen: Prof. Durk Wiersma, Clinical Epidemiology of Psychiatric Disorders, special professor, sociologist.
  This chair is linked with the Rob Giel Research Centre. Research is focused on MHC practice and concerns matters including the effectiveness of interventions and the use of MHC with the Northern psychiatric case register. One of the research lines (four PhD students) concerns the interface between MHC and justice, in particular between PMHC and forensic psychiatry. The studies include: effectiveness of assertive care for seriously dysfunctional double-diagnosis patients (Long-Term Stay), the police's role in PMHC, the effect of offence risk assessment on recidivists in out-patient forensic psychiatry, forensic psychiatric treatment in detention, and the effect of intramural forensic psychiatric care. Besides these, for PMHC, there is research into the effectiveness of measures including: Individual Placement and Support, rehabilitation, Assertive Community Treatment, contact with fellow sufferers and living care.

Annex **G**

Other contributions to the knowledge infrastructure

Other research institutions and technical universities

Various special professors are associated with Tranzo, the scientific centre for care and welfare at Tilburg University: concerning rehabilitation and civil participation of people with serious mental disorders (Prof. Jaap van Weeghel), in the addiction field (Prof. Ien van de Goor), in epidemiology (Prof. Hans van Oers), in health care policy (Prof. Henk Garretsen) and in forensic psychiatry (Prof. Chijs van Nieuwenhuizen). A special chair has been founded in the Social Sciences Faculty (Prof. C. van der Feltz-Cornelis).

The AIAR research institute in Amsterdam is conducting research into addiction and all aspects that play a role in it. The Amsterdam School for Social Science Research is doing research into the municipality's 'behind the front door' projects. The Verwey-Jonker Institute is an independent research institute for consultancy and innovation in the societal field in Utrecht. The IVO Research Institute in Rotterdam, as well as carrying out research into all kinds of addictions, also conducts research in the field of social shelter and care.

There are lecturerships at various technical universities through which practice-oriented research into PMHC issues is carried out. Examples of these lecturerships are: PMHC at the Hanze University of Applied Sciences, Groningen, Innovative social service provision at the Utrecht University of Applied Sciences, Women's refuges and approach to domestic violence at Avans

University of Applied Sciences, and Care for people with a mental limitation at the HAN University of Applied Sciences.

Municipal Health Services (GGDs)

Research at GGDs is scarce and is mainly linked to PMHC or the Public Health Care Academic Collaborative Centres. Amsterdam GGD is very active and has seven staff conducting PMHC research within the Epidemiology, Documentation and Health Promotion cluster. Rotterdam-Rijnmond GGD's policy-supporting research is often conducted by third parties on request of the GGD. The West Brabant and Hart voor Brabant GGDs are active in the field of assertive care research.

Expert centres

The Trimbos Institute is the national expert centre for mental health care, addiction care and social care. The Institute researches, develops and promotes the implementation of knowledge. PMHC research particularly takes place within the Reintegration programme (including the Social Shelter Plan of Action monitor, research into local care networks and ACT and FACT). MOVISIE collects, validates, enriches and distributes knowledge about welfare, care and social safety, and advises on the application of said knowledge. PMHC is one of the themes. The Phrenos Expert Centre develops and distributes knowledge about treatment, rehabilitation, recovery and social acceptance for people with psychotic or other serious and long-term mental disorders.

The Trimbos Institute, ZonMw and MHC the Netherlands (GGZ Nederland) have made collaborative agreements in a covenant to better coordinate the different phases of the MHC knowledge cycle. PMHC was included in the Knowledge Agenda 2010.

Statistics Netherlands (CBS) is preparing a national estimate of the extent of the number of effectively homeless people.

The Netherlands Organisation for Health Research and Development (ZonMw) and the Netherlands Organisation for Scientific Research (NWO)

Distributed over ZonMw programmes from the last ten years, around 44 projects in all have been funded that address PMHC themes (global estimate of the amount: 9 million Euros). The Fortitude (*Geestkracht*) programme, practical care

projects section, funded eleven PMHC projects. There is no more budget for the Fortitude programme. ZonMw is deliberating about a follow-up to the programme that appears successful from interim evaluations. Subprogramme Two in the fourth Prevention Programme is targeted at the prevention of mental disorders.

The ZonMw Social Shelter Knowledge Programme (budget 1.9 million Euros) has completed three basic projects: client profiles in social shelter, women's refuges, and an overview of shelter methodology. The programme moreover funds three projects: two concerning the effectiveness of a client-oriented basic methodology, critical time intervention in shelter, and one directed at structural improvement in client participation. A final round for client-driven projects has started.

The Public Health Academic Collaborative Centre programme promotes the formation of two PMHC collaborative centres and funds four projects (budget 2 million Euros). In the context of the programme 'Care to Improve' (*Zorg voor Beter*), bodies including the Trimbos Institute are conducting an Assertive Care implementation project, and specific improvement routes for long-term mental health care (MHC) are being developed (including the theme: Social participation and recovery-directed care). The Risky Behaviour and Dependence programme promotes research into effective interventions for care and the prevention of addiction, including judicial measures, among other things. Concerning ethical issues, a project into the ethics of using compulsion and duress for pregnant addicts is running. The Youth programme promotes knowledge development for broad questions regarding the young, including child-rearing issues.

On the matter of research in forensic psychiatry, ZonMw concluded in 2007 that the time was ripe for a cohesive research programme focused on quality improvement in forensic psychiatry. The WODC (Research and Documentation Centre) has set up a detention (TBS) research programme. This programme is intended to contribute to the scientific basis of the detention measure by researching the effectiveness of treatments. A second main topic is monitoring of the practice of detention implementation. The prime task of the forensic psychiatry expert centre is that of 'linking and arbitration'.

By order of a private principal (the VCVGZ MHC Research Support Foundation), NWO is conducting the 'Violence against psychiatric patients' programme (budget of 0.5 to 1 million Euros annually). The choice of this subject stems from the observation that the prevalence of violence against psychiatric patients is much greater than that of violence perpetrated by psychiatric patients. The NWO 'Brain and Cognition: Safety' programme

concerns neurobiological variables in research into judicial behavioural interventions.

Ministry of Health, Welfare and Sport

The Ministry of Health, Welfare and Sport has made 2.5 million Euros available to the Shelter Federation for improvements in women's refuges. Late in 2009 a cohort study was initiated into the homeless in the four great Dutch cities. The study is costing one million Euros and is being conducted by the Social Care Research Centre and the IVO Research Bureau (by order of the Ministry of Health, Welfare and Sport's Social Support Directorate).