

Summary

Study background

Since 1 February 2008, a 'behaviour modification measure' (GBM) can be imposed on adolescents who have committed one or more criminal offences. This measure expands the possibilities for influencing the behaviour of these adolescents. By means of a personalised programme, the GBM intends to provide a suitable educational response aimed at bringing an end to the criminal career of adolescents and preventing further problems.

When the GBM programme was launched, there was an anticipated intake of 750 adolescents per year. After impact analyses were conducted by Drost et al (2009) and Drost, Van der Grift & Jongebreur (2010), the anticipated intake was first adjusted downwards to 150 to 250 per year, and then to 130 per year starting in 2013.

The fact that evidence-based behavioural interventions that can be used as part of a GBM were limited and not available on time was one of the reasons for the limited recommending, demanding and imposing of the GBM by the Child Care and Protection Board, the Public Prosecution Service and the juvenile courts, respectively, according to a study conducted by the department and the impact analyses (Drost et al. 2010). There was no national coverage, it was limited in scale and there were waiting lists in some regions.

To increase the availability of behavioural interventions for the GBM, and thus promote the use of the GBM, the Ministry of Security and Justice decided in 2009 to begin the central procurement of behavioural interventions for the GBM through the Forensic Care Department (DForZo) of its Custodial Institutions Agency (DJI) in the form of a pilot. The ministry's Research and Documentation Centre (WODC) asked the DSP group to evaluate this pilot.

Study approach

The study was conducted from December 2011 to June 2012. The goal of the study was to determine how the process of care procurement for the GBM works in practice, whether the target – nationwide, customised care, i.e. evidence-based behavioural interventions, available on time – is being achieved and to assess whether the care procurement itself is working according to plan. The following research methods were applied:

- document analysis (policy documents, internal memos and internal notes, internal evaluations of tenders, framework agreements and theories on care procurement)
- analysis of registration data from 2009-2011 from DForZo, the Child Care and Protection Board, Dutch Youth Care, care providers and the Public Prosecution Service
- a file search of 50 extensive investigations involving GBM by the Child Care and Protection Board (the so-called USO-GBM) in the first half of 2009 (period preceding the care procurement pilot) and 50 USO-GBM in the first half of 2011 (period after contracting the care providers for GBM)
- interviews with five national representatives of cooperating organisations, three policymakers and a representative for DForZo

- questionnaires for the 36 contracted care providers regarding a number of implemented projects up to and including the first quarter of 2012 and problem areas experienced (26 questionnaires were returned)
- phone interviews with six regional team leaders of the Child Care and Protection Board, seven regional team leaders of the juvenile probation service and thirteen care providers in the five selected regions

Based on the document analysis and the interviews with the national representatives of the chain partners, the policy logic behind the set-up of the care procurement pilot was reconstructed and an assessment framework has been formulated which includes criteria for the premises in the policy logic and for good care procurement. The practical implementation of the care procurement was then described and evaluated by means of this assessment framework. The outcome (in which more GBM is recommended and imposed) was also tested against the criteria formulated in the assessment framework for this purpose.

Policy logic, procurement model and theory of care procurement

The policy logic concerning the care procurement pilot is based on the premise that care procurement of accredited behavioural interventions for the GBM leads to a nationwide offer of evidence-based behavioural interventions that are available on time, which in turn leads to an increase in the number of GBMs imposed.

The schematic representation of the policy logic appears in the conclusion. In this graphic, we use colour to indicate how the various elements played out in practice.

A deliberate choice was made for a coordinated care procurement model in which the procurement is outsourced to DForZo: various organisations in the youth care and judicial chain exert an important influence on the organisation and implementation of the procurement function. Based on responsibilities tied to the procurement, explicit consideration is made of the wishes and needs of these chain partners, like the Child Care and Protection Board, the Youth Care Agency (juvenile probation service), the Public Prosecution Service and the juvenile courts.

For the pilot, a choice was made for the coordinated care procurement of four accredited evidence-based behavioural interventions that focus on reducing relapse.

Good care procurement must satisfy a number of criteria. The strategic processes must have a certain level of professionalism or development and the supporting processes must be sufficiently geared towards efficient and effective procurement for public purposes. Based on the Dutch adaptation of the Michigan State University Model for the public procurement task, the so-called MSU+ model, we have formulated criteria which must be satisfied by the strategic and supporting processes.

The care procurement pilot in practice

We can conclude that the coordinated care procurement up to contracting has proceeded in accordance with the intentions. Prior to the pilot, DForZo had a market analysis performed and determined the procurement strategy. The procurement procedures were well designed and implemented. The interventions implemented are retrospectively declared. This makes the care procurement for GBM different than the care procurement in other contexts. In the agreements

made through the Healthcare Insurance Act and the Exceptional Medical Expenses Act (AWBZ) regarding the same interventions, production agreements are made in advance.

Since an overestimation was made of the GBM imposed, however, the care providers were given the wrong idea of the production expected. There seems to be a process-based mismatch between expectations of supply and demand. The contract is technically sound, but since little to no GBM is imposed it is hardly implemented. This makes the contracts not especially interesting to care providers from a commercial perspective. For them, there is only added value if the volume increases and more production can be guaranteed. For many care providers, the administrative burden is now disproportionate to the yield. The overestimation of the demand has led to several problems.

The strict separation of the tactical procurement (by DForZo) and the operational procurement (by the juvenile probation service, based on the judgment) creates a complex steering relationship, and this thus gives DForZo few options for steering towards the provision of procured interventions. The monitoring of the demand and the use of the interventions was limited, certainly after the GBM project organisation of the Ministry of Security and Justice and the GBM national working group ceased activities.

Care offer achieved

Prior to the start of the pilot, there was no national coverage with respect to the four accredited behavioural interventions. Two procurement rounds took place. DForZo concluded zero hours contracts with 36 care providers for 10 interventions. The care providers distributed information about their offer of accredited behavioural interventions. In some regions, this led to greater use of these interventions (also outside the context of the GBM).

With respect to the target of achieving national coverage with accredited interventions, we can conclude that the care offer has increased – particularly with respect to Multisystemic Therapy (MST) and Multidimensional Family Therapy (MDFT) – but national coverage has not been achieved. This was particularly the case in the districts where there was no coverage prior to the pilot. Coverage is also not available in all remote areas of the districts (due to the maximal travelling distance for workers and clients) and, while extra coverage was achieved in some districts, this has since been retracted due to the minimal demand.

Use of accredited behavioural interventions in the GBM

In setting up the pilot, it was assumed that national coverage of accredited evidence-based behavioural interventions would result in a greater inclusion of these interventions in GBM recommendations, more demands for GBM and more impositions of GBM.

The number of GBMs imposed has not risen since the start of the procurement pilot: 92 GBMs were imposed in 2009, 93 in 2010 and only 72 in 2011 (source: Public Prosecution Service). This number is far below all expectations. Based on the registration data of the Child Care and Protection Board, 40% of the extensive investigations (USO GBM) started by the board resulted in a GBM recommendation in 2009 and 2010, while this figure was 49% in 2011. The number of GBM recommendations made by the board first increased to 142 in 2010, but then fell to 122 in 2011. In comparison with the number of recommendations, however, the number of GBMs imposed fell over

the entire period: 94% of the recommendations resulted in a GBM in 2009, 66% in 2010 and 59% in 2011.

The assumption that a more widely available offer of accredited evidence-based interventions leads to more GBM recommendations and more GBMs being imposed cannot be substantiated.

Furthermore, it is striking that the accredited interventions make up only a limited portion of the GBMs imposed. The file search revealed that the employees of the Child Care and Protection Board (and/or reporters from the Netherlands Institute of Forensic Psychiatry and Psychology) only included accredited behavioural interventions in 40% of the GBM recommendations, based on the feasibility study by the juvenile probation service. Figures from the 36 contracted care providers (to the extent they have been supplied), in combination with the data of DForZo, show that at least 66 accredited interventions were started between 2010 and the first quarter of 2012. Assuming that the care providers who have not supplied data do not appear further in the declaration data of DForZo, we do not estimate this number to be much higher in reality. It also happens that several accredited interventions are included in one GBM. The estimate is that at least one the accredited intervention is carried out in a maximum of roughly half the GBMs.

Problem areas

There are several problem areas in the care procurement of GBM.

The primary problem is that little GBM is recommended, demanded and imposed.

One of the reasons given for this is that the population suitable for GBM is more limited than was initially estimated because the offences are not serious enough and an adolescent and/or his parents are not motivated, the penalty is seen as too severe or the available offer has already been implemented on a voluntary basis or in another judicial framework. It should be noted that this has taken place at the same time as a fall in juvenile crime and decrease in the number of adolescents admitted to the Public Prosecution Service and sentenced between 2007-2011 (Public Prosecution Service 2011 annual report).

Another important reason is the complexity of the process leading to a GBM, consisting of the chain recommendation-feasibility study-demand-imposition. Many parties are involved that have to come up with a recommendation and an action plan in a short period of time. When one of the four accredited interventions is being considered and it is possible to recommend this in another judicial framework, the GBM track is often abandoned. It is also the case that not all chain partners in all districts are enthusiastic about the GBM product. This is due not only to the complexity of the process leading to a GBM, but also to the severity of the punishment and the fact that the added value with respect to the possibilities within the special conditions is not seen.

The procured interventions are not available in all districts. It has also been found that the juvenile probation service and the Child Care and Protection Board are not always aware of the available offer via care procurement. The project organisation which was connected to the nationwide implementation of the GBM ceased activities at the beginning of 2011, thus removing the support structure and, as of 2011, also the incentive for the measure.

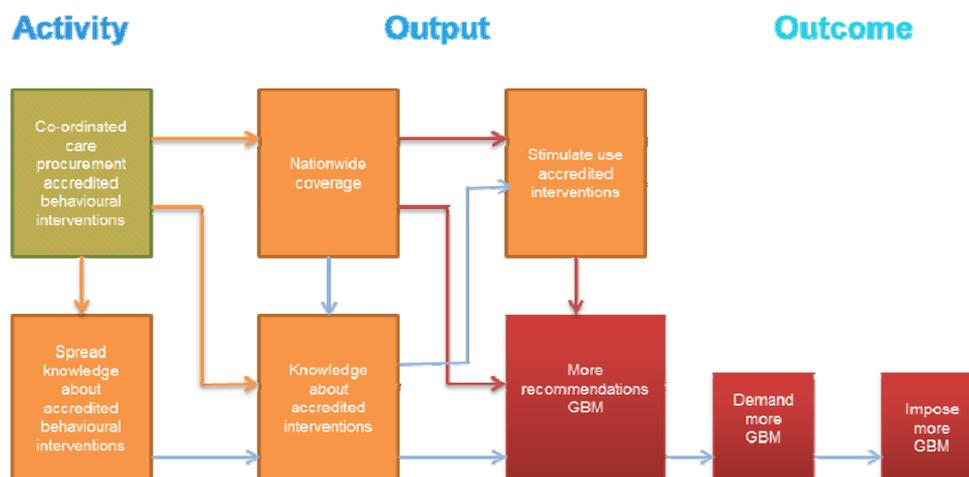
It is also notable that the figures have been poorly kept. The figures on the number of GBMs imposed by the Public Prosecution Service and the number of GBMs carried out by the juvenile probation service do not correspond. The interventions imposed as part of the GBM programme are not being registered. As a result, the national chain partners have no up-to-date information on the use of the accredited evidence-based interventions as part of the GBM programme.

Another problem is that some providers already terminated their offer due to the minimal intake. What's more, a few other providers – which were started especially for the use of the accredited interventions as part of GBM teams – anticipate that the offer will disappear if the volume remains insufficient and/or the pilot does not continue. These are primarily providers which do not provide the offer in other frameworks.

Conclusion

The goal of the study was to determine how the process of care procurement for the GBM programme works in practice, whether the target – nationwide, customised care (accredited interventions) available on time – is being achieved and to assess whether the care procurement itself is going according to plan.

Though the coordinated care procurement worked technically well up to contracting, it has not brought about the desired result, i.e. contributing to the increase in the number of GBMs imposed. The offer has indeed increased, but national coverage was not achieved. This is summarised in the diagram below. (Green means achieved, orange means partially achieved and red means not achieved).



Achieving coverage has proven to be an insufficient incentive for the GBM. More is necessary than solving this one issue. The study found that the low number of GBMs imposed is caused by the complexity of the process that leads to a GBM. If the accredited evidence-based behavioural intervention, or another package of suitable interventions, can also be imposed in another criminal framework, then that would be the preference. Moreover, the low number of GBMs imposed should also be seen in the context of the decrease in the number of adolescents being sentenced.

Despite the problem areas identified, almost all respondents – including the national and regional chain partners and care providers – are in favour of continuing the central procurement of accredited behavioural interventions for the judicial framework, not just for the GBM, but in a broader sense. If an adolescent needs care as part of a criminal measure, the Ministry of Security and Justice must finance this care. And, as it pertains to equality of rights, adolescents who are in need of an intervention as part of a sentencing must be able to receive this care everywhere in the Netherlands.