



## Short report

## Violent offenders as a target population for Public Mental Health Care

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## ABSTRACT

The study sought to specify which part of a population of young adult violent offenders in Amsterdam (mean age 24.9 years,  $sd = 8.2$ ) were eligible for Public Mental Health Care (PMHC). The results of a semi-structured clinical interview were used ( $N = 454$ ), which included the Self-Sufficiency Matrix (SSM-D). Using the SSM-D and two distinct definitions of what constitutes a need for PMHC, the size of the PMHC target population was determined twice. Depending on which definition was used, 35.9% (mathematical algorithm which put weights to single SSM-D domains) and 34.8% (problematic levels of self-sufficiency on a selection of domains) appeared to be eligible for entering the PMHC system. The study confirms that a substantial proportion of vulnerable people are among the forensic population.

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## 1. Introduction

The Public Mental Health Care (PMHC) system provides care and support for individuals and families with severe and complex problems, amongst other target populations. Clients of the PMHC system are typically those who do not actively or independently seek help for their problems or who do not have their needs met by regular health services.<sup>1</sup> Possible explanations for this specific type of vulnerability include the presence of multiple competing needs, the conditional nature of the health care system (e.g. one has to have health insurance) and the lack of a perceived need for care.<sup>2,3</sup>

Studies have shown that many forensic populations (e.g. delinquents, arrestees, prisoners, detainees) constitute (future) target populations for the PMHC system.<sup>4–6</sup> This is indicated by an accumulation of addictive behaviour, psychiatric disorders and social problems, in combination with a general lack of personal coping skills, including the tendency to inadequately use health services.<sup>6–8</sup> Moreover, the majority of PMHC clients are signalled by the police or (via hotlines) by citizens who worry about or experience nuisance from fellow local residents.<sup>6,1</sup>

Despite consensus about the vulnerability of forensic populations, actually determining whom the PMHC should treat is

difficult. In deciding whom to allocate to PMHC and whom to refer to different (private) social or health care providers, professionals typically weigh all available information about the clients' situations against an implicit reference framework of the PMHC target group, current municipal policy and personal experience. Therefore, the present study sought to further investigate and specify the vulnerability of an emerging forensic population of violent offenders.

## 2. Methods

## 2.1. Setting and study population

A diversion program was initiated in Amsterdam in 2011 to reduce the number of violent high impact (i.e. on the victim) crimes. Examples of such crimes are theft and burglary, public/aggravated assault and armed invasion/robbery. The diversion program is primarily based on civil law, rather than criminal law, and was implemented by the municipality on a city level. Organisations that contribute to the program represent a wide array of stakeholders, including law enforcement (police, public prosecution, jails, and probation services), social services and health care (public health service, (forensic) mental health care). Inclusion criteria for the program are that persons need to have been an arrested suspect at least three times in the preceding five years (the list is updated every six months) for a violent high impact

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crime, of which at least one had to have been committed (or attempted) in the last two years. Also, subjects had to have been arraigned to the examining magistrate in the same period. Offenders with only one or two of such violent crimes but with at least 33 additional arrests are also included. Once a person is enrolled in the program he is assigned to a professional who is responsible for designing an integrated care plan, including measures in the domain of justice and health care.

Since provision of health care is a key feature of the program, the PHS identifies persons with (mental) health and social problems by having them screened by psychiatric nurses, psychologists or psychiatrists. If written consent is provided, reports of (recent) mental health evaluations are requested as well. Results of the screening are reported to a supervising psychiatrist, with whom a working diagnosis is formulated. Together with representatives from the major health care providers in the city, a treatment advice is then formulated. If necessary, the PHS then refers and actively guides subjects to health care. To date, at least 60% of those enrolled in the diversion program were screened, all on a voluntary basis. About 70% of those who were screened resided in prison at the time of screening; others were screened at a place and time that suited them best, including locations of the public health service or even at home. Based on a previous evaluation, it is furthermore estimated that 50%–70% of the referrals are successfully followed by treatment.

than, instruments like the Health of the Nation Outcome Scales (HoNOS)<sup>9</sup> and the Camberwell Assessment of Need (CAN).<sup>9–12</sup> The SSM-D was introduced in the Netherlands in 2010 and developed as an observational screening tool that provides a reliable assessment of the degree of self-sufficiency on essential life domains.<sup>13</sup> For this aim, self-sufficiency is defined as the realization of an acceptable level of functioning either by oneself or by adequately organizing the help of informal or formal care providers. The SSM-D comprises 11 domains (see Table 1) and categorizes the level of self-sufficiency on each domain on a 5-point scale with 1 = ‘acute problems’; 2 = ‘not self-sufficient’; 3 = ‘barely self-sufficient’, 4 = ‘adequately self-sufficient’ and 5 = ‘completely self-sufficient’, thus forming a matrix. Indicators that specify each level of self-sufficiency for every domain are defined, and described in each cell of the matrix. The SSM-D has adequate psychometric properties (i.e. internal consistency, convergent validity and interrater agreement).<sup>14</sup>

Two SSM-D based definitions of the PMHC target population were applied. First, Lauriks et al. previously used the SSM-D to develop a decision support tool (DST), in order to substantiate allocation decisions to PMHC for homeless people in Amsterdam.<sup>13</sup> In other words, the SSM-D can be used to predict which part of a homeless population would be allocated to the PMHC system by professionals, solely based on their individual SSM-D profile.<sup>13</sup> The predicted probability of being eligible for PMHC, given the scores on the SSM-D domains, can be calculated as follows:

$$P(\text{allocation}) = \frac{1}{1 + e^{-(14.45 - .13(F) - .50(D) - .65(H) - .06(Do) - 1.02(M) - .06(Ph) - .99(A) - .14(ADL) - .37(S) - .31(C) - .43(J))}}$$

## 2.2. Outcomes

The screening consists of a semi-structured diagnostic interview, which includes the Dutch version of the Self-Sufficiency Matrix (SSM-D). Self-Sufficiency Matrices were developed in the U.S. in the 1990's and are related to, but considerably less familiar

where *F* = Finances score; *D* = Day-time activities score; *H* = Housing score; *Do* = Domestic relations; *M* = Mental health score; *Ph* = Physical health score; *A* = Addiction score; *ADL* = Daily life skills score; *S* = Social network score; *C* = Community Participation score; *J* = Judicial score.

**Table 1**  
Self-sufficiency of subjects (N = 454).

SSM-D domains	Acute problems (%)	Not self-sufficient (%)	Barely self-sufficient (%)	Adequately self-sufficient (%)	Completely self-sufficient (%)	Total (%)
Finances	29.3	26.2	27.5	9.7	7.3	100
Day-time activities	20.3	39.9	20.0	16.3	3.5	100
Housing	18.7	7.3	40.7	25.3	7.9	100
Domestic relations	2.9	18.5	42.1	26.4	10.1	100
Mental health	2.0	24.9	26.2	30.4	16.5	100
Physical health	0.2	4.2	8.6	13.9	73.1	100
Addiction	5.9	18.1	23.3	17.8	34.8	100
Activities daily life	0.2	2.0	33.3	28.0	36.6	100
Social network	8.4	23.1	49.8	17.8	0.9	100
Community participation	13.9	22.0	32.2	23.8	8.1	100
Judicial	17.4	53.7	21.4	7.3	0.2	100
<b>Target population PMHC<sup>a</sup></b>						
Total (%)	100					
Definitely (%)	35.9					
Probably (%)	13.0					
Probably not (%)	15.0					
Definitely not (%)	36.1					
<b>Target population PMHC<sup>b</sup></b>						
Yes	34.8					

<sup>a</sup> According to the decision support tool designed by Lauriks et al.<sup>13</sup> for the Amsterdam Public Mental Health Care (PMHC) system.

<sup>b</sup> Problematic levels of self-sufficiency (SSM-D scores < 3) in the domains Mental Health and/or Addiction in combination with social problems (Finances or Day-time activities or Housing).

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