Strategy Plan for Social Relief

Dutch Government
Four major cities
7 February 2006

CONTENTS

SUMMARY

- The Dutch cabinet and the four major cities wish to improve the living conditions of people who are homeless (or in danger of becoming homeless) and, in doing so, to substantially reduce the disruption and criminality that is often associated with their behaviour. The risk of dereliction as a result of homelessness should be minimised. This Plan is a strengthening of the existing collective approach and will provide an extra impetus to tackling the problem of homelessness. Moreover, this Plan will provide new instruments.
- In the four major cities, there are 10,000 homeless people and 11,800 people who are in danger of becoming homeless. Because the majority of them suffer severe and complex problems, they often miss out on opportunities.
- The cabinet and the four cities have established that no legal changes are necessary to tackle the problems of this group and to solve them where possible. However, it is necessary to provide administrators with procedures and instruments that they can use to make the existing approach more targeted and more effective.
- Central to the Plan is individualised treatment based on seamless co-operation, mutual trust and a solution-orientated work attitude. The aim is to solve the problems without losing sight of reality and feasibility. The approach will be effective and suited to the purpose.
- The individualised treatment will be shaped by creating for each person in the target group a phased programme in which personal aims are included in the areas of housing, care, income and daily occupation. The phased programme will not be optional, neither for the target group, nor for the agency involved.
- Each city will translate this Strategy Plan into a ‘city compass’ within which will be indicated the community orientation of the city, the care agency, the housing corporation and the care provider. Underpinning this are the contracts, which the city will agree with the autonomous parties in the care and housing sectors.
- The city itself will supply effective identification and initiation of shelter and care, an adequate level of support provision, collective healthcare insurance and extensive debt-assistance projects; the housing corporations will provide adequate housing; the care agency will be responsible for care in the volumes and specifications it has agreed with the city, facilitated in this by the cabinet. The care assessment will take place uniformly and fit within the AWBZ [National Act on Exceptional Medical Expenses] agreements.
- The Plan will be executed over seven years. During those seven years, the entire group will be included gradually.
- At the end of the seven years, the target group should again be able to participate in society within their own capacities and the nuisance and criminality caused by the target group should have declined to less than 75% of current levels.
- At a much earlier stage, the influx into social relief should be reduced to a minimum, as evictions will be avoided as much as possible or be accompanied by a housing alternative and co-ordinated with aftercare, and influx of ex-detainees will be minimised.
- As big a part as possible of the target group should be able to live independently. Sometimes support will be necessary, and suitable forms of accommodation will be developed for this, with new forms of accommodation being deployed at the bottom of the accommodation ladder. A start will be made on this within a year.

- For a part of the target group, the approach can mean that they should be taken into an intramural facility, whether or not custodial, because existing outside of this would not be feasible for them. Rotterdam and Amsterdam will make a start on this, also within a year. Utrecht and The Hague will also realise permanent accommodation in due course.
- In order to execute the Plan satisfactorily, the Government and the cities will make substantial investments in improving the implementation in the first year. A considerable number of solid procedures and instruments will be introduced, so that it will be clear to the administrators where they stand and what is expected of them.
- These procedures and instruments are ready for use and included in this Plan, and cover the entire chain of social relief, from identification up to and including exit to a stable living situation.
- Cities will (where possible) realise expanded capacity in the coming years based on best practices.
- Government and cities will operate this Plan, but social organisations, such as the housing corporations, healthcare insurers and care providers, support it and will contribute to its execution.
- On the basis of partly available, partly estimated data on the care requirements of the target group, 2/3 of cover for the Plan will be sourced from AWBZ funding and 1/3 from municipal funding. This ratio is an assumption based on the required division of responsibility between AWBZ and municipality, i.e. the municipality taking responsibility for the initial, short-term, co-ordinated care, and the AWBZ for the long-term care.
- A condition for the raising of the government expenditure level for this target group in the coming years is that cities will at least maintain their current level of expenditure for this group (€136 m).
- The Government will decide by 1 July 2006 on the adjustment of the social support funds allocation formula.
- For purposes of the OGGZ [Dutch public mental health care policy] tasks of central municipalities, the total budget for the specific expenditure will be increased by € 60.6 m from 1 January 2007. A decision will be taken later as to the distribution of this sum across the 43 central municipalities.
- The Dutch Government and the cities will meet every six months to consider the progress of the Plan's execution. If necessary, the Plan will be adjusted. The ambitions and financing will also be considered and adjusted if necessary.
- In the context of monitoring the execution of the Plan, each of the four major cities has been 'adopted' by a member of the Government. The distribution is as follows: Amsterdam: Minister Zalm; Rotterdam: State Secretary Ross; The Hague: Minister Donner; Utrecht: Minister Dekker.
- The Plan will also be carried through to the other cities in co-operation with the VNG [association of Dutch municipalities].

A The problem

In the four major cities, around 21,800 people are living in a very vulnerable situation. Their lives are in a state of decline and dereliction. The four cities consider that they have a more persistent problem with this than the other central municipalities, and also that it is a problem in which they invest disproportionately[1]. The cabinet, the four major cities and social organisations want the people concerned to be able to participate as fully as possible in society. That is difficult, for these people are suffering from psychiatric disturbances (including addiction) or serious psycho-social problems. At the same time, they have other problems in other areas of life. They see no opportunity to provide for their own subsistence (housing, income, social contacts, hygiene, etc.). They cannot succeed in solving their problems.

The table below shows an estimate of the problem in the four major cities.

Table 1a. Categories of vulnerable persons in the G4 [Big 4] (partly overlapping with M.O. [Social Support])

	Amsterdam	Rotterdam	The Hague	Utrecht	Total
Long-term, care-dependent (chronic psychiatric clients), derelicts	6,000	7,000	4,400	4,400	21,800
Nuisance care-avoiders[2]	2,000	1,500	400	800	4,700
Repeat offenders[3]					
Addicts	*1,100*	*600*	*350*	*350*	*2,400*
Mentally disturbed	*400*	*350*	*250*	*118*	*1,118*
Addicted and mentally disturbed	*400*	*350*	*300*	*100*	*1,150*
Other	*300*	*425*	*100*	*50*	*875*
Total	*2,200*	*1,725*	*1,000*	*618*	*5,543*

Within these groups is the actual target group for social relief. This refers to actual homeless and residentially homeless persons. The size of these two groups together in the four major cities amounts to over 10,000. A consequence of homelessness is that through their vagrant behaviour and dereliction they often create public nuisance or commit crimes.

[1] See also RFV [Council for Financial Balance] recommendation dated June 2005 and SGBO [VNG research & advisory bureau] study '*Financieringsbewegingen op het grensvlak van MO en AWBZ'* [Finance movements in the interface between Social Relief and the National Act on Exceptional Medical Expenses] dated May 2005.
[2] Persons who cause public nuisance whereby there is a (causal) relationship with serious psychiatric problems, addiction and homelessness.
[3] Persons of 18 years or older who have more than 10 criminal convictions.

Table 1.b Target Groups for Social Relief (based on situation as on 1 January 2006)

Homeless persons

	Amsterdam	Rotterdam	The Hague	Utrecht	Total
Actual homeless[4]					
Addicts	*1,500*	*1,035*	*700*	*350*	3,585
Mentally disturbed	*1,000*	*530*	*400*	*250*	2,180
Addicted and mentally disturbed	*400*	*300*	*250*	*150*	1,100
Other	*100*	*435*	*150*	*100*	785
Total	3,000	2,300	1,500	850	7,650
Residential homeless[5]					
Addicts	*450*	*200*	*200*	*150*	*1,000*
Mentally disturbed	*450*	*250*	*200*	*150*	*1,050*
Addicted and mentally disturbed	*100*	*150*	*100*	*100*	
Other					*450*
Total	*1,000*	*600*	*500*	*400*	*2,500*

On 5 September 2005, a cabinet delegation, municipal executives from the four major cities and administrators of social services agreed that the derelict condition of vulnerable individuals should not continue. An improved operational approach to the problems of this group was required. In the IBO [Inter-departmental policy research] study '*De maatschappelijke opvang verstopt'* [The social relief bottleneck] it was established that people (of necessity) remain too long in shelter. A policy was then set in motion to promote through flow. That is beginning to bear fruit. But more is required to get the group with the severest problems into a stable living situation that suits themselves and their environment. Central in this should be an individualised, human approach. Prospects should be created for these people, and an end should also be brought to the associated criminality. In recent months, the Government and the four major cities have therefore created this Strategy Plan in consultation with social services.
This Plan is a strengthening of the collective approach and will provide an extra impetus to it. Moreover, new instruments will be issued with this Plan.

[4] Persons who do not have their own living accommodation and who have to sleep for at least one night (in the month) outdoors, in the open air and in covered public areas, such as doorways, bicycle sheds, stations, shopping centres or cars; who sleep indoors in shelters provided by social relief, including one-day emergency accommodation; who sleep indoors at the homes of friends, acquaintances or family, without prospects of a place to sleep for the following night.
[5] Persons who are registered as tenants with social relief institutions (boarding houses and social relief *pensions* etc., living accommodation based on private initiative aimed at semi-permanent occupancy by homeless people and private commercial boarding houses where mainly homeless people live).

B The strategy

The Strategy Plan rests on two central pillars:

- Individual treatment using tailored, phased programmes and personal client managers (personal lifeguards). This individual treatment will eventually cover all 21,800 persons. It will start with the 10,150 actual homeless.
- 100 % seamless co-operation between all the parties and agencies involved. This seamless co-operation will be manifest on two levels: administrative and operational:
  - ✓ At the administrative level, the municipalities will act as policy co-ordinators. In that role, they will take the initiative of agreeing (long-term) contracts with care agencies and housing corporations concerning the supply of care and living accommodation for the target group. From 1 January 2007, the health insurers should also be involved, since by then the entire extramural medical GGZ [mental health care] and the first year of the intramural medical GGZ will be part of the Care Insurance Act. This transfer is not expected to obstruct the policy co-ordination of the municipalities. A municipality will be able to exert influence on the policy of the insurer via the collective insurance it agrees for this target group. Furthermore, it is expected that the insurer and what is now the care agency will be the same party. It will be up to the care agencies or health insurers to contract the care from care providers. The care and living accommodation supplied should be adequate and suitable. The contracts concluded will reflect the freely agreed priority of the three autonomous partied involved (municipalities, insurers and providers) for the target group.
  - ✓ At the level of client intake, the field co-ordinators will be responsible for the seamless working of the client's relevant chain of support. The field co-ordinators will be commissioned by the municipality. They will have disposal over the above-mentioned contracts and work within the frameworks of the administratively contracted areas. The field co-ordinators will maintain the data that follow the client through the chain, and will determine on the basis of these where the problem areas and shortcomings lie.

This Strategy Plan provides for instruments with which both pillars of the Plan can be embodied. The Plan does not start from a zero situation. It reinforces the approach that has already been followed for some time: a non-optional approach for individual and institution. The central philosophy in the Plan that the cabinet, the four major cities and the social services involved wish to implement is contained in the following key concepts: co-operation; integration; trust; the client and the aim at the centre; no unnecessary fuss over competences, powers and rules. It will be about municipal co-ordination based on collectively formulated contracts between municipality and care agency. Not simply words, but more especially action. This means that no rules will be amended or powers changed, but that practical, administrative, contractual and operational co-operation will be carried out, geared towards realising the aims set out in this Plan. The Government, the cities and the social services are going on the assumption that this approach will work. They now have no reason to suppose that this will not be the case, for the aims are uncontested and the co-operative input speaks for itself.

In administrative consultation between Government and cities, it will be considered on a six-monthly basis whether this work method suffices. In the event that, contrary to expectations, it does not, then all the parties involved will examine in close

consultation what the cause of this has been. Measures will then be taken, suited to the cause and seriousness of the found defects. Change of legislation and of powers and financial arrangements will not be ruled out. Effectiveness will be the measure. The cabinet, the four cities and the social services expect a breakthrough with this approach in the coming years.

C The setup of the Plan

- The Plan is made up of three “layers”.
- *Chief aims*. The chief aims reflect the condition to be achieved following full implementation of the Plan. That condition concerns the concrete situation in which the target group and the individuals within it find themselves in terms of income, living accommodation and mental and physical wellbeing. The degree of realisation of the chief aims will be measured by indicators. The Plan is intended to be fully implemented over 7 years, and the expiry date is set at 28 February 2013. That is when the last administrative consultation will take place concerning this Plan.
- *Operational aims.* The operational aims reflect conditions that are to be achieved as part of the realisation of the chief aims. They are therefore interim stops on the way to the final destination. There are two types of operational aims:
  - ✓ Operational aims that concern the one-off creation of conditions in terms of administrative, organisational or operational provisions (agreeing contracts, building systems, setting up an organisation, training functionaries, etc.).
  - ✓ Operational aims that concern actual production. These will always concern *numbers per unit of time or based on time limits.*

All the chief aims and all the operational aims in this Plan are concrete, quantified and provided with set timelines. It follows that some of the aims will be reproduced in tables.

- *Instruments.* Instruments are the concrete means of achieving the aims. This Plan contains instruments in the form of model agreements between agencies (administrative level) and model procedures for the execution. All the instruments are fully formed, and managers and functionaries can go straight to work with them. The instruments in this plan should be seen as a service provision to the practical execution.

D The chief aims (final situation to be achieved)

Realisation of the chief aims should lead to a final situation in the four major cities whereby the conditions are present by which 21,800 vulnerable persons are again able to participate in society within their capabilities without causing a nuisance to their environment as a result of homelessness or criminality. That is not to say that deviant behaviour will be abolished, or that no one will become homeless again. There is a limit to the malleability of society, nuisance behaviour notwithstanding. “Deviant behaviour” has always existed, and Dutch society will have to accept that. Nevertheless, when people are lost and/or cause unacceptable disruption on account of that behaviour, government intervention is justified. When that point is reached depends on local circumstances.

Because we are not dealing here with a static group, more is required than simply working on throughput in social relief. The point is also to restrict the influx from detention and evictions. The Plan assumes that the seamless co-operation will bring an end to the outplacement of this group from care institutions, whether or not

following unacceptable behaviour. The eventual result will be a shift of focus from temporary shelter and temporary care to the prevention of appeals for shelter and towards structural forms of residing, if possible of working, and structural care where necessary (possibly also intramural, including custodial).

The chief aims of this Strategy Plan are as follows:

- The present 10,000-plus homeless persons and homeless persons who will be added from now, to be provided with incomes, with structural forms of living accommodation suited to the individuals concerned, with non-optional evidence-based care programmes (temporary if possible, structural where necessary) based on realistic diagnoses (including programmes based on the addiction policy and forms of possibly custodial intramural psychiatric facilities), and, as far as possible, with feasible forms of work. Indicators: homelessness and the stability index (stable living accommodation, regular income, stable contact with the support services and form of daily occupation).
- Homelessness as a result of eviction almost non-existent. The number of evictions in 2008 reduced to less than 30% of the 2005 figure. To the extent that evictions still take place, alternative and suitable living accommodation at the bottom end of the housing market to be offered. Indicators: number of evictions per year and number of evictions leading to homelessness per year.
- Homelessness as a result of detention almost non-existent. Indicator: number of cases of homelessness following detention.
- Homelessness as a result of leaving care institutions almost non-existent. Indicator: number of cases of homelessness after leaving care institutions.
- In a large proportion of the target group, nuisance behaviour reduced according to the Safety Monitor (to maximum 75% of the current level in 7 years). Indicators: number of convictions and number of reports of harassment. For this, registration data can be used that are agreed within the framework of GSB [Major Cities Policy] III. These refer to persons who create a permanent nuisance owing to, for example, a psychiatric disorder and/or drugs and alcohol addiction.

It may be obvious that these aims are ambitious and that a programme covering several years will be necessary. The total target group in the four major cities can be divided (according to the estimate) into 10,150 homeless persons and 11,800 derelicts (who run the risk of becoming homeless). In relation to this subdivision, the following can be said concerning treating, phasing and prioritising the execution of the Plan. In the entire Plan, there are three main components:

- *Firstly*. Improvement of the situation of the 10,150 homeless. With many of these 10,150 individuals there now exists a relationship (many of them using the provisions of social relief). It is therefore possible to continue the existing contacts, available treatment and provisions. This represents a relatively easy start (or continuation), but also a high priority. Therefore this group will be in the first phase of the Plan’s implementation
- *Secondly*. Prevention of the group of 11,800 from further deterioration (in this case, from becoming homeless). Prevention is the main focus here. The prevention policy is in the first phase of the implementation of the Plan. To a significant extent, the influx of the 11,800 can be avoided by preventing homelessness as a result of eviction and the realisation of good co-ordination with aftercare following release from detention. In both cases it is possible to

continue from an already far-implemented policy and tested practice. This mainly involves a determined extra effort of execution. That also applies to the exodus from the standard Mental Healthcare Policy and those individuals who are expelled from social relief shelters because of unacceptable behaviour
- *Thirdly*. Supplying the 11,800 with firmer foundations in their vulnerable lives (care, social contacts, daily occupation, etc.). As yet, there exists in the main no contact with these individuals. This therefore implies a relatively substantial extra input. Given the limits on capacity and funding, this part of the Plan will have to be dealt with mainly in the second phase.

The phasing is dealt with in the operational aims.

E The operational aims (interim stages to be realised)

E1 Operational aims with regard to effecting preconditions

The aims are organised sequentially per actor. This does not change the fact that the execution of the Plan is the collective responsibility of Government, cities and social services.

To be realised by Government (partly already realised)

- From 1 January 2006 by Government proposal (Ministry of Finance) the Salaries Tax Act was amended, making it possible to allocate a tax-free expense allowance for carrying out voluntary work of €150 per month with a maximum of €1500 per year. If the voluntary work forms part of a reintegration programme (relating exclusively to WWB [Work & Social Assistance Act]), the municipality can provide exemption for an expense allowance up to the above-mentioned sum in respect of social security benefit.
- From 1 January 2006 the Government (Ministry of Justice) appointed 183 FTEs to Social Services in the Penitentiary Institutions. This is to aid the seamless transfer of ex-detainees into municipalities.
- From 1 January 2007 the Government (Ministry of Health) will provide for the transfer of a sum of €54.1 m of OGGZ [Public Mental Healthcare Policy] resources from the AWBZ [National Act on Exceptional Medical Expenses] to the 43 central municipalities' social relief/addiction policy for purposes of the induction function, i.e. the identifying, tracing, contacting and maintaining contact as well as the induction itself and the unsolicited aftercare. To this will also be added the sum of the AFBZ [Special Medical Expenses General Fund] subsidy scheme of OGGZ, i.e. around €6.5 m. From 1-1-2007, a total of €60.6 m. will be added to the specific allocation. A decision will be taken as regards the distribution of this sum across the 43 central municipalities (and therefore the sum in respect of the four major cities).

To be realised by the cities

- From 1 March 2006, Rotterdam, Amsterdam and Utrecht have agreed a collective basic insurance and an (austere) collective supplementary insurance for 2006 and The Hague from 1 January 2007 in line with the possibilities set out in instrument 7. They also made a start on that date with an organisational provision that over time will facilitate budget management for the entire target group, also in line with the possibilities set out in instrument 7. These organisational provisions contain the minimum procedure offered to everyone who comes in contact with social relief or GSD [municipal social services];

budget management is offered or made compulsory if it cannot be accepted voluntarily and it will apply to clients in receipt of unemployment benefit.

- From 1 June 2006 all four major cities have implemented the following instruments administratively and operationally (i.e. administratively agreed and equipped functionaries). (NB It seems advisable to implement this entire cluster of instruments in one administrative programme).
  - ✓ Instrument 1: model intake form for MO and AWBZ
  - ✓ Instrument 2: model procedure for the individualised approach
  - ✓ Instrument 3: model agreement on data exchange in reference to privacy legislation
  - ✓ instrument 4: model individual programme plan
  - ✓ instrument 5: BOPZ [Mental Health Act] guidelines
  - ✓ instrument 6: model procedure for effecting care supply
  - ✓ instrument 7: model approach to uninsuredness and budget management
  - ✓ instrument 8: model approach to effecting supply of living accommodation
  - ✓ instrument 9: model protocols for prevention of evictions
  - ✓ Instrument 10: wage projects scheme
  - ✓ Instrument 11: model approach to debt assistance and debt repayment
  - ✓ Instrument 12: model procedure for co-ordinating aftercare in cases of release from detention
- From 1 October 2006 all four major cities have:
  - ✓ Based on instrument 2 (or preferred alternatives), implemented or reaffirmed the co-ordination points and appointed all the required field co-ordinators and client managers or made administrative agreements with other organisations concerning availability of client managers and the operation of the system of seamless chain co-operation at operational level in general.
  - ✓ Based on instruments 6 and 8, created long-term care needs plans and long-term provision plans for living accommodation and, based on these, set up long-term contracts with care agencies and housing corporations concerning the supply of care and living accommodation. These contracts cover all forms of care inasmuch as they are financed by the AWBZ (ambulant, residential, etc.) and all forms of accommodation (individual, collective, etc.) in respect of the target group. In this connection, the proposed abolishment of the contracting obligation for intramural AWBZ-financed institutions as of 1 July 2006 is of importance. This is notwithstanding the fact that earlier in 2006, contracts can only be agreed for the year 2006.
- From 1 Jan 2007, Amsterdam and Rotterdam have started with a provision for permanent accommodation as a result of the approach described in instrument 13. The Hague and Utrecht will also realise permanent accommodation over time.

To be realised by social services

- From 1 October 2006, local social services (care agencies and housing corporations) to lend their co-operation to the concluding of contracts concerning the supply of care and living accommodation, and care agencies to carry through the implications of the contracts agreed with municipalities to the contracts agreed with care providers.

E2 Operational aims concerning actual production

These operational aims demonstrate the quantified timelines for the implementation of the Plan.

To be realised by Government
None
To be realised by the cities
The timelines are shown in the following tables 2a to d inclusive. In the tables, allowance is made for credible differentiation between the cities associated with the starting situation in each of the cities. The operational aims track the available financial frameworks shown in section K below.

Table 2a Operational aims of the municipality of Amsterdam

Aims in respect of actual production	**2006**		**2007**		**2008**		**2009**		**2010**		**2011**		**2012**	
	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec
Group of 10,150 homeless														
Intake and programme initiation phase	2000	2400		2800		3200		3600						
Programme completion in final phase	2000	2200		2400		2600		2800						
Group of 11,800 preventive cases														
Intake and programme phase					15%	30%	45%	60%	75%	90%	100%			
In final phase								15%	30%	45%	60%	75%	90%	100%

Table 2b Operational aims of the municipality of Rotterdam

Intake and programme initiation phase	**2006**		**2007**		**2008**		**2009**		**2010**		**2011**		**2012**	
	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec
Group of 10,150 homeless														
Intake and programme initiation phase	750	1000	1400	1800	2100	2400	2700	2900						
Programme completion in final phase			300	550	800	1100	1400	1740						
Group of 11,800 preventive cases														
Intake and programme phase					15%	30%	45%	60%	75%	90%	100%			
In final phase								15%	30%	45%	60%	75%	90%	100%

Table 2c Operational aims of the municipality of The Hague

Intake and programme initiation phase	**2006**		**2007**		**2008**		**2009**		**2010**		**2011**		**2012**	
	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec
Group of 10,150 homeless														
Intake and programme initiation phase	start	300	500	700	900	1300	1500	2000						
Programme completion in final phase				300	600	900	1200	1500	1800	2000				
Group of 11,800 preventive cases														
Intake and programme phase					660	1320	1980	2640	3300	3960	4400			
In final phase								660	1320	1980	2640	3300	3960	4400

Table 2d Operational aims of the municipality of Utrecht

Intake and programme initiation phase	2006		2007		2008		2009		2010		2011		2012	
	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec	30-Jun	31-Dec
Group of 10,150 homeless														
Intake and programme initiation phase	300	400	525	675	825	975	1125	1250						
Programme completion in final phase	400	450	500	575	650	675	750	875						
Group 11,800 preventive cases														
Intake and programme phase					470	945	1400	1900	2350	2850	3150			
In final phase								470	945	1400	1900	2350	2850	3150

To be realised by the social services
Fulfilment of agreed contracts.

F The instruments
Instruments are the tools available to the administrators and functionaries for executing the Plan. The instruments offered in this Plan are not intended to be mandatory. They are intended to facilitate[6]. It is within the jurisdiction of local parties (cities/councils/aldermen, e.g. the municipal social services or cities in consultation with autonomous third parties – care agencies and housing corporations, in particular) to use or not to use these instruments. If another approach is deemed more effective, then it should be taken. Maximum effectiveness will be the measure, and only the result will count. And at the operational level, the instruments should not act as a strait-jacket. On the contrary, space for creativity, for unorthodox solutions for people with complex problems in diverse areas, should remain. The instruments are wide-ranging. They offer the administrators and functionaries footholds for carrying out the steps in the programme throughout the entire chain of social relief – from identification up to and including exit into a stable living situation.

This Plan contains the following instruments:
1. Model intake form for MO and AWBZ
2. Model procedure for the individualised approach (including client manager)
3. Model agreement on data exchange in reference to privacy legislation
4. Model individual programme plan
5. BOPZ [Mental Health Act] guidelines
6. Model approach to effecting care supply

[6] An exception to the facilitating nature of the instruments is instrument 11: wage projects scheme; this scheme reflects the legal framework.

7. Model approach to uninsuredness and budget management
8. Model approach to effecting supply of living accommodation
9. Model protocols for prevention of evictions (rent arrears and nuisance behaviour)
10. Model approach to debt assistance and debt repayment
11. Wages projects scheme
12. Model procedure for co-ordinating aftercare in cases of release from detention
13. Approach to realisation of permanent living accommodation

The instruments are shown in part II of this Plan.

G The administrative framework

The administrative framework of this Plan is as follows:

- The Plan was created by the cabinet and the four major cities. Cabinet and Municipal Executives have approved it. The Government and the cities have committed themselves from within their various remits to the realisation of this Plan.
- GGZ Netherlands and Aedes subscribe to the Plan and will actively support its execution. They are calling upon their affiliated organisations to co-operate on the implementation of the Plan.
- The National Association of Homeless, the Social Relief Federation and the Salvation Army subscribe to the Plan and will actively support its execution.
- In order to make the co-operation between the cabinet and the four major cities in this Plan more visible, in imitation of the youth policy there will be "adoptive" relationships created between government officials from the cabinet and the various cities. The adoptive relationships will be as follows:
  - ✓ Amsterdam: Minister Zalm
  - ✓ Rotterdam: State Secretary Ross
  - ✓ The Hague: Minister Donner
  - ✓ Utrecht: Minister Dekker

The adoption will be given substance through working visits and will also play a role in monitoring the execution of the Plan (see section L).

H The legal framework

Of importance to this Plan are the following current programmes of legislative amendments and appendices:

- *BOPZ*. The proposed amendment to the Dutch Mental Health Act and appendices. These amendments are described in instrument 5.
- *Supervised aftercare.* The cabinet is investigating the added value of a (legal) supervised aftercare register, associated with the BOPZ (Parliamentary Paper 29 325 No. 2 page 9).
- *WMO [Social Support Act].* (Parliamentary Paper 30 131). Approval yet to take place. Provisional date of implementation: 1 January 2007.
- *AWBZ* The Secretary of State for Health has upheld the proposed abolition of psychosocial grounds. Prior to taking a definite decision on the abolition, a study will take place into the method of care assessment in respect of clients from within social relief. The outcome of that will determine under which conditions the abolition of the grounds will take place.

So far, no new legal programmes have been provided for in the execution of this Plan. Please refer in this connection to information contained in section B.

I Chain co-operation

In section B (Strategy) is indicated that the second central pillar on which the Plan rests is formed by seamless co-operation between all the parties and institutions involved at both administrative and operational level. The formulation and functioning of this second pillar is crucial and should therefore be entirely clear. In conjunction with that stated in section B, therefore, the following should be noted:

- For the execution of this Plan, besides Government and the cities, three other categories of autonomous parties are necessary. These are the care agencies, the health insurers, the care providers and the housing corporations. The cities will have to agree contracts with their local partners in these segments concerning the delivery of care and the supply of living accommodation. The cities will take the initiative of negotiating these contracts (regional administration), but it concerns negotiation between equal parties. De relationship between the cities and these parties as far as the administrative level is concerned will be solely contractual. The contract will be the expression of the administrative commitment and will subsequently function as the communal compass. It goes without saying that parties should perform within the legal parameters that are applicable to them. The mutual rights and obligations will be specifically established in these contracts in such a way that the parameters for the administrators will be entirely clear. A component of the contract are agreements on the conditions that must be met in order to be able to deliver care or living accommodation (e.g. the guarantee of care with living provisions that require supervision) or effective application of debt assistance. Contracts should be agreed annually on 31 December at the latest concerning agreements for the following year. Should this fail to be done, it will become subject to the political-administrative consultation between Government and G4 that will take place every six months
- In the case of the housing corporations, they themselves will supply the provision. That is not the case as regards the care agencies. The care agencies will be obliged, given their contracts with the municipality, to ensure that care providers deliver the care in the volumes and specifications agreed between the care agency and the municipality. The care agencies will agree purchase contracts for this with care providers. After 1 July 2006 (abolition of contract obligation), that could refer to all the national institutions. The municipality will approach the care agency in this regard if necessary. The care providers will therefore be no contractual partners of the municipality
- As regards the care that will be paid for by virtue of the basic insurance, the policy agreed will be the determinant. Along the lines of this Plan, the municipalities will agree collective insurance for the entire target group with the required cover
- For the entire execution, work is to be carried out within the framework of the agreed contracts and also in conscientious consultation with the chain partners, and with mutual respect for each other’s professional autonomy, to ensure a seamless and effective chain at client level. This will be practically embodied in agreements on division between institutions of client management and also in a practical and purposeful pragmatic approach, and, for example, connecting with the existing ACT [assertive community treatment] programmes. Client managers may find themselves within the jurisdiction of the municipality, but also outside of it.

J Effectiveness and suitability

The following section discusses the financial basis of the Plan. But first, a few general remarks on the twin concepts of effectiveness and suitability.

This Plan is ambitious; therefore effectiveness and suitability must be central to it. In order to achieve maximum effectiveness and suitability, among other things the following assumptions must be maintained and measures taken:

- All unnecessary bureaucracy should be avoided. This Plan itself will make as big a contribution as possible to this. It will also be expected of all those involved that they make this the starting point of their operations. That means, among other things, as few switches as possible, as few procedures, delegation, etc., as possible. The apprehension and opposing of unnecessary bureaucracy will be a permanent point of focus in the monitoring of the implementation (see section L)
- Provisions in the context of buildings will be created with as much suitability as possible and carried out straightforwardly and responsibly. This means, among other things: using existing buildings as much as possible; possible conversion of provisions currently seen as temporary in the social relief sector into structural provisions (through transfer of property and management to the corporation sector if that is logical, practical and feasible)
- The individual programmes will be practical, non-optional, tried and tested and suitable. That means, for example, only embarking on care programmes where necessary and useful; evidence-based programmes only; no therapy programmes if the chances of success are low; no therapy and care programmes if it has not been established for sure that the party concerned will continue to co-operate. Non-optional means that opportunities will definitely not be offered ad infinitum. But what if people do not accept the opportunity? If they subsequently create no nuisance or criminality, there will be no problem. If they demonstrate criminal behaviour they will be prosecuted and possibly detained. But what if they persist in disruptive behaviour? Then society has two alternatives: accept the behaviour as a fact of life, or reject the behaviour and take suitable measures. That means that an equal balance should be sought between maintaining the ambition of this Plan (we really want to bring people to the highest level of functioning possible), sober realism (not investing in illusions) and discipline. Sometimes no more than a scant stabilisation will be feasible, by using a provision for compulsion, if all else fails
- According to estimates, it is mainly on the care side that the biggest risk is found in financial developments that could become prohibitive to the execution of the Plan. Furthermore, the provisions in the cities were mainly developed based on the possibilities within the local context. With expansion of capacity, cities wish in the coming years to do this based on best practices where possible. In order to support such an approach, an advisory group will be formed, consisting of a group of experts in the area of addiction care, psychiatric support, public mental health care, chain co-operation in assertive care, evidence-based treatment methods and social relief. This advisory group will be available for the duration of the Plan's implementation to provide advice to the cities and the Monitoring Taskforce on evidence-based intervention in particular for this target group
- An intensification of focus for this group will lead to greater use being made of the provisions for the group, be that through expansion of the provision level or through existing provisions becoming more accessible to the group. That

involves two risks. First, there is the problem of displacement: the increased focus and with that increased use of provisions will be at the expense of other groups. That necessitates political choices. Secondly, there is the risk of an (inter)national pull effect. The latter must be avoided. The restrictions announced in Progress Report IBO 2005 on national access to living accommodation for homeless persons can help here. Both risks should be a permanent component of the administrative “thermometer” (see L)

- The approach to this target group could be more effective – more suitable. However, that should not mean that less attention should be paid to the justification of expenditure. From the point of view of equal rights, suitability will not be achieved by failing to maintain certain rules.

K The 2006-2009 financial framework

Below, the steps are described that have led to the present financial framework of this Plan, as well as the subsequent steps necessary for maintaining the framework in the course of the Plan's implementation:

1) Starting point for determining the capacity are the 12 building blocks of the OGGZ. These are derived from Opinion Document OGGZ G4.
2) On the basis of the currently available data, the cities have made the best possible estimate of the capacity of the provisions (PXQ) required to be able to serve the entire group of 10,150 homeless in the G4 during the period 2006-2009.
3) Based on currently available data, the cities estimate the extra expenditure, to have the currently estimated required capacity in 2009 and beyond, structurally at almost €175 m; for 2006, at €61 m. Using these estimates, the cities will have taken 100% of the target group into the programme by 2009.
4) Based on the current, partly available, partly estimated, data on the care requirement of the target group, 2/3 of the cover will be sourced from funding from the AWBZ and 1/3 from municipal funding. This ratio is an assumption, based on the required division of labour between AWBZ and municipality, i.e. the municipality dealing with the preliminary, short-term arrangements and co-ordination, and the AWBZ with the long-term care. This is explained in the table below.

Table K.1 Overview of the extra costs estimated by the cities for 2006-2009

		2,006	2,007	2,008	2,009
Amsterdam	Municipality	2,563,333	9,660,000	15,146,667	17,980,000
	AWBZ	5,126,667	19,320,000	30,293,333	35,960,000
	Total	7,690,000	28,980,000	45,440,000	53,940,000
Rotterdam	Municipality	10,046,433	14,776,433	16,624,767	16,974,767
	AWBZ	20,092,867	29,552,867	33,249,533	33,949,533
	Total	30,139,300	44,329,300	49,874,300	50,924,300
Utrecht	Municipality	3,501,667	8,243,333	10,323,333	10,806,667
	AWBZ	7,003,333	16,486,667	20,646,667	21,613,333
	Total	10,505,000	24,730,000	30,970,000	32,420,000
The Hague	Municipality	4,236,667	9,500,000	12,070,000	12,563,333
	AWBZ	8,473,333	19,000,000	24,140,000	25,126,667
	Total	12,710,000	28,500,000	36,210,000	37,690,000
G4	Municipality	20,348,100	42,179,767	54,164,767	58,324,767
	AWBZ	40,696,200	84,359,533	108,329,533	116,649,533
	Total	61,044,300	126,539,300	162,494,300	174,974,300

5) Cities and care agencies will make agreements on the input of support and care to the target group. The Ministry of Health and Welfare will ensure that care agencies come to similar agreements with cities. Subsequently, care agencies will make the actual production agreements with care providers based on indexed care. The cabinet will empower the care agencies to do this. The care assessment will be uniform and fit within the AWBZ parameters.
6) A condition for raising the expenditure on the Government side in respect of this target group in the coming years is that cities should at least maintain their current spending level for this target group (€136 m.).

7) The Government (Secretary of State for Health and Minister of the Interior and Kingdom Relations) will decide before 1 July 2006 on adjustment of the allocation formula for social relief.
8) For purposes of the OGGZ tasks of the central municipalities, the total budget for the specific allocation will be increased by €61 million. A decision has still to be taken concerning the distribution of this sum across the 43 central municipalities (in connection with the above-mentioned allocation-formula study).
9) The above figures are estimates. For purposes of the six-monthly progress consultations, the cities will update the estimates every year before mid-February. In performing the update, the realisation figures will be used (PXQ). To this end, progress will be monitored and best practices used.

L Procedure for monitoring implementation

The monitoring of the implementation will take two forms.

- On a monthly basis, the administrative Task Force that has created the Plan will meet to establish progress. For this, the Task Force will be renamed the Implementation Progress Monitoring Group. The group will provide a summarised report to the relevant officials on a quarterly basis or as and when there is a specific requirement for it. In the event that the implementation goes off the rails or problems arise, suitable action will be taken at the required level. To constitute the Progress Group, GGZ Netherlands, Aedes, the Dutch Federation of Shelters, the Salvation Army, the Dutch health/care insurers[7] and the VNG will be invited. The Committee of Five will be invited to participate in the tasks of the Progress Group. At Government's request, Mr Etty will act as independent adviser of the Progress Group, which will be led by the Director of Social Support from the Health Ministry.
- Every six months, an administrative assessment will take place between Government and cities, in which progress will be discussed and in which any necessary adjustment to the work method or planning may be made (partly based on current available knowledge). This consultation will in any event take place once a year, in February, since that is also a suitable time to discuss any financial issues and take decisions on them. This consultation will be carried out on the Government side by the Minister and State Secretary of Health and the Minister of BVK [Administrative Renewal and Kingdom Relations]. If required, other members of the Government will take part in the consultations. On the part of the cities, the administrative consultations will be carried out by the four aldermen for Social Relief.
- Also in this connection, all the existing and planned monitors concerning the cities will be brought under this procedure.
- Ministers will carry out working visits to their 'adopted' cities at appropriate times.

[7] It should be considered whether the role of the insurers in the implementation phase of this plan should be strengthened in connection with the basic health insurance (2006) and transfer of the curative mental health care (2007).

M Translation to other cities

This Plan is naturally also of importance to all those towns that are confronted with the problems of homelessness and dereliction.
This has two aspects:

- Availability of the instruments. The facilitating toolbox that is included in this Plan is of course also available to the other towns. The cabinet and the VNG (VNG as first dialogue partner for G27 and 43 central municipalities) will translate the plan through to the other towns and provide it to them in mutual consultation.

The distribution yardstick for the specific amount available for social relief/ addiction policy. The payment will be distributed in accordance with a distribution yardstick across the 43 central municipalities (including the four major cities). As already indicated in the financial section, the Government will announce the outcome of the adjustment to the allocation formula before 1 July 2006. Adjustment to this payment is a matter for consultation between Government and the 43 central municipalities collectively.

II Overview of instruments

1. Model Application and Diagnosis Form (ADF) for MO and AWBZ
2. Model procedure for individualised approach (including client manager)
3. Model agreement on data exchange in connection with privacy legislation
4. Model individual programme plan
5. Guideline for applying BOPZ [Psychiatric Hospitals (Compulsory Admissions) Act]
6. Model approach to effecting care delivery
7. Model approach to uninsuredness and budget management
8. Model approach to effecting delivery of specific living accommodation
9. Model protocols for prevention of domestic evictions (rent arrears or anti-social behaviour)
10. Model approach to debt assistance and debt rescheduling
11. WWB [Work & Social Assistance Act] wage projects scheme
12. Model procedure for arranging aftercare following release from detention
13. Approach to realisation of provision for permanent accommodation

Instrument 1 : Model Application and Diagnosis Form (ADF) for MO and AWBZ

Purpose of the instrument
Using the Model Application and Diagnosis Form, the starting situation, including the set diagnoses, will be documented. The form will subsequently link up with the individual programme plan to be created (Instrument 4). It is intended that the entire target group of around 21,800 people will be issued with an ADF, which will be used by the client managers and all other partners in the chain concerned with the individual client. The ADF should of course be available electronically.

Starting points of the municipality/CIZ [needs assessment body] central registration form for the OGGZ [public mental health care] target group

- The screening and/or assessment form referencing all the provisions in the OGGZ for the MO [Social Relief] target group. When registration takes place in one of the provisions under the OGGZ, the questions on this form are used as starting points. The extent to which registration in the day/night shelters takes place can vary per municipality.

- The form is a combination of the CIZ MO form and the screening form that is used by Central Admissions, Utrecht and The Hague. The screening form of Central Admissions Utrecht and The Hague is evaluated positively by referees and care providers. The MO form, to our knowledge, has not been officially evaluated, but appears to be a good instrument for care assessment. However, it is less suitable for allocation of care by Central Admissions. In order to allocate the best care provider, targeted information is required concerning problems in 8 areas of concern.

- The draft form was developed in co-operation with the Trimbos Institute, the CIZ national expertise centre, General Central Admissions Utrecht, Central Reception Centre Rotterdam and the Central Admissions for Social Relief, The Hague.

- The form may in any event be included in the registration systems of the Central Admissions that have been developed in The Hague, Rotterdam and Utrecht by Conclusion ICT projects. A large part of the items can be used for purposes of reporting on client characteristics, client tracking, the supply and demand ratio and cumulative figures on intake and outflow in the OGGZ.

- The form consists of 2 parts: a Central Admissions application form and a questionnaire. If, in the view of the referee who registers the person, there are grounds for an AWBZ indication, the referee or case manager should also complete the questionnaire. In the other cases, only the application form is completed.

The application form (ready for use) is included in Appendix 2 of part IV of the Plan.

Instrument 2: Model procedure for individualised approach (including client manager)

Purpose of the instrument

This instrument is intended to deploy a balanced chain co-operation in respect of the individual client. It is therefore of crucial significance and will be used by everyone involved in the execution of this Plan.
The instrument covers:

a. Procedure and administrative framework of the co-ordination point and appointment of field co-ordinators
b. Tasks and powers of the co-ordination point
c. Tasks and powers of the client management
d. Work method of the client manager (systematically phased plan)
e. Obligations in connection with the privacy legislation
f. Key points in summary

a Procedure and administrative framework of the co-ordination point and appointment of field co-ordinators

- Each municipality will be responsible for a co-ordination point. The co-ordination point will carry out the management duty of the municipality at system level. It will be organised by the Municipal Executive, and brought within a municipal service (e.g. the GGD [municipal health service]). It will be manned by field co-ordinators, who will be employed by the municipality and organisationally included in the co-ordination point.
- The cities will be responsible for the adequate functioning or organisation and equipping of all the co-ordination points with this Strategy Plan by 1 October 2006 at the latest.
- The co-ordination point will also be the local point of contact for patients who are eligible for a treatment programme, and will follow the progress of the treatment programme until the patient can be deregistered.

b Tasks and powers of the co-ordination point

- The co-ordination point (the field co-ordinators) has the following tasks:
  - ✓ Planning of resources and production
  - ✓ Agreeing contracts on the supply of provisions (care, accommodation, etc.)
  - ✓ Functioning as a link to other bodies (e.g. judiciary)
  - ✓ Functioning as main reporting centre for potential patients
    (NB: It will be agreed in advance which local parties may register, such as e.g. co-ordinators of local care networks, the safety-net team of the GGD, the co-ordination point of Central Reception and the client managers of the administrative institutions)
  - ✓ Organisation of a screening committee for registered patients with complex problems
  - ✓ Allocation of clients to (the client managers of) administrative institutions (taking account of the existing contractual frameworks: e.g. the volume of purchased care programmes)
  - ✓ Registration and monitoring of the client data and treatment programmes deployed
  - ✓ General support of the client managers and the administrative institutions.

- ✓ Intervention when a treatment programme stagnates, for example through initiating consultation and co-ordination between chain partners concerning sequence and priorities for the individual client
- ✓ Monthly reporting to the municipal Social Relief executive

- The co-ordination point will be set within the boundaries by the municipal executive generally empowered to act.

c Tasks and powers of the client management

- Following the assignment of a patient to an administrative institution, the relevant client manager will have the following tasks:
  - ✓ Creation and establishment of the individual programme plan (instrument 4)
  - ✓ Co-ordination of all the activities that are to take place within the framework of the programme
  - ✓ Management of the client's electronic file (client tracking system) and the monitoring of the BOPZ guidelines (instrument 5)
  - ✓ Monthly reporting to the co-ordination point
  - ✓ Assisting the client towards establishing diagnoses, care and support (including legal proceedings/Mental Health Act), work and income (including budget management, debt rescheduling and wage schemes), living accommodation (including supervised) and daily occupation, etc.

- For the purposes of carrying out his tasks, the client manager will have the following powers:
  - ✓ Access to information on the client with all the relevant chain partners
  - ✓ Co-ordination with other chain partners, in particular the police and the judiciary (probation) (including temporary suspension and resumption of benefit and co-ordination of compulsory orders).

d Work method of the client manager (phased plan)

In line with the above tasks, the work method of the client manager will be as follows:

- The client manager will process within one week the intake of the clients assigned to him, using the Application and Diagnosis Form (instrument 1), create the electronic file based on the intake, establish what further information is required in the form of diagnoses and further information gathering, and extend actions where necessary to his chain partners, providing them with access to the electronic file of the relevant client and making agreements with the chain partners concerning the provision of further information (in principle within two weeks)
- Within 1 week after the due date of the requested information, and if necessary following consultation with his chain partners, the CM will create the individual programme plan (instrument 4) and discuss it with the client, making a binding agreement with him/her (both adding signatures to the programme plan).
- He will subsequently ensure, using his powers, that the programme is carried out and will intervene if it flags and adjust the programme plan if necessary.
- He will report on a monthly basis to the co-ordination point on the progress of the individual treatment programme. The co-ordination point will provide a standard electronic form for this purpose.

e Obligations in connection with privacy legislation

- Before the client manager (or other functionary) starts to fill in the application and diagnosis form (instrument 1) or the individual programme plan (instrument 4) he should read the introduction to these forms to the client (see following point d). He should provide the client with a fully completed copy of the form.
- The client manager and all the other functionaries in the chain who have contact with the client have an obligation of confidentiality towards everyone (including colleagues and seniors) concerning the client's individual data. (Under the terms of the agreement, all the functionaries in the chain involved with the same client will have access to the client's data, and further no one. This is so arranged in view of the correlation in the approach and the causation between problem, measure and aim.)
- If the client requests insight into his data, the client manager should point out to the client that all the data that he has a right to are included in the ADF or the individual programme plan, of which the client has a copy (article 12 of the agreement). If necessary, he should provide him with a new copy.
- If the client requests a change to his data, the client manager should, on behalf of the responsible person – if necessary following consultation with other involved functionaries in the chain – provide the client within 14 days with a reasoned decision in writing concerning the request (article 13 of the agreement)
- If the client requests suspension of the processing of the data, the client manager should, on behalf of the manager, provide the person concerned within 4 weeks with a reasoned decision in writing (article 14 of the agreement)
- The client manager should manage the file of the person concerned and also monitor the term for which the data should be held under the privacy legislation, and ensure the destruction of the data before the expiry of this term.

f Key points in summary:

- The client manager is not required to negotiate with chain partners concerning the deployment of provisions. The frameworks for the deployment are administratively established pursuant to contracts agreed by the co-ordination point and partners (care agencies and housing corporations) and clear in terms of volumes and funding per period of time. It is the task of the co-ordination point, based on the data provided by the client managers on a monthly basis, to ensure that the client managers can operate within the available frameworks and budgets.
- The client manager will always endeavour to reach agreement with the chain partners concerning the course to be followed. He will report to the co-ordination point cases in which the execution of the individual programme is stagnating or is threatening to stagnate and will provide reasons. One reason may be that the chain partners do not agree on the supply of care or services.
- If agreement between chain partners cannot be reached, the relevant field co-ordinator of the co-ordination point will enter consultations with the body with which agreement has not been met and will endeavour to come to a solution of the problem on the basis of the equal contractual relationship. If necessary, administrative consultation will take place.

Instrument 3: Model approach and model agreement on data exchange in connection with privacy legislation

Function and use of the instrument:
The model approach and the model agreement on data exchange with the execution of the Strategy Plan for Social Relief for the homeless and derelict clarifies to organisations and individuals who work together within this framework what they should do and what they should bear in mind with regard to privacy legislation. The model agreement enables these organisations and individuals to exchange data within the parameters of the privacy legislation. It is derived from the model agreement on data exchange in respect of an individualised approach to adult repeat offenders. Amendment and subscription to this agreement on the part of the co-operating organisations effectuates the application of the privacy legislation in the framework of this Plan. The requirements of the privacy legislation are also accounted for in the other relevant instruments included in this Plan. This concerns the instruments 1, 2 and 4, the application and diagnosis form, the procedure for an individualised approach and the individual programme plan. See Appendix 3 of part IV of the Strategy Plan for the 'Guidelines for Social Relief Data Exchange'**.** The guidelines can be used as an aid in planning and applying this model agreement. For other questions, the Privacy Helpdesk of the Ministry of Justice can be consulted: helpdeskprivacy@minjus.nl.

Content of the instrument
This instrument contains the following components:
a. An overview of what administrators and authorised managers have to do.
b. An overview of the obligations of client managers and other persons in the chain having contact with the client
c. A model agreement on data exchange. Administrators and authorised managers of organisations involved can apply this agreement to the situation in their own city and subsequently maintain it as standard
d. An overview of the stipulations included in other relevant instruments within this Plan.

a Overview of what administrators and authorised managers have to do
- Administrators and managers should apply the model agreement to the situation in their own city, document it, sign it and place it at the disposal of relevant functionaries. With that, the agreement is implemented.
- The Municipal Executive should report the data exchange issuing from the agreement and the other instruments to the CBP [Dutch Data Protection Authority], using the website www.cbpweb.nl. The Municipal Executive is not required to await permission before taking action. This also will establish that only those individuals in the chain that have client contact have access to the client's data (electronic or on paper) (included in instrument 2).
- The Municipal Executive should ensure that the computerised system also meets with the requirements of the privacy legislation. It is also responsible for including this in the notification to the CBP.

b Overview of the obligations of client managers and other individuals in the chain who have contact with the client

- The client manager (or other functionary) who is about to complete the application and diagnosis form, (instrument 1) or the individual programme plan (instrument 4) should first of all have the introduction on this form read to the client (see the following point d). He should provide the client with a copy of the fully completed form.
- The client manager and all the other functionaries in the chain who have contact with the client have an obligation of confidentiality towards everyone (including colleagues and seniors) concerning the client's individual data. (Under the terms of the agreement, all the functionaries in the chain involved with the same client will have access to the client's data, and further no one. This is so arranged in view of the correlation in the approach and the causation between problem, measure and aim.)
- If the client requests insight into his data, the client manager should point out to the client that all the data that he has a right to are included in the ADF or the individual programme plan, of which the client has a copy (article 12 of the agreement). If necessary, he should provide him with a new copy.
- If the client requests a change to his data, the client manager should, on behalf of the responsible manager – if necessary following consultation with other involved functionaries in the chain – provide the client within 14 days with a reasoned decision in writing concerning the request (article 13 of the agreement)
- If the client requests suspension of the processing of the data, the client manager should, on behalf of the manager, provide the person concerned within 4 weeks a reasoned decision in writing (article 14 of the agreement)
- The client manager should manage the file of the person concerned and also monitor the term for which the data should be held under the privacy legislation, and ensure the destruction of the data upon expiry of this term.

c Model agreement on exchange of data concerning individualised treatment of homeless and derelict persons
(---: to be completed locally**)**
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1 Introduction
In the city of **---,** around **---** people are living in a very vulnerable situation, in a state of dereliction. These people struggle with psychiatric disturbances (including problems of addiction), or with serious psychosocial problems. At the same time, they have other problems in other areas of life. Over **---** of them are homeless or sleeping rough. The consequence of this is that, because of their vagrant behaviour and derelict state, they are often a source of public nuisance and criminality.
In order to improve their individual circumstances and to protect society, an individualised approach is important. By using an individualised approach, the vicious circle in the lives of these people can be broken. In accord with the executives who subscribed to the Strategy Plan for Social Relief in the four major Dutch cities on 27 January 2006, the executives and managers of the relevant organisations in **---** have embraced this conclusion: the current situation is no longer acceptable and a more effective approach to the problems of this group is necessary, in which individualised treatment should be the centre point, with consideration given to the total circumstances of the homeless. In order to gain a clear picture of the target group, it is necessary that the co-operation in **---** between the relevant institutions be optimised. Data exchange and information transfer will play a big part in this.

2 Considerations
Considering that for an adequate implementation of social relief with all that it entails and the handling of any nuisance and criminality caused by the target group of homeless and derelict persons as indicated in the Strategy Plan for the four major cities dated 27 January 2006 in **---,** various parties wish to join in co-operation with a view to realising an individualised approach, which therefore necessitates data exchange, and all the relevant parties, hereby named in full: police, Public Prosecution Service, Custodial Institutions Service, probation service, social relief institutions, Municipal Health Services, Dutch Mental Healthcare Association institutions, addiction centres, housing corporations, social services, youth care agency, municipalities, etc., being mindful of their duties:

Party	Task involved in implementing social relief:
Police	The detection of punishable offences, maintaining public order and providing aid to those in need of it
Public Prosecution Service	The investigation and prosecution of punishable offences and the supervision of sentences carried out
Custodial Institutions Service	The execution of custodial punishments and measures, as well as offering persons entrusted to their care the opportunity of social rehabilitation
Probation Service	Assisting with and carrying out research into and providing information on (ex) detainees
Social relief institutions	Offering temporary shelter, support, information and advice to persons who have abandoned their home situation
Municipal Health Services	Contacting and supporting vulnerable persons and risk groups, and functioning as a reporting centre for signals of crisis or threats of crisis
Dutch Mental Healthcare Association	Treatment and support of persons with psychiatric and/or addiction problems
Addiction Centres	Treatment and support of persons with addiction
Housing corporations	Offering permanent living accommodation.
Social Services	Providing support to persons who do not have the means to obtain the costs of sustaining life
Youth Care Agency	Offering support and assistance to young people and/or their parents with behavioural problems
Municipality	Co-ordination and direction

and taking account of the privacy legislation applying to them in particular:

Party	Privacy legislation with grounds of provision
Police	• Police Files Act • Police Files Decree
Public Prosecution Service	• Judicial Data and Criminal Records Act • Providing indications of prosecution data for purposes beyond those of criminal procedures
Custodial Institutions Service	• Custodial Institutions Act with associated penal measures
Probation Service	• Probation and After-Care Order 1995 • Own privacy regulations
Social relief institutions	• Personal Data Protection Act • Own privacy regulations Depending on the function carried out (if required): • Social Work Professional Code • Medical Treatment Contracts Act • Assertive Outreach
Municipal Health Services	• Medical Treatment Contracts Act • Assertive Outreach
Dutch Mental Healthcare Association	• Medical Treatment Contracts Act • Assertive Outreach
Addiction Centres	• Medical Treatment Contracts Act • Assertive Outreach (if required)
Housing corporations	• Personal Data Protection Act
Social Services	• Work and Social Assistance Act
Youth Care Agency	• Youth Care Act • Own privacy regulations
Municipality	• Personal Data Protection Act

agree to work together within a joint co-operation on Social Relief in **---**. The exchange of specific personal data is unavoidable in this. The data and information exchange essential to this co-operation is arranged as follows:

3 Definitions

- *Participant*: one or more of the Parties participating in the co-operative arrangement for the individualised treatment of the target group
- *Personal detail*: every detail concerning an identified or identifiable natural person
- *Special personal detail*: a personal detail concerning someone's religion or creed, race, political affinity, health and sexuality, and also personal data concerning membership of a trade union. Also, crime-related personal data and personal data concerning unlawful or objectionable behaviour in connection with an imposed prohibition pursuant to that behaviour
- *Target group:* Those persons who require an offer of temporary shelter, support, information and advice because they have abandoned or are in danger of having

to abandon their home situation, whether or not by force, as a result of one or more problems, or whose general situation is such that they could land in such circumstances, and who are not able or not yet able to sustain themselves independently in society.

- *The person concerned*: the client of social relief, to whom a personal detail relates
- *ADF:* The Application and Diagnosis Form that contains relevant personal data in the context of the registration and diagnosis of the person concerned
- *The individual programme plan:* the personal file describing the aims following from the ADF and to be achieved in order to improve the situation of the person concerned in the various areas of concern, the actions to be taken to this end and the associated rights and obligations of the person concerned
- *Case study consultation:* the consultation of Social Relief, in which the participants exchange data on the person concerned and make agreements on his individual treatment
- *Employee*: the person who is employed at the responsibility of one of the parties involved, participating in the consultation and having access to the individual care plan
- *Registration source*: the original file of a participant from which the personal data originate
- *Processing of personal data*: every action concerning personal data, including the collection, documentation, classification, storage, amendment, change, requesting, consulting, using, issuing, distributing or any other form of supplying, collating, associating as well as protecting, deleting or destroying of personal data
- *Supply of personal data*: making personal data known or making them available
- *Collection of personal data*: obtaining personal data
- *Responsible manager*: the natural person, legal entity or any other administrative body that, alone or with others, establishes the aim of, and the means for, the processing of personal data
- *Consent of the person concerned*: every free, specific and information-based expression of will by which the person concerned accepts the processing of personal data relating to him
- *Administrator*: the person who processes the personal data on behalf of the responsible manager.

4 Aims; association of aims; causation and correlation

Data exchange within the co-operative arrangement of Social Relief and the creation and administration of a personal file (ADF and individual programme plan) of the person concerned is necessary in relation to the following aims: improvement of physical and mental wellbeing, income situation and residential situation of the homeless person and reduction of the social nuisance resulting from the current living circumstances of the person concerned. These are the collective aims of the organisations involved. In reference to all the measures to be included in the individual programme plan in the framework of the execution of the Strategy Plan for Social Relief, there will be assumed to be a causal relationship with the problem and with the aim to be achieved, so that a cohesive whole is assumed.

5 Obligation of confidentiality

Inasmuch as participants are not already bound, an obligation of confidentiality applies to those employees who have access to or – in accordance with the stipulations of this agreement – obtain by any other method personal data from the Social Support consultations and/or the individual programme plan. This obligation covers the keeping in confidence of personal data of which the employees gain knowledge, with the exception of any legal instruction that obliges them to divulge the information, or if the need arises within the context of their function. Personal data relating to convictions are only issued with the permission of the Public Prosecutor.

6 Data set

- 6.1. Parties will process both personal data and special personal data. Parties will only process data if and for as long as this is necessary to the realisation of the above-mentioned aims. In this, parties will process no more data other than those that are necessary to achieve this. The data will be sufficient to the aims for which they are processed, relevant and not superfluous
- 6.2. The data referred to in instruments 1, 2 and 4 of the Strategy Plan for Social Relief are deemed to be wholly necessary to all the parties involved in the individualised treatment of the client.

7 Responsible manager

The manager responsible for data processing within the co-operative arrangement for Social Support is the Municipal Executive of **---**. The actual execution of the tasks of the responsible manager will lie with either the co-ordination point or with the client manager.

8 Security and direct access

- 8.1 The responsible manager will secure the personal data of the persons concerned against loss or any form of wrongful processing. He or she will take the necessary and fitting technical and organisational measures to this end. These measures relate to, among others and not exclusively:
  - ✓a) Measures relating to access to the personal data
  - ✓b) The reading and writing authorisation of the participants
  - ✓c) The required level of security
- 8.2. The responsible manager, the participants and administrator are obliged to act in accordance with the security and access guidelines as created by the responsible manager and carried out by the administrator.

- 8.3. In this, use will be made of Privacy Enhancing Technologies (www.cbp.web.nl).

9 Storage and removal of personal data

- 9.1. The personal data in the individual programme plan will not be kept any longer than necessary to the purpose or purposes of the individual programme
- 9.2. The personal data in the individual programme plan will in any event be removed and destroyed when the data referred to are removed from the registration source of the participant
- 9.3. The personal data will be removed and destroyed from the individual programme plan in any event 5 years from the last contact between the person concerned and one of the parties
- 9.4. The personal data will be retained for longer than 5 years after the last contact in reference to criminal conviction between the person concerned and one of the parties solely for statistical or scientific purposes
- 9.5. The responsible manager will decide before expiry of this term whether the data will be retained for a longer period for the purposes mentioned in section 9.4. The responsible manager will ensure that the data will be used solely for this purpose and will take the necessary precautions to this end.

10 Obligation to inform

- 10.1. The responsible manager will supply the following information in writing to the person concerned:
  - ✓ The aims of the Consultation on Social Relief and the individual programme plan
  - ✓ The identity of the responsible manager

  This will be done by allowing the person concerned to read the introduction in the ADF (instrument 1) in which these elements are included, prior to initiating the intake
- 10.2. This information is issued via the procedure indicated in section 10.1, prior to the point when the responsible manager obtains from the person concerned the personal data for documenting in the individual programme plan. The information need not be issued if the person concerned is already in possession of it
- 10.3. In the event that the responsible manager obtains personal data without the knowledge of the person concerned, the person concerned should be informed to this effect at the point when the data is first documented by the responsible manager. This should also take place using the procedure described in section 10.1, bearing in mind the fact that a relevant stipulation is included in the introduction in the ADF. The information need not be issued if the person concerned is already aware of it.

11 Rights of the person concerned

The person concerned has three rights:

- 11.1. Right of inspection
- 11.2. Right of correction
- 11.3. Right of objection.

12 Right of inspection

The right of inspection is regulated within the framework of the implementation of this Plan, as the person concerned is provided as standard with a copy of both the application and diagnosis form (ADF), and the individual programme plan. The ADF contains all the data of the person concerned, except those that should remain confidential and cannot be issued in connection with:

- Prevention, detection and prosecution of punishable offences
- State security
- Weighty economic and financial interests of the State
- Supervision in connection with the foregoing
- Protection of the person concerned or of the rights and freedoms of others.

In the event that the person concerned later requests insight into his data, the client manager should either refer to the copies of the forms (or if necessary issue a new amended copy) and to consider whether the grounds of exception apply. The person concerned should direct his request to the Municipal Executive, for the attention of the client manager.

13 Right of correction (i.e. correction, supplementation, removal and/or screening)

- 13.1 The person concerned should direct his or her request for correction to the responsible manager, for the attention of his client manager. The person concerned should indicate in the request the corrections he wishes to see carried out and for what reason
- 13.2 The responsible manager should comply with the request as soon as possible, but within two weeks of receipt of the request at the latest, provided that the personal data relating to the person concerned:
  - ✓a) are factually incorrect
  - ✓b) are irrelevant or not sufficiently relevant to the aim of the processing
  - ✓c) are otherwise processed in conflict with a legal provision
- 13.3 The responsible manager should ensure that any decision to correct, supplement, remove and/or screen is carried out within two weeks of the decision being taken
- 13.4 The responsible manager should provide reasons for any decision not to comply with, or not fully comply with, the request. The responsible manager should communicate this as quickly as possible, but within two weeks of receipt of the request at the latest, in writing to the person concerned.

14 Right of objection

- 14.1 The person concerned may notify the responsible manager at any time concerning his/her objection to the processing of his/her personal data in the individual programme plan in connection with special personal circumstances
- 14.2 The responsible manager should assess within four weeks of receipt of the objection whether it is justified.

15 Reporting

- 15.1 The data processing issuing from this co-operation agreement is subject to the Personal Data Protection Act. The responsible manager should ensure that the data processing is reported to the Dutch Data Protection Authority (using the website www.cbpweb.nl)
- 15.2 In the event that the issue of data to this co-operative arrangement has consequences for any existing reports to the Dutch Data Protection Authority,

each organisation will bear individual responsibility for amending this report in the correct manner.

16 Changes and additions to the agreement

- Changes in the aims of the data processing as meant in this agreement and changes in the use and manner of obtaining the personal data should result in changes or additions to the agreement
- Changes and additions to this agreement will require the consent of all the parties. The resulting changes in the data processing should be reported to the Dutch Data Protection Authority.

Signatures

The Municipal Social Relief executive **---**

Signed:
The Director of **---**

Signed:
The Director of **---**

Signed: etc.
---

d Overview of the stipulations included in other instruments in this Plan, relevant to the privacy legislation

Instrument 1: Application and diagnosis form (ADF)
The model contains the following introduction:
The aim of Social Relief is to improve your personal and social situation. In order to make this possible, details are required to be entered in this form. These details may be supplied by you, and may also be obtained from other organisations. In that case, it will be indicated in the form from which organisations the details have been obtained. This form contains all the details that refer to you, except those that are confidential. When the form has been completed, you will receive a copy. In connection with the collection of the required information and diagnosis to be carried out, completion of the form can take up to three weeks. You have the right to request changes to the details, in which case you can inform your client manager (the person who gave you a copy of the form). Final responsibility for the form rests with the Municipal Executive of **---**.

Instrument 2 Model procedure for individualised treatment (including client manager)
The foregoing section b is incorporated in instrument 2.

Instrument 4 Model individual programme plan
The model contains the following introduction:
The aim of this individual programme plan is to improve your personal and social situation. In order to achieve this, the measures included in this Plan are necessary. This Plan contains rights and obligations and should be signed by you. Following perusal of your details and signing, you will receive a copy. This Plan forms the other

part of the Application and Diagnosis Form that you were given and in which all your details are contained. Final responsibility for the content of the programme plan rests with the Municipal Executive of **---**.

Instrument 4: Model individual programme plan

Purpose of the instrument

With the aid of this instrument, the client's problem situation as a whole will be defined and the content and terms of the aims to be reached, the appropriate measures to be deployed, and by whom, will be established. For the client, the client manager and all the partners in the chain, this individual programme plan will subsequently be the guide for their actions. As a model, the 8-phase supervision plan will be used as developed by the NIZW [Dutch Institute for Care and Welfare]. The model is supplemented with proceedings.

a General notes

- The individual programme plan forms an entity with the Application and Diagnosis Form (ADF) (instrument 1) and appertains to this. All the personal data are contained in the ADF. Naturally, they do not need to be repeated in the programme plan. Insofar as the individual programme plan (hereinafter: the programme plan) is referred to in the following, it is understood to include also the ADF
- For application of the stipulations in connection with the privacy legislation (under other subsequent stipulations), instrument 2, the model procedure for individualised treatment, is assumed to form a part of the programme plan
- Established diagnoses and starting points are shown in the ADF per area of concern.

b Introduction to the individual programme plan

This programme plan is intended to support the supervised programme. The programme is intended to improve (or stabilise) personal and/or social functioning. The measures contained in this Plan are necessary to achieve this. The Plan contains rights and obligations and should be signed by you. After perusal and signing you will receive a copy. This Plan belongs with the Application and Diagnosis Form that you were also given and which contains all your details. Final responsibility for the content of the programme plan rests with the Municipal Executive of **---**.

c Details of the client manager

Name; shift; telephone; e-mail address.
The client manager will act as the general point of contact for the client and monitor the implementation of the programme, in contact with the chain partners.

d Aims and actions per domain
These should be established per client. Some general indications are provided below.

d1 Definitions, descriptions and notes

- *Chain Unit:* co-operative arrangement between police/judiciary/care agencies concerning the target group of mental health patients causing public nuisance. The Chain Unit can generate compulsion via the judiciary in cases of non-compliance
- *Social Services Hotlines*: public reporting centres at every sub-municipal council; reports will be investigated by GGD and police; cases will be taken into custodial care
- *Care Plan*: the care plan/programme plan will be created and executed by a case worker from the outpatients department and will contain the treatment plan concerning the medical and psychiatric problems of the patient. The care plan will also indicate the living accommodation and work situation required; the field co-ordinators will realise the requested provision. The care plan is therefore identical to the individual programme
- *Application for BOPZ* measure: the doctor will request the GGZ, providing reasons, to issue a medical statement with a view to obtaining temporary authorisation
- *Legal Mentor:* the legal mentor is the legal representative of the patient. He will make decisions if the patient is unable to do so concerning the proposals for care
- *Governor*: If the patient does not co-operate with budgeting, it may be necessary to appoint a governor via the subdistrict court
- *Crisis Accommodation Plan:* the crisis accommodation plan will provide for emergency accommodation if the patient can no longer be maintained within shelter. In the case of crisis involving substance abuse, crisis accommodation will be a detox department of the addiction clinic. With psychiatric crisis, this will be the psychiatric hospital. If the patient has been subject to an ISD [Institute for Systematic Offenders] measure, he will be returned to the ISD institution.

Appendix 5 of part IV of the Plan contains the model individual programme, which is based on the 8-phase supervision model.

Instrument 5: Gauge for applying the BOPZ [Psychiatric Hospitals (Compulsory Admissions) Act]

Purpose of the instrument:
The BOPZ guidelines can improve the execution of the BOPZ Act by increasing the knowledge level among institutions and professional groups. The instrument contains concrete actions aimed at this. The key principle of it is that it should be made as clear as possible to everyone involved what may be expected from the application of the BOPZ Act and within what term and in what way even better insight can be obtained within the current possibilities of application, and also what proposed adjustments will further increase the legal possibilities of application of the Act in the future (on condition of parliament's approval).

a General

- The main problem with BOPZ is the *application of the law.* The law offers sufficient possibilities, but so far not much use has been made of it by institutions and professional groups
- In view of this fact, the first line to be taken is to clarify the possibilities of the existing law and to have it used by the institutions and professional groups. This will be achieved by the establishment in the near future of two guidelines
- On top of this, additional possibilities will be included in the law (assuming parliamentary approval).

The key message to client managers, chain partners and professionals is therefore: use the law!

b Actions aimed at better application of the BOPZ Act

b1 Instrument 5A: National guidelines on serious addiction
In the first place, national guidelines will shortly be introduced concerning serious addiction and BOPZ. The purpose of the guidelines will be to improve the use of the BOPZ Act in cases of addiction. The creation of these guidelines will be carried out as follows:

- The Task Force (which created this Strategy Plan), or its successor in the form of the Progress Group, will organise in June 2006 at the latest a conference with the aim of establishing these guidelines. To this end, a sub-group has been created, in which the four major cities and the Ministries of Health and Welfare and Justice participate. Rotterdam is leading the sub-group. All the parties involved (politicians, inspectorate, Mental Health Care institutions, departments, judicial authorities, Public Prosecution Service, police and professional groups) will be invited to the conference.
- Rotterdam guidelines are already available, which have been operational since 2004 and which, in anticipation of the national guidelines, can also be used in the G4. The operation of the guidelines is evaluated internally on an annual basis by the administrators. Also, application of the BOPZ Act is monitored by Erasmus University. The most recent monitoring data show that, following implementation of the guidelines, the number of BOPZ admissions of addicts has doubled.
- In preparation of this conference (i.e. by 31 January 2006 at the latest), GGZ Netherlands will create a preliminary document, based on existing case law, parliamentary discussions, findings from the two first evaluations of the BOPZ

Act and specialist literature. This has been agreed between Rotterdam and GGZ Netherlands
- The Rotterdam guidelines and the preliminary document of GGZ Netherlands are the starting point for establishing the national guidelines
- The four major cities will implement the new guidelines from 1 March 2006.
- Application of the guidelines will be followed in the context of monitoring the implementation of this Strategy Plan (see Section I subsection L).

b2 Instrument 5B: National guidelines on conditional discharge by medical director and supervision of compliance with conditions by the institution

In the second place, "guidelines on conditional discharge by medical director and supervision of compliance with conditions by the institution" will shortly be introduced. The creation of these guidelines will be carried out as follows:

- GGZ Netherlands will develop these guidelines in consultation with AWBZ experts and medical directors. Rotterdam will provide a pilot proposal by 1 March 2006 at the latest to speed up this development
- The four major cities will adopt the guidelines from 1 April 2006
- Application of the guidelines will be followed in the context of monitoring the implementation of this Strategy Plan (see Section I subsection L).

b3 Instrument 5C Decision-making procedure for compulsory admissions

The NVvP [Dutch Psychiatric Association] is currently developing a decision-making procedure for compulsory admissions, at the request of the Ministry of Health and Welfare. The first report instalments were received in January 2006, namely concerning case law and the scientific underpinning of the application and effects of compulsory admission. The third instalment, concerning experience in practice of the parties involved, is expected around mid-March 2006. It is expected that by the end of 2006 the decision-making procedure/guidelines will be ready.

c Realised and proposed amendment of legislation

(Where applicable, on condition of parliamentary approval)

- On 1 January 2006, the observation authorisation took effect. This provides the possibility of, in the course of a compulsory admission, investigating the extent to which a further compulsory admission or other measure is required
- On 1 November 2005, the Second Chamber accepted the addition to the BOPZ Act of the *self-binding* method. This method makes it possible for a patient, before a situation of compulsory admission arises, to indicate in which cases his refusal to be admitted can be ignored. This concerns treatment following admission: which treatment may be applied under certain circumstances. This method will take effect following acceptance by the First Chamber
- A bill has been sent to the Council of State (for urgent recommendation) that will formulate rules for:
  - ✓ A conditional *authorisation* that may also be issued if the person concerned does not expressly consent to it
  - ✓ Compulsory *treatment* also being possible in cases where it can reasonably be assumed that, without the treatment, the risk, on grounds of which the patient should remain in hospital, cannot be removed within a reasonable period of time. This will facilitate earlier compulsory admission when there is acute danger within the institution.

The recommendation of the Council of State on the bill concerning conditional authorisation and compulsory treatment has in the interim been issued. Work is currently being carried out on the processing of this recommendation into the bill. The legislative proposal is expected to be submitted to the Second Chamber at the beginning of February 2006.

Instrument 6: Model procedure for effecting care delivery

Purpose of the instrument

This instrument describes the procedure to be followed in effecting delivery of the AWBZ-funded care considered necessary in the context of this Plan, taking account of the positions of the parties involved in respect of the relevant legislation. A description is also given of the agreements to be included in the contracts. This instrument builds on the current agreements and prioritisation between city administrations and care agencies for the target group. This instrument should be seen as the manifestation of proposals contained in the general part of this Plan under B (Strategy) and I (Chain co-operation).

a Starting points in the application of the instrument:

- Municipalities, care agencies and the Ministry of Health and Welfare will give priority to admitting homeless persons with a twofold diagnosis into the programme, so that the necessary care, shelter, living accommodation, budget management and other instruments will lead, from within individualised treatment, to stabilisation and/or improvement of the physical and social position of the client and restriction of social disruption.
- The municipality will not interfere in the powers and obligations of the care agency. Where tension arises surrounding the legal obligations, the Ministry of Health and Welfare is accountable for assistance towards the legislators and supervisory bodies (CVZ [Dutch Health Care Insurance Board], CTG [Health Care Charges Board], National Board for Hospital Facilities, etc.).
- The municipality will ensure that individual programme plans put into effect fit within the care agency's contracted parameters, so that client managers will always have at their disposal the care indicated in the individual programme plan and the information from the care provider necessary for this.
- The Municipal Executive will appoint one or more field co-ordinators, who will be responsible for policy co-ordination. The field co-ordinators will administer the central client tracking system and provide the care agency and care providers with the necessary access to this system, on the basis of a separate agreement within the framework of the Personal Data Protection Act (see instrument 3: model agreement).

Agreements are made between care agency and municipality on three levels:

- Long-term agreements on projected requirements and budgets
- Annual agreements
- Agreements on procedures and responsibilities
- Agreements on individual programmes.

b. Long-term agreements:
Long-term agreements between care agencies and municipalities will be possible if the legal escape clause is included for adjustment to national financial developments and system changes.
The long-term agreements will cover:

- Municipality and care agency making a joint projection of demand (qualitative and quantitative, long/short-term)
- In this, a long-term estimate is made of the financial consequences according to the various legal frameworks. This relates to the (financial) input based on the Social Support Act and also on the AWBZ
- Interim system changes, such as transfers, will not render contract agreements invalid, but may lead to amendments if the changes warrant them
- The regional contract parameters under the AWBZ form the starting point for the care agency, within which it should formulate the care purchase. If – despite the extra resources that were recently made available on a structural basis for this target group – the care agency is unable to free sufficient resources for the purpose, the parties may report this as an issue in accordance with the appropriate procedure (furnished with underpinning argument). The Ministry of Health and Welfare will decide on this. This information should be made known in the administrative “thermometer” consultation
- The Ministry of Health and Welfare will consider whether in terms of the above-mentioned underpinning argument (e.g. with disproportionately high numbers of homeless persons being entitled to AWBZ care), redistribution of regional budgets will be necessary.

c. Yearly agreements:

- Care agencies will formulate the long-term agreements mentioned under a. in their agreements and production arrangements with care institutions
- Municipalities will formulate the long-term agreements mentioned under a. in their policy and implementation in the area of social relief
- Care agencies and municipalities will make performance agreements on influx, throughput and outflow. Where the municipality applies to other chain partners for their part in the programme plans, the care agency will do this in respect of the care providers. If a care provider cannot or will not meet the performance agreements, the care agency will contract other suppliers
- Care agencies and municipalities will assess performance and process on a yearly basis.

d. Agreements on procedures and responsibilities

- The municipality is responsible for identifying and providing temporary shelter to homeless persons and, if required, guiding them to other facilities (including AWBZ institutions)
- The care agency is responsible for contracting support/treatment and accommodation (to be carried out by the chain), inasmuch as this can be financed under the AWBZ
- Care agencies and municipalities will make procedural agreements on any interim changes (e.g. if it appears that the prognoses strongly differ from the real situation)

- Care agencies and municipalities will inform each other at agreed times concerning progress in production
- Care agencies and municipalities will carry out material checks collectively concerning co-financed facilities
- The municipality will organise at set times an administrative platform with care agency and care providers
- Municipality and care agency will collectively ensure a co-ordination structure that will lead to optimum co-operation between the chain partners
- The municipality is responsible for operating the co-ordination point (field co-ordination at system level).

e. Agreements on individual programmes

The agreements on individual programmes state:

- The individual programme is set up by the client manager
- The municipality agrees with the CIZ [needs assessment body] that the care assessment will be carried out by the client manager (with a mandate from CIZ)
- Patients with complex problems will be registered with the field co-ordinators / co-ordination point, after which the patient will be assigned to a care provider
- The care agency will help with the assignment if the client so requests (mediation)
- The assignment will lead directly to care provision, taking account of the above statements on the regional contracting parameters
- The client manager will (co-)monitor the execution of the programme plan and inform the field co-ordinators / co-ordination point on progress
- The field co-ordinators will intervene when an individual programme is stagnating
- The care agency will request explanation from the care providers at individual client level (care provision and funding) on the basis of the (currently under preparation) agreements on costing and accounting under the AWBZ
- It will be included in the contracts between care agency and care providers that an action calling for execution of an individual programme carried out by the client manager directed at the care provider should be considered to effect the purchase contract between care agency and care provider (and therefore should be carried out).

Instrument 7: Model approach to uninsuredness and budget management

Purpose of the instrument

This instrument indicates the way in which health insurance (both basic and supplementary, if that is considered desirable) for the target group can be realised and how it can be ensured that the resulting obligation to pay the premium will be met.

a. Categorisation

Two issues should be distinguished here:

- Insurance cover of the (appropriate) health costs of the persons concerned. For this, the collective insurance instrument will be used
- Fulfilment of the obligations issuing from the policy, i.e. payment of the premium. For this, the budget management instrument will be used.

b. Collective insurance

The following approach will be taken:

- For the year 2006, the four major cities will set up a collective basic insurance for Care in respect of persons entitled to social assistance and other minimum income groups. The collective policy contract will include the stipulation that the policy may be applied to new persons from the target group throughout its entire term at the point when the new persons are admitted in the context of Social Relief, and appear not to be insured
- Rotterdam, Utrecht and Amsterdam agreed a collective contract in 2006 for health costs
- The Hague entered an agreement in 2006 with Azivo and with Delta Lloyd concerning a warning system, enabling prompt action to be undertaken if social assistance customers do not meet their payment obligations
- Rotterdam, Amsterdam and Utrecht will also continue their current collective supplementary insurance for 2006 for the same group as for the basic insurance
- For 2007 and subsequent years, the four major cities will endeavour, whether or not collectively, to agree collective insurance covering health costs for both the basic (including the transfers from the AWBZ) and the supplements considered necessary, under which the entire Social Relief target group falls

This approach is important from two perspectives:

- The entire target group will in principle be adequately insured (provided the payment obligations are met). This means that the care that is covered under the basic insurance can be taken up and used in the individual programme (see uninsuredness below)
- Since it concerns the same insurer for the entire target group, there is a greater likelihood – depending on the contracting policy of the insurer – that co-operation will be carried out with a permanent group of suppliers in the delivery chain. This will facilitate the making of agreements across as closely linked a chain as possible
- *Care supplement* The aim will be to pay the care supplement directly to the insurer.

c. Budget management

Concerning the entire Social Relief target group, it is highly likely that individuals will have problems meeting the obligations stemming from the health insurance policies (i.e. payment of the premiums) independently. (If individuals are able to meet their obligations independently, it is questionable whether they belong within the target group.) If they do not meet their obligations, they will become uninsured and the risk of debt will increase because of the penalty system. It is desirable to prevent uninsuredness as much as possible. In order to achieve that, where necessary and where possible, budget management will be deployed as an instrument for the target group. This will be done as follows.

- The cities will purchase collective insurance (see above: collective insurance).
- Within the framework of the individualised approach (see instruments 1, 2 and 4), and at the point of intake:
  - ✓ Firstly: on the basis of the collective policy, health insurance will be effected for the person concerned, inasmuch as the person concerned appears not yet to be insured
  - ✓ Secondly: standard budget management will be offered (with an explanation of the importance of this in respect of the availability of care)
  - ✓ Thirdly: the sum for the health insurance will be transferred automatically, insofar as the client is in receipt of social security benefit.
- In the first instance, voluntary co-operation in budget management will be asked of the person concerned. With this, urgent emphasis will be put upon the importance of this
- Municipalities can impose compulsory budget management, citing article 57 of the Work & Social Assistance Act, on those people who are in receipt of social security benefit and who are not able to organise their own lives. Municipalities should have reasonable grounds for imposing this. Among other things, the fact that an individual belongs in the target group can provide sufficient grounds
- Budget management will be carried out at the responsibility of the municipalities
- Within the framework of budget management, among other things debt rescheduling programmes will be effected and financial transactions carried out for purposes of the health care insurance. In this way, uninsuredness will be prevented.

d. Risk group

Even with the application of this model approach, there is still a restricted group that is likely to remain uninsured. In respect of this group, there are no legal possibilities of compelling them to co-operate in budget management. It stands to reason that in the course of executing the Plan, this (hopefully restricted) group will be fully known, since the aim is to remove anonymity from the entire target group.

e. Task Force for the Uninsured

In the report from the task force for the uninsured (letter from the Minister of Health and Welfare to the Second Chamber dated14 December 2006) the possible handling of this group is discussed. The municipalities will have made a start by 1 March 2006 on the setting up of organisational provisions for applying budget management to the entire target group.

Instrument 8: Model approach to effecting delivery of specified living accommodation

Function of the instrument

This instrument indicates which procedure to use to effect the timely supply of suitable living accommodation. It indicates in particular which elements should be included in performance agreements between municipality, corporations and care agencies on a housing plan. In the performance agreements will be established both the aims and arrangements for the concrete results of these, together with the conditions.

a Establishing the requirement

The size and nature of the target group should be established. The assumption in this context is that the target group consists of persons who:

- require residential *care* to a greater or lesser degree, on a temporary or permanent basis, i.e.: care that enables them to run a household and/or prevent them causing disruption and/or commit crime and/or neglect themselves
- are coming from an existing (care)facility in the relevant municipality

Establishing the extent of the residential requirements is not a simple matter. It requires adequate specification, and this should be substantiated at local level. It is advisable in any event to differentiate, or weigh, the following categories:

- Large-scale living accommodation for permanent occupancy (24-hour supervision) (40 places per unit)
- Other specific clinical facilities (including long-term occupancy)
- Large-scale living accommodation for short-term occupancy (corporation hotels, pensions)
- Large-scale facilities for sheltered accommodation (25 – 35 places)
- Small-scale facilities for sheltered accommodation (2-4 persons)
- Independent dwellings (with home supervision)
- Family dwellings (including emergency dwellings in divorce situations)
- Suitable dwelling units at the bottom of the ladder (for eviction situations in cases of debt or anti-social behaviour, differentiating between unwillingness and inability).

b Guarantees

The following guarantees will be formulated explicitly:

- The housing corporation(s) will guarantee suitable housing
- The municipality will guarantee timely application of zoning plans if that is necessary to the creation of the housing provision
- The municipality will guarantee the necessary home supervision inasmuch as it belongs within its remit
- The care agency will guarantee (based on and in accordance with its purchasing agreements with care providers) the necessary (assertive) care by the care providers inasmuch as this is funded by AWBZ (see also instrument 6)
- The municipality will organise the process of co-operation in execution between municipality, corporation(s) and care providers(s).

c. Concrete responsibilities and co-ordinated implementation
In conjunction with the agreed guarantees under b (above), the concrete responsibilities of relevant bodies and individuals and the co-ordination of implementation will be clearly established.

- Corporation, police and municipality each have their responsibility in the area of the livability of neighbourhoods and for tackling issues of anti-social behaviour. This should also involve the client's own responsibility, which can be translated into concrete terms by a contract between tenant/client, landlord and care agency, whereby the tenant subscribes to supervision and reliable tenancy, the care agency guarantees the supervision and the landlord supplies the accommodation
- The co-ordination of the implementation can best be placed in the hands of the client manager (individualised approach).

d. Relationship to the policy concerning prevention of evictions
Instrument 9 contains model protocols concerning the policy for prevention of evictions. The relationships with this instrument are as follows:

- An element in effecting specific living accommodation will be alternatives at the bottom of the property ladder if eviction is unavoidable
- It stands to reason that in the framework of agreeing contracts, both instruments should be considered in context.

e. Care and supervision
Points to note in defining the supervision to be agreed are:

- Quality supervision is not only necessary on grounds of individual problems, but also to support the livability of neighbourhoods. Precisely in these neighbourhoods, the housing pressure in respect of the vulnerable groups is severe, since they contain cheaper and smaller homes
- OGGZ [municipal mental healthcare] clients who return to the housing market from other regimes (including addicts, recipients of social support and ex-detainees) can be included in the policy already in operation for delivering effective transitional care, including preparation for running a home (see, among other things, instrument 12, model procedure for co-ordinating aftercare in cases of release from detention).

f. Funding
It should be clearly established in the contract who will pay for what, so that this does not form an obstacle to the implementation. The following points should be noted here:

- Aftercare for OGGZ clients, including home supervision, will (still) partly be funded from the AWBZ (70%) (indexed) and partly from municipal resources (30%).
- Funding via probation will sometimes be possible.
- The province will distribute the resources for youth care.
- People in search of living accommodation, who as yet receive no assistance but who do belong to the target group, will apply in the first instance mainly to the low-threshold shelter facilities. The housing-related assistance will have to be

organised and funded, for example, by the care organisations, whereby some of them will receive a subsidy from the municipality.
- Corporations have a social responsibility, including the housing of special groups (even if that cannot be done entirely cost-effectively).

g. Planning and monitoring

The local agreements should be provided with a (realistic) plan and agreements concerning a structural monitor. Previously set indicators for monitoring could be:

- Reduction of the number of clients in social relief
- Shorter average stay in shelter facilities
- Decline in the number of evictions
- Effect on livability of neighbourhoods
- Compliance with process agreements
- Realisation of new living arrangements

See also the indicators included in the chief aims and the operational aims in the general section of the Plan.

Instrument 9: Model protocols for preventing evictions as a result of rent arrears or anti-social behaviour

Purpose of the instrument

With this instrument, municipalities in co-operation with housing corporations and private landlords can prevent domestic evictions through early acknowledgement of the signs and problems that could eventually lead to eviction, and introduce the appropriate assistance.

a Instrument 9A: Protocol for prevention of eviction in connection with rent arrears

- *Phase 1.* Identification of rent arrears by the landlord (1- maximum 3 months rent arrears)
  - ✓ The landlord initiates debt-collection procedure.
  - ✓ Prior to engaging a bailiff, the landlord provides the tenant with information on a payment schedule and invites the tenant to contact him. If necessary, the landlord initiates contact himself.
  - ✓ In the event that more problems arise during contact with the tenant, the landlord requests the local care network to take an active approach.
- *Phase 2*. Bailiff (2 to maximum 4 months rent arrears)
  - ✓ If there is no response from the tenant, the file is passed to a debt-collection agency or bailiff.
  - ✓ The bailiff again offers, on behalf of the landlord and with emphasis, a payment schedule.
  - ✓ If the tenant accepts the offer of a payment schedule and there appear to be other problems in addition, the landlord requests the care network to take an active approach.
  - ✓ The bailiff takes no action while the payment schedule is being introduced.
- *Phase 3*. Subdistrict court (3 to 5 months rent arrears)
  - ✓ The summons is issued.
  - ✓ With the issue of the summons, the tenant is reported to the care network (preferably to a control centre).In cases of families with children, the care network will involve the Youth Care bureau.
  - ✓ The care network fulfils the role of manager and co-ordinator and ensures that an offer of payment schedule and care is provided.
  - ✓ In exchange for accepting the payment schedule, (debt assistance, budget manager, credit bank) the landlord orders the bailiff to suspend the action.
  - ✓ In situations where a deterrent appears necessary, the landlord does not suspend the bailiff's action.
- *Phase 4*. Following a court ruling
  - ✓ If the tenant, following a court ruling, then accepts a payment schedule with debt assistance and budget management, the landlord orders suspension of the ruling.
  - ✓ The ruling is finally withdrawn when the debt is settled.
- *Phase 5*. Eviction without homelessness

  If the above does not prove effective, the summons is carried out and eviction follows. In that case, the local care network helps the tenant to look for alternative accommodation, so that homelessness is prevented. A condition as regards the level of accommodation offered is that it should not represent a bonus for bad behaviour.

b Instrument 9B: Protocol for prevention of eviction in connection with disruption

Disruption can arise through criminal activity, anti-social behaviour and multiple problems of a tenant. When disruption is caused by criminal behaviour, a legal course will be taken. Disruption through anti-social behaviour is the most common form of disruption. In cases of disruption caused by multiple problems, all kinds of support organisations will be called in and several parties involved. Co-ordination, by, for example, a client manager, is important here and can operate through the local care network (GGD – municipal health service).

In cases of disruptive behaviour, the following protocol will apply:

- *Phase 1*. First and minor incident of disruption is notified
  - ✓ A complaint is sent to the landlord.
  - ✓ The landlord hears the complainant.
  - ✓ The landlord investigates the complaint, settles the simple issue and informs the complainant.
  - ✓ The landlord registers the complaint and creates a dossier
  - ✓ The landlord handles the complaint within two weeks and expedites it quickly.
- *Phase 2.* Plan of action under conditions of continued or significant disruption, whether or not in association with multiple problems
  - ✓ A report is submitted to an anti-social behaviour hotline or local care network.
  - ✓ The anti-social behaviour hotline or local care network ensures that, in co-operation with police, social services, landlord, psychiatric nursing service (GGD), a treatment plan is created. This can consist of: agreements with the tenant, with the landlord, a contract of conditions, domestic supervision, last chance for another dwelling, etc.
  - ✓ A maximum period of 3 months will apply to this phase. If the disruption is not settled wholly or partly after 3 months, phase 3 will follow.
- *Phase 3* Eviction. In the event that the measures under phase 2 have no effect, eviction follows. In that case, the local care network helps the tenant to look for alternative accommodation, so that homelessness is prevented. In order to prevent rough sleeping, alternative living accommodation can be offered that meets the criteria that it cannot be experienced as a bonus for bad behaviour and that disruption should not be caused to other citizens (in cases of isolated locations).

c Overview of responsibilities

- Tenant
  - ✓ Prompt payment of rent
  - ✓ No anti-social behaviour
- Landlord
  - ✓ Early notification
  - ✓ Offer of payment schedule
  - ✓ Guidance to (debt) assistance
  - ✓ Personal approach
- Municipality
  - ✓ Providing opportunity for clear and simple guidance to care services (control centre)
  - ✓ Adequate capacity for debt assistance and credit bank
  - ✓ Information to public and private landlords

Instrument 10 Model approach to debt assistance and debt rescheduling

Purpose of the instrument
This instrument is aimed at a better approach to debt issues through debt assistance and debt rescheduling. Debt assistance and debt rescheduling should be available to the target group and those persons who are at risk of belonging to the target group: waiting lists are not acceptable. The financial forecast for this Plan allows for the personnel capacity required for debt assistance. Debt assistance should be low-threshold and practical. The instrument bears a direct relationship with the component of budget management from instrument 7 and with instrument 2, the procedure for the individualised approach (including client manager).

The city of Utrecht indicates that debt assistance and debt rescheduling there works well because the responsibility for debt assistance and budget management is placed with a Social Relief body, under supervision of the credit bank without being obliged to involve the conditions of the NVVK [association of municipal credit banks] (the project 'City Finance Management').

a Proposed measures
In the first place, a number of proposed or optional measures, which will be contributory factors in changes of legislation, are significant. These are:

- *VAT exemption on* non-*exempt activities of members of NVVK*.
  The NVVK has requested the Minister of Finance to apply a VAT exemption to the non-exempt activities of its members (debt assistance and budget management). A solution is realised through the amendment of the Implementation Decree on sales tax of 1968 in connection with the review/simplification of the sociocultural exemption. This amendment took effect on 1 January 2006.
- *Mandatory course on budgeting*
  The Ministry of Justice is preparing a proposal for improving the system of conditional sanction methods and broader application of special conditions. In the framework of conditional penalties, there is the possibility of imposing a course on budgeting as a special condition. The proposals will be sent to the Second Chamber before 1 March 2006.
- *Prevention of problem debts*
  The DSB group [financial service provider], Salvation Army, municipality of Tilburg and other parties in the market are currently undertaking initiatives to expand debt registration. In this, they are fulfilling their responsibility with a view to the importance of preventing over-crediting. The Finance Ministry will play an encouraging role in consultation with the initiative group in order to realise this expansion of registration. Furthermore, besides measures within the Financial Services Act – such as information provision (including refinement of credit advertising legislation) and credit checks – the Ministry of Finance will take a number of additional measures aimed at preventing problem debts arising through over-crediting, namely the lowering of the maximum credit earnings and lowering the threshold for the BKR [Credit Registration Office] check.
- *Admit* the *social relief target group to the WSNP* [*Debt Rescheduling (Natural Persons) Act] under obligation of integral assistance and budget management.*
  The bill proposed for amending the WSNP raises the complication that the grounds for admission will go from optional to mandatory. In such case, this target group will no longer be eligible for legal debt rescheduling. Municipalities

will be obliged to take responsibility for effective support of the target group in the admissions hearing of the WSNP.
- Develop a regulation for mandatory participation of creditors (including the CJIB [Central Judicial Collection Agency]) in debt assistance for this target group (WSNP).

- Mandatory register of protective guardianship (see curatorship register) for prevention of over-crediting/possibility of annulling agreements.

b The role of the client manager

Instrument 2 discusses the role and powers of the client manager. It is important here to obtain an overview of the target group by name, date of birth and gender. The social relief institutions will be obliged to register their clients, and subsequently the clients' details will be reconciled through a computer file link (see instrument 4). The client managers will maintain the following approach to debt assistance and budget management:

- The client managers will co-ordinate, as part of an individualised approach on behalf of their clients, an integrated supply of support, including cash and clothing benefit, applying for benefit, arranging a bank account, seeking appropriate assistance with underlying problems, budget management and debt rescheduling.
- If a person is placed in a Social Relief facility, compulsory budget management will be a condition of this. The costs of this will be defrayed in the daily fee. Budget management can be purchased by the Social Relief facility from recognised institutions for debt assistance (the NVVK guarantees national coverage with the institutions affiliated with it) and recognised guardians.
- The client will at any rate have disposal over a product range consisting of:
  - ✓ (Preventive) budget management carried out by municipal credit banks/recognised NVVK debt assistance institutions
  - ✓ Debt assistance carried out by municipal credit banks/recognised NVVK debt assistance institutions
  - ✓ Psychosocial support
  - ✓ Protective guardianship
  - ✓ Curatorship
  - ✓ Mandatory drug rehabilitation/addiction care
  - ✓ Stabilisation programme (debt assistance) carried out by municipal credit banks/recognised NVVK debt assistances institutions
  - ✓ Non-monetary support for persons in receipt of unemployment benefit (transferring payment of fixed costs/disbursing weekly expenses)
  - ✓ G4 agreements with district courts concerning WSNP influx.

Where necessary, client managers will be responsible for requesting protective guardianship. Protective guardianship will require permission from the client (if possible) or his family (if permission from the client is not possible) or the Public Prosecutor (if the client cannot and the family cannot or will not give permission). The request for guardianship will be submitted to the court (subdistrict court).

Instrument 11: Wage scheme

Function of the instrument

The instrument reflects the framework within which the cities can deploy wage projects for homeless persons and rough sleepers in the context of reintegration and daily occupation. Via these wage projects, a homeless person can become eligible for an hourly wage for work carried out. If the work complies with relevant fiscal regulations, use may be made of the voluntary scheme for cost reimbursement.

a Legal framework

The WWB/fiscalisation offers the following possibilities to be deployed in wage projects:

- Maximum six-month exemption of 25% of the wage up to a maximum of €165 per month
- An annual, one-off tax-free incentive premium of up to €1,976. Following allocation, may be disbursed in weekly or monthly sums (via budget management)
- Allocation of a tax-free reimbursement of expenses for carrying out voluntary work of €95 per month with a maximum of €764 per year
- Allocation of a tax-free expense allowance for carrying out voluntary work of €150 per month with a maximum of €1,500 per year, provided that this contributes towards obtaining employment [this is new and came into force on 1 January 2006].

b Notes

- 3. If the voluntary work is not part of a rehabilitation programme, €91 of the unemployment benefit up to a maximum of €736 may be exempted (cf. current voluntary workers' remuneration). With a view to introducing more flexibility, the old weekly sum of €21 will be converted into a monthly sum. This offers the target group more leeway.
- 4. If the voluntary work contributes towards obtaining employment, the municipality may exempt the voluntary worker's remuneration. In considering whether to facilitate this within the Work & Social Assistance Act, the discussion surrounding the wage projects played an important role. The Finance Department states that is acceptable for the monthly remuneration to fluctuate a little above the €150, in connection with movements in the work or payment pattern, as long as the general overview is consistent and the annual sum does not exceed €1,500. Therefore some flexibility exists here, too.
- The annual sum of €1,500 converted into monthly is €125. A temporary employee can therefore earn €125 from voluntary work every month. The municipality of Utrecht indicates that this sum corresponds with what an average temporary employee earns on a monthly basis. Most temporary workers do not achieve the €165 per month.
- Besides the above-mentioned measures, programmes aimed at social activation/rehabilitation may be offered to recipients of Work & Social Assistance benefit. For this purpose, resources from the W section can be deployed.

Instrument 12: Model procedure for aftercare following release from detention

Function of the instrument

The instrument should contribute to a seamless transfer from detention by the judicial authorities to the municipalities (in the framework of this Plan for the G4) in such a way that the conditions for social rehabilitation are optimised. This instrument consists of three parts:

- Administrative agreements between Government / G4 in respect of completion of current programmes aimed at solving issues or realising conditions for a good system of complementary aftercare
- Standard operational procedures
- Rules relating to the handling of the domicile issues that Government and G4 will apply.

It should also be noted in a general sense that there may be initial problems to be expected in respect of some parts of the procedure, or a need for a somewhat more gradual transfer and realisation of deadlines than is indicated below. Also, there are relationships with other instruments and the general part of the Plan. The following points are relevant:

- In the task description, it is assumed that the social service employee will be the point of contact. Further task agreements will have to be made within the judiciary between social service employees, the programme supervisors from the prison system and the probation service
- The current co-operation agreement in the framework of the Major Cities Policy between the judiciary and the G4 is restricted to the treatment of persistent offenders, a programme that may not be interfered with lightly. Instrument 12 partly concerns another target group. At operational level, a solution will have to be sought for problems arising in practice. Government and G4 will follow the execution of the realisation/implementation of this instrument with a view to solving unexpected issues adequately
- For the context (the co-operation structure as a whole) in which this instrument will function, we refer to the general part of the Plan and to other instruments, including instrument 2, procedure for an individualised approach
- For tackling the issues involving the Central Judicial Collection Agency, we refer to instrument 10, the model for debt assistance and instrument 4, the model individual programme
- Financial aspects of this instrument are a part of the total organisation and operate along with the estimates for instrument 2, procedure for an individualised approach.

a Definitions/delineation

- Target group: The group of homeless and derelicts, as described in section IA, remaining in detention and on behalf of whom efforts are aimed at rehabilitation.
- Supplementary aftercare: efforts to reintegrate ex-detainees into society, aimed at housing/social support, care, work, training, income/debt rescheduling.

- Aftercare in a judicial framework: aftercare carried out under the responsibility and powers of the judiciary (social services and probation service), in cases where there is a judicial basis[8]
- Aftercare in a municipal framework: aftercare carried out under the responsibility and powers of the municipality, without there being a judicial basis
- Programme plan: the individual programme plan described in instrument 4
- Social Workers: social services employees working within the Penal Institutions (PIs),
- Social Relief Client Manager: the functionary described in instrument 2
- The co-ordination point. The Social Relief co-ordination point described in instrument 2. This co-ordination point also acts as contact and information centre for the social workers. In that capacity it is a co-ordination point for aftercare. The co-ordination point is managed by a field co-ordinator.
- Network contacts: functionaries from various services that supply parts of activities aimed at social rehabilitation (the execution of the individual programme plan)
- CJIB: Central Judicial Collection Agency.

b Administrative agreements

- Co-ordination point. The G4 will ensure that the co-ordination point will be operational as contact point for the judiciary (social workers and/or probation service) by 1 March 2006
- Social Workers. The judiciary will ensure that the 183 FTE social workers appointed from 1 January 2006 will be fully operational from 1 January 2007, at any rate in respect of the present target group and the persistent offenders, so that the standard procedure shown in this instrument can operate fully[9]. As part of the deployment of the social workers, they will have this Plan at their disposal and in particular the parts of it that relate to them, including the Individual Programme model (instrument 4).
- The judiciary and the G4 will develop in consultation a suitable system of information exchange as soon as possible, taking account on the one hand of the electronic client tracking system used by the PIs as well as the national format of information transfer between PI and municipalities in preparation at the judiciary, and on the other hand the client tracking system and the model individual programme used by the municipalities
- The judiciary is considering the possibility of regionalising detention (transferring detainees well before the end of their detention into the PI in the region of the municipality of future domicile). This issue will be put on the agenda for the Strategy Plan administrative progress consultation between Government Social Relief /G4 in March 2006.

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[8] A judicial basis exists where there is preventive imprisonment, an intramural or extramural detention variant, or where special conditions are attached to the framework applying to the client, as imposed by the public prosecutor.

[9] Agreements have been made between the judiciary and the G4 concerning the rehabilitation of persistent offenders. The social relief strategy plan provides for the treatment of derelicts. If the judiciary and G4 wish to make binding agreements in this instrument, both parties will have to give priority to this target group.

c Standard operational procedures

- Each detainee will be linked up with a regular social worker 8 weeks prior to the release date (or upon commencement of detention if the term of detention is shorter than 6 months). The tasks of the social worker are screening, crisis intervention, material assistance, psychosocial support and transfer in four basic areas: identity papers, income, living accommodation and care. Up to the date of release, the social worker will be responsible for the aftercare. The social worker will work in consultation with the host municipality.
- 8 weeks prior to release at the latest (or as soon as possible in cases of shorter terms of detention) the following should be organised:
  - ✓ The social worker establishes in consultation with the detainee concerned and with the municipality concerned which municipality will accommodate the person concerned after the release date. In this, the rules of domicile shown below will apply
  - ✓ The social worker registers the person concerned as timely as possible, but 2 months before the release date at the latest (unless the term of detention is shorter) with the co-ordination point in the relevant municipality if this has not yet been done. (N.B. 24,145 detainees will be released within two months in 2005, representing 55.9 % of the total. The DJI [custodial institutions service] is currently considering what the social workers can do exactly, since in this connection detention can be seen more as a brief hiatus in an ongoing social process)
  - ✓ The co-ordination point determines who will act as client manager for the person concerned following the release date and communicates this to the social worker
  - ✓ The social worker contacts the client manager and obtains his network contacts, (see instrument 2) in the various services if he considers it necessary and reports to them
  - ✓ The social worker creates an individual programme in consultation with the future client manager. This is a shared individual Plan of Approach with as concrete as possible final qualifications and also a timeline for those elements that should be organised before the end of the detention. The dossier has a standard construction. The format for the individual programme is in principle the model as discussed in instrument 4. However, this also depends on the systems in use by the PIs (see also the relevant administrative agreement)
- The social worker engages the aftercare activities issuing from the programme plan in the available period prior to the release date, in interaction with the network contacts, maintaining appropriate registration in the electronic dossier. Insofar as it is considered desirable, he maintains contact with the future client manager
- The social worker transfers the dossier to the co-ordination point in the last week prior to the release date, in consultation with the client manager
- If the detainee has debts, including fines owed, then the social worker contacts the Social Services and the model procedures for debt assistance (instrument 11) are applied, if possible. The fines then form part of the total debt assistance programme.

d Rules of domicile

Assumptions:

- No one should fall between two stools.
- Anyone who leaves a penal institution and has an official address or postal address may register with the relevant municipality.
- Where it concerns members of the target group, the G4 will apply the concept of regional association. That means that anyone who, during the three years prior to the detention can demonstrate that he had his main residence for at least two years in the region of the central municipality concerned, may register and make use of the necessary Social Relief facilities and care. As a rule, the client concerned returns to the municipality he came from.
- The DJI and the G4 assume the principle of 'quid pro quo', meaning that the client concerned may use the facilities offered, provided he co-operates as far as he possibly can on an individual treatment plan that is aimed at enabling him to function to the best of his abilities (with the client manager as 'lifeguard').
- Code of conduct: the DJI and the G4 will not reject any request for co-operation on a solution within the work method described below.

Work method

- The social worker will always contact the co-ordination point of the municipality where the person concerned remained during detention. He will investigate the support plan and be advised by the municipality
- The social worker will aim his activities at a return of the person concerned to the municipality, unless otherwise decided in consultation with the municipality of origin
- If, on reasonable grounds, it is decided to select another municipality for domicile, this will be done in close consultation (social worker, original municipality, new municipality and client involved)
- The municipalities concerned will be responsible for coming to a mutual agreement
- The social worker will, with the co-operation of the municipality of origin, encourage the client concerned to return to the municipality of origin. Where, in exceptional cases, the client can demonstrate that he has reasonable grounds for wishing to relocate to another municipality, the municipalities concerned will try to meet that request, on condition that it represents a positive contribution to the programme
- If no municipality of domicile can reasonably be established, the social worker will consider how a feasible domicile can be determined, based on other criteria. Factors that come into consideration are place of birth and home town of family or other persons with whom the person concerned can be expected to maintain a positive social relationship. Account may also be taken of the place where the person concerned last availed himself of social relief facilities
- After establishing the place of domicile, the host municipality will extend full co-operation to the social worker in order to achieve the terms of the treatment plan. That means: having living accommodation prepared, care and support available, as well as an advance on welfare benefit and agreements on timely organisation of the benefit payment.

Scope

- These agreements apply to the DJI and the G4.
- As soon as the agreements have been confirmed by the administrators, action will be taken to win the central municipalities to this work method.

Instrument 13 Realisation of facilities for long-term accommodation

Function of the instrument

This instrument contains the starting points for (the realisation of) long-term accommodation.

Starting points for long-term accommodation

At the Administrative Conference of 5 September, the G4 requested a new type of provision within the BOPZ [Psychiatric Hospitals (Compulsory Admissions) Act], which offers long-term protected accommodation of chronically drug-addicted persons. The Secretary of State for Health responded that this provision may be realised by AWBZ [General Law on Special Health Costs] funding. Instrument 13 describes the starting points for long-term accommodation.

The present care chain for serious drug addicts is primarily aimed at treating and rehabilitating within a municipal context. The care supply developed in the last thirty years is now very diverse and varies from ambulant care to long-term clinical treatment. For a particular group of drug addicts, the present available range of intervention does not appear to be effective. This group is said to be untreatable and is a cause of much disruption to the environment in practice[10]. It concerns chronically addicted and comorbid patients, who are eligible for admission under the Mental Health Act, and who cannot be maintained in the existing facilities and therefore often end up on the streets again. For this category of patients another approach is necessary, aimed at long-term protected accommodation.

To summarise the starting points of the approach, the current care forms will be exchanged for a supportive accommodation/care/treatment concept within a facility for long-term accommodation, whereby the emphasis is on improving the quality of life. In the short term, the aim of abstinence from drugs and rehabilitation is not the primary aim. For the long term, return to society is a possibility. In order to support the patient with that development, it is important that he builds up relationships and (re)learns skills. That will generally involve long periods of time – more time than the patient will initially allow himself. For that reason, it is considered necessary to use compulsory admission for this group of patients, via the current Judicial Authorisation and the Authorisation for continued stay.

Care providers who request expansion of AWBZ places for the realisation of long-term accommodation should take account of the following points:

- **Target group**: patients suffering from long-term drug addiction and serious psychiatric disturbance, whether or not in combination with physical neglect, largely admitted by the powers of the BOPZ [Mental Health Act]. It concerns both men and women.

[10] By “untreatable” is meant the apparent collective inability of patient and support to realise change for the better. Long-term accommodation is aimed at offering this group of patients prospects of improvement.

- **Care provision/treatment plan**
  The aims of the treatment and admission to facilities are to reduce the danger of further degeneration and to stabilise, and, where possible, to achieve improvement in the psychiatric, social and physical condition without aiming for abstinence from drug use. Rehabilitation will remain in prospect.
  The care provision will contain at least the following parts:
  - diagnosis and establishment of the treatment plan
  - treatment of somatic, addictive, psychiatric and psychosocial problems
  - teaching of social skills
  - development of interests and skills in the area of daily occupation
  - placement in one of the protected forms of institutional living accommodation
  - the opportunity for a varied and purposeful daily occupation.

- **Procedure for placement and release**
  Placement will take place by means of a regional placement procedure. This could take the following form:
  - ✓ When a patient has received a court order, the responsible support provider (or client manager) will register the patient with the municipal Placement Committee for long-term accommodation (to be set up for this purpose).
  - ✓ Following registration, the Placement Committee will assess the seriousness of the patient's situation and decide whether or not on placement in long-term accommodation. This decision is binding.
  - ✓ To extend the stay in long-term accommodation, the institution will request an Authorisation for continued stay.
  - ✓ A patient will be released from long-term accommodation in keeping with the guidelines on conditional release, which are developed by GGZ [Mental Healthcare] Netherlands. A patient will only be released if he is registered well in advance of release (e.g. 2 months) with the local client manager and Placement Committee, if the latter has been able to design an adequate aftercare programme and is therefore in agreement with the release. If necessary, release may take place based on a provisional authorisation.

- **Location and premises**
  Nationally located facilities where the patients are admitted forcibly, or a facility within the patient's own municipal care chain where long-term accommodation exists as an integral part of the municipal OGGZ [Public Mental Healthcare] /care chain.

III Overview of the tables included in the Plan

1. Tables 1a and 1b Overview of target group and
2. Tables 2a to 2d Operational aims for execution of the Plan

IV Other information and background items

1. Report of the Administrative Conference on Social Relief 5/9/2005
2. Function-orientated care assessment form
3. Social Relief Manual for Data Exchange
4. Model Individual Programme