Role of the living group in treatment

Qualitative research into the coordination between individual treatment and treatment in the living group in a forensic setting

Wendy Buysse, Arjun Swami-Persaud, Daniël Hofstra, Marga van Aalst and Bianca Szytniewski

Contact information

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Wendy Buysse

wbuysse@dsp-groep.nl

06-24384734

Marga van Aalst

mvanaalst@dsp-groep.nl

06-15081010

Daniël Hofstra

dhofstra@dsp-groep.nl

06-16799438

Arjun Swami-Persaud

aswamipersaud@dsp-groep.nl

06-15076076

Bianca Szytniewski

bszytniewski@dsp-groep.nl

06-48068306

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Treatment in forensic institutions

Young people and adults who come into contact with the judiciary, who receive a custodial sentence or measure and who have a psychiatric disorder or psychological problems are placed in a forensic institution. Adults can be admitted to a forensic care institution as part of their punishment. Young people stay in juvenile detention centres (JJIs), where they live among young people who came into contact with the judiciary but have no psychological problems or psychiatric disorders. Only 15% of young people in a JJI stay longer than three months. For adults in forensic care institutions, the length of stay depends on the forensic title on the basis of which they are placed in the institutions. In both types of institutions, offenders receive treatment. As part of the treatment they spend a great deal of their time in a living group. Every offender has a treatment plan in which the goals and the interventions, therapies and activities to achieve those goals, are laid down. The treatment takes place in the living group, and also outside the living group - individually or in groups. Both within the JJIs and in adult forensic care institutions, treatment is aimed at reducing the risk of recidivism and preparing offenders for their return to society. The work and living climate must enable proper treatment and supervision.

Reason for this research

A great deal of knowledge is available about the influence of the work and living climate of a living group on the development and treatment of offenders. However, there are still gaps in knowledge in both the JJIs and adult forensic care institutions about how, in practice, the living group and the treatment in that living group fit in with the individual treatment goals of the offender. The Quality Forensic Care Program (KFZ) and the Department of Correctional Institutions (DJI) of the Ministry of Justice and Security (JenV) found that there was insufficient insight into the vision of institutions and professionals on the relationship between individual treatment and treatment in the living group. What do the professionals involved think of the role of the living group and what are the desired roles / responsibilities of the employees in the living groups, and of the individual practitioners and therapists? What opportunities for improvement do they see for the coordination between individual treatment and treatment in the living group?

DSP-groep conducted a qualitative study between 1 July 2018 and 1 July 2019 on behalf of the Scientific Research and Documentation Centre (WODC) of the Ministry of JenV on how the individual treatment of persons in JJIs and forensic care institutions for adults in practice relates to the treatment in the living group.

Research questions

The aim of this research is to provide insight into the purpose, role and position of the living group as part of the treatment of offenders. Based on this, we formulate improvement opportunities for coordination between the living group and the individual treatment.
The following main questions are central to this research:

- What is the vision of DJI and forensic institutions on the role of the living group in the individual treatment, and the coordination between the individual treatment and treatment in the living group?
- How is the role of the living group and the relationship between the individual treatment and treatment in the living group fulfilled in practice?
- How does the reality in the various institutions relate to the vision of DJI and / or the institutions? What are similarities and differences?

Approach

The research was conducted in three phases. The first phase consisted of an exploration of the theory (vision) through interviews with the head of treatment of the three JJIs and seven adult forensic care institutions, a group interview with three representatives of DJI and the Forensic Care Service, a document analysis and a literature review. Based on the first phase, an analysis framework has been drawn up with five effective elements that influence the link between individual treatment and treatment in the living group.

The second phase consisted of an in-depth investigation into one living group in six institutions (three JJIs, a forensic psychiatric centre, a forensic psychiatric clinic and a forensic psychiatric department). The research consisted of interviews with the forensic practitioner, the manager of the living group and the group workers, observations of coordination moments and situations in the living group, file research and three case studies. For each case, interviews were held with the offender, the mentor, the forensic practitioner and, when possible, other practitioners involved. In addition, the treatment plan has been analysed. A description has been made per institution and per case.

In the third phase we analysed the six institutions and the three cases per institution in which we compared vision and practice. In the analysis we looked at how, in practice, the preconditions for and the effective elements in the analysis framework are given substance. We mainly looked for examples in which the preconditions are met, and then how the active element works in practice.

Conclusions and areas for improvement

All JJIs work with the same basic methodology YOUTURN. In this method, the living group is a valuable part of the treatment. Offenders can practice skills in the living group and their behavior is observed. The living group also provides structure and feedback opportunities. Depending on the nature and seriousness of the offender's problems, additions or adjustments to the basic methodology are made.

Within forensic care institutions there is not a basic methodology for all institutions. Institutions choose the methodology that fits the problem of the target group. There are different views on the deployment of the living group in individual treatment and the extent to which that deployment is possible.

We conclude that the professionals in practice - even if there is a less clear-cut vision of the role of the living group - do have a similar picture about the role of the living group in the treatment of offenders. The practical implementation works well to a greater or lesser extent, both at the level of the living group and at the level of the cases in this study. In both the JJIs and the forensic care institutions in this study we see five roles of the living group in practice:
1 practice skills from individual treatment;
2 simulating daily life and society;
3 observation of behaviour;
4 actively use group dynamics for advice and feedback; and
5 provide structure and stabilize.

In the JJIs and in the forensic care institutions in this study, the Risk-Need-Responsivity (RNR) model forms the basis for organizing the treatment of offenders. Based on this model and the interviews with the heads of treatment, five effective elements with accompanying preconditions have been formulated for good coordination between individual treatment and treatment in the living group:
1 need principle;
2 responsivity principle;
3 good information transfer;
4 knowledge and expertise of the treatment team; and
5 transfer and generalization.

Based on the in-depth research, we conclude that the five effective elements with corresponding preconditions are put into practice. The extent to which the preconditions, and consequently the active element, have been worked out differs per active element between institutions and also between cases within institutions.

In practice, the preconditions for the requirement principle are largely met in the JJIs and forensic institutions. The treatment plan includes goals to reduce the dynamic criminogenic risk factors and - albeit to a lesser extent - to reinforce protective factors (requirement principle). If the goals are known to the offenders and the treatment team and translated into concrete interventions, therapies and approaches (individually and on the group), then we see more coordination in practice between individual treatment and treatment in the living group. The translation of the treatment goals into practical actions in the living group does not happen in all cases.
In order to give substance to the responsivity principle, the JJIs on the one hand adjust the basic methodology to the learning style, motivation and cognitive skills of a specific target group (for example, offenders with a mild intellectual disability (Lvb)) and, on the other hand, provide tailor made solutions within the basic methodology. Components of the methodology are adapted to the offender (for example, exemption from participation in group activities). In forensic institutions mostly custom-made solutions are

provided. There is less of a basic methodology that has been adapted for a specific target group. For each offender the institution looks at what is needed to achieve the treatment objectives. If these preconditions are worked out properly and the responsiveness principle is also met, then we will see more coordination.

Good information transfer consists of planned and unplanned systematic information exchange moments between disciplines. A lot of consultation takes place between the different disciplines involved in the treatment, both planned and unplanned. Planned information transfer mainly plays a role for coordination of the broad outlines. In practice, however, systematic unplanned information transfer about daily-to-day life is the means to coordinate individual treatment and treatment in the living group. This only works well if the information transfer also establishes a connection with the individual goals. The extent to which this happens in practice differs per institution and per case. Within the JJIs, unplanned information transfer is facilitated more than in forensic care because there are more "natural" transfer moments. Information transfer between group leaders and external professionals is a bottleneck in some institutions. The mentor plays an important role in both the JJIs and the forensic institutions in the connection between individual treatment and treatment in the living group.

For proper coordination, the treatment team must have specific knowledge and expertise. More coordination takes place if:

- there is a supported vision of the role of the living group and the responsibilities;
- there is a stable team with (theoretical) knowledge of both the problems and the methods from the individual treatment;
- the team has specific professional competences;
- the team can apply the techniques in the living group.

The JJIs of this study provided more internal training and supervision on the methodology and the application of the methodology in the living group. Methodical meetings are mentioned in the forensic care institutions or they are in the pipeline. A methodology discussion is a good setting for coordination about the role of the living group in treatment. In the methodology discussion, improvement of expertise and supervision of the methodology take place. In this study it has not become clear how and to what extent the improvement of expertise takes place in those methodology discussions.

Finally, good coordination between individual treatment and treatment in the living group ensures transfer and generalization between individual treatment and treatment in the living group. The use of the same techniques and planned and unplanned practice moments is a precondition for this. The extent to which this happens differs between institutions and cases, as well as the extent to which this is dealt with in supervision. This is not about transfer and generalization to daily life outside the institution, but about the transfer and generalization of individual treatment to treatment in the living group.
Based on the findings, we have formulated the following improvement options for better coordination between treatment in the living group and individual treatment:

- Make a shared vision of the role of the living group in the individual treatment part of methodology discussions or peer review / supervision within the institution.
- Improve expertise in translating criminogenic and protective factors from risk assessments to treatment goals.
- Improve expertise in translating "abstract" treatment goals into practical goals and actions in the living group.
- Ensure a shared picture of the treatment goals and treatment plan for offenders and the treatment team.
- Facilitate and encourage unplanned information transfer by ensuring that the institution has "organization time".
- Link individual treatment goals to planned and / or unplanned practice moments in the living group.
- Ensure clarity about which information may or may not be exchanged between professionals.
- Improve the form and content of internal expertise improvement to better the coordination between individual treatment and treatment in the living group.
- Look for solutions to cope with the large staff turnover.
- Further research into the added value of a basic methodology versus customization is required.

All in all, we conclude that for proper coordination between individual treatment and treatment in the living group, it is important that the institution and the treatment team of a specific living group realize the importance and role of the living group. It is important that this is worked out on paper and that it is known to all professionals involved in the treatment. And that those professionals act accordingly. Some improvement are, to a greater or lesser extent, beneficial to all institutions. The options for improvement mentioned above should ensure that the unplanned daily transfer of information is given sufficient time, so that individual treatment and treatment in the living group form an integral whole.

DSP-groep BV
Van Diemenstraat 410
1013 CR Amsterdam
+31 (0)20 625 75 37

dsp@dsp-groep.nl
KvK 33176766
www.dsp-groep.nl

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