Significant
Thorbeckelaan 91
3771 ED Barneveld
+31 342 40 52 40

Ch. Comm. 3908 1506
info@significant.nl
www.significant.nl

Preliminary study of record-keeping in the TBS sector

WODC (Research and Documentation Centre), Ministry of Security and Justice
Barneveld, 10 July 2015
Reference: AW/bv/14.258
Author(s): Wouter Jongebreur, Jan Reitsma and Annemarijn Walberg

Summary

Background and Motivation

01 In 2011, a study was carried out for WODC (the Research and Documentation Centre at the Ministry of Security and Justice) into the execution of TBS orders (Van Nieuwenhuizen *et al.*, 2011)[1]. TBS, an abbreviation of *terbeschikkingstelling,* refers to detention under a hospital order. The main aim of the 2011 study was to provide information on how the execution of TBS orders takes shape in practice and to determine to what extent the findings of academic research are being applied in the treatment of forensic patients. In the course of this study, it became clear that some information on forensic patients was either unavailable or difficult to obtain. This study prompted the State Secretary for Security and Justice (hereinafter the 'State Secretary') to ask the clinics to make sure that their patient files were more accurate (see Dutch Parliament, Lower House 2011-2012, 29452, no. 144). In 2013, the State Secretary announced that there would be a follow-up study into the recording of information and compilation of files in the clinics.

02 WODC wanted to avoid a large-scale study being set up only to discover that shortcomings in the recording of information meant that the research questions could not be answered. WODC therefore asked Significant to perform a preliminary investigation first. The aim of this investigation was to assess whether the recording and accessibility of data on forensic patients and their treatment in the clinics are of sufficient quality to enable a new study of the execution of TBS orders to be started.

Approach for the Preliminary Study

03 In this preliminary study, record-keeping was examined by means of a questionnaire sent to the clinics. Additional information was obtained from phone interviews, and a meeting was held at the end. Following consultation with the supervisory committee, the study by Van Nieuwenhuizen *et al.* was used as a point of reference for the aspects to be focused on in the investigation of the files. That questionnaire from 2011 contains the aspects relating to forensic patients (including a specification of categories) for the investigation of the files. The current preliminary study was geared to forming an initial general impression of record-keeping before any actual examination of the files.

04 The following activities were performed in this preliminary study:

a. An interview was held with Ms Chijs van Nieuwenhuizen to discuss the objectives and findings from the previous study.
b. An overview was drawn up of topics that were investigated in the files in 2011 and the extent to which information on these topics was recorded by the clinics.
c. We sent the list of aspects to be studied in the investigation of the files to all the clinics by e-mail. We also asked the clinics to state for each topic whether information on individual patients was recorded and if so, whether this was done systematically. We also asked whether the topic was a need-to-know

[1] C. van Nieuwenhuizen, S. Bogaerts, E.A.W. de Ruijter, I.L. Bongers, M. Coppens, R.A.A.C. Meijers (2011). *TBS-behandeling geprofileerd. Een gestructureerde casussenanalyse*. [Profile of TBS treatments. A structured case analysis] The Hague: WODC, Ministry of Security and Justice.

or nice-to-know topic and for what purpose the information was being recorded. The clinics filled in and returned the document to us, after which we conducted a phone interview to discuss the list and ask more in-depth questions. The focus was on topics that were not always being recorded or not being recorded at all. The following aspects in the implementation of this approach are relevant to the interpretation of the results:

i. Nine of the eleven clinics filled in the questionnaire and an interview was held with each of these nine clinics.
ii. It turned out that the clinics found the questionnaire lengthy and time-consuming to complete; they were therefore selective in what they chose to answer in order to keep the task manageable.
iii. In the phone interviews, the focus was on the topics that stood out, in particular the items that were being recorded either not at all or only to a limited degree.
iv. Based on the clinics' answers, we drew up a classification per section of the record-keeping, the extent to which information is recorded systematically and the clinic's opinion of whether that aspect is nice-to-know or need-to-know information.

d. We studied one file in two of the clinics to get an idea of how files are put together and the practical feasibility of an investigation of the files.
e. We carried out an analysis and synthesis of the data that we had collected.
f. We held a group meeting with experts in which we checked the key findings. The participants also discussed what information is need-to-know information and for what purposes. Building on this, they also discussed wishes for further improvements from the perspective of actual practice.

Findings

Record-keeping

05 The survey gave an initial impression of record-keeping at present in the clinics. In general, the clinics say that they record information on most of the topics and that this is need-to-know information. The current approach to record-keeping satisfies the clinics' requirements from the point of view of individual treatment. However, there are differences in how information is recorded, and this is not always in line with the formulation of the questions and the categories used in the 2011 questionnaire. In practice, uniform definitions and record-keeping methods are lacking for many parts of that questionnaire. Much of the information is recorded as free-format text and is fragmented across various parts of the file.

06 This way of recording information is often inadequate for purposes that extend beyond the treatment of the individual patient within the clinic (such as transfers between clinics, generating management information that could allow internal quality improvements and for purposes that are important to external parties). This information is not easy to access, as information is often not recorded systematically and traceably. Consequently the options are limited for analysis and the production of information that transcends the level of the individual patient file. Current record-keeping methods also turn out to be inadequate for academic research purposes (which was what this preliminary study was all about).

07 Not all information is recorded in patient files as some aspects are applicable at a level above that of the individual patient. Some clinics do record this information in other sources, for example in department

descriptions or in policy documents. A few clinics stated explicitly that they did not record such information although they did consider this to be desirable. This concerns the following aspects:

a. Security objectives
b. Implementation of the treatment on offer
c. Milieu therapy/sociotherapy
d. Treatment climate
e. Communal living group
f. Problems

08 Some of the aspects are either only recorded by some of the clinics or are not recorded systematically in line with the questionnaire. Broadly speaking, this concerns the following aspects:

a. The stage in the execution of the TBS order
b. The formal context
c. The 'what works' responsivity principle
d. The use of care programmes

The Assessment

09 The survey also gives a picture of the status of file creation for follow-up research. The clinics' record-keeping as described above is not geared to research purposes. Researchers would probably need to apply their own interpretation of the data in order to arrive at scores for the files with regard to the questions and categories used in 2011.

10 When the study was carried out in 2011, limitations were observed in the files in a number of areas. The results of the current survey suggest that these limitations still apply to a large extent. Broadly speaking, these limitations from a research perspective concern:

a. The treatment stage
b. The treatment
c. Milieu therapy/sociotherapy
d. Problems

11 Little has changed in the nature of the information being recorded. However, there are various parallel developments that are related to the recording of information and creation of files, for example the TBS primary process assessment framework [*Toetsingskader Primair Proces TBS*], the national database for TBS risk assessments [*Landelijke Databank Risicotaxaties-tbs*], Routine Outcome Monitoring, and the core set of performance indicators for forensic psychiatry [*Kernset prestatie-indicatoren Forensische Psychiatrie*]. The effects of these developments were not measured directly in this study and there is as yet only limited evidence. However, these developments and the agreements made in that context on recording, generating and providing information do offer hope for the future.

12 The participants in the group meeting did see the benefit from and need for further improvement with regard to some of the topics that are not currently being recorded in a systematic and uniform manner[2]. This list could be the start of a 'Top X' for further improvement. The participants in the group meeting also mentioned topics that were not included in the current study but *were* topics where further improvement would be advisable.

13 An initial suggestion for the Top X consists of:

a. Topics that emerged as eligible in the study:
    i. Treatment (objectives and evaluation)
    ii. The treatments that are on offer
    iii. Setup for milieu therapy/sociotherapy
    iv. The 'what works' principles
b. Desired additions to the existing questionnaire:
    i. Quality of the therapeutic relationship
    ii. Somatic screening
    iii. Timely contact after patient is discharged from the clinic

14 It became clear in the meeting that there was a strong and widely felt need for a chronological overview (‘route map’) of the patient's treatment: when did the treatment start, what treatment modules were deployed, what was the result, what was the treatment setting, and so forth. This route map could be a record both of what has taken place and of the plans for the future. The route map could also include information about the outcomes of risk assessments and possibly the stage in the treatment, execution of the order, and leave. The route map would have added value, both internally and externally (in assessing leave requests and in transfers to another clinic).

Follow-up Options

15 At present it seems likely that any new investigation of files would produce similar results to the 2011 study. The insights and conclusions from such a study would also probably not be any different to those already obtained from this preliminary survey. The effort and interpretation required to obtain the information, which is not being recorded with research goals in mind, are such that the practical options for an investigation of files for research purposes are limited.

16 Options for further improving record-keeping were identified in the study. Broadly speaking, they involve the following steps:

a. Obtain a picture of how the various developments, such as the TBS primary process assessment framework, the national database for TBS risk assessments, Routine Outcome Monitoring, and the core set of performance indicators for forensic psychiatry, are related to one another and determine which topics for further improvement require additional action.
b. The Ministry of Security and Justice and the council of treatment directors within the TBS sector (*Landelijk Beraad Hoogst Inhoudelijk Verantwoordelijken*, LBHIV) should make clear agreements on

[2] It was acknowledged that the other topics were not being recorded in a uniform manner but further improvement was not seen to be a priority.

further improvements to record-keeping based on the Van Nieuwenhuizen questionnaire and the outcomes of the current study.

c. The details of the further improvements can be fleshed out based on a priority list that has the backing of the clinics. It is however important to make sure that the shape that further improvements take is in line with existing agreements and ongoing initiatives. One suggestion is to start by working out the specifics of the 'route map', given that all those involved see definite added value in this initiative.