

Summary

English title:

In. Focus. Out.

An evaluation of 'care conferences' for long-term residents (15+ years) in forensic mental health care

The treatment trajectory of many patients in high security forensic mental health settings in the Netherlands – having received a TBS-entrustment-order – encounters delays or impasses. For quite a number of patients this results in long-term residency. Almost ten years ago, the focus was directed to a group of patients that remained in the system for more than 15 years (242 then, now almost a hundred more). It was remarkable that most of these patients (about 150) did not officially have the Long-term Forensic Psychiatric Care (LFPZ) status, which means that they stay in separate wards in which they no longer receive extensive treatment aimed at reintegration in society. To keep this group in focus the Ministry of Justice and Safety started the Project 15-plus in 2017, which in practice meant that these patients would be discussed in so called ‘care conferences’. Care conferences originated in practice as a meeting structure (and later received that name), in which an individual patient is discussed as a case conference with relevant stakeholders. In the care conference of the project, a large multidisciplinary group of people is involved in developing a plan for the next step in the treatment, often through thinking out-of-the-box. In the field of forensic mental health care the care conferences are already known and held in high regard, even though to date

the instrument had not yet been scientifically studied or evaluated.

The aim of this study is therefore to evaluate the care conferences held as part of the Project 15-plus, and considered a promising solution to the perceived problem of long-term residents in the TBS-system. Both in terms of content and methodology, the study consists of four parts. First, we examined the characteristics of current long-term residents by means of file research. We compared their characteristics with characteristics of a comparable group from 2013 and examined to what extent the characteristics of this 15+ group have changed. In addition, an in-group comparison was made between the 15-plus patients with and without the official LFPZ-status. We also investigated which characteristics – of both the person and the care conference – are related to the outcome of the care conference meeting. Secondly, we researched through interviews how conferences are valued and evaluated by the parties involved and how the outcomes of the care conferences are handled. Thirdly, we did comparative research with Canada, England and Germany by means of literature and online interviews with foreign experts, to look for similar practices in comparable contexts, to possibly profit from relevant foreign insights. Finally, we investigated possible policy implications of the findings, as requested especially for the aim of early identification of

cases that might profit from case conferences to tackle early treatment impasses. Within this last part of the research, through a focus group and expert meeting, we also looked at how the effectiveness of the care conferences could be further improved. In those meetings we also assessed to what recommendations the results of the earlier parts of the study could lead.

The four main questions (A to D) of this evaluation study are formulated as follows:

A. Characteristics of the target group and – the outcomes of – the care conferences
What are characteristics of current long-term residents compared to those from 2013 and which characteristics of both person and care conference are related to the outcome of the meeting?

B. Evaluation of the implementation – and the outcomes – of care conferences
How are the meetings valued and evaluated by the parties involved and how are the outcomes of the care conferences handled?

C. Comparison with relevant foreign insights and practices
Is there something comparable to a care conference abroad and what is known about its functioning?

D. Potential policy implications of the findings for **early identification**

To what extent can the results of this study be used for early identification of (sub-populations of) patients in early treatment impasses who could (or may not) benefit from a care conference (or other policy intervention)?

To answer the main questions, sub-questions were formulated in order to include all relevant aspects of the main questions in the results of this study.

A

To answer part A, we analyzed 100 files of long-term (15+) residents in the TBS-system. We focused on the following five sub-questions:

❓ **What are the most important demographic, diagnostic, judicial and treatment characteristics of the TBS patients who received a 15+ care conference?**

If we look at the characteristics of the long-term residents, we can conclude that the TBS patients in this research population (15+ with

care conference) form a heterogeneous group. On average, they are mostly men with Dutch nationality of around 55 years of age, who were convicted for the first time around the age of 20, and were educated to a lower school level. They often suffer from (often comorbid) addiction disorders (in remission) (70%), personality disorders (70%), psychotic problems (41%) and more than a quarter of the long-term TBS patients have an intellectual disability. In 42% of the cases, a sexual offense was (partly) the reason for the TBS order. More than half of the TBS patients have been in 4 to 6 clinics while touring the system. About a third are on supervised leave.

❓ **In which of the above characteristics does the LFPZ group differ from the other 15+ group?**

We can conclude that the differences between 15+ patients in the LFPZ and non-LFPZ are small. The group of 15+ patients in the LFPZ is older than the group that is not in the LFPZ, they have been in detention for longer and their age at the time of the first conviction is also somewhat higher. The groups do not differ significantly from each other on any other characteristic, so that the groups are strikingly similar.

❓ **How do these characteristics relate to the characteristics of the groups established by Lammers et al. (2014)?**

Compared to the group in 2013, there seem to be no major changes in the populations. If we compare the groups (LFPZ and non-LFPZ) with characteristics that these groups exhibited in 2013, little seems to have changed (for example, in terms of ages, percentages of sexual offences, TBS duration and incidents). It is likely that differences found in diagnostic categories are best explained by methodological differences with the study of Lammers et al.

❓ **What are the characteristics of care conferences, what are the bottlenecks identified in the care conferences in the progress of treatment and can these be related to certain types of patients?**

If we look at the character of the care conference, we generally see that the patient, the lawyer, the ministry, and a representative of the own and another clinic are present, complemented with relevant parties in the case at stake. In general, a wide range of bottlenecks gives rise to a care conference (apart from the 15+ years as direct reason). The most common bottleneck identified for a conference is the lack

of an effective treatment. We see this significantly more often in long-term residents in the LFPZ. In the non-LFPZ group we see 'Relapse, incidents, transgressive and disruptive behavior' significantly more often as an identified bottleneck.

❓ What types of advice have emerged from the care conferences, and to what extent have they been adhered?

If we look at the outcomes of care conferences, we see that they more often result in concrete advice than in advice for an investigation. Substantively, advice for a new type of treatment is most often the result of a conference, followed by advice for a transfer to a follow-up facility. The advice not to transfer, for example because someone is in the right place, is in a quarter of the cases the outcome of the care conference. The reported adherence, in terms of carrying out the advice, is high. However, it cannot be established to what extent this also means that a true next step is being realized (among other reasons because investigating a possible next step with a negative outcome still counts as adherence to the advice).

❓ How do the above characteristics and subgroups relate to the outcomes of care conferences?

In conclusion, and looking at how the characteristics of the group relate to the outcomes, there is not a particular group with certain outcomes. We see that patients with intellectual disability are more likely to have the advice of reconsidering diagnostics. Patients with psychotic disorders are more likely to have the advice 'no change', while patients with personality disorders are less likely to have this outcome. Remarkably enough there are no clear associations between the type of bottleneck and the type of advice. This fact suggests that each patient needs unique and tailor-made advice for progress.

B

To answer part B, we conducted an interview study in order to map the appreciation of those involved. We collected data from 55 semistructured interviews with people who are (or have been) involved in care conferences with long-term TBS patients. We interviewed 9 different types of parties involved: organizers from the

Ministry and DJI/DIZ, forensic evaluators, probation officers, judges, lawyers, public prosecutors, practitioners from the clinics and patients.

We focused on the following five sub-questions:

❓ What is the background of the 15+ care conferences, how are they set up and organized, and what are the goals?

The background of the Project 15-plus lies in noticing, focusing on and mapping out long-term residents in the TBS-system with the main aim of arriving at more appropriate and responsible follow-up processes, which can also be the aim of individual care conferences. Currently, representatives of the Ministry (also as chairs of the meeting), the clinic and the lawyer are considered as possible initiators or applicants for a conference. A care conference usually lasts two hours, with the patient being present in the first hour. Other attendees are parties involved in the process, or parties that have played a role in the treatment, or are experts with regard to the specific problem at hand. The means that form part of the care conferences – the common goal ownership and out-of-the-box thinking – have gradually become (procedural) goals themselves. Especially from the side of lawyers,

the care conference is also seen as a possible test of the course of the clinic, precisely because the legal position of the patients offers very few options in that regard.

❓ To what extent, according to the parties involved, are the goals being achieved, and what are the effective elements of the care conference?

We can conclude that respondents unanimously believe that, also in a financial sense, the benefits of care conferences far outweigh the costs. Looking at goals, mapping of the target group has been achieved. Both the conferences and the study at hand have provided a picture of the current characteristics and bottlenecks. As along the way also the outcome of remaining in the current facility is counted as 'appropriate follow-up', also this goal is easily achieved, although this does not mean that a next step in the trajectory is being taken. The project has given the Ministry a good overview of the possibilities and impossibilities in the field. In this way, the ministry can somewhat steer the development of follow-up facilities of which there is a shortage. Respondents are under the impression that in general follow-up processes are often found through care conferencing.

The so-called 'perspective taking' has been found as a positive case-transcending effect. This means that by placing all those involved in one room during the conference, people are given the opportunity to look at the case from each other's perspective (transformative learning). This creates more knowledge of each other's efforts and a greater understanding of the dilemmas experienced in different positions. The Ministry, the field and the patient are literally given 'a face' vis-à-vis each other as a result of this project. The 'face' of the patient is considered as valuable by the Ministry in decision-making processes with regard to the patient at hand, which is otherwise only done on paper. The fact that the parties involved factually come together in this way helps enormously for mutual relationships and for insight into what others have to offer in terms of care (expertise). At the case level, this is reflected in the goal of communality. All parties, including the patient, feel heard during a care conference and seem to share a common goal. The other procedural goal of thinking out-of-the-box is also regarded by many as an effective element. The tailored approach, the informal and 'fluid' character of the meetings – based on consent – are also mentioned in this regard, as well as

the 'overriding authority' of the Ministry which is sometimes able to break through formal barriers.

❓ How do the parties involved value the care conferences, what is the possible added value of care conferences compared to other instruments?

The instrument of the care conferences is much appreciated and they are an addition to the existing set of instruments for assessing treatment duration – and progress and resolving impasses. Due to its success, the demand for care conferences is so great that the supply cannot be met within the desired time frame. Due to these capacity problems, the effectiveness may decrease.

A disadvantage of care conferences compared to existing instruments is the time investment for all participants. But it is precisely the setting of a care conference that renders advices or agreements more status in comparison to other structures of deliberation. The fact that the conference can extensively address the contents of the treatment is an advantage over formal instruments regarding the duration of the TBS-order, like the periodic judicial review. According to some, the care conferences should

be regarded more as a last resort, in case subsidiary instruments do not offer a solution.

❓ Which points for improvement are there according to the parties involved?

Points for improvement are primarily related to the lack of capacity to organize care conferences. Everyone is positive about expanding the capacity (of Ministry personnel) to this end. Because most of those involved would like to safeguard the instrument, for many this is also an argument for embedding it in law or policy, which is at the moment not the case. Otherwise, the instrument may be too vulnerable in a future budget cuts. Certainly the legal profession is pressing for a (stronger) legal position for the patient in such a regulation, because that would be appropriate with regard to such an important instrument for treatment progress. Some clinic representatives however fear that such juridification may jeopardize the beneficial communal character of the care conferences.

❓ What broader application possibilities of care conferences do the parties see?

Broader application possibilities lie primarily in being able to request care conferences for a broader target group (than 15+ patients), as has

already become a common practice. Such case identification would therefore be based more on the basis of customization, for example in the event of a real impasse (long) before the term of 15 years is reached. In addition however, especially lawyers propagate to keep some kind of categorical indication. Possible categorical indicators for a care conference are a certain number of transfers, exceeding a term before reaching a leave status (as agreed by parties in the field), lack of agreement between the clinic and independent evaluators, et cetera. For a categorical line based on the treatment duration especially lawyers suggest to link up with the every four-year requirement of independent evaluation, for example from 8 years onward. Broader applications among target groups other than TBS patients with a long length of stay are also mentioned. For example, in patients with a maximize TBS-order (of four years imposed for a non-violent offence) or in illegal aliens within the TBS system. Potential expansion must be accurately weighed against the ongoing capacity shortages.

C

To answer part C, we conducted comparative research and collected foreign insights. We conducted interviews with experts from the respective countries in addition to a literature search. In this section, we focused on the following two sub-questions:

❓ Are there comparable practices to care conferences in Canada, England and Germany?

In Canada, England and Germany, we first looked for similar contexts as the TBS-order. As the TBS-system, both for diminished and non-responsible offenders, is somewhat in between the penitentiary and (forensic) mental health circuit, we defined such a context as: a framework of deprivation of liberty of indeterminate duration in the penitentiary or (forensic) mental health circuit. As in these contexts the contents of the execution of the legal framework impacts the eventual length of stay, comparable informal instruments could exist. The fact that we did not find such practices in Germany may be explained by the fact that the formal decision making process related to the duration of the deprivation of liberty is

focused more on proportionality and provides more possibilities for testing the contents of the execution of such frameworks. In the Canadian and English context however, somewhat comparable practices can be found. In the Canadian (forensic) mental health care circuit 'pre-hearings' (before the review board), and in the English penitentiary circuit 'case conferences' (before the parole board), were considered somewhat comparable practices. However, different from the Dutch conferences, these are generally initiated and also chaired by the multi-disciplinary bodies that formally decide on the duration of the detention.

❓ If so, how do they function and what can we learn from them for the Dutch situation?

Primarily the following findings from the comparative international research are relevant for the Dutch context and are taken into account for the recommendations:

- linking the care conference – for example in terms of timing – to official decisions, for example about prolongation of the TBS-order or (continuation of) LFPZ placement,

- formalizing the care conferences in law or policy (and to what extent),
- also considering the prolongation court as the initiator of a care conference,
- in addition to customization, also maintaining categorical tests on long-term residency,
- giving judicial authorities more authority over the execution of the TBS-order and, the longer the custodial measure lasts, to test it more rigorously,
- taking into account the role of budget and political influence as a brake on the legal position (of the long-term resident),
- promote a (regional) consultation structure between the parties (and facilities) involved.

D

To answer part D, we gathered knowledge about policy implications and early identification of cases by means of a focus group and expert meeting. The aims of these were also to discuss the findings of the study to come to recommendations which can be supported by the parties involved.

In this section, we focused on the following two sub-questions:

❓ Does the interpretation of the results of the components (A, B, C) in an expert meeting show that it would be possible to design a substantive 'TBS monitoring system', in which legal, diagnostic, treatment and risk parameters are included?

Mainly due to the limitations of the file study, the results from this study insufficiently support the possibility of designing a monitoring system for all TBS-patients. First of all, due to the impossibility of performing comparative analyzes with data from groups leaving the TBS more swiftly. Secondly, because of the inability to use risk assessment data, the continued monitoring of which is viewed by the experts to be the most solid scientific fundament for a monitoring system. However, also based on a history of failed attempts, reservations should be made when creating a monitoring system in general and for the purpose of early identification in particular. There are many practical, methodological, legal (privacy) and ethical objections, including the danger of misuse of such data for financial consequences of clinics.

❓ **Does the interpretation of the results of the components (A, B, C) in an expert meeting show that it would be possible to identify specific (sub)groups of TBS-patients, for which (early) intervention policies could be created, like care conferences?**

In relation to this question a similar disclaimer, with regard to the limitations of the study, should be issued as in the former question. To the end of early identification, a monitoring system of all TBS-patients is considered a disproportionate means. Possibly, a better registration of relevant information of case conferences held, and the trajectories of the patients at hand, by the Ministry itself could help for early identification in the future. For example indicators, such as a certain number of transfers, could be used for identifying utility and necessity of a care conference.

This research has resulted in four recommendations both for policy and (follow-up) research and monitoring. Recommendations for policy are: firstly, increasing the (personnel) capacity at the Ministry for care conferences, as well as the range of tasks to include case selection, preparation, reporting (and monitoring) and guaran-

teeing the follow-up; secondly, maintaining a combination of customization on request and categorical criteria independent of the request for the case selection of care conferences (in which the categorical criteria should then be regarded as 'yes, unless' indications); thirdly, safeguarding/embedding the care conferences in law or policy after a reorientation of all possible instruments to question the method of execution of the TBS-order and to problematize the lack of progress; and finally, organizing the case-transcending effects in other ways than via care conferences.

Recommendations for future research and monitoring are: firstly, supplementing the current study in order to overcome its limitations, especially with a follow-up, and possibly comparison groups of short-term residents (either or not based on risk assessment data); secondly, supplementing such a quantitative study with qualitative research into explanations for successful case conferences and treatment progress; thirdly, not implementing a monitoring system for all TBS-patients to the end of early identification in this context; and finally, supporting a possible monitoring function in this context of the involved Ministry personnel with

a standard form for the reporting of care conferences, in which relevant data is included.