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Process evaluation study of observation units in Teylingereind [Procesevaluatie Observatieafdelingen Teylingereind].
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Summary

This is the report on a process evaluation study of the two observation units in the Teylingereind Forensic Centre. The units started up in 2009. The first (‘de Ven’) carries out clinical observations on juvenile suspects for the purpose of decision diagnostic assessment, while the second (‘de Gaag’) performs clinical observations for the purpose of treatment diagnostic assessment of juvenile delinquents on whom an ‘institutional placement order’ (PIJ-maatregel) has been imposed. The adolescents stay at a unit for seven weeks and are examined by a multidisciplinary team containing a research leader, an editor, a lawyer, psychiatrist, psychologist, test assistant, art therapist, social milieu investigator, teacher, and group leader(s) or clinical social worker(s).

The overarching question of the process evaluation was: What is the background, the goal, the working method and the current functioning of the observation units in Teylingereind and is there an understanding of (measurement of) the degree to which the goals of the units are achieved? To answer this question the study was designed to take place in three phases. The first phase addressed the background, goals and working method of the observation units; the second addressed the current functioning of the units; and the third focused on the experiences of the users of the clinical reports (treatment practitioners, public prosecutors, judges) and the follow-up programme for the adolescents.

The research methods required to answer these questions had to be adapted in several ways because of objections raised by Teylingereind. For example, the current functioning of the observation units could not be assessed using direct, independent observation measures, as Teylingereind supposed that it might affect the diagnostic process. Instead, more indirect observation was carried out, based predominantly on the information presented by staff during staff meetings and in their written reports. Consequently, some of the information gathered in this study mainly reflects written
communications between the staff of the observation unit. Furthermore, the unit for treatment and PIJ-prolongation advice (‘de Gaag’) had to be disregarded in the process evaluation study: it was temporarily closed as few or no new clients were presented. This study therefore mainly targeted the ‘de Ven’ unit.

Data collection took eight months (15 February – 15 October 2010). Interviews were held with 55 individuals connected with the observation units (initiators - i.e. representatives of the institutions who took the initiative to set up the observation units - staff members, the adolescents themselves, their parents, treatment practitioners, public prosecutors and judges). In addition, questionnaires were filled out by 14 other individuals (initiators, the adolescents, and judges) to provide us with information on a variety of subjects. The diagnostic process of 21 investigations was completely or partly mapped using observation and file research. A total of 20 reports (i.e. the final product of the observation unit) were evaluated by noting the presence or absence of the categories and items. The reports were compared to 20 clinical reports from ambulatory (triple, residential or clinical) investigations.

**Phase 1** focused on the background, goals and working method of the observation units. According to the literature and statements made in interviews with the initiators, problems in the field of youth delinquency that threatened the quality of the diagnosis and treatment of juvenile delinquents prompted the establishment of the units. The initiators are members of the Forensic Consortium for Adolescents (ForCA). They view the clustering of expertise in the observation units as an important tool in tackling and resolving these problems. Accordingly, they view improvement of the quality of diagnosis and treatment of juvenile delinquents as the overarching goal of the observation units. More specifically, ForCA distinguishes four main goals: (1) to optimize the quality of forensic diagnosis and advice; (2) to effectively coordinate forensic diagnosis and advice on the one hand and the (possible prolongation of) enforced treatment on the other; (3) to increase the body of knowledge regarding the diagnosis and treatment of juvenile delinquents and to make this knowledge more accessible to professionals; (4) to promote professional development in the diagnosis and treatment of juvenile delinquents for staff of organizations participating in ForCA. These goals are regarded as equally valid for the two different units.
The ForCA ‘observation working method’ team was created to develop a working method for the observation units. According to the team itself, it has brought together the expertise of the young offenders' institutions and of the Pieter Baan Centre (PBC), a psychiatric observation centre for adults, to establish 'best practice'. This so-called best practice lacks a theoretical foundation. It has resulted in a protocol for the diagnostic process (‘observation and report’ protocol), and protocols and writing guides for the final clinical report. The process and the observation method is the same for the two observation units, i.e. decision and treatment diagnostic; however, the two units use a separate protocol for reporting. All these protocols are contained in a handbook (Teylingereind, 2010). However, the handbook does not contain a protocol for carrying out observational activities.

In phase 1 of the process evaluation two conclusions were reached: (a) because of the lack of a theoretical framework it is unclear how the observation units can contribute to solving the problems that were the reason for establishing them, and (b) the working method of the observation units is not inferred from the goals they have set, nor is it tested against these goals. The consequence of (a) and (b) is that it is unclear how their ‘best practice’ is or can be empirically validated.

Based on the literature and statements made by the initiators, the researchers formulated 14 criteria or goals which would be useful for a more substantive process evaluation of the observation units. The criteria are: (1) multidisciplinary teamwork, (2) expertise from the behavioural sciences, (3) systematic work, (4) protocol compliance, (5) collaboration between the institutional partners in the field of juvenile delinquency, (6) feedback on outcomes and results, (7) satisfaction on the part of the users of the clinical reports, (8) registration of findings, (9) integration of research and clinical practice, (10) education and training of staff, (11) exchange of knowledge/expertise between the ForCA member organizations, (12) production of clinical reports, (13) timeliness of clinical reports and (14) processing speed. These criteria were classified under the four main goals formulated by ForCA for the improvement of the quality of the diagnosis and treatment of juvenile delinquents.

Phase 2 focused on the current functioning of the observation units. From the opening of the unit on 1 May 2009 up to 15 October 2010 (closure of data collection), 62 male adolescents between the ages of 14 and 24 were placed in the ‘de Ven’ unit for a clinical report. From the opening of the 'de Gaag' unit on 18 August 2009 up to 19
March 2010, 15 male adolescents between the ages of 18 and 22 were placed in the unit for treatment or PIJ-prolongation advice. The latter unit has been temporarily closed since 19 March 2010 because no or few new clients were presented. Since the temporary closure of the ‘de Gaag’ unit to date (15 October 2010) four individuals have been placed in the ‘de Ven’ unit although they required treatment advice.

The selection and placement of adolescents differs depending on the unit involved. The individuals in the ‘de Ven’ unit are placed there by order of the examining magistrate. The Netherlands Institute for Forensic Psychiatry and Psychology (NIFP) fulfils the role of ‘placement assessor’. The most commonly mentioned criterion for placement in the ‘de Ven’ unit is ‘Diminished compliance, communicativeness or motivation of the young person’. In most cases the criterion means that the individual did not cooperate with an earlier diagnostic assessment, has stated that he is going to refuse to cooperate or is expected to do so. The adolescents in the unit for treatment and PIJ-prolongation advice (‘de Gaag’) are placed there by the Individual Cases Department (IJZ) at the Ministry of Security and Justice. Although in most cases it is the director of a young offenders' institution who submits the request, the IJZ selection officer has the competence to make placements. The NIFP does not play any role in this regard.

To ensure compliance with the ‘observation and report’ protocol, intermediate reports must be entered in file information or digital information systems (e.g. the Treatment Registration and Evaluation System, or BRES). Because many activities were not systematically documented, many missing values were registered in this part of the study. In such cases, it is not clear whether the item has not been executed at all or whether the item was executed but not registered. Results suggest a lack of transparency, particularly in the activities of the teacher, the clinical social worker and the psychiatrist, resulting in an inadequate exchange of information between formal meetings. Not every member of the team involved in a case was using the BRES digital information system, which might have contributed to this lack of transparency.

Taking into account the limitations imposed by the missing values, we can conclude that at least 58% of the items of the protocol were carried out on time (all missing values counted as not being carried out on time or not being registered or both). In particular during the multidisciplinary meetings (two interim meetings and one final meeting) compliance with the protocol was good (> 80%). In the weeks between meetings compliance was much lower.
The findings also show that some items were not carried out at all, or not carried out on time, for example, the meetings between the adolescent and the psychiatrist and psychologist in certain weeks, informing the parents about the advice given, and sending the report to the client within two weeks of the individual leaving the unit. The reasons staff gave for deviating from the working plan protocol were: lack of cooperation from the adolescents concerned, the fact that planned activities in the protocol were not carried out or were carried out later, or the assertion that the planning was not practicable and new appointments had to be made.

Compliance with the protocols for the clinical report was good at overall level, i.e. at the level of the paragraphs. At a micro level, as regards content, compliance with the report protocols fluctuated strongly. The protocols were not taken as standard, but used as open-ended guidelines. Very often the staff carrying out observation had to answer many different observation questions for each case. To answer these questions they used participatory observation methods. Observation tasks were not planned beforehand. Instead, in most cases the situation determined the direction of the observation activities. As a consequence, observations were steered by incidents, and reports were retrospective in nature. At the moment the teachers and art therapists are engaged in a process of structuring and systematizing the observations.

A comparison of the clinical reports of the observation units with the clinical reports of the comparison group revealed considerable similarity. The differences between the two types of report were mainly found, as expected, in respect of the 'behaviour in the living unit', 'school' and 'art therapy' paragraphs. These topics are not part of ambulatory diagnostics. The differences (except for art therapy, as it is not available in any of the other types of diagnostic setting) became smaller when only cases of residential and clinical diagnostics were included in the comparison group. Nevertheless, the differences remain substantial. Interviews with the staff of the observation units and the users of the reports show that from their point of view the information gathered in these areas is not always sufficiently integrated in the final report or is not considered in the advice.

The juveniles and their parents had a neutral or positive opinion of the observation units. It is noteworthy that a relatively large number of the adolescents had the impression that some behaviours were elicited because observers tried to trigger behaviour. They found this uncomfortable. Indeed according to one young man it led to dangerous situations. In addition, the timing of the presentation of the
outcome of the investigation and the advice to be given to the court to the individual concerned may lead to youngsters feeling insufficiently informed.

In phase 2 of the process evaluation it was found that (a) the teacher, clinical social worker and psychiatrist in particular do not report transparently; (b) compliance with the ‘observation and report’ protocol is fairly good during the multidisciplinary meetings, but significantly lower in the weeks in between; (c) some items are structurally not carried out or not carried out on time, either because of changes in the appointments and/or because adolescents refuse to cooperate; (d) compliance with the report protocol is good at a general level, but fluctuates strongly at content level; (e) no specific observation method has been developed for either unit, although the goals of the diagnostic units are different (decision vs. treatment), (f) the observations are mostly participatory in nature and steered by incidents; the reports are retrospective, (g) the clinical reports of the observation units are in general comparable to the ambulatory reports, (h) staff, adolescents and their parents have in general a neutral to fairly positive view on the observation units.

Phase 3 focuses on the experiences of the users of the reports and the follow-up stage. The users of the reports are positive about the form (clarity, readability, comprehensibility) of the reports. They all think that the observation units can be of added value for the youth forensic field. However, the practitioners questioned the added value of the unit for treatment and PIJ prolongation, as it functioned before its temporary closure. Nevertheless, they accepted the treatment advice given in the reports.

The public prosecutors and the judges believe that the reports from the observation units contain sound recommendations or advice, that the units are acquiring more experience with complex cases and that they are centres of expertise. The sentencing and treatment advice given in the reports is in most cases accepted by the public prosecutors and judges. The reasons given by the users of the report for not following the advice given include: legal errors, discrepancies within or between reports that are not explained, and the idea that the juvenile has been described too positively (i.e. a failure to identify socially desirable behaviour).

The findings of the third phase of this study include the following points: (a) the users of the reports (practitioners, prosecutors and judges) are generally positive about the form of the reports. They found the reports clear, readable and
comprehensive, (b) practitioners are more negative about the usefulness and added value of the reports, but follow the advice given in them, and (c) public prosecutors and judges are fairly positive about the usefulness and added value of the reports and usually follow the advice.

In sum, the main findings of this process evaluation are as follows.

- There is no theoretical framework underlying the working method of the observation units.
- No specific observation method is available for each unit, reflecting the different goals of the units.
- The process that leads to the final report lacks transparency.
- The implementation of the procedure needs to be more systematic.
- The staff, adolescents and parents involved are generally positive about the observation units.
- The added value of the observation units is not (yet) visible or is insufficiently visible.
- Judges and public prosecutors are positive about the reports. Practitioners however, are critical of (the added value of) the reports written for the purpose of treatment advice.

When the answers to the research questions are related to the earlier mentioned criteria of how the observation units would distinguish themselves from other forms of diagnostic assessment, it appears that only one criterion has been fully met, namely working with a multidisciplinary team. The other 13 criteria have not (yet) been met or have only been partially met.

A process evaluation is based on the assumption that a working method will realise the desired effects when it is implemented as prescribed. The prescribed working method in turn is based on certain theoretical considerations about the processes or mechanisms by which the intended effects can be achieved. On the basis of the results of this study, we conclude that an evaluation of the effects of the observation units at this point would not be useful. Before such an evaluation can take place the observation units should be able to convincingly demonstrate that the following five
points have been realised: (1) the main goals have been operationalized, so it can be determined to what extent these goals have been achieved, (2) a theoretical framework has been made explicit which gives insight into the processes or mechanisms of how the goals are achieved, (3) this theoretical framework has been detailed in methods (procedures and reporting) for the various disciplines, separately for decision and treatment diagnostic assessment, (4) both within and between disciplines there is systematic registration, reporting and communication, including between scheduled team meetings, (5) there is systematic feedback on the reports in the form of the decisions taken in court, and this feedback is reflected upon.