CLOSE(D) CARE

Group climate in a secure forensic setting for individuals with mild intellectual disability

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CHAPTER 01.

General introduction

Lauren

Lauren is 23 years old when she gets admitted to a high intensive care unit at Trajectum, a Dutch secure forensic treatment facility that specialises in the treatment of adults with mild intellectual disabilities (MID) or borderline intellectual functioning (BIF), severe challenging behaviour, mental health problems, and/or a history of substance abuse.

There has been an extensive history of professional support since birth. She is the youngest child in a family with four children. Her father is regularly detained because of criminal activities. Lauren's mother works as a prostitute and is addicted to drugs. She is also regularly detained for drug-related offences. The family lives in a trailer when Lauren is born. Her parents argue a lot involving physical violence and are unable to take care of their children. Two months after her birth, Lauren is placed out of home and cared for in a foster family. This is where she initially develops well. From time to time she has contact with her biological father and siblings.

Lauren visited a school for special education for children with learning disorders and behavioural problems where she needs a lot of guidance. When Lauren is ten years old, she is sexually abused by her foster brother. In the same year, her biological sister and grandmother die. After this, Lauren shows more problematic behaviour. She is aggressive, shows self-injury, comes into contact with the police for vandalism and runs away from the foster family several times. After this it goes downhill with Lauren. She is increasingly aggressive, self-injures more often and more severely, destroys objects, screams and spits at her foster parents. Sometimes she is depressed and suicidal and indicates she suffers from voices inside her head. Her mood changes quickly. After an outburst of anger, she regrets her behaviour, feels bad and injures herself. Lauren receives outpatient youth care. When Lauren is twelve years old, she attends a school for secondary special education. Soon after, her behaviour becomes unmanageable. She runs from the classroom into the street, beats teachers, cuts herself and pounds her head against the wall. There are many conflict situations in which Lauren is no longer approachable. At the age of thirteen, she gets admitted to residential youth care where she is frequently transferred to more closed wards in various institutions because of risky behaviour such as arson, aggression towards social workers, serious self-harm and suicidal behaviour. In between admissions, she stays in the foster family, where several ag-

gressive incidents occur. Among other things, she threatens her foster parents with a knife. She also uses alcohol and drugs from the age of sixteen.

At the age of nineteen, Lauren commits arson and assault several times and was admitted by means of a TBS order (in Dutch: Terbeschikkingstelling: "disposal to be treated on behalf of the state"), as she was considered not to be legally accountable for her crimes because of her MID in combination with severe psychopathology. At first she stayed at a prison and a regular forensic treatment facility. Here, the support and treatment did insufficiently account for her special needs due to her MID in combination with severe mental health problems. Lauren was secluded in a locked room for almost every day of the year in combination with coercive measures like psychical restraint (whereby one or more sociotherapists held her) and involuntary medication. For this reason, she was referred to Trajectum.

Introduction

In the Netherlands, there are more individuals like Lauren with mild intellectual disability (MID; IQ 50–70) or borderline intellectual functioning (BIF; IQ 70–85) who have (severe) mental health problems or challenging behaviour, in combination with a range of problems in different areas of life. It concerns individuals who lost their grip on life, who cannot take care of themselves, who do not ask for help or even refuse help, who are difficult to stabilise and frequently end up in crisis situations. Many are dependent on alcohol and/or drugs and exhibit aggressive or criminal behaviour (Neijmeijer, 2020). In addition, socioeconomic problems regularly co-exist such as poverty, debts, unemployment, homelessness, relatively frequent hospitalisation, loneliness and vulnerability (Woittiez, Eggink, Putman, & Ras, 2018). Lives, like Lauren's, are characterised by fragmentation: lack of social and adequate professional support, problems at school, no job or meaningful activities, and multiple unsuccessful treatments. These problems are not only related to the persons themselves, but also pertains to an increasingly complex society that places high demands on their cognitive, social, emotional and adaptive skills (Didden, Troost, Moonen, & Groen, 2016).

This target group is overrepresented in Dutch mental healthcare, prisons, forensic care (Kaal, Smits, & Vrij, 2017; Mosk & Degraeve, 2019), and addiction centers (Luteijn,

Didden, & Van Der Nagel, 2017) because of comorbidity between their intellectual disability, mental health problems and challenging, risky or even criminal behaviour. Treatment for individuals with MID-BIF within mental health care is not seldomly unsuccessful (Didden et al., 2016; Nieuwenhuis, Noorthoorn, Nijman, Naarding, & Mulder, 2017). MID-BIF is often not recognised or recognised too late. Unawareness is likely to result in false diagnosis, inadequate treatment, more lengthy admissions, more coercion during admittance, and poor treatment outcomes. Interventions and questionnaires have not been adapted to the needs of individuals with MID-BIF, and the support and treatment does insufficiently account for this target group (Nieuwenhuis et al., 2017). During treatment individuals are frequently transferred to new settings where they have to start all over again and develop a working alliance with new staff (Didden et al., 2016; Roest, Van der Helm, & Stams, 2016). Due to this combination of MID-BIF, severe challenging behaviour, mental health problems, and/or a history of substance this target group – including Lauren - need intensive care and monitoring in a specialised secure (forensic) treatment setting.

Secure (forensic) treatment

Individuals with MID-BIF are only placed within a secure forensic setting if they are a danger to themselves or to others, and if other forms of care are assumed to be insufficient. If voluntary care to eliminate harm (to self or others) is not possible, risky and/ or criminal behaviour can lead to compulsory treatment under civil or criminal law. In the Netherlands the Care and Compulsion Act (in Dutch: WZD) applies to individuals with MID-BIF in whom a mental disorder results in behaviour that can lead to harm to themselves or to others (civil law). Compulsory treatment can also be imposed by criminal law. Many countries now recognize that those who have committed a criminal offense, (partly) due to a mental disorder, form a distinct population that needs some specialised forensic treatment and care besides imprisonment (Clercx, Keulen-De Vos, Nijman, Didden, & Nijman, 2020). In the Netherlands, as in the case of Lauren, individuals can also be admitted by means of a TBS order (in Dutch: Terbeschikkingstelling: "disposal to be treated on behalf of the state"). These individuals are convicted of a serious violent offense but are considered to have diminished responsibility for their crime because of severe psychopathology and/or MID-BIF. Therefore, mandatory stay (and treatment)

within a secure forensic setting is imposed.

Secure forensic treatment is usually organised in such a way that 8 to 12 individuals live together in a living group, supported by trained sociotherapists. Individuals are staying on these living groups for a certain period of time and receive treatment and support 24 hours a day by a team of professionals. Sociotherapists support clients during daily routines, work and educational activities, individual and group therapy sessions and leisure activities. They work in collaboration with psychologists, psychiatrists and psychotherapists, who supervise the sociotherapists and provide additional one-to-one treatment. Depending on the risks and needs, clients of some units have more autonomy, while in other units clients receive one to one guidance throughout the day. Based on the risk of (re)offending, legal status and treatment phase, clients move to living groups with different levels of restrictions and security. The goal of treatment is to rehabilitate individuals and prepare them to return to society and to offer perspective. Rehabilitation can also mean that individuals are directed to assisted or semi-independent living environments.

Therapy - security paradox

Offending behaviour and criminal recidivism can be effectively reduced within or after a secure forensic setting if treatment is supportive, evidence-based, responsive and based on relational care (Fazel, Fimińska, Cocks, & Coid, 2016; Hachtel, Vogel, & Huber, 2019). Secure forensic treatment creates a difficult dual role for professionals, not only providing care and building a therapeutic relationship with the individual client, but also being responsible for protecting others, assessing risks and managing control over the autonomy of the individual client (i.e., *therapy-security paradox*; Inglis, 2010; Jacob, 2012). Restriction of freedom does not always come from the clients' (e.g., restriction to prevent self-harm) or immediate danger to others, but also from the interest of the safety of society as a whole (Clercx et al., 2020).

The impact of involuntary admission and treatment on the therapeutic relationship is widely recognised as diminishing treatment outcomes, a topic which is often being critically discussed (Arnold et al., 2019). More awareness arises that coercive measures during compulsory treatment can also have harmful effects (De Valk, 2019). The more coercion during treatment in secure (forensic) settings - as was seen in the case of Lauren in the form of daily seclusions – the more risk of escalation, aggression and recidivism

may occur (Kowalinski, Schneeberger, Lang, & Huber, 2017; Parhar, Wormith, Derkzen, & Beauregard, 2008; Ros, Van der Helm, Wissink, Schaftenaar, & Stams, 2013). Also, coercive measures (i.e., seclusion, restraint) may be (re)traumatizing for the clients but also for sociotherapists (Lambert, Barton-Bellessa, & Hogan, 2015).

The feeling of being coerced into therapy decreases the therapeutic alliance (between client and sociotherapists) and atmosphere on the living group, which results in lasting harmful effects on a client's motivation for treatment and treatment outcomes in different domains (Arnold et al., 2019; Chieze, Hurst, Kaiser, & Sentissi, 2019; De Valk, 2019; Roest et al., 2016). In addition, coercive measures may not always provide the intended protection and may even increase the risks of escalation resulting in a coercive cycle of interaction between clients and sociotherapists (Patterson, & Bank, 1989; Sameroff, 2009). In the example of Lauren, the daily seclusions led to more frequent and severe self-harm, suicidality and aggressive incidents. In general, it has been shown that treatment in a secure setting does not necessarily have the assumed positive effects on aggression, suicidality, and absconding (Huber et al., 2016; Schneeberger et al., 2017).

Secure forensic treatment implies a difficult dual role for professionals, not only providing care and building a therapeutic relationship with the individual client, but also being responible for protecting others, assessing risks and managing control over the autonomy of the client

However, compulsory treatment does not necessarily have to result in negative treatment outcomes. Compulsory secure (forensic) treatment is considered to work if there is a therapeutic group climate with fulfilment of psychological basic needs such as connectedness, competence, autonomy through shared decision-making and a good quality of the relationship between (socio)therapist and client (Hachtel et al., 2019; Ryan & Deci, 2017; Schaftenaar, 2018). Therefore, reducing (feelings of) coercion may improve treatment outcomes and prevent expulsion from secure settings. Health care professionals should therefore be encouraged to find the right balance in their dual-role relationship with the client. A caring, fair, and trust-evoking quality of therapeutic interventions blended with a firm (authoritative) but not authoritarian or punitive control seems to be necessary to motivation for change in therapy and the ability and skills to (being able to) change (Van der Helm, Kuiper, & Stams, 2018). This can help to motivate clients to engage and stay in therapy and reduce offending behaviour or recidivism, de-

spite an initial lack of motivation, inability, or limited skills and/or severe psychopathology. A possible advantage of compulsory treatment, due to a legal framework, is the more consistent and longer treatment duration in comparison to voluntary treatment, but prolonged residential treatment can be challenging for maintaining motivation (Van der Helm, Wissink, De Jongh, & Stams, 2012). This continuity of care and the additional provision of supportive aftercare may explain good levels of satisfaction in compulsory treatment along the way and resulting better levels of functioning (Hachtel et al., 2019; Schaftenaar, 2018)

Secure forensic treatment for individuals with MID-BIF

Secure (forensic) treatment for individuals with MID-BIF is focused on accepting disabilities, compensating skill deficits and stimulating or increasing competencies. It typically consists of therapeutic approaches or interventions that are also being used in forensic settings for individuals without intellectual disability, while interventions have been adapted for offenders with MID-BIF (Didden, Nijman, Delforterie, & Keulen-De Vos, 2019; Keulen-De Vos & Frijters, 2015).

While there is currently no single treatment model that addresses all of the unique characteristics of this target group, interventions and rehabilitation programs of individuals with (mild) intellectual disability in secure forensic settings are often based on the risk, need and responsivity (RNR) principles of Andrews and Bonta (2006) and the Good Lives Model (GLM; Ward, Mann, & Gannon, 2007). Both models though are facing empirical problems (Ziv, 2017).

The *RNR model* consists of three principles: risk, need and responsivity. The risk principle assumes that care intensity should be matched to the level of risk posed by the client. The need principle states that treatment should be targeted at the individual needs that are related to criminal behaviour, the so-called criminogenic needs. The responsivity principle assumes that the treatment must be responsive to the client's unique characteristics and personal circumstances (Andrews & Bonta, 2006). Extensive research has been carried out to examine the usefulness of the RNR model in various types of offenders, including individuals with an intellectual disability (Frize, Kenny, & Lennings, 2008; Hocken, Winder, & Grayson, 2013; Lindsay et al., 2013). According to this model, to determine the adequate type of treatment and level of care intensity, individualised

criminogenic needs ought to be assessed.

However, effective treatment should also focus on general needs and strengths, such as physical health, quality of life, social and cultural factors, personal abilities and interests, as they add to a client's risk for recidivism (Andrews & Bonta, 2006). A model that focuses on these needs and strengths is the GLM (Ward et al., 2007). The GLM focuses on developing a balanced, prosocial personal identity and goal-seeking to develop a life that is healthy, self-determined with minimised risk for (re)offending. The GLM is a general rehabilitation theory, developed to suit all types of offenders (including offenders with ID), but in practice mainly used in sexual (ID) offenders (Aust, 2010).

These theoretical principles for effective secure forensic treatment addresses the therapy-security paradox as described earlier. A disturbed balance between the focus on treatment and the focus on risk threatens the effectiveness of secure forensic treatment. Therapeutic flexibility is needed for clients to practice new competences and is characterised by responsiveness and opportunities for growth and development. Risk management on the other hand is characterised by structure, predictability, safety, control, and affective rule keeping at the living group among others. This is needed to avert chaos, anarchy and aggression among individuals within secure forensic care (Van der Helm, Boekee, Stams, & Van der Laan, 2011).

To enable real change in everyday lives of individuals with MID-BIF it is important to consider the environmental and interpersonal context in secure forensic treatment

Multidisciplinary working and specialist skills are considered essential in understanding, assessing and managing risk and complex needs and delivering successful treatment in secure forensic settings (Haines, Perkins, Evans, & McCabe, 2018). Just as the interaction between clients and therapists within sessions is crucial for therapeutic change, (socio) therapists are also part of multidisciplinary teams who are concerned with the broader context of clients' lives. Generalization is necessary for interventions such as cognitive behaviour therapy or anger management to have benefits in everyday life beyond the original learning environment. Especially since individuals with MID-BIF have difficulties generalizing learned skills across novel contexts with other situations. To enable real change in everyday lives of individuals with MID-BIF it is important to consider the environmental and interpersonal context in secure forensic treatment (Jahoda et al.,

2009). Clients should be able to use what they have learned in everyday situations to help maintain development and positive change in their lives (Wampold, 2019). Effective treatment is highly context-dependent and the quality of staff-client relationship (therapeutic alliance) shapes treatment outcomes more strongly than treatment methods or specific psychotherapy techniques (Asay & Lambert, 1999; Davis, Garske, & Martin, 2000; Hachtel et al., 2019; Luborsky et al., 2002). As individuals within secure forensic care spent most of their time on their living group, apart from work and educational activities, individual and group therapy sessions and leisure activities, group climate is assumed to exert a substantial influence on the effectiveness of treatment. Trieschman, Whitakker and Brendto already referred to 'the other 23 hours' in 1969.

Group Climate

It has long been recognised that group climate plays an important role in the efficacy of treatment in secure (forensic) settings (World Health Organization, 1953). Group climate was found to be related to motivation for treatment, treatment engagement, treatment satisfaction, therapeutic alliance (Bressington, Stewart, Beer, & MacInnes, 2011; Johansson & Eklund, 2004; Long et al., 2011; Van der Helm, 2011), better wellbeing and mental health (Van Ginneken, Palmen, Bosma, & Sentse, 2019), treatment dropout and dismissal (Beech & Hamilton-Giachritsis, 2005; Moos, Shelton, & Petty, 1973), and reduced levels of aggression and recidivism (Auty & Liebling, 2019; Schubert, Mulvey, Loughran, & Losoya, 2012; Van der Helm, 2012). Group climate is a complex and multifactorial construct with a lack of conceptual clarity around the components and factors that influence group climate (Van der Helm, 2011). In both research and clinical practice, the range of theoretical perspectives of group climate and lack of a shared definition has led to a somewhat fuzzy concept (Doyle, Quayle, & Newman, 2017; Tonkin, 2015). In this thesis we will use the term group climate, referring to the definition of Stams and Van der Helm (2017, p. 1065): *'the quality of the social and physical environment in terms of the provision of sufficient and necessary conditions for physical and mental health, well-being, contact and personal growth of the residents, with respect for their human dignity and human rights, as well as (if not restricted by judicial measures) their personal autonomy, aimed at recovery and successful participation in society'.*

Within secure (forensic) care settings, group climate can vary from closed and

repressive to open and therapeutic. A therapeutic group climate is characterised by a structured and safe environment, with support from sociotherapists, provision of opportunities for personal growth, and clear rules and limits (Doyle et al., 2017; Tonkin, 2015; Stams & Van der Helm, 2017). By contrast, a repressive group climate is characterised by a lack of structure, unduly strict control, loss of autonomy, absence of mutual respect, boredom, feelings of despair, aggression, and lack of perspective (De Valk, 2019). A range of organisational factors as well as sociotherapist and client characteristics are seen to potentially influence group climate. Altering these factors through provision of staff support, a clear ward ethos and focus on a person centred approach to care (that empowers clients) may be key to a therapeutic group climate. These factors may help develop the secure base and care orientation that facilitates growth and change in the client group while maintaining sociotherapists' ability to form therapeutic relationships with clients (Doyle et al., 2017). This secure base and support provides treatment motivation (Van der Helm, 2012; Van der Helm et al., 2018).

From the perspective of the main motivation theory, the self-determination theory (SDT; Ryan & Deci, 2017), sociotherapists and other professionals should be responsive to the client's needs for competence (i.e., perceptions of ability), connectedness (i.e., feeling socially accepted, included, and supported), and autonomy (i.e., exercising responsibility, choice, and decision-making) to facilitate cognitive, social and emotional development (Ryan & Deci, 2017; Van der Helm & Vandevelde, 2018). These three basic psychological needs overlap with the characteristics of the therapeutic group climate (Van der Helm et al., 2018) and can be translated into three main tasks of sociotherapists in secure forensic settings for MID-BIF: 1) making contact and maintaining a therapeutic alliance with clients (connectedness), 2) stimulating growth, development and competence (creating learning moments and offering space to practice with new behaviour), 3) with as little restriction of autonomy as possible (as much independence and freedom of movement as possible) (Van der Helm et al., 2018). Dealing with these complex tasks requires a high degree of professionalism from sociotherapists. This professionalism is largely determined by work experience and the competencies and skills of sociotherapists, such as being reliable, available, predictable, to be able to maintain contact with important people in the environment of the clients, and to be able to recognize and influence group dynamic processes on the living group. In addition to these person-related factors, the professional behaviour of sociotherapists is also influenced by prevailing team functioning and by the organisational culture (Van Miert, & Dekker 2020).

Thesis outline

Despite the growing body of literature on secure (forensic) treatment which highlights the importance of understanding group climate in the light of effective treatment, there is still a gap between what we know and what we need to know about group climate in secure forensic settings for individuals with MID-BIF (Bressington et al., 2011; Schubert et al., 2012; Tonkin, 2015; Van der Helm, 2011). The relationship between group climate, treatment outcomes, and organisational outcomes is well researched and well documented in forensic and psychiatric services since Moos' early research in the 1960s. Research into these outcomes for individuals with MID-BIF is largely lacking (Bell, Tonkin, Chester, & Craig, 2017; Moos & Houts, 1967; Tonkin 2015; Willets, Mooney, & Blagden, 2014; Van der Helm, 2011). Providing a reliable and valid assessment of group climate in secure forensic settings for individuals with MID-BIF is recommended given the important impact of group climate on wellbeing and treatment outcomes in secure forensic care worldwide (as demonstrated above). Researchers have developed a number of questionnaires that can be used to measure group climate (see Tonkin, 2015). In this thesis we use the Group Climate Instrument (GCI; Van der Helm, 2011) because of the overlap with the Self Determination Theory (Ryan & Deci, 2017). Also, de Valk and others (2016) pointed out that repression is an important factor to take into account because of the risk secure forensic settings bear (compulsory treatment). Measuring, giving feedback and reflecting on group climate with sociotherapists and organisations may offer important insights of how group climate develops, and how group climate can be improved for the benefit of both clients, sociotherapists and organisations. When time and resources are devoted to the monitoring of group climate in these settings, it is crucial that monitoring is guided by psychometrically sound measurement. Otherwise, it will hinder rather than help attempts to improve secure forensic treatment for individuals with MID-BIF. If changes to working practices are made on the basis of inaccurate data, the changes will unlikely have the desired impact on quality of group climate and treatment.

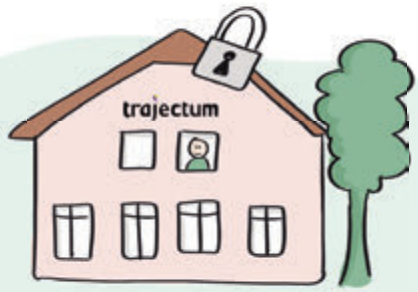
This thesis aims to examine group climate in secure forensic care for individuals with MID-BIF from the perspective of the individuals with MID-BIF themselves and the sociotherapists working with them. The quantitative and qualitative date that are used for the chapters 2, 3, 4 and 5 are collected at Trajectum, a secure forensic treatment facility for adults with MID-BIF and externalizing behaviour problems (i.e., aggression or

sexual offenses) and/or internalizing problems (e.g., self-injurious behaviour or suicide attempts), located in the northern and eastern part of the Netherlands. The findings of this thesis may contribute to establish guidelines for daily practice to enhance the provision of support and treatment of individuals with MID-BIF in secure forensic care, and provide suggestions for future research. **Chapter 2** describes the validation and the psychometric properties of the Group Climate Instrument (GCI), which is a self-report measure adapted for individuals with MID-BIF. Secure (forensic) settings can use this questionnaire to assess group climate as perceived by individuals with MID-BIF. The following cross-sectional studies and qualitative study presented in this thesis should be considered as first step in research on (the effects of) group climate for individuals with MID-BIF. **Chapter 3** involves the results of a multilevel analysis with regard to the associations between group climate, aggressive incidents, and coercive measures in individuals with MID-BIF of a secure forensic setting. **Chapter 4** presents the results of a qualitative study and provides an in-depth account of how individuals with MID-BIF perceive their group climate in a secure forensic setting. This study was aimed at providing a framework on group climate from the perspective of individuals with MID-BIF. Giving voice to these individuals may provide relevant insights for secure forensic settings. In **chapter 5**, a study is presented into the associations between group climate as perceived by individuals with MID-BIF and work climate as experienced by sociotherapists in a secure forensic setting. By means of structural equation modelling and multilevel analyses it was explored what factors in the work climate were associated with the group climate.

Finally, **chapter 6** provides an overall conclusion of the thesis and a reflection on the main findings and in which the perspectives of individuals with MID-BIF, professionals and science are integrated. Suggestions for future research and implications for secure forensic treatment for individuals with MID-BIF are discussed. Additionally, the strengths and limitations of the thesis are mentioned.

MENSEN MET COMPLEXE PROBLEMEN

Gedwongen behandeling werkt alleen als er sprake is van:



Gedwongen opname in klinisch forensische behandelsetting

LEEFGROEPEN

Onder begeleiding van sociotherapeuten

BEVEILIGING VERSUS BEHANDELING

Complexe taakopgave

Orthopedagogische visie: accent op emotioneel, sociaal en cognitief functioneren van cliënt

GESLOTEN/ REPRESSIEF

Kwaliteit leefklimaat is van essentieel belang voor de effectiviteit van behandeling

OPEN/ THERAPEUTISCH

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CHAPTER 02.

Psychometric properties of the Group Climate Instrument (GCI) in individuals with mild intellectual disability or borderline intellectual functioning

Abstract

Background: This study examined the psychometric properties of the Group Climate Instrument (GCI) in a sample of $N = 189$ adults (79% male) with mild intellectual disability or borderline intellectual functioning (MID-BIF) who were residents of a treatment facility in the Netherlands. **Method:** Construct validity of the GCI was examined by means of confirmatory factor analysis. Also, reliability and convergent validity of the GCI were examined. We also examined the variability in perception of the living group climate between and within living groups by computing intraclass correlations (ICC's). **Results:** The model contained four first-order factors: support, growth, group atmosphere, and repression, and a second-order factor overall climate, providing preliminary support for construct validity of the GCI. Reliability coefficients were good for all factors. Preliminary evidence for convergent validity was found in significant moderate associations between subscales and single item ratings for the factors of group climate. The ICC's indicated that a considerate proportion of variance can be attributed to between-group differences. **Conclusions:** The GCI might be used to assess perception of the living group climate for individuals with MID-BIF in psychiatric and forensic care settings, although further development of the GCI and replication of our findings seem necessary.

Introduction

There has been an extensive history of research into group climate in (secure) residential settings for more than 50 years (Tonkin, 2015). The notion that psychiatric and correctional units have a discernible social climate and the importance of such a climate has been recognised by the World Health Organization (WHO; 1953) and Moos (1975). The WHO stated that climate is 'the most important factor in efficacy of treatment' administered to psychiatric patients in prison and forensic psychiatric hospital settings, including individuals with intellectual disability (Tonkin, 2015).

A therapeutic group climate is essential for effective treatment in residential care (Schubert, Mulvey, Loughran, & Loyosa, 2012). Research shows that the quality of the group climate has a positive influence on the development of clients (Van der Helm, 2011). Transactional processes between sociotherapists and clients and processes between clients make up most of the living group climate within the group (Van der Helm,

Stams and Van der Laan, 2011). To create a therapeutic group climate sociotherapists should be responsive to fulfill basic psychological needs of the clients, such as the need for autonomy, competence, and relatedness (Ryan & Deci, 2017).

A distinction can be made between an open and a closed group climate. An open group climate is characterised by safety, mutual respect between clients and sociotherapists, structure in the day program, prospects for growth and support to clients. Support provided by sociotherapists, which builds on meaningful relationships and responsivity to the needs of each individual client, sets the groundwork for successful rehabilitation (Andrews & Bonta, 2010). An open group climate has been shown to be associated with active coping, improved social information processing, empathy, prosocial behaviour, motivation for treatment, a longer period of treatment (no drop out) and higher levels of internal locus of control in participants (Lipsey, 2009; Stams & Van der Helm, 2017; Van der Helm, Beunk, Stams, & Van der Laan, 2014; Van der Helm et al., 2013). An open group climate is also associated with lower levels of aggressive and destructive behaviour of clients in secure care (De Decker et al., 2018; Ros, Van der Helm, Wissink, Schaftenaar, & Stams, 2013).

A closed (i.e. repressive) group climate, by contrast, is characterised by unfulfilled basic psychological needs as a result of rivalry, aggression and insecurity among sociotherapists and clients and among clients on the group. In such a climate sociotherapists are inclined towards restricting clients' autonomy, and excessive control instead of support, connectedness and flexibility toward clients. Furthermore, a closed group climate is characterised by a lack of responsivity by sociotherapists, insufficient prospects for growth, an oppressive atmosphere in the group, and aggression among clients and among clients and sociotherapists (Harvey, 2007). Also, a closed group climate has negative consequences for the safety of both sociotherapists and clients (Van der Helm, Boekee, Stams, & Van der Laan, 2011).

Van der Helm, Stams, and Van der Laan (2011) provided an overview of climate research and found the same dimensions in a range of instruments measuring group climate, namely 'support', 'growth', 'atmosphere', and 'repression'. These dimensions overlap with the basic psychological needs of clients (i.e., connectedness, autonomy and competence) from the perspective of the self-determination theory (Ryan & Deci, 2017). The dimension of 'support' represents the degree of sociotherapists' responsivity and support to clients. The clients' perception of support is based on connectedness: that is the positive relationship between client and sociotherapists, whereas responsivity concerns the

sociotherapists' response to the needs and characteristics of clients (i.e., feeling accepted, supported and included) (Ryan and Deci, 2017; Van der Helm et al., 2011). Research has shown that responsivity can be accomplished through offering support, stimulation of development, a trustworthy and respectful manner of treatment, and consistency in procedures and sociotherapists' availability (Ackerman & Hilsenroth, 2003; Marshall et al., 2003). 'Growth' concerns perceptions of learning and development and hope for the future, perceptions of the ability to feel competent and giving meaning to residing in the facility. Experiencing autonomy (i.e., exercising responsibility, choice, and decision-making) is essential for clients to be able to develop socially and emotionally (Van der Helm et al., 2011; Ryan & Deci, 2017). 'Repression' assesses perceptions of a lack of autonomy that threatens the basic psychological need of connectedness, competence and autonomy: strictness and control, unfair rules, lack of flexibility on the group and boredom among clients (De Valk, Kuiper, Van der Helm, Maas, & Stams, 2016; Harvey, 2007; Van der Helm, Klapwijk, Stams, & Van der Laan, 2009; Van der Helm et al., 2011). 'Atmosphere', finally, indicates the degree to which structure, security and trust among clients is fostered by both the physical as well as the social environment within the group (Van der Helm et al., 2009; Van der Helm et al., 2011).

Research highlights the importance of understanding group climate in the light of effective treatment for individuals with MID-BIF

As shown above, research highlights the importance of understanding group climate in the light of effective treatment for individuals with MID-BIF (Bressington, Stewart, & MacInnes, 2011; Schubert et al., 2012; Tonkin, 2015). Although the relationship between group climate and treatment outcomes is well-researched and well-documented in forensic and psychiatric services since Moos' early research in the 1960s, research into these outcomes for individuals with mild intellectual disability of borderline intellectual functioning (MID-BIF) is largely lacking (Bell, Tonkin, Chester, & Craig, 2017; Moos, 1989; Tonkin, 2015; Willets, Mooney, & Blagden, 2014). Tonkin (2015) shows that group climate can be measured in a reliable and valid manner and several instruments are available for measuring group climate in clients without MID-BIF. It is important that measurements are based on solid psychometric properties; otherwise, monitoring group climate will hinder rather than help improving the quality of client care.

Measuring group climate repeatedly and giving feedback to professionals working with these clients has been shown to improve group climate but also to increase treatment motivation and empathy and diminish criminal cognitions which can facilitate return to society (Tonkin, 2015). The Group Climate Instrument (GCI) was developed to measure the group climate and has been proven to be a valid and reliable measure in other settings such as residential youth care, prisons and psychiatric (forensic) institutions and for different age groups (Van der Helm et al., 2011). The majority of studies however have been undertaken with adolescents, therefore the validity of the GCI with adults (with MID-BIF) is less well established (Bell et al., 2017). To the best of our knowledge, no studies have been published on the psychometric characteristics of the Group Climate Instrument adapted to individuals with MID-BIF in secure treatment facilities.

The aim of this study is to examine the psychometric properties (i.e., construct validity, convergent validity and internal consistency) of the Group Climate Instrument (GCI, Van der Helm, et al., 2011) in a sample of individuals with MID-BIF (N = 189) who were residents of a secure treatment facility. As transactional processes between clients and sociotherapists and between clients make up a large part of the climate we propose the perception of the group climate to quality to be most salient in a group level as opposed to individual or facility-level. It is important that changes to working practices are made on the basis of the perspective of clients for which the GCI provides an important tool.

Methods

Participants

The sample of participants consisted of 189 participants, all residents of Trajectum, a (forensic) secure treatment facility for individuals with MID-BIF located in the northern and eastern part of the Netherlands. All 441 residents were invited to participate in the study. In total 208 residents participated (47% response rate). Data of 19 participants (9% of 208) were excluded from the analyses because of missing data of intellectual functioning (IQ), resulting in a sample of 189 participants. Participants (79% male) were aged between 18 and 69 years (M = 38.3, SD = 12.9). Of the participants, 44% had a mild ID (IQ 50-69) and 56% had borderline intellectual functioning (IQ 70-85) (M = 69.8, SD = 8.7). Besides MID-BIF, participants had severe problem behaviour in combination with mental health problems and/or serious problems in all areas of life, often with a history

of substance use. Comorbidity is high: most of the participants were diagnosed with more than one disorder, not including MID-BIF. For most of the participants the type of problem behaviour was the reason for admittance. Most of the participants were admitted because of externalizing behaviour problems (i.e.. aggression or a sexual offense) and/or internalizing problems (like self-injurious behaviour and suicide attempt) (Delforterie, Hesper, & Didden, 2020).

Participants were placed in the facility under criminal law or civil law. In the Netherlands, individuals who have committed a serious crime and are not legally accountable due to a mental disorder are sentenced by court to detention under hospital orders. This measure is not a punishment but an entrustment act for individuals with mental disorders which aims to protect society against the risk of recidivism trough incarceration and treatment. Treatment goals of participants placed under civil law include stabilization and referral to regular mental health care. These participants are in need of intensive care in a secure setting due to severe behaviour and mental health problems, similar to participants placed under criminal law in terms of required intensity of treatment and level of security. The treatment duration in both cases is rarely shorter than two years and can last ten years or more, depending on the participants' legal status and risk of (re)offending.

The facility consists of 58 groups, and the modal ward size is 8 beds. The mean treatment duration at Trajectum is two years and four months, although this is largely dependent on the participants' legal status and risk level. During treatment, participants move to wards with different levels of restrictions. Participants of this sample resided on wards which had different security levels; 59% of the participants resided on a low secure ward, 20% of the participants resided on a medium secure ward and 21% of the participants resided on a high secure ward.

Procedure

Data were collected in the context of routine monitoring of the ward's climate within the facility. The study received approval from the local institutional review board. Each year, participants who resided in the facility were individually interviewed and completed the GCI. For the purpose of exploring psychometric properties of the instrument, only data from the first wave were used which were collected in March and April 2016. Participation was on a voluntary basis. The researcher gave oral and written information to par-

ticipants concerning data collection, study aims and objectives. All participants and their legal guardians were informed that the research was strictly confidential and anonymous, data were only reported on a ward-level and – upon approval – signed an informed consent form. In addition the multidisciplinary treatment team determined whether a participant was able to give informed consent tot participate. The active consent method was used, explicit consent was given by all of the participants. Questionnaires were given a code to guarantee anonymity of the participants. The names of participating participants were replaced by a code to ensure privacy.

Students of Windesheim University of Applied Sciences and (assistant) researchers of Trajectum were trained to conduct the questionnaire and signed a written statement of confidentiality. Most participants were assisted to complete the questionnaire by a student or (assistant) researcher who read the questions and answering categories out loud and explained the questions to the participant if necessary. Alternative scripted phrases to enable questions to be explained in a different way were part of the training they received. If used, this would provide an additional way of checking participants' understanding whilst preventing students and researchers from projecting their interpretation of the questions on to participants. The completed questionnaires were returned to the researcher (first author), after which the scores were entered into SPSS version 24 (IBM, SPSS Statistics) for analyses. Data on participant and context characteristics (gender, age, IQ, security level, legal status) were extracted from the records of the participants and added to the SPSS database.

Group Climate Instrument

The quality of the group climate was measured with the revised Group Climate Instrument (GCI) which was adapted for individuals with MID-BIF by using simpler wording compared to the original version (PGCI; Van der Helm et al., 2011). The original version was reviewed for clarity, comprehensiveness, understanding, sensitivity, and practical relevance during a brainstorm session with 10 young adults with MID-BIF and a researcher. Based on this review the questionnaire was shortened (from 36 items to 29 items) and items were reformulated/ simplified. (e.g., 'Sociotherapists listen to my opinion' instead of 'Sociotherapists pay attention to me and respect my feelings' or 'Sociotherapists help me when I ask them to' instead of 'When I have a problem, there is somebody I can turn to'). This resulted in a revised 29-item questionnaire.

The GCI has four subscales: (1) support, (2) growth, (3) atmosphere, and (4) repression. A total scale score is a combined score in which the subscale scores are added (after recoding of the items of the repression scale). The GCI was used to assess whether the group climate is more open or more closed. The four factors are evident in both a closed and an open group climate score. The balance between these two (i.e., open versus closed) is decisive in terms of the quality of the climate. The outcomes produced by the GCI provide an in-depth insight into group climate from the clients' perspective and are being used to guide clinical practice and improve quality of client care.

The GCI consists of 29 items that can be scored on a Likert-scale ranging from 1 ('not applicable') to 5 ('entirely applicable'). The *Support* subscale contains eleven items and measures the responsivity of the sociotherapists towards the needs of participants, including giving attention to participants, taking complaints seriously, and providing respect and trust. An example item of the growth subscale is: 'The sociotherapists treat me with respect.' The Growth subscale consists of six items and measures the degree to which participants feel they learn, gain hope for the future, and comprehend the benefit of their stay at the ward. An example item of the growth subscale is: 'I learn the right things here.' The *Repression* subscale has seven items and measures the experience of strictness and control, unfair and coincidental rules, and a lack of flexibility in the group. An example item of the repression subscale is: 'You need to ask permission for everything here.' The *Atmosphere* subscale consists of five items and measures the degree to which participants trust one another, feel safe and secure towards one another (both clients and sociotherapists), are able to find rest, and receive sufficient daylight. An example item of the atmosphere subscale is: 'We trust one another here.'

In addition to filling out the GCI, participants were asked to evaluate the various factors of group climate by giving a report mark (single item rating) between 1 (very poor) and 10 (excellent) to a statement, corresponding to the four subscales of the GCI. The statement 'The support you receive from sociotherapists' corresponded with the subscale support; the statement 'What you learn here' corresponded with the subscale growth; the statement 'The atmosphere at the ward' corresponded with the subscale atmosphere; and the statement 'The rules at the ward' corresponded with the subscale repression.

The GCI could be used to monitor group climate in secure, forensic facilities for individuals with MID-BIF on a regular basis

Statistical analyses

Construct validity of the GCI was examined by means of confirmatory factor analysis (CFA). We used the lavaan package (Rosseel, 2012) in the R environment (version 3.4.1; R Core Team, 2017). A multifactor model was specified in which each item loaded on only one factor. The fit of the model was examined using the Comparative Fit Index (CFI), the Tucker–Lewis Index (TLI), Root Mean-Square Error of Approximation (RMSEA), and the Standardised Root Mean Square Residual (SRMR). For a good-fitting model, cut-off values of CFI > 0.90, TLI > 0.90, RMSEA < 0.05, and SRMR < .08 are required (Hu & Bentler, 1999; Kline, 2005). We used the robust MLR maximum likelihood estimation procedure to account for non-normality. A non-significant Chi-Square indicates exact model fit, a ratio between the $\chi 2$ statistic and the degrees of freedom (df) lower than 2.5 indicates a close fit to the data (Hu & Bentler, 1999). A modification index, giving the expected drop in chi-square if the parameter in question is freely estimated, was used to improve model fit. Thus, parameters that could improve model fit by freeing those parameters were identified. Further improvement of model fit was achieved by removing one item that did not load significantly on the factor (one item of the repression scale).

Next, convergent validity was examined by calculating Pearson r correlations between the subscales of the GCI and the report marks (between 1 and 10). A positive moderate to strong correlation between the subscales support, growth and atmosphere and the corresponding report marks is seen as indicative of convergent validity of the three subscales. A negative moderate to strong correlation between the repression subscale and the corresponding report mark for repression indicates convergent validity of the subscale repression. Pearson's correlations of r = .10 - .30 are seen as small, r = .30 - .50 are seen as a moderate, and r > .50 are seen as a large (Cohen, 1988). Reliability analyses were conducted in SPSS 24 (both Cronbach's alpha and Guttman's Lambda-2). Alpha's above .70 and 0.79 were fair; between 0.80 and 0.89 were good (Cicchetti, 1994). For interpreting reliability estimates, including Guttman's lambda-2 (λ-2), there are some general rules of thumb; λ-2 above 0.70 are sufficient for group-level studies (Guttman, 1945; Osburn, 2000). In order to determine what proportion of the variance in each of the four group climate subscales could be attributed to the group level and the individual level we computed the intraclass correlation coefficient (ICC) which is calculated by dividing the level-2 variance by the total variance (Raudenbush & Bryk 2002). Items with an ICC close to zero indicate that variation is mainly within clients, instead of between groups. On

the other hand, items with an ICC that approximates 1 indicate that variation is mainly between groups, instead of within clients. Since our goal was to measure group climate, a group construct, it is important to examine the variance of scores at the between-group level.

Results

Results for the Group Climate Instrument indicated a good fit to the data. Confirmatory factor analysis was conducted on all 29 GCI items. Results showed factor loadings ranging from .234 to .828 (Table 1). The model showed an acceptable fit to the data: $\chi 2(334) = 457.152$ ($p < .001$); CFI = .931; TLI = .922; RMSEA = .048 (90% CI = .036 - .058); SRMR = .071. The ratio between the $\chi 2$ statistic and the degrees of freedom was 1.37. One item of the repression subscale (i.e., *'Clients must ask permission for everything.'*) did not load significantly on the repression factor, and was deleted from the model to improve model fit. Further analyses were conducted with 28 items. Table 1 presents the final factor solution, showing the items and the corresponding factor loadings. The model that best fitted the data contained four first-order factors: support (11 items), growth (6 items), group atmosphere (6 items), and repression (5 items), and a second-order factor 'overall climate'.

Table 1. Standardised Regression Weights of the Group Climate Instrument (28 items)

Item No.	Subscale/Item	Standardised estimates for first order factors	Standardised estimates for second order factors
	Support		.956
2	Sociotherapists help me when I ask them to	.726	
5	I trust the sociotherapists.	.760	
6	I think the sociotherapists are honest.	.814	
7	I get attention from the sociotherapists.	.712	
8	The sociotherapists listen to my opinion.	.697	
17	Because of the sociotherapists I try new things.	.578	
18	When I have a complaint it will be dealt with.	.570	
22	There are always enough people around to help me.	.539	
24	The sociotherapists have little time for me. I think the sociotherapists deal with angry clients in	-.390	
25	a good way.	.587	
26	The sociotherapists often talk things through with the clients.	.651	
	Growth		.806
11	I work on my goals here.	.603	
12	I think it is good that I'm here.	.657	
13	Here I learn how to behave outside the institution.	.674	
16	I get to decide things for myself here.	.309	
19	What I learn here helps me.	.826	
21	I learn the right things here.	.793	

	Repression		-.722
15	The sociotherapists always get their way.	.234	
20	I'm bored here.	.557	
23	I feel understood by the sociotherapists.	-.671	
27	There is nothing to do here.	.330	
28	It is dirty and it smells bad here.	.396	
29	This ward makes me feel down.	.824	
	Atmosphere		.820
1	There is a good atmosphere on the ward.	.571	
4	I feel good at the ward.	.818	
9	The turmoil on the ward drives me crazy.	-.305	
10	On the ward clients trust each other.	.524	
14	It is safe on the ward.	.828	

To examine convergent validity of the GCI, Pearson's r was used to calculate correlations between the subscales of the GCI and the report marks (between 1 and 10). We found that repression had a negative correlation with the statement 'the rules at the ward' (r = -.339, p < .01). Positive correlations were found between support and 'the support you receive from sociotherapists' (r = .681; p < .01), growth and 'what you learn here' (r = .666; p < .01) and atmosphere and 'the atmosphere at the ward' (r = .663; p < .01) (Table 2). All correlations are moderate to strong and were in the expected direction which may be seen as supportive of convergent validity.

Table 2: Correlations between subscale scores and report marks.

	Subscale Support	Subscale Growth	Subscale Repression	Subscale Atmosphere
Report mark 'The support you receive from sociotherapists'	.681**	.584**	-.361**	.513**
Report mark 'What you learn here'	.542**	.666**	-.248*	.450**
Report mark 'The rules at the ward'	.356**	.407**	-.339**	.477**
Report mark 'The atmosphere at the ward'	.498**	.401**	-.293**	.663**

Note. **$p < .01$.

The Group Climate Instrument was found to be internally consistent, with alpha's ranging between .642 and .882. The ICC's for the group climate subscales and the total climate scale ranged from .193 to .385. These results indicate that a considerate proportion of variance (roughly 19-39%) can be attributed to between-group differences (i.e., the group level). Means, standard deviations, ICC's, and results of reliability coefficients in terms of Cronbach's alpha (α) and Guttman's Lambda-2 (λ-2) are displayed in table 3.

Table 3. Results of the reliability analyses of the Group Climate Instrument (28 items).

Subscale	λ-2	α	M	SD	ICC
Support	.884	.882	3.668	0.815	.279
Growth	.795	.786	3.809	0.971	.300
Repression	.662	.642	2.883	0.727	.193
Atmosphere	.770	.762	3.283	0.808	.340
Overall climate	.922	.918	3.556	0.754	.385

Discussion

The aim of this study was to explore the psychometric properties of the GCI for individuals with MID-BIF who resided in a (forensic) secure treatment facility. We used conventional single level CFA to examine the factor structure of the GCI. The present study provides preliminary evidence for the construct validity and reliability of the GCI for individuals with MID-BIF. Results showed an adequate fit for a first-order and second-order model, which indicates construct validity of the GCI. Reliability coefficients for all scales were satisfactory. The support subscale loaded highest on the overall group climate scale, which indicates that support is the most important indicator of group climate for individuals with MID-BIF. One item of the repression subscale (i.e., *'Clients must ask permission for everything'*) did not load significantly on the repression factor as a result of which it was deleted from the model to improve model fit. This finding may be related to the fact that the repression subscale had relatively lower loadings on the overall climate scale but also to the heterogeneity among the items in order to adequately capture the multifaceted nature of the construct (De Valk et al., 2016; Heynen, Van der Helm, Stams, & Korebrits, 2014; Van der Helm et al., 2011). The finding that this item is unsuitable to measure repression cannot be explained by current research. The ICC's found in the present study indicated that a substantial portion of variance can be attributed to the between-group level. In other words, the group in which each client resided accounted for a considerate proportion of the variability in perception of group climate. Our results indicate that the perception of the clients who reside in the same group is more similar to each other compared to clients from different groups. Multilevel analyses are recommended to explain between-group variance.

There are several limitations of this study that need to be acknowledged. First, although the main aim of the study was to assess construct validity and reliability of the GCI for individuals with MID-BIF, client and other characteristics may be differentially related to (sub) scale scores of the GCI. Future studies should examine possible differences in perceived group climate between different subgroups, addressing within-group (IQ, diagnosis, age, gender, legal status, criminal history, etc.) and between-group (security level, ward size, intensity of support etc.) variables. It cannot be ruled out that the participants did not understand some of the questions. However, because there were no drop-outs and no missing data, we believe this did not influence our results. In order to keep the level of interviewing as high as possible, monthly meetings were organised

to align with all interviewers how to present and explain information to participants unambiguously. Neither the possibility of socially-desirable answers can be excluded. Consistency in answering patterns, the fact that the questionnaire contains both positively and negatively formulated items and interviewers were not in any way involved in treatment suggests that the influence of social desirability was minimised.

A further limitation is that we used a single item measure to assess convergent validity of the GCI. This may yield biased results, because the statements corresponding to the subscales may not capture all relevant aspects of the different factors of group climate. Future studies should assess convergent validity of the GCI with a validated group climate instrument, such as the EssenCES (De Vries, Brazil, Van der Helm, Verkes, & Bulten, 2018). Also, future studies should examine concurrent validity and predictive validity of the GCI in populations with MID-BIF. Concurrent validity can be assessed by relating group climate to aggressive behaviour during treatment, such that a positive group climate could be associated with fewer aggressive incidents (De Decker et al., 2017; Ros et al., 2013). Predictive validity can be established by examining the relationship between quality of the group climate and treatment outcomes (Bressington et al, 2011; Schubert et al., 2012; Tonkin, 2015).

Future studies on the GCI should focus on the clustered nature of group climate measures

Another important methodological limitation is that we used conventional single level CFA to examine the factor structure of the GCI. The ICCs found in the present study indicate that a substantial portion of variance can be attributed to the between-group level. Therefore, multilevel analysis is warranted (Hahs-Vaughn, 2016; Hox, 2002). The assumption is that the perception of group climate varies across individuals, and groups vary in average level of group climate. Also, it can be argued that the perception of the group climate is determined by characteristics of the group more strongly than characteristics of participants. An important advantage of MCFA is that the factor structure of a measure can be examined at both the within-group level and the between-group level (Huang, 2017). However, in the present study, the sample size was insufficient to conduct a multilevel confirmatory factor analysis (MCFA). Future studies on the GCI (and other group climate instruments, see Tonkin, 2015) should focus on the clustered nature of group climate measures (individuals are nested within groups). It is important to examine

the factor structure of the GCI at both the within-group level and between-group level, to test whether the factor structure of the GCI is the same at both levels. Future research on the factor structure and reliability of the GCI at the between-group level is important to assess construct validity of the GCI.

Conclusion

The present study is the first study that examined psychometric properties of the GCI adapted to measure perceived living group climate in individuals with MID-BIF and severe behavioural problems. The GCI could be used to monitor the living group climate in secure, forensic facilities for individuals with MID-BIF on a regular basis. That contributes to our understanding of how the living group climate can be improved for the benefit of both sociotherapists and clients with MID-BIF in secure settings. The current findings are found not only in secure residential care for children, adolescents and adults without MID-BIF (Heynen et al., 2014; Strijbosch et al, 2014; Van der Helm, 2011) but also in residential care and treatment for adults with MID-BIF. These outcomes also brings us a step closer to a standardised instrument that can be used to measure living group climate in different kinds of settings and in a broader range of target groups and to evaluate the effectiveness of interventions that aim to improve living group climate.

1e STUDIE

METEN VAN HET LEEFKLIMAAT

GROUP CLIMATE INSTRUMENT (GCI)

Minder complex taalgebruik

GCI gevalideerd voor doelgroep LVB

Betrouwbaarheid & validiteit

GESCHIKT OM PERIODIEK AF TE NEMEN

INZICHT IN LEEFKLIMAAT

ONDERDEEL VAN VERBETERCYCLUS

KWALITEIT VAN HET LEEFKIMAAT

De GCI onderscheidt vier factoren van het leefklimaat. Afhankelijk van deze vier factoren kan in beeld worden gebracht of er sprake is van een meer open of gesloten leefklimaat

Ondersteuning

Groei

Repressie

Sfeer

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CHAPTER 03.

Group climate, aggressive incidents and coercion in a secure forensic setting for individuals with mild intellectual disability or borderline intellectual functioning: A multilevel study

Abstract

Background: This study examines associations between group climate, aggressive incidents, and coercive measures in adults with mild intellectual disability or borderline intellectual functioning (MID-BIF) of a secure forensic setting. **Method:** Participants (N=248) were interviewed about their perception of group climate utilizing the Group Climate Instrument. Data on aggressive incidents and coercive measures were retrieved from the facilities' electronic database. A multilevel structural equation model was fitted in which variability in perception of group climate within and between living groups was examined. **Results:** An open and therapeutic group climate was associated with lower levels of aggression within and between groups. A higher number of aggressive incidents was significantly associated with a higher number of coercive measures. **Conclusions:** The findings have implications for the understanding of how group climate may play a role in reducing aggressive incidents at the living group in treatment of individuals with MID-BIF in secure forensic settings.

Introduction

A high number of aggressive incidents in secure forensic care is considered a serious problem, not only for clients but for sociotherapists as well (Robinson, Craig, & Tonkin, 2018; Ros, Van der Helm, Wissink, Stams, & Schaftenaar, 2013). According to the results of a study presented by one of the Dutch labour unions (CNV Zorg & Welzijn, 2018) addressing aggressive incidents in Dutch health care for people with intellectual disabilities, more than 50% of the 640 caregivers experienced physical (70%) or verbal (79%) aggressive incidents in their work. About half (53%) reported an increase in aggressive incidents during the past year. These results are worrying given the range of negative consequences for victims, the aggressor, and the organisation in which aggressive incidents occur. Negative consequences for the victim can include psychological effects (e.g., anxiety, sleep disturbance, fear, anger, and resentment) as well as physical injury (Knotter, 2019). Sociotherapists and clients may feel less safe in living groups where there is a high number of aggressive incidents. For the aggressor, aggressive incidents can disrupt their rehabilitation because of coercive measures, conviction and prosecution, and transfer to another facility. For the organisation, aggressive incidents against

staff and residents ultimately reduce the efficacy and effectiveness of rehabilitative efforts (Robinson et al., 2018). Also, aggression may lead to an unsafe working environment for staff and to an increased risk on sick leave and burn out symptoms (De Looff, Nijman, Didden, & Embregts, 2018). It is therefore important that studies explore which factors are related to aggressive incidents in secure (forensic) settings for individuals with Mild Intellectual Disability or Borderline Intellectual Functioning (MID-BIF; IQ 50-85).

A high number of aggressive incidents in secure forensic care is considered a serious problem, not only for clients but for sociotherapists as well

Research suggests that a positive group climate is important to reduce aggressive incidents in secure forensic settings (Robinson et al., 2018). Group climate has been defined as 'the quality of the social and physical environment in terms of the provision of sufficient and necessary conditions for physical and mental health, well-being, contact and personal growth of the residents, with respect for their human dignity and human rights, as well as (if not restricted by judicial measures) their personal autonomy, aimed at recovery and successful participation in society' (Stams & Van der Helm, 2017, p. 4). A structured and safe environment, with adequate support from sociotherapists, opportunities to learn and develop (growth), clear rules and limits, and a safe atmosphere among clients characterizes an open and therapeutic group climate (Van Der Helm, Beunk, Stams, & Van Der Laan, 2014). By contrast, a closed and repressive group climate is characterised by a lack of structure, unduly strict control, loss of autonomy, absence of mutual respect, boredom, feelings of despair, aggression, and lack of perspective (De Valk, Kuiper, van der Helm, Maas, & Stams, 2016). A range of studies shows that there is a relation between the quality of group climate and the number of aggressive incidents in secure forensic settings (De Decker et al., 2018; Heynen, Van Der Helm, Cima, Stams, & Korebrits, 2016; Meehan, McIntosh, & Bergen, 2006; Robinson et al., 2018; Robinson & Craig, 2019; Ros et al., 2013; Van den Tillaart, Eltink, Stams, Van der Helm, & Wissink, 2018).

In secure forensic settings, clients live with approximately eight other clients together in living groups under 24/7 supervision of professional caregivers (i.e., sociotherapists). Therefore, the quality of sociotherapist-client relationships is a crucial element of a safe and therapeutic group climate. To maintain safety at the living group, sociotherapists attempt to regulate aggressive behaviour of clients. Unfortunately, too often this involves

restricting the client's freedom using coercive measures (Hui, Middleton, & Völlm, 2016). In secure forensic settings, coercive measures can take the form of seclusion (placement of a client alone in a locked room that has been designed for this purpose or in a client's room), restraint, involuntary medication, and involuntary food and/or fluids. Researchers, care organisations, the inspection for Dutch Health Care, labour institutions and other partners in health care stated in the last two decades that the use of coercion should be minimised (Kersting et al., 2019; Knotter, 2019). Coercive measures should be limited to situations in which staff and other clients at the living group need to be protected from aggressive behaviour as a last resort when acute danger or harm is likely (De Valk et al., 2016). Coercive measures often do not prevent the aggressive behaviour of clients in the long term but, paradoxically, may strengthen and maintain it (Knotter, Wissink, Moonen, Stams, & Jansen, 2013; Parhar, Wormith, Derkzen, & Beauregard, 2008). Coercion was described by Van Der Helm et al. (2014) as part of a structure in secure forensic settings that is necessary to set boundaries and prevent chaos and anarchy. However, the degree of coercion should always be proportional in relation to 'dangerousness' to avoid institutional repression. Institutional repression threatens, and may even harm, the effectiveness of secure (forensic) treatment, and therefore must be prevented. (De Valk et al., 2015, 2016).

Coercive measures should be limited to situations in which staff and other clients at the living group need to be protected from aggressive behaviour as a last resort when acute danger or harm is likely

The current study examines the association between the group climate, aggressive incidents, and coercive measures in a secure forensic setting for clients with MID-BIF. While there is (preliminary) evidence for the importance of group climate in managing aggressive incidents in residential youth care (De Decker et al., 2018; Van den Tillaart et al., 2018), secure forensic and psychiatric settings (Robinson et al., 2018; Ros et al., 2013), and prison settings (Akerman, Needs, & Bainbridge, 2018), little attention has been paid to group climate and its relation to aggressive incidents in secure forensic settings for individuals with mild intellectual disability or borderline intellectual functioning. This is striking considering that aggression in Dutch health care for people with intellectual disabilities (CNV Zorg & Welzijn, 2018) as well as in forensic health-care settings in many countries (Robinson et al., 2018) is recognised as a significant problem. Based on

studies in Dutch and German residential youth care (De Decker et al., 2018; Heynen et al., 2016) and secure psychiatric settings (Ros et al., 2013), we hypothesize a negative association between aggressive incidents and support, atmosphere, and growth. Also, we expect a positive association between aggressive incidents and repression. More specifically, when clients experience more support, a more positive atmosphere and more possibilities for growth, there would be less aggressive incidents on the living group. Also, more aggressive incidents were expected when clients report more repression. To date, no studies have been conducted to explore the relations between coercive measures, aggressive incidents and group climate for individuals with MID-BIF. Based on studies from De Valk (2015, 2016) we hypothesize a positive association between repression and use of coercive measures on the one hand and a positive association between aggressive incidents and coercive measures on the other hand. Also, we expect that the relation between group climate and coercive measures is mediated by aggressive incidents, such that in a therapeutic climate with higher levels of support, atmosphere, and growth, less aggressive incidents occur and therefore less coercive measures are expected. When clients experience more repression, more aggressive incidents may occur, thus leading to more coercive measures.

Due to the nested data structure (clients are nested within living groups) multilevel analysis will be used to examine whether group climate is related to the frequency of aggressive incidents in clients with MID-BIF. We also examined differences in perceived group climate between different subgroups, addressing within-group (age, IQ, gender, legal status, and treatment duration) and between-group (security level, group size, and care intensity) variables.

Method

Participants

The sample consisted of 248 participants (76% male), aged between 18 and 93 years (M = 41.4, SD = 13.2), who were residents of Trajectum, a secure forensic treatment facility for individuals with MID-BIF located in the northern and eastern part of the Netherlands. They resided in 58 living groups; modal group size was 9 participants. Living groups varied from solely male groups (22%) to mixed groups (78%).

All 441 residents were invited to participate. In total, 248 residents were willing to

participate. Of the participants, 48% had a mild intellectual disability (MID; IQ 50-69), and 52% had borderline intellectual functioning (BIF; IQ 70-85). The mean total IQ was 69.7 (SD = 9.7). IQ-scores were based on diagnostic testing results and retrieved from the files of the participants. Participants had severe problem behaviour in combination with mental health problems and/or serious problems in all areas of life, often with a history of substance use. Most participants were admitted because of externalizing behaviour problems (i.e., aggression or a sexual offense) and/or internalizing problems (such as self-injurious behaviour and suicide attempt) (Delforterie, Hesper, & Didden, 2020). Participants were placed in the facility under criminal law (40%), civil law (23%) or were voluntarily admitted (37%). All participants need intensive care in a secure setting due to severe behavioural and mental health problems, similar to participants placed under criminal law in terms of required intensity of treatment and level of security. Treatment duration in both cases is rarely shorter than two years and can last ten years or more, depending on the participants' legal status and risk of (re)offending.

In this sample (N=248), mean treatment duration at the moment of data collection was two years and two months. Based on the psychopathology of the participants and the phase of the treatment (i.e., observation, treatment, and rehabilitation), treatment programs (e.g. aggression, addiction, or sexual offending behaviour), the security levels and care intensity vary between the units. While in some units the support is more distant, in other units the participants receive one to one guidance throughout the day. In this sample 5% of the participants resided in a high intensive care unit, 18% medium to high care unit, 24% on a medium care unit, 25% on a low to medium care unit and 28% on a low care intensity unit. Depending on the risk of (re)offending, legal status and treatment phase, residents move to living groups with different levels of restrictions and levels of security. In this sample 66% of the participants resided in a low secure living group, 16% resided in a medium secure living group, and 18% resided in a high secure living group.

Procedure

Data were collected in the context of routine monitoring of the ward's climate within the facility . Each year, participants who resided in the facility were individually interviewed and completed the GCI. For the purpose of exploring associations between group climate, aggressive incidents, and coercive measures, only data from one wave were used

which were collected between June 2017 and July 2018. Participation was voluntary. The researcher provided oral and written information to participants concerning data collection, study aims, and objectives. All participants and their legal guardians were informed that the research was strictly confidential and anonymous. Data were only reported on a living group-level. The multidisciplinary treatment team determined whether a participant was able to give informed consent to participate. The active consent method was used. All participants gave explicit oral and written consent. Approval for this study was obtained from the Ethics Committee of the Faculty of Social Sciences (ECSS) of the Radboud University (ECSW2017-3001-471). Questionnaires were given a code to guarantee anonymity of participants. Names of participants were replaced by a code to ensure privacy.

The questionnaires were used by trained (assistant) researchers of Trajectum, specialised in working with individuals with MID-BIF and forensic histories. If necessary, participants were assisted in completing the questionnaire by a (assistant) researcher who read the questions and answering categories out loud and explained the questions to the participant if necessary. Alternative scripted phrases to enable questions to be explained differently were part of the training they received. If used, this would provide an additional way of checking participants' understanding while preventing researchers from projecting their interpretation of the questions on to participants. Completed questionnaires were returned to the researcher (first author), and scores were entered into SPSS version 24 (IBM, SPSS Statistics) for analyses. Characteristics on participant level (gender, age, total IQ, legal status, treatment duration at the living group and the facility) and group level (security level, care intensity, composition, and size) were extracted from participants' records and added to the SPSS database.

Data on frequency of aggressive incidents and use of coercive measures were obtained from the facilities' electronic database (see Instruments).

Instruments

The Group Climate Instrument. Participants were interviewed about their perception of group climate utilizing the revised Group Climate Instrument (GCI) (Neimeijer, Roest, Van der Helm, & Didden, 2019; Van der Helm, Stams, & Van der Laan, 2011). The GCI is a self-report questionnaire containing 29 items using a 5-point Likert-type scale varying from 1 ('not applicable') to 5 ('entirely applicable'). There is preliminary evidence for

the construct validity and reliability of the GCI for individuals with MID-BIF, based on confirmatory factor analysis (Neimeijer et al., 2019). These results are in line with other studies that used the GCI measure in other settings and for other target groups (Tonkin, 2015). The GCI consists of four subscales: support (α = .88), growth (α = .79), repression (α = .64), and atmosphere (α = .76). Together, the 29 items measure overall Group Climate (α = .92).

Responsivity of sociotherapists towards the needs of participants is an essential characteristic of the support subscale. Growth assesses learning opportunities, hope for the future, and comprehension of the benefit of staying on the ward. The perception of strictness and control, unfair and coincidental rules and a lack of flexibility on the living group encompass the repression subscale. Last, the atmosphere subscale assesses the degree to which participants treat and trust each other, feel safe and secure, and can find rest on the living group. The overall climate scale of the GCI includes all four dimensions and is bipolar. At the 'positive end' of the scale group climate should be regarded as open and therapeutic, whereas at the 'negative end' of the scale group climate should be regarded as closed and repressive (Van der Helm et al., 2011). The four factors – support, growth, atmosphere, and repression - are evident in both a closed and an open group climate score.

Aggressive incidents and coercive measures. Sociotherapists electronically register each aggressive incident committed by a client and use of coercive measures on the living group. Aggressive incidents and use of coercive measures were examined using incident reports maximally three months before and after administering the Group Climate Instrument was completed. This interval was chosen to avoid accidental snapshots of the number of aggressive incidents and coercive measures and to ensure sufficient frequency of aggressive incidents and coercive measures. Three different types of aggressive incidents were distinguished: verbal aggression, physical aggression, and aggression against property. Examples of physical aggression are hitting, kicking, biting, and spitting. Examples of verbal aggression are threatening, yelling, and scolding. Aggression against property refers to destroying furniture or kicking the door or wall. In the 58 participating living groups, in total 1,003 aggressive incidents had occurred in the study period, in which 161 participants were involved. The number of aggressive incidents per participant (as perpetrator) varied from 0 to 53, with an average of 4.01 per participant (*SD* = 7.33).

A distinction between four different types of coercive measures was made: physical restraint (where one or more sociotherapists hold a client), seclusion in client's own

At the ‘positive end’ of the scale group climate should be regarded as open and therapeutic, whereas at the ‘negative end’ of the scale group climate should be regarded as closed and repressive

room, seclusion in a locked room (designed for this purpose), and involuntary medication (the administration of rapid tranquillisation via intramuscular injection against a client's will). A total of 425 coercive measures were used during the study period, involving 92 participants. The number of coercive measures per participant varied from 0 to 116 (M = 1.70, SD = 8.30).

Statistical analyses

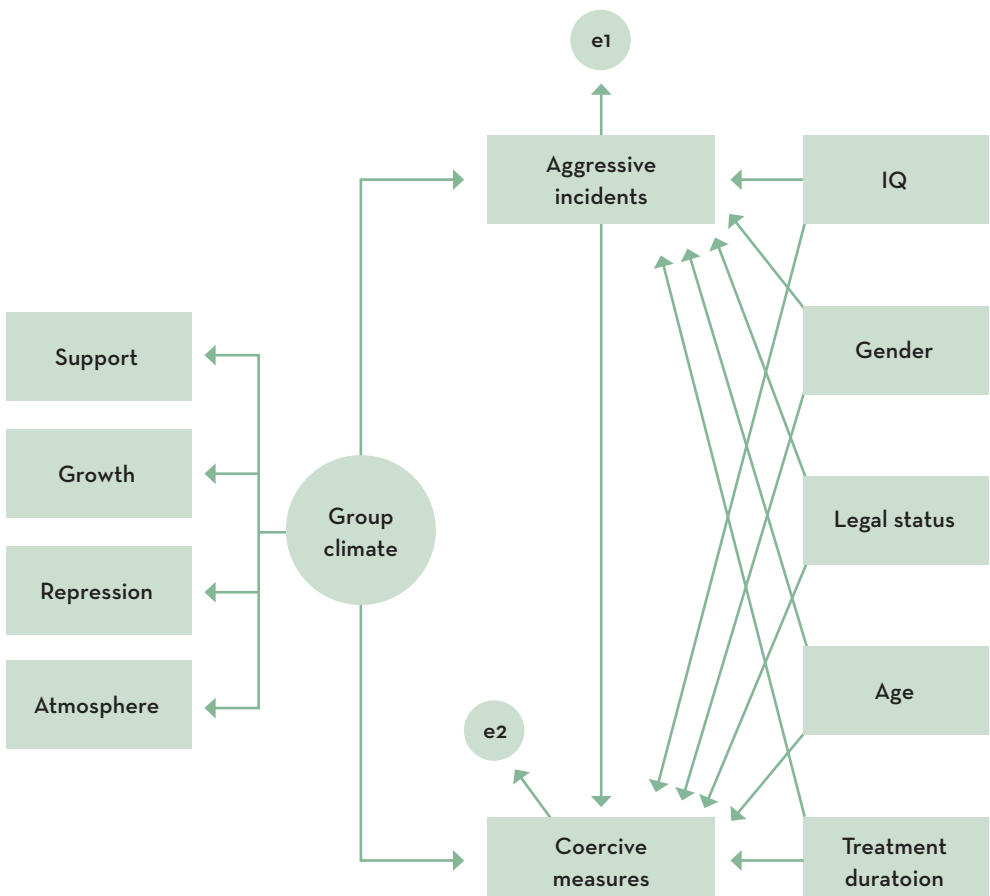
First, assumptions were checked (missing data, multivariate outliers). We addressed missingness of the data using Little's MCAR test. We also examined multivariate and influential outliers using visual inspection of the data as well as examining values for Cook's distance and Mahalanobis distance. Further, we examined associations between group climate, coercive measures, and aggressive incidents using bivariate correlation analyses (Pearson's r). Pearson's correlations of r = .10 - .30 are seen as small, r = .30 - .50 are seen as moderate, and r > .50 are seen as large (Cohen, 1992). Subsequently, we tested the hypotheses through multilevel structural equation modelling (MSEM), due to the nested data structure (clients were nested within groups), using Mplus software version 6.11 (Muthén & Muthén, 2017).

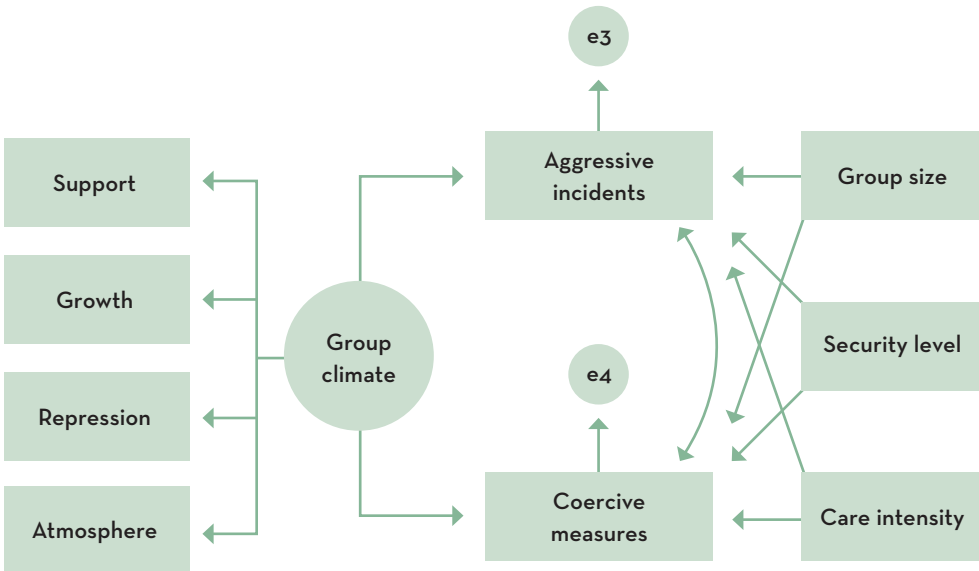
We followed the procedures outlined by Hox (2010). First, intraclass correlation coefficients (ICCs) were calculated to examine between-group variability (i.e., the degree of non-independence in the data) (Raudenbush & Bryk, 2002). ICCs greater than zero are indicative of nested data structures, in which case multilevel analysis is warranted (Byrne, 2012). Then, the covariance matrix was decomposed into a pooled within- and between-level covariance matrix. The pooled within-level covariance matrix was used to examine the within-level part of the model, and the pooled between-level covariance matrix was used to examine the between-level part of the model. Next, a multilevel structural equation model was fitted in which the within- and between-level models were estimated simultaneously using the 'type = two-level' option in Mplus. Maximum likelihood (ML) was used to estimate all models. We followed the guidelines on using the MSEM framework to test multilevel mediation as outlined by Preacher, Zyphur, and Zhang (2010), as well as the provided Mplus syntax.

We hypothesised a direct effect of group climate on aggressive incidents. More specifically: a negative association between aggressive incidents and support, atmosphere and growth. Also, we expected a positive association between aggressive incidents

and repression. Furthermore, we hypothesised a direct, positive association between aggressive incidents and use of coercive measures. We also examined differences in group climate between subgroups, addressing within-group (age, IQ, gender, legal status, and treatment duration) and between-group (security level, group size, and care intensity) variables. Legal status was coded as voluntary versus forced treatment. The hypothesised model is depicted in Figure 1.

Figure 1. Hypothesised model of the relation between group climate, aggressive incidents, and coercive measures





A measurement model was examined using the pooled within-level covariance matrix. In this model, group climate was specified as a latent variable, using four indicators: *support, growth, repression, and atmosphere.* Second, a structural model was examined in which a direct effect from group climate on aggressive incidents and coercive measures (both represented by observed [composite] variables) were specified, as well as an indirect effect such that aggressive incidents mediated the relation between group climate and coercive measures. Third, the pooled between-level covariance matrix was used to examine the hypothesised measurement and structural models at the between-group level. The variable repression was recoded such that a higher score was indicative of less repression because research on MSEM has found that reversely scored variables may cause convergence problems (Gustafson, & Stahl, 2005). Also, negative residual variance at level-2 is a common problem in MSEM, which can result in non-convergence of the model (Kim, Dedrick, Cao, & Ferron, 2016). The variable growth at the between-part of the model (level-2) displayed negative residual variance. Because the residual variance was close to zero and non-significant, it was fixed to zero, which is a recommended practice when using multilevel SEM (Hox, 2010).

Exact model fit was calculated with a Chi-squared test. Because the Chi-squared test is sensitive to sample size, fit measures that are less sensitive to sample size were

also used (Cheung & Rensvold, 2002): comparative fit index (CFI), Tucker-Lewis index (TLI), the root mean square error of approximation (RMSEA), and the standardised root mean square residual (SRMR). The SRMR at the within-group level (SRMRW) and between-group-level (SRMRB) were examined. Modification indices, giving the expected drop in chi-square if the parameter in question is freely estimated, were used to improve model fit. A non-significant Chi-square value is considered to indicate an exact fit to the data. The following fit values indicate a good fit to the data: TLI > .95; CFI > .95; RMSEA ≤ .05; SRMR ≤ .08, and values of TLI > .90; CFI > .90; RMSEA ≤ .08 are indicative of acceptable model fit (Cheung & Rensvold, 2002).

Results

Preliminary analyses

There was a very small proportion of missing values on the self-reported group climate data, ranging from 0% to 4.8% per variable. Little's MCAR test (χ^2 (63) = 54.70, p = .763) was not significant, indicating that missing values were completely at random. Missing values were imputed through expectation maximization. Two cases were identified as influential outliers regarding the variable coercive measures. These cases displayed a coercive measures score of 116 and 49, respectively, while the scores of the sample excluding these outliers had a range of 0-18 *(M* = 2.66, *SD* = .30). Also, values for Cook's distance (43.8 and 17.9, respectively) and Mahalanobis distance (186.7 and 32.4) as indicators for multivariate outliers were very high for these cases compared to the means of these values in the sample (Cook's distance M = 0.18 and Mahalanobis distance M = 1.99). The analyses reported below were run with and without the outliers and results indicated that they impacted the results significantly, particularly the parameter estimates of the between-level models. For example, the ICC of the variable coercive measures was extremely low (.01) with outliers present compared to the ICC value without outliers (.30). Also, between-level models with outliers indicated standardised beta's greater than 1, as well as very large standard errors of standardised estimates of associations involving the variable coercive measures. Therefore, these two cases were removed from the dataset.

Table 1 shows the means, standard deviations, and ICCs of the study variables as well as the correlations among these variables.

Tabel 1 Group Climate, Aggressive Incidents, and Coercive Measures: Means, Standard Deviations, Intraclass Correlation Coefficients (ICCs), and Correlations

	N	*M*	*SD*	ICC	2	3
Support (1)	248	3.54	0.68	.16	.70**	-.65**
Growht (2)	248	3.57	0.79	.13		-.57**
Repression (3)	248	2.78	0.70	.16		
Atmosphere (4)	248	3.39	0.79	.24		
Total group climate (5)	248	3.49	0.60	.20		
Aggressive incidents_total (6)	248	3.82	7.03	.11		
Aggression against property (7)	248	0.86	2.13	.08		
Physical aggression (8)	248	1.08	2.71	.07		
Verbal aggression (9)	248	1.89	3.94	.12		
Coercive measures_total (10)	248	1.05	2.66	.30		
Confinement in a segregated room (11)	248	0.20	0.96	.42		
Fixation (12)	248	0.33	1.58	.11		
Confinement in a clienst' own room (13)	248	0.33	1.01	.15		
Separation (14)	248	0.18	0.69	.38		

* p < .05. ** p < .01. (two-tailed)

4	5	6	7	8	9	10	11	12	13	14
.49**	.92**	-.22**	-.17**	-.07	-.25**	-.09	-.07	-.01	-.10	-.08
.36**	.82**	-.16**	-.17**	-.08	-.15*	-.07	-.07	.01	-.08	-.10
-.44**	-.81**	.28**	-.24**	.16*	.26**	.16*	.08	.06	.16*	.12
	.66**	-.26**	-.21**	-.17**	-.23**	-.12	-.06	-.11	-.06	-.04
		-.29**	-.24**	-.14**	-.29**	-.13*	-.08	-.05	-.13*	-.11
			.74**	.73**	.88**	.53**	.15*	.47**	.40**	.18**
				.37**	.53**	.34**	.19**	.20**	.30**	.16**
					.42**	.67**	.19**	.66**	.38**	.29**
						.30**	.04	.28**	.29**	.04
							.60**	.65**	.62**	.62**
								.02	.33**	.41**
									.04	.12
										.38**

A small to moderate significant negative correlation was found between group climate total score and aggressive incidents (r = -.29, p < .001). Significant small to moderate correlations in the expected direction were found between group climate subscales and different types of aggressive incidents, except for non-significant correlations between *support, growth*, and *physical aggressive incidents*. Also, a small significant negative correlation was found between group climate total score and coercive measures (r = -.13, p = .043). However, no significant correlations were found between group climate subscales and different types of coercive measures, except for a small positive correlation between *repression* and *confinement in a client's room* on the one hand (r = .16, p = .011) and a small positive correlation between repression and coercive measures total score on the other hand (r = .16, p = .014). Significant small to large positive correlations were found between different types of aggressive incidents and different types of coercive measures, except for the relation between confinement in a segregated room and verbal aggressive incidents, which was non-significant. Results indicate that an open and therapeutic group climate, characterised by higher degrees of perceived support, growth, and atmosphere and a lower degree of perceived repression, was associated with a lower number of aggressive incidents, but not significantly associated with coercive measures. Also, a higher number of aggressive incidents were associated with more use of coercive measures.

Participants' perceptions of an open and therapeutic group climate were associated with lower numbers of aggressive incidents, and institutional repression was associated with more aggressive incidents

No significant correlations were found between aggressive incidents and participants' age, IQ, gender, legal status, treatment duration, group size, care intensity, and security level. Coercive measures was significantly and positively related to participant's gender (r = .25, p < .001), legal status (r = .22, p = .001), and care intensity (r = .15, p = .022). Furthermore, coercive measures correlated negatively and significantly with group size (r = -.21, p = .001). No significant correlations were found between coercive measures and participants' age, treatment duration, and security level. These results indicate that coercive measures were more frequently enforced on female clients compared to male clients, clients who received treatment involuntarily, and those receiving more intensive care. Also, coercive measures were more often reported in smaller groups.

Structural equation modelling

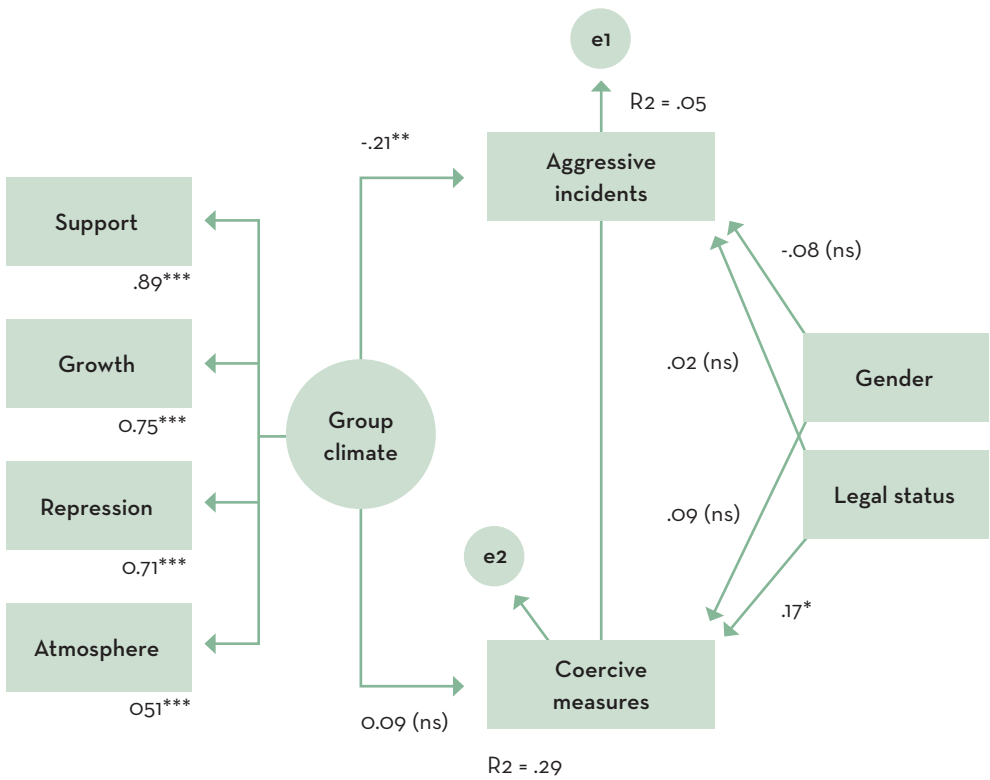
First, a measurement model was examined using the pooled within-level covariance matrix. A model with group climate represented as a latent variable showed an acceptable fit to the data: $\chi^2(2) = 5.56$, $p = .062$, CFI = .986, TLI = .959, RMSEA = .097, SRMR = .032. Second, the structural model was specified, in which a direct effect was specified from group climate on aggressive incidents, which was represented by an observed (composite) variable, as well as direct effects from group climate and aggressive incidents on coercive measures, which was also represented as an observed variable. An indirect effect was specified such that the relation between group climate and coercive measures was mediated by aggressive incidents. Results showed a good fit to the data: χ^2 (8) = 12.63, $p = .125$, CFI = .986, TLI = .974, RMSEA = .055, SRMR = .043. Next, a measurement model was fitted using the pooled between-level covariance matrix, in which group climate was specified as a latent variable, which resulted in poor model fit: χ^2 (2) = 25.71, $p < .001$, CFI = .894, TLI = .682, RMSEA = .452, SRMR = .065. Modification indices suggested a correlation between residual variances of the indicators *atmosphere* and *support*, which resulted in good model fit: χ^2 (1) = 0.94, $p = .331$, CFI = 1.00, TLI = 1.001, RMSEA = .000, SRMR = .013. The structural model indicated a good fit to the data, based on the majority of fit indices: χ^2 (6) = 8.56, $p = .200$, CFI = .991, TLI = .979, RMSEA = .086, SRMR = .040.

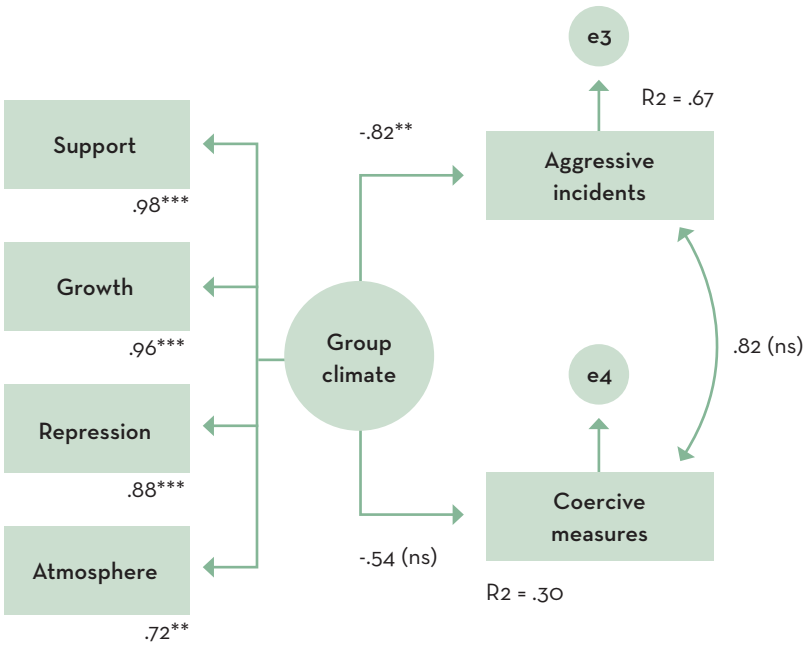
Subsequently, a two-level model was fitted, in which the within- and between-level models were examined simultaneously. Also, *gender* and *legal status* were included as within-level covariates. Between-level covariates group size and care intensity were considered, however, including these variables in the model showed a significant deterioration in model fit of the between-level part of the model. The final model (see Figure 2) showed a good fit to the data: χ^2 (24) = 38.71, $p = .029$, CFI = .970, TLI = .947, RMSEA = .050, SRMRW = .076, SRMRB = .068. However, results indicated a standardised beta coefficient greater than 1 between aggressive incidents and coercive measures. Therefore, a covariance between aggressive incidents and coercive measures was specified at the between-level part of the model.

Results indicated that, at the within-group level, group climate was negatively related to aggressive incidents ($\beta = -.21$, $p = .005$), but not significantly related to coercive measures. Aggression ($\beta = .51$, $p < .001$) and legal status ($\beta = .17$, $p = .011$) were significantly related to coercive measures. The relation between group climate and coercive measures was significantly mediated by aggression (indirect effect, $\beta = -.11$, $p = .010$). At the

between-level, group climate was significantly related to aggression (β = -.82, p = .005), but not to coercive measures (β = -.54, p = .05). This means that a positive group climate was associated with lower levels of aggression at both the within- and between-level, such that participants' perceptions of group climate were associated with lower levels of aggression, and variation in levels of perceived group climate between groups was also associated with aggression at the group level.

Figure 2. Two-level structural equation model of the relation between group climate, aggressive incidents, and coercive measures





Discussion

In the present study, the relation between group climate as perceived by individuals with MID-BIF staying in a secure forensic setting, aggressive incidents, and use of coercive measures on the living group was examined. First, our results support the hypothesised negative relation between the quality of group climate and aggressive incidents. Also, the number aggressive incidents was positively related to coercive measures, and proved to be a mediator of the relation between quality of group climate and coercive measures. Participants' perceptions of an open and therapeutic group climate were associated with lower numbers of aggressive incidents, and institutional repression was associated with more aggressive incidents. Although the conclusions regarding the relation between group climate and aggressive incidents generally are in line with those of earlier studies (De Decker et al., 2018; Heynen et al., 2017; Ros et al., 2013; Van den Tillaart et al., 2018; Van der Helm et al., 2012), some findings of the present study are inconsistent with earlier studies. The reason for these inconsistencies might be that studies were conducted in different settings, with different populations, and used different group climate

questionnaires and measures of aggressive incidents (Robinson et al., 2018).

Unexpectedly, we did not find an association between support, growth, and physical aggressive incidents. It is therefore concluded that physical aggressive incidents are mainly related to atmosphere and repression. The association between repression and aggressive incidents in general (including physical aggressive incidents) is in line with the deprivation model which states that aggression is not so much caused by client characteristics but by environmental factors such as sociotherapists' behaviour (Bosma, Van Ginneken, Sentse, & Palmen, 2019; Harer & Steffensmeier, 1996). However, the cause-effect relationship is still unclear, the association between aggression and repression stresses the importance of awareness on processes in which these factors interact. An explanation for the link between atmosphere and physical aggressive incidents might be the way atmosphere is measured with the GCI. This construct has a multifaceted character and measures among other things perceptions of safety and cohesion between clients. These facets are consistent with outcomes of the systematic review by Robinson et al. (2018) in which they stated that client's perceptions of safety, the level of cohesion between clients and the atmosphere of the environment are important elements of group climate which are associated with institutional aggression.

However, the cause-effect relationship is still unclear, the association between aggression and repression stresses the importance of awareness on processes in which these factors interact

Second, we found that a higher number of different types of aggressive incidents were associated with more frequent use of different types of coercive measures. This is in line with findings of studies by Van der Helm and Stams (2012) and De Valk et al. (2016) in which they noted that transactional processes in (forensic) residential settings can transform into coercive cycles when aggressive behaviour of clients induces coercive responses by sociotherapists, which in turn, causes aggressive behaviour by clients. Third, only a small positive association between repression and coercive measures was found. This may be explained by the earlier described fact that forensic residential settings are characterised by a certain amount of coercion to set boundaries as requirement for a structured and safe environment. De Valk et al. (2016) stated that sociotherapists' acting becomes repressive when the use of coercive measures is harmful, unlawful or arbitrary.

Limitations

There are several limitations of this study that should be mentioned. First, data were collected in only one facility, which limits the generalizability of the findings. Second, it was not possible to derive causal relations between group climate, aggressive incidents, and coercive measures, because of the cross-sectional design. We expect, however, bi-directional relations between the aspects of group climate and the number of aggressive incidents on the living group. Further studies with a longitudinal design are needed to explore causality between group climate, aggressive incidents, and coercive measures. Third, the sample size did not allow us to include more variables in the multilevel structural equation model. Also, regarding further analyses of different subgroups (e.g., differences between the hypothesised relation among men and women), future studies on the association between group climate, aggressive behaviour and coercive measures should use a larger sample, representing multiple organisations. Further, future studies might explore how other personal and contextual characteristics, for example, diagnoses of clients, team functioning and organisational factors, interact with aggressive incidents and use of coercive measures.

Implications

The current study supports the importance of the relation between the frequency of aggressive incidents and social environmental factors, which underlines the transaction models underlying inpatient aggression in daily practices (see Jahoda, Willner, Pert, & MacMahon, 2013). It can be expected that interventions focused on this transactional model will show an impact on both the group climate and the prevalence of aggressive incidents. It is advised that ongoing training of sociotherapists is facilitated by organisations, focussing on providing support, creating possibilities for growth, and creating a safe atmosphere in which learning becomes possible for clients with MID-BIF. In an open and therapeutic group climate, the occurrence of aggressive incidents may decrease and may contribute to better treatment results. Also, organisations should strive to minimize repression, as repression hinders the development of a therapeutic group climate, motivation for and susceptibility to treatment, and in the end rehabilitation (De Valk et al., submitted).

To create a therapeutic group climate and stimulate clients to develop, sociotherapists should be responsive to fulfil basic psychological needs of the clients, such as the need for autonomy, competence, and relatedness (Ryan & Deci, 2017). Giving clients the opportunity to make decisions themselves in their daily care may help to restore some feelings of control over their own lives (Blair & Kennedy, 2014). Providing opportunities to choose for themselves has been suggested to be an important component of interventions that aim to reduce the aggressive behaviour of clients with ID (Knotter et al., 2013). Another implication for secure forensic settings for individuals with MID-BIF relates to the continuing need of improving sociotherapists' expertise and competences. It is important that sociotherapists are educated in psychological and psychiatric problems underlying aggressive behaviour.

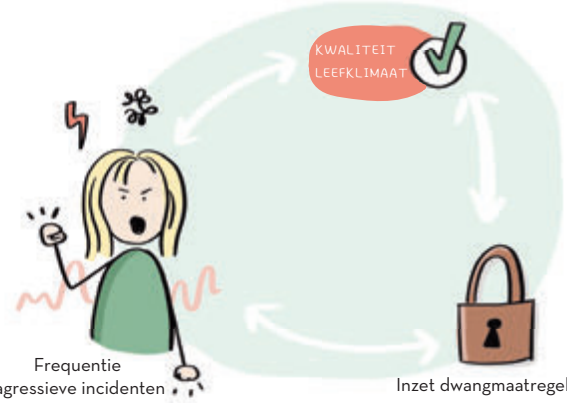
There is a continuing need of improving sociotherapists' expertise and competences

At last, further research is necessary in order to understand how work or team climate affect the quality of the group climate. There is preliminary evidence to suggest that a positive work climate, as perceived by sociotherapists, seems necessary in the degree to which sociotherapists can build an open and therapeutic group climate (Van der Helm & Stams, 2012). Establishing a more open and therapeutic group climate may not only result in a decrease of aggressive incidents, but also in a safer work climate for professionals.

2e STUDIE

SAMENHANG LEEFKLIMAAT, AGRESSIE-INCIDENTEN EN INZET DWANGMAATREGELEN

De GCI werd gebruikt om samenhang te onderzoeken



Frequentie agressieve incidenten

Inzet dwangmaatregelen

STEEKPROEF

248

CLIËNTEN

BEHANDELEN

Open en therapeutisch klimaat hangt samen met lagere frequentie van agressieve incidenten

SPANNINGSVELD

Er konden geen causale relaties vastgesteld worden vanwege het cross-sectionele onderzoeksdesign

BEHEERSEN

Repressief leefklimaat was gerelateerd aan hogere frequentie van agressie

TEAM SOCIOTHERAPEUTEN

Systematische analyse van agressie en reflectie op professioneel handelen bij incidenten wordt aanbevolen

KENNIS EN KUNDE

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CHAPTER 04.

“Back off means stay with me”. Perceptions of individuals with mild intellectual disability or borderline intellectual functioning about the group climate in a secure forensic setting

Abstract

Purpose: No studies have provided an in-depth account of how individuals with mild intellectual disability or borderline intellectual functioning (MID-BIF; IQ 50-85) perceive their group climate in a secure forensic setting. Giving voice to these service users may provide relevant insights for secure forensic settings. **Design:** Interpretative Phenomenological Analysis (IPA) was used to explore what individuals with MID-BIF experience with regard to their group climate. **Findings:** In the interviews about the four domains of group climate (i.e., repression, support, growth and atmosphere), five overarching dimensions appeared: 1) autonomy, 2) uniformity, 3) recognition, 4) competence, and 5) dignity. Depending on the person and the (treatment) context in which he or she resides, these five dimensions relate to all four factors of the group climate instrument. **Value:** From the perspective of individuals with MID-BIF this study contributes by providing a framework to "fine-tune" group climate on five dimensions. Training sociotherapists to be sensitive to interpret ambiguous signals on these dimensions can contribute to optimizing group climate in secure forensic settings.

Introduction

A therapeutic group climate is related to positive therapeutic outcomes, such as motivation, coping, therapeutic alliance, recidivism, and organisational outcomes including staff and client satisfaction and less aggressive incidents (Gaab, Brazil, De Vries, & Bulten, 2020; Willets, Mooney, & Blagden, 2014). Moreover, the Dutch government underlines the importance of a safe and humane climate that encourages self-reliance and a safe return to society in its policy for correctional settings (Boone, Althoff, & Koenraadt, 2016). Therefore, secure forensic settings monitor their group climate as a standard practice to inform their on-going quality improvement (De Vries, Brazil, Van der Helm, Verkers, & Bulten, 2018; Neimeijer, Roest, Van der Helm, & Didden, 2019; Tonkin, 2015). An example of a monitoring instrument is the Group Climate Instrument (GCI), which was developed to measure group climate in youth prisons and secure residential treatment facilities and is nowadays used in youth prisons, secure youth care facilities, forensic mental hospitals, adult prisons, and residential care facilities for individuals with mild intellectual disabilities (Van der Helm, Stams, & Van der Laan,

2011; Stams & Van der Helm, 2017). Although short self-report questionnaires like the GCI are relatively easy to use in clinical practice, these instruments measure a simplified construct of group climate. Therefore, some studies advocate for a more in-depth insight and operationalization of group climate, for example through individual interviews with client about their group climate (Doyle, Quayle, & Newman, 2017).

We aimed to develop a better understanding of the unique experiences, challenges and needs of individuals with MID-BIF in a secure forensic setting with regard to their group climate

Although the relationship between group climate and therapeutic and organisational outcomes is well-researched and documented in secure forensic settings, less attention has been paid to group climate in secure forensic settings for individuals with mild intellectual disability or borderline intellectual functioning (MID-BIF; IQ 50-85; Robinson & Craig, 2019; Willets et al., 2014). That is remarkable given the fact that the prevalence of individuals with below average or low intelligence is high in such settings (Vincenzutto et al., 2018). Until now, no studies have provided an in-depth account of how individuals with MID-BIF perceive their group climate in secure forensic settings (Bell, Tonkin, Chester, & Craig, 2017; Robinson & Craig, 2019). Giving voice to these service users may provide relevant insights in order to develop a therapeutic climate that meets the needs of individuals with MID-BIF to facilitate overall wellbeing and positive treatment outcomes. Therefore, in the present study we used Interpretative Phenomenological Analysis (IPA) as a qualitative method to explore what individuals with MID-BIF experience with regard to their group climate. IPA is a suitable approach to explore how individuals perceive situations they are facing, and how they make sense of their personal and social world (i.e., their group climate). IPA studies typically have small sample sizes, allow for in-depth engagement with each individual case, and a detailed exploration of similarities and differences between participants (Smith, Flowers, & Larkin, 2009). By using IPA, we aimed to develop a better understanding of the unique experiences, challenges and needs of individuals with MID-BIF in a secure forensic setting with regard to their group climate. It is expected that both helpful and unhelpful aspects of group climate would be identified by the participants. Following the qualitative and explorative nature of the current study, no hypotheses were formulated (Korstjens & Moser, 2017).

Method

Setting and participants

The present study was conducted at Trajectum, a Dutch secure forensic treatment facility for adults with MID-BIF and externalizing behaviour problems and/or internalizing problems. Due to a combination of MID-BIF, severe challenging behaviour, mental health problems, and/or a history of substance abuse all residents need intensive care and monitoring in a specialised and secure setting. Most residents have committed a serious crime and are admitted by means of a disposal to be treated on behalf of the state (in Dutch: Terbeschikkingstelling or tbs) as they were considered not to be legally accountable for their crime because of severe psychopathology. Other residents are placed in the facility under criminal law, civil law or were voluntarily admitted.

Treatment is provided by sociotherapists during daily routines, work and educational activities, individual and group therapy sessions and leisure activities in collaboration with psychologists, psychiatrists and psychotherapists, who supervise the sociotherapists and provide additional one-to-one treatment. Based on the psychopathology of the residents and the phase of the treatment (i.e., observation, treatment, and rehabilitation), treatment programs (e.g. aggression, addiction, or sexual offending behaviour), the security levels and care intensity vary over the units (i.e., observation, treatment and rehabilitation). While in some units the support is more distant, in other units the residents receive one to one guidance throughout the day. Depending on the risk of (re)offending, legal status and treatment phase, residents move to living groups with different levels of restrictions and levels of security.

Based on variability in characteristics on participant level (gender, age, diagnosis, legal status, treatment duration at the living group and the facility, treatment phase) and group level (security level, care intensity, group composition, group size, treatment program) participants were invited to participate. A purposive sampling strategy was applied to ensure variability in experiences amongst the participants. Twelve individuals (4 women; 8 men) with MID-BIF participated in the study. Their pseudonyms and characteristics are provided in Table 1 (see page 72/73).

Data collection

Data were collected in tranches between November 2018 and October 2019. Oral and written information was given to participants, their legal guardians and treatment teams concerning data collection, study aims, objectives, and that data were treated confidential and anonymous. A multidisciplinary treatment team consisting of a sociotherapist, a psychologist, and a psychiatrist determined whether a participant was able to give informed consent and to participate. Residents with severe and acute psychotic problems were excluded in accordance with ethical guidelines with regard to legal capacity. All included participants, and if applicable their legal guardian, gave their oral and written consent. Ethics approval for this study was granted from the Ethics Committee of the Faculty of Social Sciences (ECSS) of the Radboud University (ECSW2017-3001-471). The COREQ criteria list for qualitative research was used to guide the analysis and report (Tong, Sainsbury, & Craig, 2007).

In line with the IPA method, we used semi-structured interviews (Smith, 2011; Smith & Osborn, 2008). A topic list with visual support about group climate was used to guide the interviews. Consistent with the four subscales of the Group Climate Instrument (GCI; Neimeijer, Roest, Van der Helm, & Didden, 2019; Van der Helm, Stams, & Van der Laan, 2011), the central topics of the interviews were support, growth, atmosphere, and repression. First, the interviewer asked the participant which topic was most important to them (e.g., 'If we look at these four domains of the group climate (support, growth, atmosphere, and repression), which element do you think is the most important to you?') and stimulated them to share concrete experiences on this topic (e.g. how does the participant view the kind of support he/she is given or how do the participant and sociotherapists get along). Also participants were asked to give examples of a 'good' and a 'bad' day on the living group.

Interviews were carried out in an open and flexible manner with topics being covered according to the direction taken by the participants, aiming to initiate a dialogue with participants, while remaining open to other subjects raised by the participants themselves. At the end of the interview, participants were given the opportunity to mention additional topics. The interviews were conducted by the first and second author who are licensed psychologists with extensive experience in working with individuals with MID-BIF in a secure setting. The interviewers used a not knowing attitude and asked in depth about concrete examples of situations, behaviour of sociotherapists and own

Table 1. Pseudonyms of the participants and their individual and treatment characteristics.

	Individual Characteristics				
Pseudonym	Gender	CA (in years)	Level of functioning	Additional diagnoses	Legal status
Oliver	m	39	BIF	PTSD, personality disorder, schizophrenia or other psychotic disorders, substance abuse, gambling disorder	Criminal law
Jack	m	34	BIF	Sexual disorder, personality disorder	Criminal law
Harry	m	28	MID	ASD, schizophrenia or other psychotic disorders, substance abuse, attachment disorder, depressive disorder	Civil law
Sophie	f	35	BIF	PTSD, personality disorder, depressive disorder	Civil law
Charlie	m	25	MID	ADHD, PDD NOS, Personality disorder, aggression regulation problems	Civil law
Thomas	m	28	BIF	ASD, sexual disorder, personality disorder	Criminal law
Laura	f	33	MID	PTSD, personality disorder, schizophrenia or other psychotic disorders Substance abuse, obsessive compulsive disorder	Civil law
Rachel	f	45	MID	PTSD, personality disorder schizophrenia or other psychotic disorders, substance abuse	Criminal law
Oscar	m	18	MID	ADHD, social contact disorder	Civil law
James	m	43	BIF	ASD, schizophrenia or other psychotic disorders	Criminal law
Emily	f	22	BIF	ASD, schizophrenia or other psychotic disorders, attachment disorder	Voluntary
William	m	33	MID	ADHD, attachment disorder, substance abuse	Civil law

Note. F = female, M = male, BIF = Borderline Intellectual Functioning; MID = Mild Intellectual Disability; ADHD = attention deficit hyperactivity disorder, ASD = autism spectrum disorder; PTSD = posttraumatic stress disorder; PDD-NOS= pervasive developmental disorder - not otherwise specified; AT facility = admission time in the facility; AT group = admission time at the group, care intensity:2 on 8 = 2 staff on 8 clients (client staff ratio)

Treatment Characteristics

AT facility	AT Group	Treatment phase	Security level	Care intensity	Treatment program
5 years, 1 month	3 years 11 months	Closed treatment	Closed setting within in the clinic	Normal: 2 on 8	Sex offenders program
7 years, 1 month	1 year 9 months	Closed treatment	Closed setting within in the clinic	Medium high: 3 on 8	Sex offenders program
2 years, 10 months	8 months	Semi-closed tratment	Semi cloesd on the property of the clinic	High: 4 on 8	Individual program
7 years, 6 monts	3 months	Resocialisation	Semi closed on the property of the clinic	Medium high: 3 on 8	Outflow program/ last phase treatment program
4 years, 1 month	3 years, 5 months	Closed treatment	Closed setting on the property of the clinic	Medium high: 3 on 8	Individual program
3 years, 1 month	4 months	Closed treatment	Closed setting on the property of the clinic	Normal: 2 on 8	Sex offenders program
7 years, 1 month	1 year, 10 months	Closed treatment	Closed setting within the clinic	Very high care: 4 on 6	Individual program
4 years, 9 months	1 year, 9 months	Closed treatment	Closed setting within the clinic	Medium high: 3 on 8	Group addiction program
5 months	4 months	Observation	Closed setting on the property of the clinic	Medium high: 3 on 8	Inflow program/first phase treatment program
1 year, 4 months	1 year, 4 months	Closed treatment	Closed setting within in the clinic	Medium high: 3 on 8	Group aggression program
5 years, 6 months	5 months	Resocialisation	Semi cloesd on the property of the clinic	Normal: 2 on 8	Outflow program/ last phase treatment program
2 years, 4 monts	2 years, 3 monts	Closed treatment	Closed setting within the clinic	High: 4 on 8	Individual program

experiences of the clients. The duration of the interviews ranged from 25 minutes to 58 minutes with a mean duration of 37 minutes. The interviews were audio-recorded with the participants' informed consent and transcribed (verbatim) for coding purposes. Afterwards, the audio recordings were deleted.

Analysis

The transcribed interviews were analysed using IPA. IPA can be used for a detailed exploration of how people make sense of their personal and social world by exploring an individual's personal perception or experience as opposed to an objective description of the object or event itself (Smith & Osborn, 2008). IPA is a dynamic process based on the assumption that the researchers have an active role in the research process and influence the extent to which they access the participant's experience and how they interpret and make sense of that experience. The clinical experiences of the researchers are important to be able to properly interpret the experiences of the client in the light of their complex problems and unique context in which they reside (Zomerplaag, 2017). Therefore, we thought IPA better suitable than other procedures such as Grounded Theory (Glaser & Strauss, 1967) and thematic analysis (Braun & Clarke, 2006).

Data analysis was carried out by the first and second author independently and followed the stages set out by Smith and others (2009). The first stage involved the close reading and rereading of the transcript to become familiar with the interview content. Second, the transcript was read line by line, noting points of interest and significance on a descriptive, linguistic and conceptual level. Third, the transcript and initial notes were reread, with emergent themes noted. At the fourth stage, themes that were considered as connected were grouped into overarching themes and given a descriptive label, after which these groups of themes were discussed within the research team. As a result, some additional changes were made in the grouping or descriptive labelling of themes. To ensure that the analysis was carried out in a rigorous way and that interpretations made by the first and second author were of an explicit nature, all stages involved a discussion with a third researcher to provide an audit of the analysis. These stages were repeated for each transcript after which the overarching themes for each interview were compared and discussed with the research team to find patterns across cases. After 12 interviews had been reviewed, no new theoretical aspects emerged from further coding and comparison and saturation was reached (Mason, 2010). The dimensions and themes that

emerged during interviewing and analysis are reported in a tabulated outline (see Table 2). Expert checks were carried out with the fourth and fifth author who are experts both in forensic care for individuals with MID/BIF and group climate.

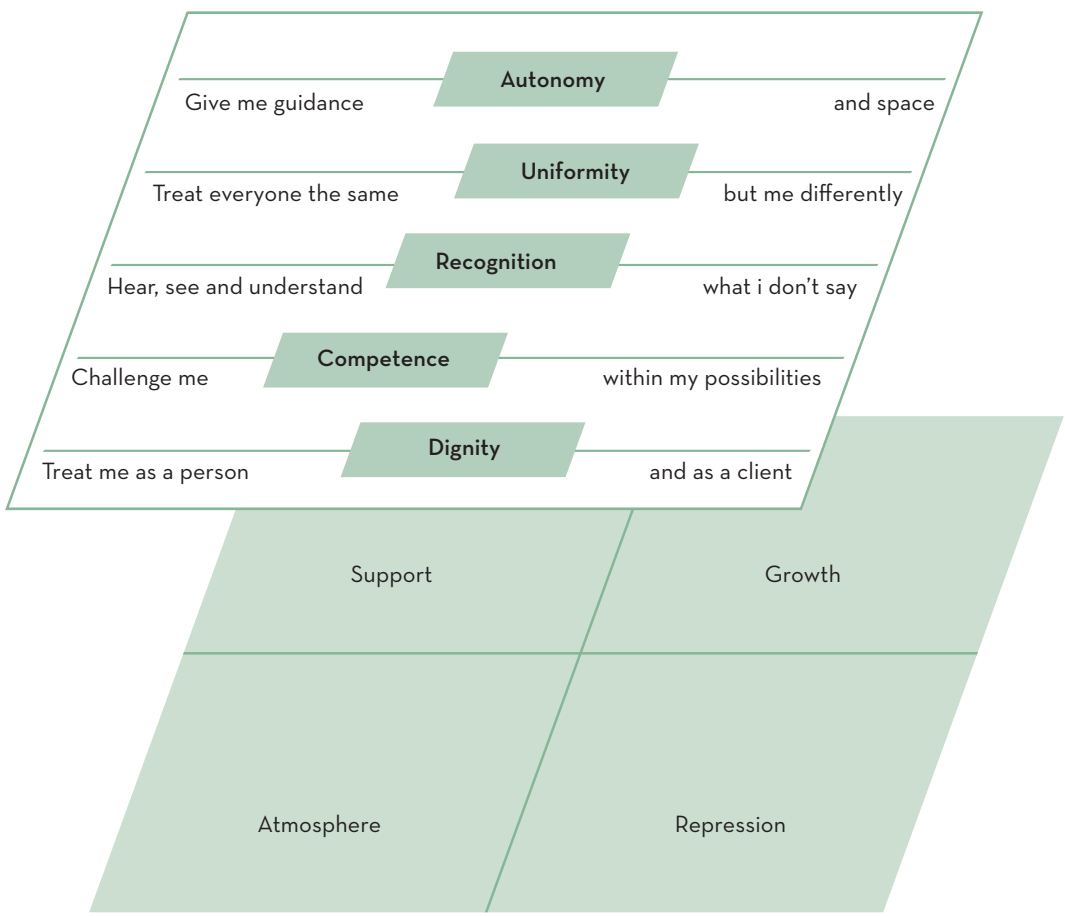
Table 2. Tabulated outline with dimensions and themes.

Topic	Dimension	Themes
	Autonomy	guidance, personal space, structure, rules, (in)dependency, protection, safety, self-determination, control, limits, clarity, predictability, dominance, risky behaviour
	Uniformity	individual approach, group approach, exceptions, uniqueness, belonging, feeling disadvantaged, equality, fairness, cohesion
Group climate (support, growth, atmosphere, repression)	Recognition	being seen, being heard, understanding, without words, trust, empathy, presence, proximity, responsibility, connection, professional distance, engagement, contact
	Competence	challenge, possibilities, disability, meaning, strength, feedback, daily activities, encouragement, short term, long term, perspective, development, expectant acceptance, meaningful involvement, coping, personal growth, small steps
	Dignity	humanity, disability, disorder, coercive measures, us versus them, honesty, privacy, identity, self-esteem, individual needs, normalise, ordinary

Results

In all interviews we identified five overarching dimensions that might help sociotherapists to optimize the four factors of the group climate (i.e., support, growth, repression and atmosphere) at an individual level (see Figure 1). These dimensions are: 1) Autonomy, 2) Uniformity 3) Recognition, 4) Competence, and 5) Dignity.

Figure 1. The five overarching dimensions as a 'mixing console'



1. **Autonomy: Give me guidance and space**

"I don't like that [when sociotherapist are strict]. That way you will never become independent. (…) The sociotherapists should have protected me by not letting me go on my own. But they left me on my own (...) I was constantly taking drugs and I was constantly using again." (Charlie).

"[When clients don't obey the rules] it is important that there is structure and the sociotherapist talks to the client (…) When ...the sociotherapists are in the office, I feel unsafe. Then I am afraid that I will be touched and use violence. If the sociotherapists are there, it does not happen (...) I like it when a sociotherapists makes jokes and doesn't pay strict attention to what I am doing. There are also sociotherapists who are very strict, just like prison guards. It might be better for me if someone is strict and watches over me. Some sociotherapists say nothing, while it is better if they do say something" (Rachel).

All participants discuss the limitations in their autonomy that they experience with regard to their privacy, freedom of movement and self-determination at different levels and how these limitations frustrate them. Sometimes they refer to small and everyday things, such as the kitchen cupboards that are locked or that they (cannot) choose which toppings they would like to have on their bread. At other times, it concerns matters that have a major impact on their lives, such as the granting of leave or the extension of their obligatory treatment. At the same time, they realize that these restrictions in autonomy are necessary to ensure the safety and quality of life in the groups and to protect society and / or themselves. According to the patients, it is important that sociotherapists understand when and in which situations they should give the person space and when not. This decision is complex because the potential safety risks and the autonomy of the person compete with each other and risk behaviour is related to various individual and contextual factors, which change over time. For example, Charlie emphasizes at the beginning of the interview that it is necessary for his recovery to increase his independence, while later in the interview he talks about the moments in which he, due to a lack of supervision, uses drugs.

"If I go outside the clinic, I first think about how much time I need and then I discuss this with the sociotherapists. Then we make the appointment together. I like that" (Harry).

"I am not a twelve year old child. We are all adults, and that is sometimes forgotten. Please note that the way people say things makes it more or less easy for me to accept things and that it should above all be a respectful way of saying things and not an authoritarian one" (Oscar).

"I would like to see a prostitute. (...) Then I was told that it was not possible yet. I would like to see them explain and tell me what they expect from me. I want to know why it's not possible and what I have to achieve, own or control so that I do can go there" (Thomas).

When rules, boundaries and agreements are nevertheless used as a means to provide support and safety, the participants, like Harry, Oscar, and Thomas, indicate that it is important that sociotherapists do this in a respectful and mature way, explaining to them why these measures are being taken. Participants, like Harry, would also like to have a voice in how these restrictions look like and they want these restrictions be enforced in a consistent manner, because failure to enforce them consistently leads to uncertainty and can lead to an increase in problem behaviour. Finally, the participants, like Thomas, would like to know how, when and in what way these restrictions in autonomy will be settled. According to participants, it is crucial that the sociotherapist understands their individual characteristics and the relatively need for support in relation to the individual need for space and autonomy.

2. Recognition: Hear, see and understand what I say and what I don't say

"In the beginning people thought when I was angry and when I cursed and raged: oh, he is losing his mind again. But you can also ask yourself, what's going on in his head? What is going on? Could we solve those puzzle pieces? (…) Sociotherapists shouldn't pretend to be some kind of superman who can help all the people here. Or that they have life experience (...) If you have experienced the same as I did you would also be here in this clinic, you would also have been to prison (...) It's better to say: "I understand your

situation". Well, that's another thing. Better: I try to understand. But not: I understand, because you don't understand!" (Charlie).

"Sociotherapists should notice when things are not going well, even if I do everything to put on my mask. It is not always easy to tell people everything when you don't know them very well. I always take precaution first and then I talk to someone. (…) It is part of the knowledge of the sociotherapists that they know what someone needs (…) If I had talked earlier I could have prevented self-injury, that is not due to the sociotherapists because they couldn't have seen it come" (Sophie).

These quotations show that clients demonstrate internalizing and externalizing behaviour that has led to such a great risk or problem that 24-hour support and supervision is necessary. Participants expect sociotherapists to view their behaviour as a symptom of an underlying problem or need and that they are able to analyse and anticipate to this behaviour. Instead of responding to the externalizing behaviour of Charlie, the sociotherapist should pay attention to his underlying fear and uncertainty and anticipate to his need for affinity (see also Anglin, 2014). This is difficult because the observable behaviour often deviates from the implicit and unspoken message and many clients try to mask their underlying problems (Charlie: *"Back off means stay with me"*). Nevertheless, participants feel that sociotherapists should have the knowledge and skills to interpret their ambivalent signals properly because of their education and work experience.

"Listen to you ... Don't twist things and be open and honest. And they have to trust me, because otherwise it makes no sense... If people do not keep their promises, my confidence will drop again (..) the sociotherapists must keep their promises and I must be open and honest" (Jack).

"The sociotherapists should ask more questions and assume less" (Thomas).

"The sociotherapist should be less often in the office, but be more involved with the group, such as a sociotherapist [who] comes to you on his own initiative [and has] a normal social conversation [with me]. If I just sit in my room all day, I don't think they will come to my room. No, why is he sitting there in his room all day, is there something going on?" (James).

The participants consider it the task of the sociotherapist to interpret their symptoms correctly in order to unravel the underlying function of the behaviour and to intervene on it. Therefore, the sociotherapist must get to know them well as a person and build and maintain a relationship of trust. For this, the sociotherapist, as James describes, must be present in the group, take the initiative for (normal) contact, not to judge, be patient and show interest in getting to know the person. Only when the person trusts the sociotherapist can he, through questions and listening, gain insight into the coping and underlying problems of the person.

3. Uniformity: Treat everyone the same, but treat me differently.

> *You have not chosen the ones you are in a group with (...) If someone is angry, that also triggers you. (...) I suffer from that. (…) when I have been on leave and come back to the group, it feels good (Laura).*

> *Look, you're staying here with eight people. If you say something wrong, it can get nasty, that makes me nervous (...) You shouldn't interfere with other clients and focus on yourself (...) ... People don't just use [drugs] without reason, talking about it [in group therapy] helps" (Rachel).*

> *It is positive that we are one group and that we trust each other... when a new client comes, you first have to see whether you can trust them (Oliver).*

The participants gave many examples that showed an ambivalent attitude about living in a treatment group. Participants emphasised that living with people who are different from themselves and often show complex, dangerous and unpredictable behaviour in a secure setting that they cannot leave, is tiring and evokes negative emotions and behaviour as they must continuously adapt to other residents and be alert for potentially dangerous situations. As a result, participants are often anxious or tensed, especially, like indicated by Oliver, when a new resident joins the group. Finally, the participants refer to negative consequences (e.g. restrictions in their freedom of movement) as a result of the problem behaviour of another person. In general, most participants do not prefer to live in a group. However, all participants described that they belong to the group and/or feel at home as the group members offer them sociability and support. Participants want to

“If someone says you are a mission to fail, that may be meant as a joke, but it makes me feel like shit …”

spend time together, participate in activities and be treated and addressed as members of their living group. However, at the same time there is a (strong) need to be seen and treated as an individual, especially when the participants discuss the structure and rules within the clinic. Although participants emphasize the need for uniformity regarding routines, rules, and clear agreements, they also stress that when routines and rules are too strict and no individual exceptions can be made, this will result in (behaviour) problems. This ambiguous attitude towards rules and agreements is formulated by Laura: *"I think the rules and agreements should be the same for everyone. (....) I think that rules should be made per person"*

As sociotherapists are responsible for maintaining the atmosphere and safety in the group, participants expect sociotherapists to take into account their need for equal treatment and clarity about rules, but at the same time they should have an eye for the individual characteristics of the person and find ways to avoid uniformity and group agreements, so that they can meet the individual needs of the participants. According to the participants, it is important to justify an individual exception to the person, the group and other professionals within the organisation.

4. Competence: Challenge me within my possibilities

"It is difficult to find a good place for me to live. I have an aggression and drug problem. ... There are only two institutions that are willing to take me (...) You have to wait very long before you can move to the next step. (...) Sometimes I went too quickly to the next stage of treatment, the step was too big (...) my future is my downfall. I am actually well at my current living group" (Charlie).

"If someone says you are a mission to fail, that may be meant as a joke, but it makes me feel like shit ... I want people to start the treatment with me so I can make it to the next step. Therapy is important, but pottering is just as important to me.
"In the future I want to live somewhere, with a dog and my daughter ... That sociotherapists come to visit me three times a week or something. (...) I prefer to be out of psychiatry, but that will probably not happen any time soon, but with an extra step in between" (Laura).

Most people strive for a meaningful life and for most participants initially this means a normal life. During their treatment participants come to realize their vulnerability and long term support need, which changes their perspective on the future. In the interviews, participants struggle with the acceptance of their disability and support needs, and the need for perspective with regard to the possibilities and dreams for the future, such as Laura. Although the perspectives on the future differ between individuals and are related to the phase and duration of the treatment and the support they receive, all participants look for a meaningful use of time within the clinic.

Like James, the participants refer to therapy, which contributes to long-term goals and, on the other hand, to activities, such as crafts, that contribute to a meaningful interpretation of the day. All participants indicate that it is important that you have a sense of feeling of independence, that you achieve something and that you have the idea that staying in the clinic makes sense. In their interviews, the participants sometimes refer to small and everyday successes, such as selling a homemade flag line made during daytime activities, preparing a meal for the group, a homemade rap or the certificates obtained for therapy. At other times they talk about moments that have a major impact on their lives in the long term, such as moving to a different stage of treatment or place of residence or contact recovery with family.

> *"I would like to move to another place, rather today than tomorrow. What I really miss is that people don't inform me about how we are going to proceed, what else do they expect from me? .... I have to ask questions about everything. Then I think, does that necessarily mean that I have to come to you and cry? I was recently told that I was nagging too much, and then they told me again, well, you also have to ask. Then I think: 'What do you want? Be straight!'" (Jack).*

Sociotherapists should pay attention to the limitations of the person and offer the person sufficient support by offering the person a day program in which there is a good balance between rest and meaningful activities and adequate verbal or physical prompting during tasks in order to gain success experiences. On the other hand, they should pay attention to the longer term perspective of people who, because of their complex problems and the context in which they find themselves, often have limited opportunities to achieve a more dignified, more experience-rich existence in a meaningful context. Since the participants' ability fluctuate during the day, sociotherapists must continuously

estimate what the person can handle at that time and in that situation and what support the person needs to undertake the activity. However, by undertaking positive activities together, which are in line with the capacity at that time, there is room for successful experiences in relation to self-image and appreciation and in relation to the sociotherapists. Although the participants recognize the importance of a phased treatment that is offered in small steps, the small steps and the lack of a clearly outlined future perspective also frustrate them. At the same time, most people are unable to sketch a written and complete treatment process because they often cannot oversee this and are focused on all things that have "not yet started". This leads to negative thoughts about themselves, the treatment and the treatment environment as a whole, which is also referred to as loss of perspective.

5. Dignity: treat me as a person and as a client

> *"Those very small and simple things can make you very happy. And then there are those very small simple things that do not fit, which can make you unhappy. It would help if the sociotherapists took more initiative to come to me. Then I feel that I do matter (...) He [a sociotherapist] treats you as a human being, explains things well and listens (...) It gives a bad feeling if they rather see you come than go (…) As the sociotherapists say: 'It was nice to go with you outside of the clinic,' it makes me feel good" (James).*

All participants state that it is important to them that sociotherapists do not see them as a client or their work, but as a person. According to them, the person must be central in their care instead of the offense, the disorder and/or the disability (see also Barnao, Ward, & Casey, 2015; Griffith, Hutchinson, & Hastings, 2013). Participants want an equal, sincere and reciprocal human-to-human collaboration between therapist and client. At the same time, the participants want a professional with clinical expertise with sufficient knowledge and skills to unravel their problems and needs and intervenes accordingly. The participants see initiating and maintaining the relationship between therapist and participant as part of the sociotherapists' tasks and responsibilities. Therefore, sociotherapists must have sufficient knowledge and skills to initiate and maintain this contact, even if the participant does not collaborate.

"My brother died last year suddenly, at the age of 22. That was a tensed situation for me (...) sociotherapists took really good care of me (...) Those days after his death I was not feeling well and constantly sad. And then the sociotherapists said: We are not going to stay here for lunch …. Then we made a sandwich together, we cycled to the camping and had lunch there with the two of us" (Emily).

Instead of planning a meeting at the unit or a conversation with Emily's psychologist about her grieving process, her sociotherapist chooses to picnic with her at a campsite near the clinic. They reminisce about her brother and talk about the loss. At that moment she was approached primarily as 'a human being' instead of as a client. At the same time, the sociotherapist must remain alert to signals that indicate a potential dangerous situation for Emily and/or her environment. In day-to-day interactions, sociotherapists should navigate between the role of fellow human beings who interact with the client in a cooperative, equal and dignified manner and offer a human existence within the clinic and between the role of professional who approaches the client using their clinical expertise and skills.

Discussion

This study established an in-depth account of the experiences of twelve individuals with MID-BIF about their group climate in a secure forensic setting. In the interviews about the four domains of group climate (i.e., repression, support, growth and atmosphere), five overarching dimensions appeared: 1) autonomy, 2) uniformity, 3) recognition, 4) competence, and 5) dignity. Depending on the person and the (treatment) context in which he or she resides, the five dimensions relate to a greater or lesser extent to all four factors of the group climate instrument (see figure 1). For example, the dimension of competence was connected to experiences related to the domain of growth, while the themes of autonomy, dignity and uniformity were strongly linked to experiences related to the domain of repression. In the interviews, the dimensions follow each other at a rapid pace and reinforce each other, as can be seen in the following quote:

"If someone calls you a mission impossible, that might be a joke, but it gives me a bad feeling (...) I recently made a very nice soapstone turtle. That turtle has become

so beautiful, so beautiful! It is now exposed in a museum. It would be really cool if someone buys it" (James).

James refers to a moment in which he feels competent - "museum-worthy soapstone turtle" - and experiences incompetence - "mission impossible" - (dimension: competence). In addition, he talks about his self-esteem (dimension: dignity) and whether or not he is seen and heard by sociotherapists (dimension: recognition). This example illustrates that there are not five separate dimensions, but five dimensions that, as sliders on a mixing panel, must be continuously adjusted and in interaction by the sociotherapists for several clients at the same time.

"When I am tense, I like that staff is with me. But when I'm mad they got to leave me alone" (William).

"When I say that everything is going well, staff has to understand that it is not going well at all, they have to get through" (Rachel).

"Back off means stay with me" (Charlie).

As can be seen in the quotes above from William, Rachel and Charlie, all participants gave ambivalent views about group climate in general and the support from sociotherapists in particular. For example, when Rachel indicates that she is doing well, this sometimes means that she is actually doing well, while this is not the case at other times. However, she expects, like the other participants, that sociotherapists can interpret her behaviour correctly and anticipate as the participants are not able to express their needs in everyday situation and regularly send out verbal and non-verbal signals that conflict with their need for proximity from sociotherapists.

"Back off means stay with me"

In addition, signals from participants, as in the quote from William, sometimes appear to differ only subtly ("tension" versus "anger"), while sociotherapists are expected to behave in opposite ways as they have to give him space when he is angry and comfort him when he is tensed (proximity vs. space). Finally, the signals and support needs vary greatly

between participants and over time. Where sociotherapists have to leave William alone when he is angry, Charlie needs the proximity of sociotherapists in a similar situation.

This indicates that it may be impossible to formulate an uniform, optimal group climate for individuals with MID-BIF in secure forensic care, but that a therapeutic group climate varies per person, per situation and over time. Sociotherapists are expected to receive the subtle and ambivalent signals sent out by the participants, to interpret them correctly within that specific context and intervene accordingly. This implies that group climate is a dynamic concept in which sociotherapists must continuously attune their actions to the ambivalent signals of multiple individual clients at the same time. This is even more complex due to ambiguous task of the professionals in this forensic context (i.e., the therapy-security paradox; Inglis, 2010; Jacob, 2012) as they have to assess and manage risks while at the same time building and maintaining a therapeutic relationship and anticipating to the needs and requirements of clients. This paradox has been the focus of scientific research for decades. The Risk, Need and Responsivity (RNR) principles of Andrews, Bonta and Hoge (1990) has been the basis of most rehabilitation and treatment programs for delinquents to date and focuses primarily on risk management and relapse prevention. As a counterpart, the Good Lives Model (GLM; Ward, 2002; Ward & Stewart, 2003) focuses mainly on promoting the well-being of the delinquent and focuses on the strengths and capacities of the individual. In the ID-literature positive behaviour support (PBS) has received increased attention (Davies, Griffiths, Liddiard, Lowe, & stead, 2015). Although these theoretical frameworks have proven to be useful within forensic care, it remains difficult, as can be seen in this study, to translate these frameworks from general directions to specific guidance for the unique person in his or her specific context. As in complex care, on the one hand you need 'big K knowledge', based on research, captured in publications and transmitted through training and education. As seen in this study, also 'small k knowledge' is important, based on personal experiences and is the result of own thinking of sociotherapists, that can be used to make the fit with the person (Zomerplaag, 2017). This complicates the work of the sociotherapists in forensic care for people with MID-BIF; working at the intersection of forensic care, psychiatry and care for individuals with intellectual disabilities. This should be integrated flexibly, taking into account different perspectives, proven methods and (legal) frameworks.

A few comments should be taken into account when interpreting the results of this study. As with any study using IPA, this study provides insight into how a small number

of participants who are part of a specific target group experience a specific phenomenon. This means that the results should be interpreted with caution in relation to generalisability to the population of individuals with MID-BIF in secure forensic care. Follow-up research must show to what extent the five overarching dimensions are specific for forensic care for persons with a MID-BIF or whether these dimensions are also present to a greater or lesser extent in the regular care for persons with a MID-BIF or within forensic care for individuals without MID-BIF. A second comment that should be made is that the four factors of the GCI (i.e., support, growth, atmosphere and repression) were used to operationalize group climate within this study. Given that group climate is measured by the GCI within this setting (see: Neimeijer, Roest, Van der Helm, & Didden, 2019; Neimeijer, Delforterie, Roest, Van der Helm, & Didden, 2020), we believe that this is an appropriate choice. Another topic list with regard to group climate might have led to other dimensions. Another comment is that in IPA the researcher is in essence adopting two positions; one which attempts to see the world from the perspective of the participant, and in effect stand in their shoes (the insider perspective). The other position is that of self-conscious and systematic explorer of the participant's perspective (the researcher perspective). It should be acknowledged that the actions and decisions of the interviewers will inevitably impact on the meaning and context of the experience under investigation (Rodham, Fox, & Doran, 2013). At the same time, given the uniqueness of the context and complexity of the target group, this is also necessary for careful interpretation. Finally, it is recommended to examine the perspective of sociotherapists with regard to group climate in follow-up research.

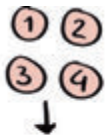
This study underlines the complex task assignment of sociotherapists in forensic care for clients with MID-BIF

This study underlines the complex task assignment of sociotherapists in forensic care for clients with MID-BIF. Group climate must be attuned to their specific characteristics, needs, learning style inherent to MID-BIF, mental disorders and risky behaviour, while at the same time risks and safety must be monitored. High-quality and effective treatment requires the integration of knowledge and skills from forensic care, psychiatry and care for individuals with MID-BIF. By training sociotherapists to highlight risks based on the functioning profile and development history of individuals with MID-BIF, it is expected

“Sociotherapists should notice when things are not going well, even if I do everything to put on my mask”

that group climate, and thus the clinical, forensic treatment, will be better connected and have an effect in terms of reducing risky behaviour. We therefore recommend investing in the knowledge, skills and attitude of sociotherapists with regard to identifying, interpreting and intervening on the living group. This study contributes by providing a frame work (i.e., a mixer) to "fine-tune" group climate on five dimensions. Training sociotherapists to be sensitive to interpret ambiguous signals on these dimensions can contribute to optimizing the group climate in a way that acknowledges the unique person in his or her specific context, which is in line with the broader trend of person-centred care in which the 'one size fits not all' principle applies (Håkansson Eklund et al., 2019).

3e STUDIE DIEPTE INTERVIEWS



GCI factoren als raamwerk voor interviews

12 volwassenen met LVB

Vergaren diepte-informatie met als doel meer details, nuances of context.

Leefklimaat begrijpen vanuit perspectief van cliënten en inzicht verkrijgen waarom het leefklimaat therapeutisch of repressief ervaren wordt

Er verschenen 5 overkoepelende dimensies uit de interviews:

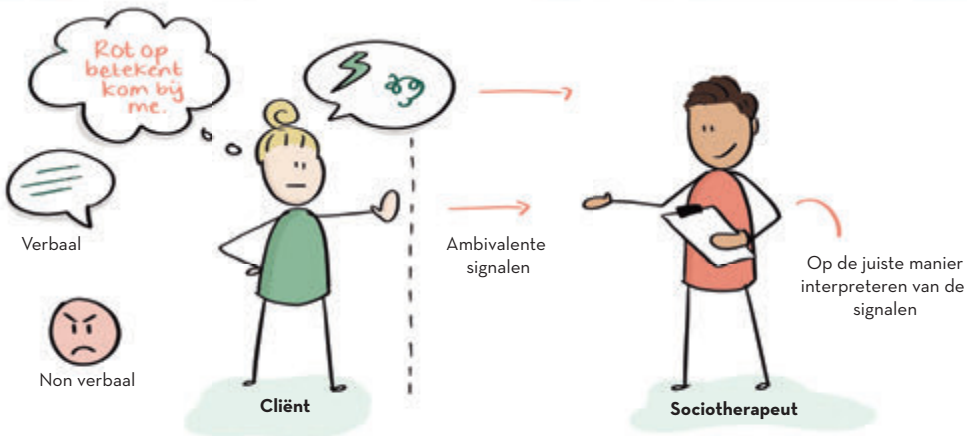
1. AUTONOMIE

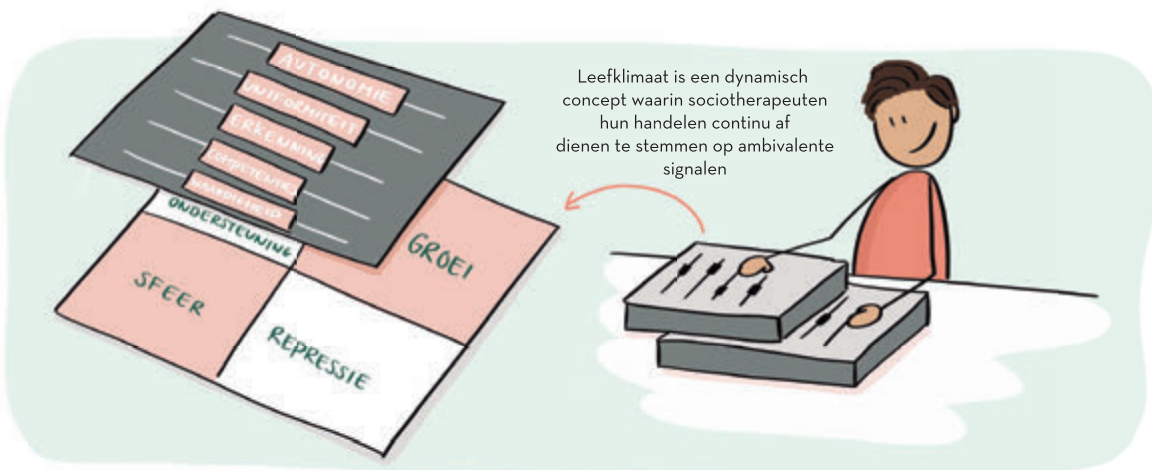
2. UNIFORMITEIT

3. ERKENNING

4. COMPETENTIE

5. WAARDIGHEID





Leefklimaat is een dynamisch concept waarin sociotherapeuten hun handelen continu af dienen te stemmen op ambivalente signalen

This chapter is submitted for publication:

Neimeijer, E.G., Roest, J.J., Van der Helm, G.H.P., & Didden, H.C.M. (2021). The association between work climate and group climate in a secure forensic treatment setting for individuals with mild intellectual disability or borderline intellectual functioning. *International Journal of Forensic Mental Healt*h.

CHAPTER 05.

The association between work climate and group climate in a secure forensic treatment setting for individuals with mild intellectual disability or borderline intellectual functioning

Abstract

Background: This study examines associations between group climate as perceived by individuals with mild intellectual disability or borderline intellectual functioning (MID-BIF) and work climate as experienced by sociotherapists in a secure forensic setting. **Methods:** The sample of participants consisted of 212 clients and 262 sociotherapists from 58 living groups. Group climate was assessed with the Group Climate Instrument and work climate was measured using the Living Group Work Climate. Structural equation modelling and multilevel analyses were used to analyse the associations between work climate and group climate. **Results:** When sociotherapists experience more job satisfaction, they experience less negative team functioning. Also,when sociotherapists experience more positive team functioning, less repression was perceived by clients. Perceived workload and negative team functioning by sociotherapists are related to less experienced possibilities for growth by clients. No significant associations were found between the other work climate and group climate dimensions. **Conclusions:** This study stresses the importance of awareness on parallel processes between work climate and group climate in secure settings for individuals with MID-BIF. Continuous attention must be paid to what teams as well as individual sociotherapists need to be able to do their important work.

Introduction

Sociotherapists who work with individuals with mild intellectual disability or borderline intellectual functioning (MID-BIF; IQ 50 – 85) in a secure forensic treatment setting face an important task. Supporting individuals with MID-BIF and creating a therapeutic group climate is of great importance for effective treatment (Robinson & Craig, 2019; Willets, Mooney, & Blagden, 2014). In order to create a therapeutic group climate, sociotherapists need to keep a balance between responsivity and reducing risks in order to avert dangerous and harmful situations for themselves, their colleagues and other clients living in the same group (i.e., therapy-security paradox; Inglis, 2010; Jacob, 2012). In secure forensic care settings for people with a MID-BIF, these principles must be integrated with an approach, in which emotional, social, cognitive and adaptive functioning of clients are taken into account. This complicates the work of the sociotherapists in fo-

rensic care for people with MID-BIF, that is working at the intersection of forensic care, psychiatry and care for individuals with intellectual disabilities.

Because daily interactions between clients and sociotherapists can be seen as transactional processes (Sameroff, 2009), it is considered that sociotherapists and the way they function is influential in creating a therapeutic group climate (De Valk, 2019). There is preliminary evidence to suggest that a positive work climate, as perceived by sociotherapists, is necessary in the degree to which sociotherapists can build an open and therapeutic group climate (Van der Helm & Stams, 2012). To enable sociotherapists to create a therapeutic group climate, it seems crucial to have a positive work climate. Work climate constitutes specific elements that influence (team)functioning and wellbeing of sociotherapists and can be defined as "the quality of the social and physical work environment in terms of the provision of sufficient and necessary conditions for occupational functioning, with respect for personnel's human dignity and human rights and characterised by work demands (quality of work) and the employee's decision latitude, aimed at the enabling of youth in recovery and successful participation in society" (De Valk, 2019, p.110; based on Heerkens, Engels, Kuiper, Van der Gulden, & Oostendorp, 2004; Stams & Van der Helm, 2017).

If we want to understand and influence the quality of group and work climate in secure forensic care settings, it is necessary that the surrounding systems are taken into account

To gain insight into the factors that influence group climate, as perceived by individuals with MID-BIF and work climate as reported by sociotherapists, it is helpful to view secure forensic treatment from a systemic perspective. If we want to understand the quality of group and work climate in secure forensic care settings and to influence them, it is necessary that the surrounding systems are taken into account (Bronfenbrenner, 1979; Olivier-Pijpers, 2020; Van Miert, & Dekker, 2020). The factors that work in systems above the micro level can be positive and supportive, but also hindering or "challenging" for the task that sociotherapists have. The mesosystem concerns the interaction between factors that directly influence the microsystem, but of which the client is not directly part. An example of the mesosystem is team functioning. The exosystem comprises contextual, external factors that directly influence sociotherapists, and indirectly clients. An

example of exosystem is the prevailing organisational culture and leadership. Factors in the meso- and exosystem together determine the quality of the work climate as perceived by sociotherapists.

To maintain the balance between reducing risks on one hand and sensitivity and responsivity on the other hand, positive team functioning is considered important. Positive team functioning can be described as team members listening to each other, having a clear communication style, giving and receiving feedback, negotiating difficult choices, resolving conflicts and investing in adequate support, expertise and evaluation of and subsequently monitoring the results of the treatment programs (Knight & Eisenkraft, 2015; Knotter et al., 2018; Van der Helm, Boekee, Stams, & Van der Laan, 2011). Team functioning is influenced by the way sociotherapists perceive their own functioning, their wellbeing and job satisfaction (Van Gink et al., 2018). Team functioning in secure forensic settings is often unstable. It is constantly affected by contextual factors, including challenging behaviour of clients or dynamics at the living group (clients with severe behavioural or mental health problems living together), dynamics of the team (for instance, feelings of unsafety among team members and low job satisfaction), absenteeism and turnover among staff (both team members and managers), and organisational factors such as vision, policy and housing (Knotter et al., 2018). For sociotherapists, who are confronted daily with challenging behaviour (which may evoke negative emotional reactions such as sadness, fear, anger and frustration), experiences positive team functioning, together with inspiring, active and coaching leadership, is as important for personal well-being and professional functioning (Deveau & McGill, 2016, 2019; Lambert et al., 2015).

Another work climate factor that may influence group climate is workload. The higher the workload and the more demanding the target group, the greater the need for emotional support for sociotherapists (Buljac-Samardžić, 2012). The need for emotional support is not only about support among team members, but also about the perceived support from a team manager and the organisation (Deveau & McGill, 2016; 2019). Research suggests that transformational and empowerment leadership has a positive impact on team functioning (Bass & Bass, 2009; Stewart, 2006). If a team manager shows empathy, expresses confidence and offers help, stressors for a team can decrease, which can improve team functioning and team performance (Buljac-Samardžić, 2012; Nijman & Gelissen, 2011).

To improve group climate in residential settings, organisations often decide to invest in team functioning by means of coaching or training (Knotter et al., 2018). The ration-

ale is that challenging behaviour of clients does not occur in isolation but in a social context affected by behaviour of staff (i.e., transactional processes). And staff members do not work in a vacuum either (Hastings et al., 2013). In addition, scientific research is also increasingly paying attention to the work climate in relation to the quality of residential care (see e.g., Lambert, Altheimer, Hogan, & Barton-Bellessa, 2011; Lambert, Barton-Bellessa, & Hogan, 2015; De Valk, 2019; Knotter, 2019; Olivier-Pijpers, 2020; Van Gink et al., 2018). However, studies on which aspects of work climate relate to group climate as perceived by clients with MID-BIF have not yet been conducted.

The current study

The purpose of the study is to examine associations between group climate as perceived by individuals with MID-BIF in a secure forensic setting and work climate as experienced by sociotherapists. This study provides knowledge by being the first study to examine the association between work climate and group climate in a secure forensic treatment setting. Structural equation modelling and multilevel analyses will be employed to analyse these relations. Analysing these relations is important as, from a social systems perspective, a living group is considered a unique social network where clients influence each other's attitudes and behaviours. When clients are staying at the same living group, they share experiences and influence each other, which should be acknowledged in the analyses. Besides group level characteristics, the quality of group climate is affected by clients' (individual) characteristics. Therefore, the present study distinguishes between characteristics of living groups and characteristics of individual clients within living groups.
It is hypothesised that if sociotherapists report low workload, a positive work environment, high job satisfaction, a shared vision, and transformational or transactional leadership, they experience a more positive team functioning, resulting in a therapeutic (i.e., positive) group climate in terms of more support, a more positive atmosphere and more possibilities for growth as perceived by clients. On the other hand, it is expected that high perceived workload, a negative work environment, a low job satisfaction, no shared vision, and laissez-faire leadership is related to negative team functioning, which is associated with a more repressive (i.e., negative) group climate.

Method

Participants and setting

This study was conducted at Trajectum, a secure forensic treatment facility for adults with MID-BIF and externalizing behaviour problems (i.e., aggression or sexual offenses) and/or internalizing problems (e.g., self-injurious behaviour and suicide attempts), located in the northern and eastern part of the Netherlands.

The study consisted of 212 participants who had MID-BIF (78% male, *M* age = 41 years, *SD* = 12.6). An IQ score was available for 183 participants: 47% of the participants had a mild intellectual disability (IQ 50-69) and 53% had borderline intellectual functioning (IQ 70-85). Mean total IQ was 69.7 (*SD* = 9.7). Besides MID-BIF, participants had severe challenging behaviour and/or a history of substance use. Most of the participants were admitted because of externalizing behaviour problems (i.e. aggressive behaviour or a sexual offense) and/or internalizing problems (e.g., self-injurious behaviour or suicidal behaviour). Participants were placed in the facility under criminal law (42%), civil law (24%) or were voluntarily admitted (34%).

The participants represented 58 living groups. These living groups consisted entirely of males (26%) or mixed gender (74%). Living groups are characterised by different levels of restrictions and levels of security, therefore participants resided in living groups with different security levels; 63% of the participants resided in a low security living group, 16% of the participants resided in a medium security living group and 21% of the participants resided in a high security living group. Living groups also differ on care intensity: 24% of the participants resided on a low care intensity unit, 24% on a low to medium care unit, 24% on a medium care unit, 22% on a medium to high care unit and 6% resided on a high intensive care unit.

A total of 262 staff members (49% male) of the same 58 living groups also participated in the study. The age of the staff members was 37.2 years (*SD* = 11.34). The majority of the staff had worked longer than four years at the organisation (38% between 4-10 years; 23% more than 10 years). One-third of the participants had worked less than two years at the organisation (10% less than 1 year; 8% between 1-2 years; 13% between 2-4 years; 8% unknown).

Procedure

Data was collected between September 2017 and April 2018. Participation was on a voluntary basis. Participants were given oral and written information about the aim of the study and the process of data collection and storage. All participants and their legal guardians were informed that the data was confidential and anonymous, and that data was only reported on a living group-level. In addition, a multidisciplinary treatment team consisting of sociotherapist, psychologist, and psychiatrist determined whether a participant was able to give informed consent and to participate. Clients with severe and acute psychotic problems were excluded. All included participants, and if applicable their legal guardian, and a representative of the treatment team gave their oral and written consent. Ethics approval for this study was granted from the Ethics Committee of the Faculty of Social Sciences (ECSS) of the Radboud University (ECSW2017-3001-471). The questionnaires were conducted by trained (assistant) researchers specialised in working with individuals with MID-BIF. Most participants were assisted to complete the questionnaire by a (assistant) researcher who read the questions and answering categories out loud and explained the questions to the participant if necessary. Alternative scripted phrases to enable questions to be explained in a different way were part of the training they received. If used, this would provide an additional way of checking participants' understanding whilst preventing the (assistant) researcher from projecting their interpretation of the questions onto participants. The completed questionnaires were returned to the researcher (first author). Characteristics on participant level (gender, age, total IQ, legal status) and group level (security level, care intensity, group composition, and ward size) were extracted from the records of the participants.

Measures

Group climate. Group climate was assessed with the Group Climate Instrument (Neimeijer, Roest, Van der Helm, & Didden, 2019; Van der Helm, Stams, & Van der Laan, 2011). This self-report measure consists of 29 items rated on a 5-point Likert type scale, ranging from 1 (*Not applicable*) to 5 (*Entirely applicable*). Each item belongs to one of the four scales of group climate: Support, Growth, Atmosphere, and Repression. The Support scale (11 items) assesses perceived support and responsiveness from group workers, such as listening to clients and taking their complaints seriously. An example

item is: 'Group workers treat me with respect'. The Growth scale (6 items) assesses clients' perceptions on possibilities for learning and hope for the future during their stay in the center. An example item is: 'I learn the right things here'. The Repression scale (7 items) assesses client's perceptions of strictness and control, unfair and haphazard rules. An example item is: 'You have to ask permission for everything here'. The Atmosphere scale (5 items) assesses the social interaction among clients in terms of mutual trust, their feelings of safety at the group, as well as how clients perceive the physical environment at the group, such as daylight and fresh air at the group. An example item is: 'We trust each other here'. The internal consistency reliability was sufficient to good for the subscales Support (α = .88), Growth (α = .81), Atmosphere (α = .75), and repression (α = .70).

Work Climate. The Living Group Work Climate Inventory (LGWCI; Dekker, Van Miert, & Van der Helm, 2019) was used to measure several aspects of the work climate as perceived by sociotherapists. The LGWCI comprises 21 scales that measure different aspects of work climate. In this study, the following scales were used: Positive team functioning (8 items), Negative team functioning (10 items), Perceived workload (8 items), Leadership (16 items), Work environment (7 items), Job satisfaction (7 items) and Shared vision (5 items). Items were rated on a 5-point Likert type scale ranging from 1 (I do not agree) to 5 (I totally agree). The internal consistency reliability of the scales was sufficient to good for the scales Positive team functioning (α = .84), Negative Team Functioning (α = .76), Workload (α = .78), Leadership (α = .81), Work Environment (α = .67), Job Satisfaction (α = .75), and Shared vision (α = .61).

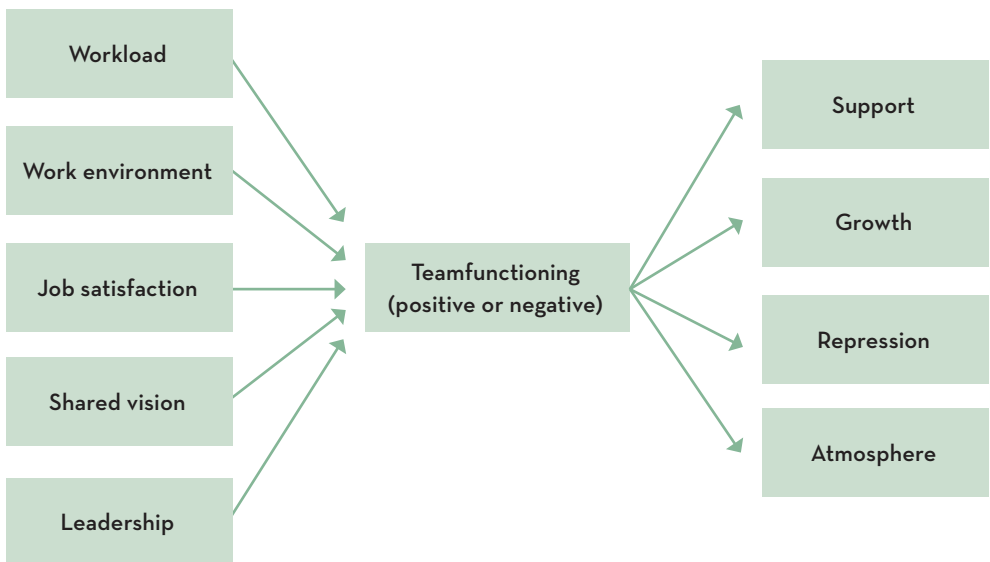
Statistical analyses

First, bivariate correlations (Pearson's r) were examined between all study variables. Because work climate and group climate were measured from different perspectives (i.e., sociotherapists' perception of work climate and clients' perception of group climate), we used group mean scores in the analyses. Thus, correlations between work climate and group climate were analysed at the group level. Subsequently, we tested the study hypotheses in a structural equation model (SEM). We hypothesised an indirect effect of the work climate factors Perceived workload, Leadership, Work environment, Job satisfaction, and Shared Vision on Group climate (consisting of Support, Growth, Atmosphere, and Repression), mediated by the work climate factors Positive and Negative team func-

tioning. The hypothesised model is depicted in Figure 1. Standardised coefficients of the direct and indirect effects can be interpreted as 'small' (.10 – .30), 'medium' (.30 – .50), or 'large' (> .50) effects (Cohen, 1992). Maximum likelihood with robust standard errors (MLR) was used to estimate the model. The 'lavaan' package in the R environment was used for the analyses.

Both the fit indices (comparative fit index [CFI], Tucker–Lewis index [TLI], and root mean square error of approximation [RMSEA]) and the model chi-square statistic were used to evaluate model fit (Kline, 2005). The following cut-off values are indicative of a close model fit: CFI > .90, TLI > .95, and RMSEA < .08, whereas a non-significant chi-square indicates exact model fit (Cheung & Rensvold, 2002).

Figure 1. Hypothesised model of the relation between work climate and group climate.



Given the nested nature of the data (clients are nested in living groups), a multilevel approach was also used to examine the relation between Group climate and Work climate. Instead of using group mean scores for both group climate and work climate, client scores of group climate were used (level-1 variable) in relation to group mean scores of work climate as a characteristic of the group in which clients resided (level-2 variable). Hierarchical linear modeling (HLM) was used to account for violation of the independence assumption of regression. HLM allows for examination of how variation in the dependent variable is attributed to differences within-group (i.e., individual level, level-1) or between-group (i.e., living group-level, level-2; Raudenbush & Bryk, 2002). The analyses were conducted using the "lme4" package (Bates, Maechler, Bolker, & Walker, 2015) in the R environment. The "lmerTest" package (Kuznetsova, Brockhoff, & Christensen, 2015) was used for the calculation of p-values, which uses the Satterthwaite approximation procedure for calculating degrees of freedom.

Several models were fit for each dependent variable, i.e. Support, Growth, Repression, and Atmosphere. First, a random intercept only model (null model) was fitted without predictors to estimate the Level-2 variance and ICC (intraclass correlation coefficient) for the dependent variables. When significant Level-2 variance is demonstrated, multilevel analysis is warranted, and Level-2 predictors were examined in a multilevel model. If no significant Level-2 variance in the dependent variable (i.e., aspect of group climate) was found, it was concluded that work climate was not related to that aspect of group climate.

Subsequently, three multilevel models were fitted. The first model included only main effects of Level-1 predictors (gender, age, and placement status). A second model included Level-2 predictors (security level and gender composition of the living group). The third model added the group mean work climate scores of staff (Team functioning, Workload, Work Environment, and Job Satisfaction) as Level-2 predictors. The variable security level consisted of three categories (low security, medium security, and high security) and was dummy-coded, using low security as the reference category. The fit of the models was compared using likelihood-ratio tests. Parameter estimates and statistical tests are reported for the initial and the final model.

Results

Preliminary analyses

First, descriptive statistics and correlations between Work climate subscales as well as between Group climate subscales were examined (Table 1). The correlations between Work climate and Group climate were in the expected direction. Most were small to moderate and non-significant. However, positive team functioning showed a significant and negative correlation with repression (r = -.31, p < .05), while Negative team functioning (r = -.37, p < .05) and Workload (r = -.29, p < .05) were significantly and negatively associated with Growth. No significant associations were found between the other Work climate and Group climate dimensions.

Table 1. Descriptives and Correlations between Group Climate Scales Reported by Clients and Work Climate Scales Reported by Staff

	M	*SD*	1	2
1. Support	3.54	.41		
2. Growth	3.53	.51	.72**	
3. Repession	2.81	.49	-.71**	-.57**
4. Atmosphere	3.38	.59	.58**	.37**
5. Leadership team manager	3.33	.36	-.08	.02
6. Leadership treatment coordinator	3.33	.36	.08	.05
7. Positive team functioning	3.71	.37	.17	.27
8. Negative team functioning	2.80	.42	-.25	-.37**
9. Workload	3.37	.34	-.26	-.29**
10. Work Environment	3.50	.41	.10	.15
11. Job Satisfaction	3.71	.32	.15	.25
12. Shared vision	3.24	.39	-.04	.09

.*N* = 58. ***p* <.01 (two-tailed) **p* < .05 (two-tailed)

3	4	5	6	7	8	9	10	11
-.55**								
-.06	.00							
.08	-.02	.05						
-.31**	.12	.06	.05					
.27	-.15	-.23	-.16	-.83**				
.04	-.09	-.18	-.10	-.14	.36**			
-.07	.09	.00	.23	.20	-.39**	-.34*		
-.04	.15	.17	.37*	.39**	-.58**	-.43**	.56**	
.07	-.09	.38*	.57**	.20	-.37**	-.30*	.24	.64**

Structural equation modeling

To examine the relationships between the Work climate factors Perceived workload, Leadership, Work environment, Job satisfaction, and Shared Vision on Group climate (consisting of Support, Growth, Atmosphere, and Repression), mediated by the Work climate factors Positive and Negative team functioning, a structural equation model was fitted to the data. The model with Negative team functioning (figure 2) showed a good fit to the data: $\chi^2(8) = 7.11$, $p = .525$, CFI = 1.000, TLI = 1.036, RMSEA = .000 (90% CI = .000-.156). The model with Positive team functioning (figure 3) also showed a good fit to the data $\chi^2(8) = 9.10$, $p = .334$, CFI = .967, TLI = .938, RMSEA = .052 (90% CI = .000-.179). Job satisfaction was negatively related with Negative team functioning ($ß = -.459$, $p = .006$) and positively related with Positive team functioning ($ß = .493$, $p = .008$). Negative team functioning was positively related with Repression ($ß = .270$, $p = .044$) and negatively related with Growth ($ß = -.365$, $p = .003$). Furthermore, Positive team functioning was negatively related with Repression ($ß = -.312$, $p = .013$).

Figure 2. Structural equation model of the relation between work climate, negative team functioning, and group climate.

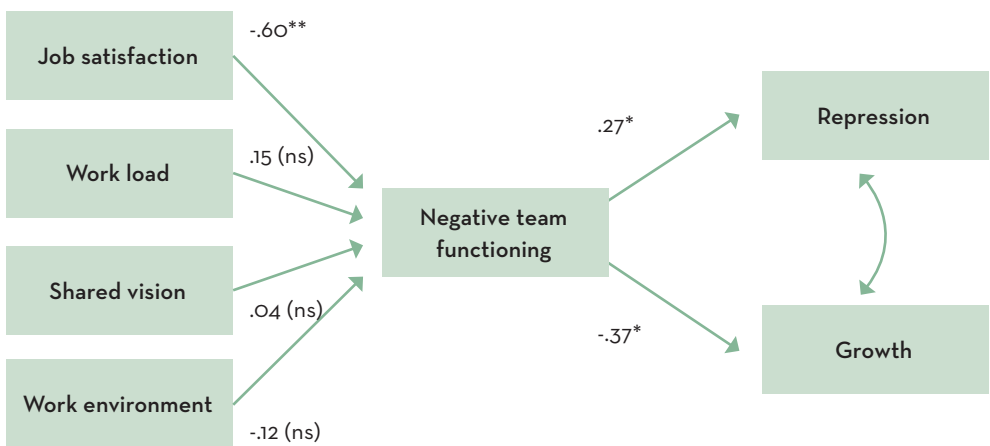
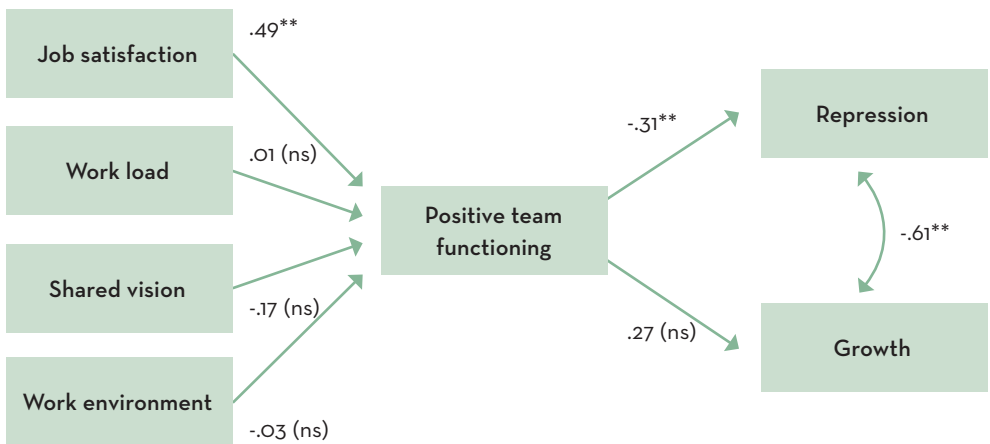


Figure 3. Structural equation model of the relation between work climate, positive team functioning and group climate.



Multilevel analyses

Because Positive and Negative team functioning were strongly correlated (r = -.72), we combined these scores into a mean score of Team Functioning for use in further analyses. A series of hierarchical linear models was conducted to examine the relation between group climate (level 1 and 2) and work climate (level 2). First, four different random intercept-only models were examined to establish whether there was significant variance at Level-2 for the dependent variables Support, Growth, Repression, and Atmosphere. Results indicated that there was significant Level-2 variance for Atmosphere (ICC = .21, Wald z = 2.39, p = .017). No significant Level-2 variance was found for Support (ICC = .09, Wald z = 1.33, p = .185), Growth (ICC = .05, Wald z = 0.78, p = .434), and Repression (ICC = .07, Wald z = 1.06, p = .290). Subsequent analyses were thus only conducted for Atmosphere. However, none of the Level-1 nor Level-2 predictors were significantly related to Atmosphere, and these explanatory models did not significantly improve fit of the intercept-only model (see table 2).

Table 2. Likelihood Ratio Tests of Multilevel Models for Atmosphere.

Model	df	LogLik	χ^2	df difference	*p*
Intercept-only	3	-239.81			
Level-1 predictors	6	-237.71	4.207	3	.234
Level-2 predictors: group characteristics	9	-237.34	0.732	3	.866
Level-2 predictors: work climate	13	-236.38	1.933	4	.748

Discussion

The aim of the present study was to examine the associations between group climate, as perceived by individuals with MID-BIF, and work climate, as experienced by their sociotherapists , in a secure forensic setting. It was hypothesised that when sociotherapists report a low workload, a positive work environment, high job satisfaction, shared vision, and transformational or transactional leadership they would experience more positive team functioning and clients would experience a more therapeutic group climate. On the other hand, it was expected that a high workload, a negative work environment, low job satisfaction, no shared vision, and laissez-faire leadership would be related to negative team functioning, and negative team functioning would lead to more experienced repression. This study only confirmed some of the hypotheses. When sociotherapists experience more job satisfaction, they experience less negative team functioning. Also, when sociotherapists experience more positive team functioning, less repression was perceived by clients. Perceived workload and negative team functioning by sociotherapists are related to less experienced possibilities for growth by clients. No significant associations were found between the other work climate and group climate dimensions. The associations between team functioning, growth and repression are in line with the ecological theory of Bronfenbrenner (1979) in which the interactions between sociotherapists and clients and between clients themselves in the microsystem are being influenced by surrounding systems such as team functioning which is part of the mesosystem.

Considering the theoretical link between work climate and group climate and the assumption in daily practice that a positive work climate is necessary to create a therapeutic group climate, it is interesting to consider possible explanations for the unconfirmed hypotheses. First of all, it is important to keep in mind that work climate and group climate are complex and multifactorial constructs which are difficult to grasp in statistical models. Although self-report questionnaires such as the GCI and the LGWCI can measure group- and work climate in a reliable, valid and pragmatic manner in clinical practice, these instruments measure a simplified construct of work- and group climate. Therefore, some studies advocate for a more in-depth insight and operationalization of group climate, for example through individual interviews with sociotherapists and clients about their experiences of their shared living and work environment (Doyle, Quayle, & Newman, 2017). It would be premature to make strong claims about the relation between work- and group climate based on this study and a dataset limited to two sources (questionnaires among individuals with MID-BIF and sociotherapists in one organisation). Arguably, a more comprehensive measure of work- and group climate would also include data from other sources as part of routine monitoring. This data could be drawn from a range of sources, including incident reporting databases containing reports of aggressive incidents, self-harm, changes in sociotherapist and client composition, and changes to working practices at the living group. These are all factors that might affect work- and group climate within secure forensic settings and, therefore, are of importance to help clinicians and researchers better understand and interpret work- and group climate data regarding a certain living group.

It is also possible that group climate aspects such as support and atmosphere are less related to work climate and/or team functioning than assumed. This would mean that the experienced group climate is mainly influenced by individual characteristics of the participants, sociotherapists or other contextual factors. Indeed, when using Bronfenbrenner's ecological theory, it should be noted that not all factors within the exosystem which comprises contextual, external factors that directly influence sociotherapists and indirectly clients, are taken into account in this study. An example is the prevailing organisational culture. After all, factors in the meso- and exosystem together determine the quality of the work climate as perceived by sociotherapists. However, considering studies on parallel processes between work- and group climate factors, it is more likely that characteristics of the present study (such as setting or client characteristics) caused the partly unexpected results. For example, Neimeijer (2013) found a significant relation between

perceived workload and repression in forensic psychiatric institutions and residential youth care institutions. Also, Van der Helm, Moonen and Roest (2013) found mutual influence between certain aspects of work- and group climate in residential youth care for children with MID.

Another possible explanation for the partly unexpected results in this study may be caused by including participants from only one organisation. Because of this, effects were only examined at two levels (individual and group level) instead of three levels (individual, group, and organisation), reducing distributed variance at the group level. Variance between groups was only found for atmosphere, no significant variance in the perception of the other group climate dimensions within and between groups was found. This corresponds to the core idea in the group climate literature that there is some perceptual consensus among individuals on group climate, which means that individuals in the same unit and organisation agree more on the perceptions of group climate than with individuals in other living groups and organisations (Van Ginneken & Nieuwbeerta, 2020). However, shared variance could be considered relatively small, but these are still proportions of variance that cannot be ignored. Even the smallest proportion of variance at the group level can still have significant individual, practical implications for individuals with MID-BIF and their sociotherapists and their perception of group- and work climate.

Overall, it can be concluded that there are some associations between work- and group climate, but that these should not be overstated. The purpose of this study was to give an indication whether there are associations – further research should explore the nature and mechanisms of these associations in greater detail. With the current cross-sectional study design, it was not possible to establish directions for the reported associations. Theoretically, it is plausible that each of these associations have bidirectional effects; for instance, team functioning as perceived by sociotherapists may affect group climate as experienced by individuals with MID-BIF, but group climate may also affect team functioning. A longitudinal design would be required to determine the possible (causal) directions of associations between work- and group climate. This is also more in line with the idea that work- and group climate are dynamic concepts that changes over time and requires multiple measures for a more reliable picture.

Furthermore, our results are based on a sample of convenience. Not all sociotherapists and clients were willing to participate in the study. Consequently, the average scores on the work climate and group climate subscales were sometimes based on only a few

team members or clients (three or more), leading to a possible selection bias and lack of generalizability. Some studies have attempted to provide guidance in this regard, but these guidelines are quite arbitrary and were not derived in any systematic, empirically based manner (Tonkin, 2015). Future research is needed to systematically investigate this issue, which will help researchers and clinicians who are seeking to measure work- and group climate in secure (forensic) settings.

Work- and group climate are dynamic concepts that changes over time and requires multiple measures for a more reliable picture

Notwithstanding these limitations, this is the first study that investigated the relation between work climate, as reported by sociotherapists, and group climate, as perceived by individuals with MID-BIF, in a secure forensic treatment setting. Although the results should be interpreted with caution, the associations found between positive team functioning and repression, between workload and growth, and between negative team functioning and growth should be considered as important findings. This stresses the importance of awareness on parallel processes between work- and group climate and supports to keep studying this relation.

Questionnaires that measure work- and group climate can identify differences within and between living groups and organisations. While our study is, at this point, unable to say how the dynamics between work- and group climate may be explained, it could still help organisations and professionals in secure forensic care identify living groups that score lower or higher than average on specific dimensions, especially if a self-report questionnaire is used in combination with other, more objective, indicators, such as registered incidents, coercive measures, sick leaves, and inspections (Molleman, 2014). Future research should investigate the determinants of work and group climate, and to what extent these can be explained by sample composition (considering the heterogeneous MID-BIF sample), living group characteristics (such as security level and care intensity) and organisational influences (management characteristics, organisational culture, and informal structures that surround the living group). This information is necessary in order to determine to what extent group climate can be influenced by policy and management decisions. If this type of research is replicated in other secure forensic settings, it would be possible to identify best practices (inter)nationally and even determine if

national-level policies have an impact on work and group climate.

Organisations are faced with the challenge of enabling sociotherapists to perform their complex tasks as much as possible. This means that continuous attention must be paid to what teams and individual sociotherapists need to be able to do their important work. Creating and maintaining a supportive, open and positive working environment requires an active commitment from organisations.

DE RELATIE TUSSEN HET LEEFKLIMAAT EN WERKKLIMAAT

4e STUDIE

LEEFKLIMAAT
- Ervaren door cliënten
- 212 cliënten
- GCI

↔

WERKKLIMAAT
- Gerapporteerd door sociotherapeuten
- 262 sociotherapeuten
- LGWCI

Er werden 3 verbanden gevonden:

1

Meer werktevredenheid → Minder negatief teamfunctioneren

2

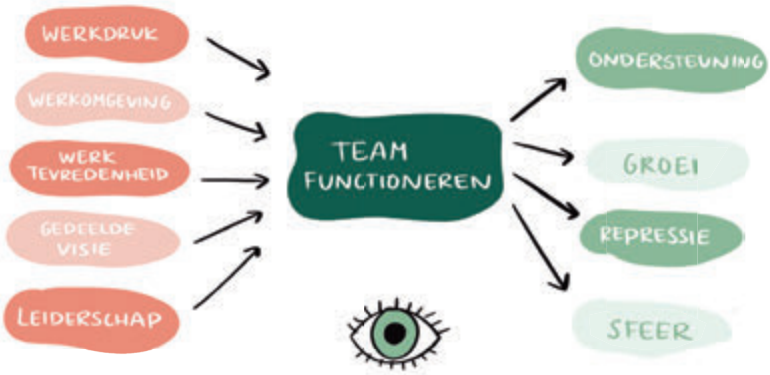
Positief teamfunctioneren → Minder ervaren repressie

3

Hoge werkdruk + Negatief teamfunctioneren →

Minder groeimogelijkheden voor cliënten

Er werden geen significante relaties gevonden tussen de overige elementen van het werkklimaat en leefklimaatfactoren



Oog voor paralelle processen tussen werk- en leefklimaat

CHAPTER 06.

General discussion

Introduction

When someone is admitted to a secure (forensic) setting, this is thought to be in the best interest of the individual and/or society. This concerns both individuals who are placed with a civil measure when their own safety is severely threatened, and individuals who are placed with a judicial measure to serve rehabilitative goals for criminal offenses. The goal of secure (forensic) treatment is to protect the individual and society from harm and to prevent recidivism. This is done by giving treatment and 24/7 support to clients. With the aim of reducing recidivism and protecting society on one hand and increasing psychological wellbeing on the other, and due to social and political pressure, forensic care has a complex task that is often carried out on the basis of risk-based thinking. The interests of many parties must be taken into account in secure forensic care: those of society and the press, government, political pressure in some cases, professionals, the client and those close to them (Livingston, Nijdam-Jones, & Brink, 2012). Social and political views and pressure, together with a complex target group, make the balance between therapy and security a precarious one. However, to be able to achieve therapeutic goals sociotherapists must be sensitive to this balance. That this balance is relevant is shown by an increasing number of (inter)national studies in which different words are given to that balance from security versus therapy (Hachtel, Vogel, & Huber, 2019; Inglis, 2010; Jacobs, 2012; Schaftenaar, 2018), and containment versus care (Martin, 2001) to guarding versus care (Hörberg, Sjögren, & Dahlberg, 2012).

Research on secure forensic care focuses mainly on topics such as risk assessment, what works principles (RNR; Andrews & Bonta, 2010), effectiveness and recidivism. Over the decade, there has also been a growing focus on features of positive psychology in secure forensic treatment. Emphasizing the 'healthy sides' of clients and their environment becomes a valuable addition to the traditionally risk-oriented vision in secure forensic treatment (see De Vries Robbé & De Vogel, 2013; Ros, Van der Helm, Wissink, Stams, & Schaftenaar, 2013; Schaftenaar, 2018). The Good Lives Model (Ward & Brown, 2004) is an example of this. Also, Andrews and Bonta (2010) argue that the effectiveness of interventions in secure forensic care is improved when performed by professionals with high quality relationship skills in combination with high structuring skills. The relationships they describe are respectful, caring, enthusiastic, focused on cooperation and giving room to personal autonomy. If there is too much emphasis placed on control and security (i.e. physical safety), it will harm the quality of care and it has a negative im-

pact on the therapeutic relationship (De Valk, Van der Helm, Beld, Schaftenaar, Kuiper, & Stams, 2015; Doyle & Jones, 2013; Gillespie & Flowers, 2009; Hachtel et al., 2019; Van der Helm, 2011). Repressive elements, such as disproportionate sanctions on undesired behaviour, can then also predominate. Research has shown that repression does not work (De Valk, 2019; Hachtel et al., 2019). An institutional culture of restraint and deprivation of liberty with too much emphasis on safety (control) can arise for several reasons such as that professionals want to protect themselves from stress or from fear and anger (Martin & Street, 2003; Van der Helm & Schaftenaar, 2014). This can create an excessive number of rules or abuse of power (i.e., a punitive context; Gillespie & Flowers, 2009). The client's perception about the therapeutic relationship is considered by researchers as one of the strongest predictors of treatment outcome (Coffey, 2006; Goldsmith, Lewis, Dunn, & Bentall, 2015). The core business in secure forensic care is therefore to form and maintain therapeutic relationships, in which professionals help clients to develop skills to deal with problems and provide for participation in society (Schaftenaar, 2015).

Emphasizing the 'healthy sides' of clients and their environment becomes a valuable addition to the traditionally risk-oriented vision in secure forensic treatment

The importance of therapeutic relationships and the fact that clients in secure forensic care spend most of their time at the living group, supervised by trained sociotherapists, makes it imperative to focus on group climate. Secure forensic treatment works better when clients are supported on a daily basis in a responsive and sensitive way by trained sociotherapists, and rely on their therapeutic relationship (Stams & Van der Helm, 2017). Although the formation of therapeutic relationships in an environment focused on safety is complicated and sometimes considered problematic (Hanrath, 2013). An underexposed target group in this context are individuals with mild intellectual disability or borderline intellectual functioning (MID-BIF).

This chapter summarizes the main findings of the studies presented in this dissertation, which focused on group climate in a secure forensic setting for individuals with MID-BIF. The first aim of this dissertation was to assess whether it was possible to measure the quality of group climate, as perceived by individuals with MID-BIF, in a reliable and valid way (chapter 2). Another aim was to gain a more in-depth account of group climate as perceived by this target group (chapter 4). This dissertation also explored

to explore the associations between the quality of group climate, aggression, coercion (chapter 3) and the interaction between group climate and work climate, as perceived by sociotherapists (chapter 5). Insights into group climate and work climate were obtained by conducting studies from the perspective of the client and the sociotherapists working with them. The data of these studies was collected at Trajectum, a secure forensic treatment facility for adults with MID-BIF and externalizing behaviour problems (i.e., aggression or sexual offenses) and/or internalizing problems (e.g., self-injurious behaviour or suicide attempts), located in the northern and eastern part of the Netherlands.

Summary of the chapters

The first study (chapter 2) examined the psychometric properties of the Group Climate Instrument (GCI) for this target group (N = 189). Construct validity, reliability and convergent validity of the GCI were examined. We also examined the variability in perception of group climate between and within living groups. The model contained four first-order factors (support, growth, group atmosphere and repression) and a second-order factor overall climate, providing preliminary support for construct validity of the GCI. Reliability coefficients were good for all factors. Preliminary evidence for convergent validity was found in significant moderate associations between subscales and single item ratings for the factors of group climate. The intraclass correlation coefficients indicated that a considerate proportion of variance can be attributed to between-group differences. It was concluded that the GCI can be used to assess the perception of group climate for individuals with MID-BIF in forensic care settings, although further development of the GCI and replication of our findings seem necessary (see key finding one).

In chapter three the associations between group climate, aggressive incidents and coercive measures were examined. Participants (N = 248) were interviewed about their perception of group climate utilising the Group Climate Instrument. Data on aggressive incidents and coercive measures was retrieved from the facilities' electronic database. A multilevel structural equation model was fitted in which variability in perception of group climate within and between living groups was examined. An open and therapeutic group climate was associated with lower levels of aggression within and between groups. A higher number of aggressive incidents were significantly associated with a higher number of coercive measures. The findings have implications for the understanding of

how group climate may play a role in reducing aggressive incidents at the living group in treatment of individuals with MID-BIF in secure forensic settings (see key finding two).

The fourth chapter provides an in-depth account of group climate by giving voice to twelve clients and examine what their experiences are with regard to the group climate. In the interviews about the four domains of group climate (see above), five overarching dimensions appeared: autonomy, uniformity, recognition, competence and dignity. Depending on the person and the (treatment) context in which s/he resides, these five dimensions relate to all four factors of the GCI. From the perspective of clients with MID-BIF, this study contributes by providing a framework to 'fine-tune' group climate on five dimensions. Training sociotherapists to be sensitive to interpret ambiguous signals on these dimensions can contribute to optimising group climate in secure forensic settings (see key finding three).

The fifth chapter and final study of this dissertation examined associations between group climate as perceived by individuals with MID-BIF (N = 212) and work climate as experienced by sociotherapists (N = 262) from 58 living groups. Group climate was assessed with the GCI and work climate was measured using the Living Group Work Climate Instrument (LGWCI). Structural equation modeling and multilevel analyses were employed to analyse the associations between work climate and group climate. When sociotherapists experience more job satisfaction, they experience less negative team functioning. Also, when sociotherapists experience more positive team functioning, less repression was perceived by clients. Perceived workload and negative team functioning by sociotherapists are related to less experienced possibilities for growth by clients. No significant associations were found between the other work climate and group climate dimensions. This study stresses the importance of awareness on parallel but related processes between work climate and group climate in secure settings for clients with MID-BIF (see key finding two and three).

Key findings, clinical implications and recommendations for future research

This section highlights three key findings from the main results reported in this dissertation. These are discussed below and integrated with knowledge from research and clinical practice. Implications, developments for group climate in secure forensic

care for individuals with MID-BIF and future directions for research are also discussed.

1. Key finding one: Group Climate can be measured in individuals with MID-BIF in secure forensic care

In this dissertation the perspectives and narratives of clients with MID-BIF were the fundamental precept in exploring group climate. As they are experiencing the group climate and cannot escape it, they can give the most valuable insights. The GCI has the potential to be an important self-report questionnaire for studies examining (changes in) group climate and secure forensic treatment in general targeting individuals with MID-BIF. Clients were asked to give their opinion about the support they receive from sociotherapists, possibilities for growth, the atmosphere at the living group and repression. The overall climate scale of the GCI captures all four dimensions and can be seen as 'bipolar'. At the 'positive' end of the scale group climate should be regarded as open and therapeutic, whereas at the 'negative' end of the scale group climate should be regarded as closed and repressive, hampering treatment of any form. Mapping this scale (i.e. group climate) turned out to be possible in a reliable and valid way for this target group in secure forensic care, just as it had been already shown in other settings such as residential youth care, prisons and psychiatric (forensic) institutions and for different age groups (Van der Helm, 2011).

By means of assessing group climate and giving staff feedback about the results, a voice was given to a target group whose voice is not often heard in scientific research. Despite the fact that limited research has been done on the perspective of clients in forensic care, the importance of this type of research (about and by clients) for improvement of care is underlined by several researchers (Coffey, 2006; Gildberg, Elverdam, & Hounsgaard, 2010; Goddess, 2008). While in the last decade there has been an increasing number of studies in forensic settings from the client's perspective (see e.g., Clarke, Lumbard, Sambrook, & Kerr, 2016; Doyle, Quayle, & Newman, 2017; Shepherd, Doyle, Sanders, & Shaw, 2015) little attention has been paid so far to the perspectives of individuals with MID-BIF in forensic care. What we learn from research from the client's perspective mainly concerns the importance of "being seen and heard" and "having a voice". Most of the experiences of clients can be traced back to a central experience to be heard or not heard (Schäfer & Peternelj-Taylor, 2003; Van den Hooff, & Goossensen, 2013). As discussed in the introduction of this chapter, the quality of the therapeutic relationship with sociotherapists is of great importance to clients, which is partially influenced by the

degree of understanding of their position by the professionals working with them (Lord, Priest, & McGowan, 2016). Viewing the world from the client's perspective can help broaden clinical professionals' as well as researchers' reference frame in order to understand and improve the quality of treatment. Norcross and Wampold (2011) for example stated that monitoring of the therapeutic process (including obtaining client feedback) is effective in improving therapeutic alliance and treatment processes.

By means of assessing group climate and giving staff feedback about the results, a voice was given to a target group whose voice is not often heard in scientific research.

Clinical implications

The GCI outcomes, as presented in this dissertation, may provide relevant insights into what steps could be taken to improve group climate as perceived by individuals with MID-BIF. In combination with the use of the Living Group Work Climate Instrument (LGWCI) to measure work climate as perceived by sociotherapists, we noticed that group climate is influenced by professional behaviour of sociotherapists (see chapter 5). Measuring group climate with the GCI and work climate with the LGWCI, and discussing the results with both clients and sociotherapists, appeared to act as an 'intervention' in itself to create awareness and plans for improvement in daily practices. This process of measuring, providing feedback, analyzing and discussing the GCI outcomes and making improvement plans can be described as a Plan-Do-Check-Act (PDCA; Deming, 1986) cycle which encourages sociotherapists to reflect on their professional behaviour and act accordingly. It was seen in clinical practice that sociotherapists reflected on how they function as a team, consider potential improvements, and develop plans about how new goals should be implemented at their living group. The GCI is important for monitoring the quality of group climate on a regular basis but can be also be used to evaluate the effectiveness of interventions (the A in PDCA) that aim to improve group climate for this target group and work conditions and training purposes for sociotherapists. To be able to understand how group climate can be improved for the benefit of both clients and sociotherapists, it is important to give clients a voice in this process.

The above is in line with a growing awareness that involving and listening to clients in decisions that affect them (i.e. shared decision making) is important to achieve better

treatment and support (Ten Brummelaar, Harder, Knorth, Post, & Kalverboer, 2017). Shared decision making is not a goal in itself, but a process that might improve the treatment outcomes and quality of life for individuals with MID-BIF in secure forensic care. However, within secure forensic care there is a tension between the participation of individuals and a context where sometimes choice-making is limited. Given the fact that care and treatment in this type of care is based on a civil or criminal law measure, the space for individuals to exert influence is initially limited. Nevertheless, more attention within secure forensic care for individuals with MID-BIF should be paid to the idea that when clients actively participate in the creation and design of their care and treatment process, the chance increases that the clients will benefit more from treatment (Frielink, 2017).

Daily clinical practice at the living group is full of (ethical and practical) dilemmas, without easy answers. Reflecting on these dilemmas in a multidisciplinary team is an important way to improve group climate

Periodically measuring group climate will support active client participation. In combination with measuring work climate as perceived by sociotherapists, it is also possible to reflect on the interaction between group and work climate aspects. Because daily clinical practice at the living group is full of (ethical and practical) dilemmas, without easy answers, reflecting on these dilemmas in a multidisciplinary team is an important way to improve group climate. See for instance the example of moral case deliberation (Spijkerboer, 2019). As the perspective on group climate may differ between clients, sociotherapists, teammanagers, psychologists and policy makers, it is useful to stimulate conversations between these different groups. In this way meaning can be given to the routine outcome monitoring of group climate and work climate. Without giving meaning to and reflecting on the outcomes, the group climate factors (i.e., support, growth, atmosphere, and repression) are used as a kind of 'empty' catch-all terms. When themes such as shared decision-making (Ten Brummelaar et al., 2017), relational working (Schaftenaar, 2018), and a therapeutic group climate (Stams & Van der Helm, 2017) are discussed systematically, professional attitudes regarding changes in clinical practices on the living group may change in a positive direction (Maio, Haddock, & Verplanken, 2018).

Implications for future research

It has been argued in this dissertation that transactional processes between clients and sociotherapists underlie the quality of group climate. Clients were asked to give their opinion about the group climate by means of the GCI questionnaire and in-depth interviews (chapter 4). At the same time, sociotherapists were asked to give their opinion about aspects of their work climate such as team functioning and leadership (chapter 5). However, no studies have yet been done on sociotherapists' account of their perception and vision on group climate and the work climate. To fully capture the transactional processes that are assumed to underlie the quality of group climate, future research should investigate whether sociotherapists hold certain attitudes or cognitions that may influence the group climate as perceived by clients. This is important because attitudes may affect their professional behaviour (Frymier & Nadler, 2017; Knotter, 2019). In other words, to influence group climate, research should assess all the directions of transactional processes between clients and sociotherapists. As part of a more integral point of view, contextual factors that directly influence the work climate of sociotherapists, and indirectly the group climate of clients, have to be taken into account (such as organisation culture, leadership, staff policies, implementation of the working method, performance monitoring, an policy in daily practice). This information can be useful in order to determine to what extent different organisational aspects influence work climate and group climate and whether organisational changes have to be made to improve quality of care.

2. Key finding two: The quality of group climate is associated with aggressive incidents and coercive measures

Aggression is a major and common problem in secure forensic care (Akerman, Needs, & Bainbridge, 2018; De Decker et al., 2018; Robinson, Craig, & Tonkin, 2018; Ros et al., 2013; Van den Tillaart, Eltink, Stams, van der Helm, & Wissink, 2018) and health care facilities for individuals with intellectual disabilities (CNV, Zorg & Welzijn, 2018; Knotter, 2019; Olivier-Pijpers, 2020). The results in this dissertation (chapter 3) show that a therapeutic group climate in which clients experience more support from sociotherapists, a more positive atmosphere at the living group and more possibilities for growth are related to less aggressive incidents. By contrast, repression was found to be associated with higher levels of aggression. Also, the number of aggressive incidents was positively

related to coercive measures and appeared to be a mediator of the relation between quality of group climate and coercive measures.

From the perspective of the self-determination theory (SDT; Ryan & Deci, 2017), a therapeutic group climate in which the amount of repression is minimised, meets three basic psychological needs of clients: a secure relational base (relatedness), exercising responsibility and decision making (autonomy), and perceptions of ability (competence). Giving clients the opportunity to make decisions themselves in their daily care may help to restore some feelings of control over their own lives and has been suggested to be an important component of interventions that aim to reduce aggressive behaviour of clients with intellectual disability (Blair & Kennedy, 2014; Frielink, 2017; Knotter, Wissink, Moonen, Stams, & Jansen, 2013).

Secure forensic settings have a long history with a main concern on safety by exercising maximum control: high fences, physical security, locked doors and so on. It is based on the idea that physical control provides clarity and guarantees everyone's safety. But maximum control actually has the risk of provoking maximum reactance and may therefore be counterproductive and may harm the quality of group climate (De Decker et al., 2018; Heynen et al., 2016; Ros et al., 2013; Van den Tillaart et al., 2018) as well as the quality of care in general (Boone, Althoff, & Koenraadt, 2016; Bowring-Lossock, 2006; De Valk, 2019; Doyle & Jones, 2013; Gillespie & Flowers, 2009; Hachtel et al., 2019; Van der Helm, 2011). Although the cause-effect relationship is still unclear, the association between repression and higher levels of aggression, as shown in chapter 3, stresses the importance of awareness on transactional processes between clients and sociotherapists that can transform into coercive cycles when aggressive behaviour of clients induces coercive responses by sociotherapists, which, in turn, causes aggressive behaviour by clients (De Valk, 2019).

Maximum control actually has the risk of provoking maximum reactance and may therefore be counterproductive and may harm the quality of group climate

This remains a field of tension in a secure (forensic) environment where limit setting is necessary for a structured and safe environment and treatment is compulsory. It is important to distinguish coercion from repression. Sociotherapists' acting becomes repressive when the use of coercive measures is harmful, unlawful or arbitrary (De

Valk, Kuiper, Van der Helm, Maas, & Stams, 2016). Perceived repression seems to be dependent of various determinants, many of which depend on the quality of the relationship between clients and sociotherapists. This implies that staff, in multidisciplinary collaboration, have a key role in detecting, preventing, or diminishing repression. Because of the persistent character of repression once it is institutionalised, it is difficult for professionals to break this vicious circle. Prevention of repression seems therefore a better option. To prevent repression, the organisational culture, ethical values, and awareness of repression must be institutionalised at all levels of the secure forensic setting and incorporated into everyday decision-making and acting (De Valk, 2019).

In research and practice different opinions are held on the proportionality of the use of coercive measures. The general attitude in the Netherlands is that coercive measures are considered undesirable, and should only ever be used as a last resort. This is in line with national legislation such as the Dutch Care and Coercion Act (in Dutch: Wet Zorg en Dwang), that has been in effect since 2020. The core principle of this legislation is: involuntary care is not applied, unless there are no less intrusive options available (Ministry of Health, Welfare and Sport, 2020). This fundamental precept implies that there must be good alternatives in situations when immediate harm for clients or others is likely. In particular, when individuals with MID-BIF are admitted to a secure forensic setting where 'involuntariness' is integrated in admission and treatment because of behaviour that can lead to harm and danger for themselves or for others.

The findings presented in this dissertation underpin the importance of group climate and work climate factors related to client and sociotherapist behaviour. In chapter 5 it was for example argued that if sociotherapists experience more positive team functioning, less repression was perceived by clients. Also, in earlier group climate research it was proposed that it is possible to offer clients a therapeutic group climate without working solely from structure and control but based on relational care (Schubert, Mulvey, Loughran, & Losoya, 2012; Van der Helm & Vandevelde, 2018). Sociotherapists and other multidisciplinary team members should therefore be encouraged to find the right balance in their dual-role relationship with clients ('firm but fair'; Hachtel et al., 2019). In clinical practice, this is less obvious than it seems.

Clinical Implications

Dealing with this highly context-dependent target group places high demands on so-

ciotherapists' professional behaviour and knowledge, attitude and competences of all professionals involved. This requires that organisations are aware of the fact that working in a high demanding working context such as a secure forensic setting and working with individuals with complex needs and a risky behaviour asks for creating the right preconditions. With regard to creating a therapeutic group climate it is advised that ongoing training of sociotherapists should be facilitated by organisations. It is, for example, important that sociotherapists are educated in developmental, psychological, and psychiatric problems underlying aggressive or challenging behaviour to be able to act in a sensitive and responsive way. In addition, teams should share knowledge about causes and functions of aggressive behaviour and share experiences on the way incidents can be solved, and should be receive emotional support and coaching while doing that (Buljac-Samardžić, 2012; Farrington, Clare, Holland, Barrett, & Oborn, 2015; Knotter, 2019). By combining this with functional analysis of the often long existing aggressive behaviour patterns, a more integrative view on aggressive behaviour could be created. A reflective team attitude towards aggression, for example by analyzing transactional processes and learning from routinely collected data of aggressive incidents and coercive measures, can improve the quality of group climate in which the occurrence of aggressive incidents may decrease and may contribute to better treatment outcomes (i.e., less aggression and increased well-being).

In this dissertation the importance of the relation between the frequency of aggressive incidents and group climate factors in daily clinical practices was discussed. Efforts aimed at improving work climate and group climate should therefore go together with education and training, emphasising the possible causes of aggressive behaviour, resulting in reduced aggression and improved group- and work climate (see chapter 3; Knotter, 2019; Ros et al., 2013).

In addition, organisations have to facilitate systematic and ongoing reflection on daily professional acting, dilemma's and decisions, for example by means of intervision, supervision or moral case deliberation during team meetings. There are high demands to sociotherapists' abilities to work together and, often under great pressure and in good consultation, to adequately analyse complex situations and to act accordingly. Ideally, interventions, education and training should target the competencies of sociotherapists, such as the ability to analyse the causes and functions of aggressive behaviour, working according to a PDCA cycle (see 3.1.2; Deming, 1986), showing an open style of communication, being able to reflect on the impact of their own professional behaviour, and

showing a responsive attitude (Knotter, 2019).

Implications for future research

It was not possible to derive causal relations between group climate, aggressive incidents and coercive measures, because of the cross-sectional design which we employed in our studies. Further studies with a longitudinal design are needed to explore causality between group climate, aggressive incidents and coercive measures. The relation between perceived repression and aggression, and between aggression and coercive measures makes it clear that there is an urgency for further research on this topic. It seems necessary to develop interventions which target not only the aggressive incidents of individuals with MID-BIF, but also focus on group climate and work climate factors and on multidisciplinary collaboration to meet the complex needs and behaviour of this target group. This might reduce the use of coercive measures.

Dealing with this highly context-dependent target group places high demands on sociotherapists' professional behaviour and knowledge, attitude and competences of all professionals involved

Future studies might also explore from an ecological theoretical perspective (Bronfenbrenner, 1979; Olivier-Pijpers, 2020) how various aspects on different system levels (onto-, micro-, meso-, macro- and chronosystem) influence (aggressive) behaviour from clients and the use of coercive measures on the living group. If we want to understand the quality of group climate in relation to aggressive behaviour of clients and the use of coercive measures, it is necessary that the surrounding systems are taken into account. In the first place by examining how work climate or team climate factors (such as team functioning and leadership) interact with aggressive behaviour and the use of coercive measures.

3. Key finding three: Group climate is a dynamic concept in which sociotherapists must continuously attune their actions to the ambivalent signals of clients

Although different theoretical frameworks have shown to be useful within forensic care (see chapter 1), it remains difficult to translate these frameworks from general directions to specific guidance for the unique client in his or her specific context. The type of support offered in a secure forensic setting for individuals with MID-BIF does not fit

easily into a single protocol or standardised guideline. Working at the intersection of forensic care, psychiatry and care for individuals with intellectual disabilities underlines the complex task assignment of sociotherapists in forensic care for clients with MID-BIF. Group climate must be attuned to the specific characteristics, needs, learning style of individuals with MID-BIF, mental disorders and risky behaviour, while at the same time risks and safety must be monitored. High-quality and effective treatment requires the integration of knowledge and skills from forensic care, psychiatry and care for individuals with MID-BIF. It may therefore be impossible to formulate a uniform and optimal group climate for this target group. As shown in chapter 4, the perception of group climate varies per client, per situation and over time. Sociotherapists are expected to receive the subtle and often ambivalent and ambiguous signals sent out by the clients, to interpret behaviour in a responsive way within that specific context and intervene accordingly (chapter 4).

To enable sociotherapists to create a therapeutic group climate that meets the specific needs of this target group, it seems crucial to create a positive work climate (as highlighted in chapter 5). In this dissertation it was concluded that there are some associations between work climate and group climate, but that these results should be interpreted with caution. This does not alter the fact that organisations are faced with the challenge of enabling sociotherapists to perform their complex tasks as good as possible. This means that continuous attention must be paid to what teams as well as individual sociotherapists need in order to be able to do their important work. In daily clinical practice sociotherapists have to do their job while basic conditions are often far from ideal. Organisations struggle to find enough qualified staff, and often there is a high absenteeism and turnover rate among staff (CNV Zorg & Welzijn, 2018). For example, absenteeism due to sickness among healthcare professionals is higher than in other professions, burnout is more frequent and the psychosocial burden on staff increases (Douwes & Hooftman, 2019; Klein Hesselink, Kraan, Venema, & Van den Bossche, 2014; Seti, 2008). High absenteeism is not only a problem for the staff members concerned, but also undesirable for the organisation and treatment process of the clients (Lambert, Barton-Bellessa, & Hogan, 2015). Knowledge and experience disappear and new staff have to be recruited and trained. This not only creates high costs, but also shortage of staff on the living group and repeatedly new faces (high percentage of flex workers) for clients and colleagues which may be detrimental to the quality of care. High turnover of staff members results in discontinuity of care and can have a negative impact on the therapeutic relationship

Committing and inspiring sociotherapists should be a spearhead for secure forensic settings when they want to keep using their valuable knowledge and skills

between clients and sociotherapists. In addition, understaffing leads to work stress and puts pressure on the work climate (including team functioning and leadership), for example because sociotherapists are asked to work overtime or to work more shifts. Not surprisingly, recent research by Statistics Netherlands (Centraal Bureau voor Statistiek, 2019) has shown that Dutch health care professionals experience an increased workload, partly as a result of regulatory pressure and administrative obligations.

Various national reports note that the accumulation of these factors puts unacceptably high pressure on professionals working in forensic care settings and that the safety of both professionals and clients is at risk. The increasing pressure on forensic care has not gone unnoticed by the Dutch government. In the 'Multi-Year Agreement Forensic Care 2018-2021', the Ministry of Justice and Security, the Dutch mental health care (GGZ), the Association for the Dutch care for individuals with intellectual disabilities (VGN), the Federation Shelter (FO) and the RIBW Alliance have made agreements to improve safety and quality in forensic care. These agreements are carried out by a Taskforce Forensic Care. The focus of this taskforce is on improving the labor market, reducing administrative burden and improving the quality of care and safety within forensic care. In this context, a national campaign 'working in forensic care' was launched in August 2020, with the aim of asking attention for this work field (Ministerie van Justitie en Veiligheid, 2018). Besides promoting this work field, forensic care should also be able to invest in their professionals in order to create the best possible quality of care. This will require financial support. Also, research-based improvements are continuously being developed like the workbook 'Forensic High Intensive Care', which has seen in 2020 its second edition. Committing and inspiring sociotherapists should be a spearhead for secure forensic settings when they want to keep using their valuable knowledge and skills in creating a therapeutic group climate.

Clinical implications

This dissertation underpins the urgency of professional assistance for organisations and professionals working in secure forensic care settings to build a healthy work climate in which a therapeutic group climate is embedded. Nationwide implementation of the multi-year-agreement including, to realise an adequate HRM policy as part of the national labour market campaign, reducing administrative burden, and above all improving quality of care by offering education and training programmes would be welcome steps in the

right direction. But these programmes achieve little unless converted into tailor-made programmes that can be flexibly adapted to meet the needs of the organisation and/or professionals. From an organisational perspective, it is therefore recommended to invest in the knowledge, skills and attitude of sociotherapists with regard to identifying, interpreting and intervening on the living group. Chapter 4 contributes by providing a framework to 'fine-tune' group climate on five dimensions. Training sociotherapists to be sensitive to interpret ambiguous signals on these dimensions can contribute to optimizing the group climate in a way that acknowledges the unique person in his or her specific context, which is in line with the broader trend of person-centered care in which the 'one size fits not all' principle applies (chapter 4; Håkansson Eklund et al., 2019).

Implications for future research

Overall, based on results presented in this dissertation it can be concluded – albeit with caution – that work climate and group climate are associated. Further research should explore the nature and mechanisms of these associations in greater detail. With the current cross-sectional study design, it was not possible to establish directions for the reported associations in chapter 5. Theoretically, it is plausible that each of these associations have bidirectional effects. For instance, team functioning as perceived by sociotherapists may affect group climate as experienced by individuals with MID-BIF, but group climate may also affect team functioning. A longitudinal design would be required to determine the possible (causal) directions of associations between work climate and group climate. This is also more in line with the idea that work climate and group climate are dynamic concepts that change over time and require multiple measures. Furthermore, follow-up research must show to what extent the five overarching dimensions as described in chapter 4 are specific for clients with MID-BIF, or whether these dimensions are also present to a greater or lesser extent in forensic care for persons with a MID-BIF in general and/or other target groups in other care settings.

Strengths and limitations

This section highlights a number of strengths and offers critical remarks concerning the studies reported in this dissertation. One of the strengths is that group climate was stud-

ied by using different research sources (i.e., literature, clients and sociotherapists perceptions) and methods (quantitative and qualitative study designs) which is viewed by researchers as the most adequate approach to study complex constructs. In this section we will discuss some methodological issues on the quantitative and qualitative studies. Another strength is that clients were actively involved in all studies by completing the GCI and/or were interviewed to explore their perceptions in greater detail. This ties in with the increasing interest in the contribution that individuals with MID-BIF can make by expressing their opinions and perceptions about the treatment they undergo (Brown, Duff, Karatzias, & Horsburgh, 2011).

Apart from its strengths, this dissertation has a number of limitations that should also be mentioned. It is relatively difficult to investigate group climate because of the breadth of this multifactorial construct, even referred to as 'intangible' (WHO, 1953). Our studies show promising results in that group climate can be measured in a reliable and valid manner in individuals with MID-BIF, though it is still difficult to fully capture this 'fuzzy' and complex construct in a questionnaire such as the GCI. Most of the group climate research is quantitative in nature. This contributes to the identification of a range of factors that influence and/or are associated with group climate but does not add to the conceptualization of group climate. After 50 years of group climate research, there is still a lack of conceptual clarity around the aspects and factors that influence group climate (Doyle et al., 2017).

Group climate can be measured in a reliable and valid manner in individuals with MID-BIF, though it is still difficult to fully capture this 'fuzzy' and complex construct in a questionnaire

The cross-sectional studies presented in this dissertation should be considered as a first step towards understanding the effects of group climate as perceived by individuals with MID-BIF in secure forensic care. Within this study design it was intended to give an indication whether there are associations between group climate, aggressive incidents, and use of coercive measures on the one hand and between group- and work climate on the other hand. It was not possible to account for fluctuations in group climate over time and to explore associations between interventions and group climate outcomes. Also, this dissertation offers no causal explanations and generalization of the results is therefore limited. To what extent the findings of the qualitative study are representative for the popula-

tion of individuals with MID-BIF in secure forensic care is hard to determine. To improve treatment outcomes for this target group and working conditions for sociotherapists prospective longitudinal research and intervention studies in larger samples are necessary.

From the perspective of Bronfenbrenner's ecological theory (1979), it should be noted that various aspects on different system levels (micro-, meso-, exo- and macro-system) have not been taken into account in this dissertation. Such as contextual factors that directly influence sociotherapists and indirectly clients. An example is the prevailing organisational culture. After all, factors in the meso- and exosystem together determine the quality of the work climate as perceived by sociotherapists. Systems are notoriously hard to influence as the famous quote of Anthony Stafford Beer says: "The purpose of a system is what it does. There is after all, no point in claiming that the purpose of a system is to do what it constantly fails to do" (Beer, 1985, p. 99). To gain insight into the factors that influence group climate as perceived by individuals with MID-BIF and work climate as reported by sociotherapists, it is helpful to view secure forensic treatment from a more holistic, systemic perspective (see chapter 5 and key finding one).

Arguably, a more comprehensive measure of work and group climate would also include data from other sources as part of routine monitoring in order to understand fluctuations in the quality of group climate over time. This data could be drawn from a range of sources, including changes in staff and client composition, changes to working practices in the organisation and/or at the living group. These are all factors that might affect work and group climate within secure forensic settings and, therefore, are of importance to help clinicians and researchers better understand and interpret work climate and group climate data regarding a particular living group. Given the fact that staff turnover is high in secure forensic settings, group climate can change quite rapidly. This raises the question how reliable and valid group climate measures are when it is monitored on a yearly basis, as in the case of our studies. There is no doubt that group climate is a dynamic concept which is important to monitor on a frequent basis. However, this must be balanced against more pragmatic concerns, such as not over-burdening clients and sociotherapists with completion of questionnaires (with the risk of resistance and low completion rates). The frequency and interval of the group climate and work climate measures should be based on consensus and broadly support by the participating clients and professionals.

Multiple studies reported significant differences in group climate as perceived by clients and staff (Tonkin, 2015). It is, therefore, recommended that both clients and

sociotherapists should be included in measures designed to monitor group climate in secure (forensic) settings, otherwise these questionnaires may not obtain a balanced and representative view of group climate. In this dissertation only clients completed the GCI and were interviewed about the group climate. It is recommended to examine the perspectives of sociotherapists with regard to group climate in future research.

A final issue worthy of mention is that in a large organisation such as Trajectum, group climate and work climate measures will inevitably involve collecting data from a subsample of the larger population. Several staff-related and organisation-related obstacles, such as high staff turnover, lack of motivation or even resistance for participating in this research, were met in daily practice that may have influenced the response rate. Therefore, bias caused by selective non-response during the research period cannot be ruled out. How large this subsample should be to obtain a reliable and representative picture of group climate and work climate is unknown in scientific research (Tonkin, 2015). Within this research a 30% response rate per living group was used, a rate which is quite arbitrary. In our studies we did not gather information about reasons for non-response. It is therefore not possible to learn from possible gaps and shortcomings in the way in which this research was organised.

Follow-up Lauren

Now six years after admission, Lauren stays on a living group with a lower security level and care intensity. In the past years, her treatment has focused on teaching her more healthier coping skills in case of increased tension, dealing with trauma and shaping a therapeutic group climate from which she experiences sufficient support to discuss her tensions and regulate them together with her sociotherapists. Although there is a clear growth in the functioning and development of Lauren, it is necessary that long-term investment is made in Lauren's personality and identity development. She experiences more relaxation and well-being and from there also shows behaviour from higher developmental phases.

However, Lauren's functioning proceeds in waves. There are still periods when she harms herself, shows aggressive behaviour, uses soft drugs, and feels that she no longer has a grip on herself. In these moments, she distrusts herself and is afraid that she will completely revert to her 'old behaviour' and will hurt herself and others.

During these periods she benefits from the proximity of her sociotherapists who sets limits for her, reassure her, identify stressors for her and put things into perspective for her. She remains highly context-dependent to prevent tension build-up and risky behaviour. The process of establishing and maintaining contact will require continued patience, tact and persistence from the sociotherapists working with her. The pitfall is to give up and get tired in this process. Lauren needs a long term reliable environment, which does not reject her, in order to ultimately be able to experience more grip and stability from herself. Therefore, extra support is offered to the sociotherapeutic team in terms of education, training, coaching on the job and intervision during team meetings. Although Lauren's behaviour can be explained by her history with adverse experiences and disharmonious developmental profile, intensive support of the sociotherapeutic team is necessary to keep this in mind in the daily support of Lauren. In addition, the team must be supported in the continuous translation that must be made in order to see the basic need behind Lauren's behaviour and to be able to respond adequately to this, despite the strong dynamics in behaviour that Lauren shows. This requires close collaboration between all disciplines involved with Lauren.

A risk with regard to the future is that an erroneous image is created, namely that Lauren has grown, receives less support and again has to deal with a more complex context. The 'good behaviour - more freedom' principle is often used within clinical forensic care. The distance to sociotherapists who offers her safety will then become too great to be able to maintain and control herself. Her coping skills will fall short to such an extent that she will only be able to shorten the distance through problem behaviour. Following this, containment and thus further escalation will start the negative vicious circle again. By stating that she is better able to function because her context provides adequate and proactive holding and limits, this risk is significantly reduced. The risks will potentially always remain and incidents and escalations must therefore keep her context alert in order to continue to give her the proximity and direction she needs. 'It is going well, so we do not change anything' should be the credo. For the future it is clear that Lauren has to rely on a sheltered living environment with 24-hour support in the care for individuals with intellectual disabilities and comorbid severe psychopathology. At the moment, it is being mapped out which organisation and living environments are eligible for Lauren's complex and intensive care needs.

Conclusion

As can be seen in the case of Lauren creating a therapeutic group climate and personalised treatment in a secure forensic setting is an ongoing challenge. Sociotherapists are assumed to be able to be sensitive to the balance between therapy and security at the intersection of forensic care, psychiatry and care for individuals with intellectual disabilities. Group climate must be attuned to the specific characteristics, needs, learning style of individuals with MID-BIF, mental disorders and risky behaviour, while at the same time risks and safety must be monitored. Working with high context-dependent clients in a complex and vulnerable context underlines the complex task assignment of sociotherapists in forensic care for clients with MID-BIF. This requires continuous maintenance.

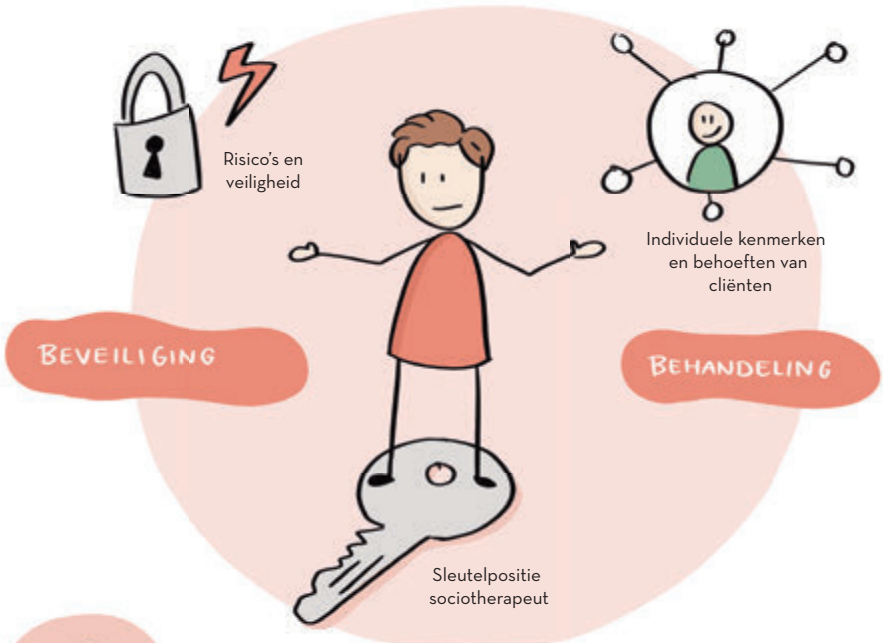
DE BELANGRIJKSTE CONCLUSIES UIT DE 4 STUDIES:

1 Monitoren van het leefklimaat is mogelijk bij doelgroep LVB

2 De kwaliteit van het leefklimaat hangt samen met agressie incidenten en dwangmaatregelen

3 Leefklimaat is een dynamisch concept waarin sociotherapeuten hun handelen continu af dienen te stemmen op ambivalente signalen

VOORTDURENDE UITDAGING



CONCLUSIES EN AANBEVELINGEN

Goede en effectieve behandeling voor deze doelgroep vereist integratie van kennis en kunde uit zowel forensische zorg, psychiatrie als de zorg voor personen met een verstandelijke beperking op de leefgroep

Landelijke druk op forensische zorg

Niet eenvoudig om een therapeutisch leefklimaat vorm te geven

Ondersteuning vanuit organisatie

CHAPTER 07.

Summary in Dutch

(Nederlandse samenvatting)

Volwassenen met een licht verstandelijke beperking of zwakbegaafdheid (verder aangeduid als LVB) vormen een kwetsbare groep in de samenleving. Bij deze doelgroep worden met regelmaat ernstige gedragsproblemen en/of psychiatrische stoornissen, problematisch middelengebruik en risicovol (en/of delict-) gedrag gezien. Deze complexe combinatie van problemen vereist intensieve zorg in een gespecialiseerde behandelsetting. Wanneer cliënten een gevaar voor zichzelf of anderen vormen en vrijwillige behandeling niet mogelijk is om dit gevaar af te wenden, kan risicovol gedag leiden tot een gedwongen opname in een klinische (forensische) behandelsetting. Gedwongen behandeling wordt meestal door de rechter opgelegd als onderdeel van een strafrechtelijke maatregel aan iemand met een psychische stoornis die een strafbaar feit heeft gepleegd. Het doel van de gedwongen behandeling is dan dat cliënten na hun behandeling geen strafbare feiten meer zullen plegen. Dat wordt ook wel het verminderen van recidive genoemd. De forensische zorg is er primair op gericht de maatschappelijke veiligheid te vergroten. Daarnaast kan de rechter ook gedwongen behandeling in het kader van een civielrechtelijke maatregel opleggen aan personen bij wie een psychische stoornis leidt tot gedrag dat gevaar veroorzaakt voor henzelf of anderen en er geen vrijwillige zorg mogelijk is om dat gevaar weg te nemen.

In Nederland worden cliënten in de klinische (forensische) zorg behandeld in leefgroepen. Naast therapieën, dagbesteding, onderwijs, trainingen en activiteiten, verblijven cliënten binnen hun klinisch behandeling het grootste deel van hun tijd op de leefgroep. Hier worden ze begeleid door sociotherapeuten. Omdat dit een het groot en belangrijk deel van de behandeling vormt, is de kwaliteit van het leefklimaat op deze leefgroepen van essentieel belang voor de ontwikkeling van cliënten en de effectiviteit van behandeling. Het leefklimaat kan verschillend worden ervaren door cliënten en sociotherapeuten, variërend van gesloten en repressief naar open en therapeutisch. Een open en therapeutisch leefklimaat wordt gekenmerkt door een veilige, gestructureerde en rehabiliterende omgeving waarin cliënten steun vinden bij hun sociotherapeuten, ruimte en mogelijkheden ervaren voor zingeving, leren en groei, structuur ervaren zonder dat ze last hebben van onvoorspelbare, harde en oneerlijke maatregelen en veiligheid en een prettige sfeer ervaren op de leefgroep waarbij er respect is voor elkaar, elkaars gevoelens, privacy en eigendommen. Zowel tussen sociotherapeuten en cliënten als tussen cliënten onderling. Uit onderzoek is gebleken dat een open en therapeutisch leefklimaat onder andere bijdraagt aan een hogere behandelmotivatie, een goede werkrelatie tussen cliënten en sociotherapeuten, een afname van agressie incidenten en recidive en meer

emotionele stabiliteit bij cliënten (Auty & Liebling, 2019; Bressington, Stewart, Beer, & MacInnes, 2011; Beech & Hamilton-Giachritsis, 2005; Johansson & Eklund, 2004; Long et al., 2011; Moos, Shelton, & Petty, 1973; Schubert, Mulvey, Loughran, & Losoya, 2012; Van der Helm, 2011; Van Ginneken, Palmen, Bosma, & Sentse, 2019).

Van een gesloten en repressief leefklimaat is sprake als cliënten weinig ondersteuning van sociotherapeuten ervaren, de mogelijkheden voor groei minimaal zijn, er een grimmige en niet uitnodigende sfeer op de afdeling heerst en er sprake is van veel repressie en beheersing van gedrag en risico's. Repressie belichaamt de oneerlijke en onderdrukkende kanten die een gesloten systeem kan hebben. Daarnaast kenmerkt repressie zich door weinig (dag)structuur, ruimte en tijd voor de cliënten, geen flexibiliteit, steeds meer een strengere regels, gebrek aan privacy, onderlinge gevoelens van onveiligheid, verveling, wantrouwen tussen de cliënten, wantrouwen naar sociotherapeuten, gevoelens van wanhoop en een gebrek aan toekomstperspectief. In een gesloten en repressief leefklimaat is er een onevenwichtige machtsbalans, een gebrek aan wederzijds respect en ligt de nadruk op straffen en regels. In tegenstelling tot een open leefklimaat kan dit alles leiden tot een afname van behandelmotivatie, meer agressief gedrag, emotionele instabiliteit bij cliënten en een negatief behandelresultaat. Uit recent onderzoek naar de effecten van dwang op de kwaliteit van het leefklimaat en behandelresultaten komt naar voren dat gedwongen behandeling kan werken, maar dat hoe meer dwang en drang wordt toegepast, hoe meer incidenten voorkomen, hoe slechter de behandeluitkomsten en hoe hoger de recidive (De Valk, 2019; Hachtel, Vogel, & Huber, 2019; Kowalinski, Schneeberger, Lang, & Huber, 2017; Parhar, Wormith, Derkzen, & Beauregard, 2008; Ros, Van der Helm, Wissink, Schaftenaar, & Stams, 2013). Gedwongen behandeling werkt alleen als er sprake is van een therapeutisch klimaat met vervulling van psychologische basisbehoeften verbondenheid, competentie en autonomie, gezamenlijke besluitvorming en een goede werkrelatie tussen cliënten en sociotherapeuten (Hachtel, Vogel, & Huber, 2019; Ryan & Deci, 2017; Schaftenaar, 2018).

Sociotherapeuten staan daarmee voor de complexe taakopgave om enerzijds, als gevolg van de problematiek van cliënten, risico's te taxeren en managen en anderzijds een therapeutische relatie op te bouwen, te onderhouden en recht te doen aan de noden en behoeftes van cliënten ('de behandeling – beveiliging paradox'; Inglis, 2010; Jacobs, 2012). Deze paradox krijgt al tientallen jaren veel aandacht in wetenschappelijk onderzoek. In de forensische zorg zijn de Risk, Need en Responsivity (RNR), de 'What works', principes van Andrews en Bonta (2006) uitgegroeid tot de belangrijkste uitgangspunten

voor effectieve forensische behandeling. In de forensische zorg voor personen met een LVB dienen deze principes te worden geïntegreerd met een orthopedagogische visie waarbij het accent ligt op het emotioneel, sociaal en cognitief functioneren van cliënten en de daarbij passende ondersteuning en bejegening op de leefgroep. Het emotionele niveau van functioneren kan ook belangrijke consequenties hebben voor de manier waarop risicovol gedrag op de leefgroep geïnterpreteerd wordt en hoe sociotherapeuten hiermee omgaan. En daarmee ook voor het inrichten van het risicomanagement en het leefklimaat. Dit maakt het werk van de sociotherapeut in de forensische zorg voor mensen met een LVB ingewikkeld: werken op het snijvlak van forensische zorg, psychiatrie en gehandicaptenzorg met integratie van verschillende perspectieven, beproefde methoden en (wettelijke) kaders.

Momenteel wordt er in binnen- en buitenland, onder meer in de (gesloten) jeugdzorg, het gevangeniswezen, de (forensische) psychiatrie en de zorg voor personen met een verstandelijke beperking, onderzoek gedaan naar het leef- en werkklimaat. Hoewel het belang van een therapeutisch leefklimaat in relatie tot effectieve behandeling breed wordt onderkend in zowel onderzoek als de praktijk, is de doelgroep LVB onderbelicht gebleven in onderzoek naar het leefklimaat. Dit proefschrift richt zich op het onderzoeken van de kwaliteit van het leefklimaat voor volwassenen met een licht verstandelijke beperking die worden behandeld in een klinisch (forensisch) behandelsetting. In de algemene inleiding (hoofdstuk 1) wordt een korte literatuurweergave gegeven van onderzoek naar klinische forensische behandeling voor deze doelgroep en onderzoek naar het leefklimaat. In de hoofdstukken 2 tot en met 5 worden de resultaten van de vier onderzoeken gepresenteerd. De data voor deze studies zijn verzameld bij Trajectum, een organisatie die specialistische behandeling biedt aan volwassenen met een LVB in combinatie met psychiatrische-, verslavings-, en/of gedragsproblematiek, al dan niet binnen een forensische kader.

Hoofdstuk 2: het meten van het leefklimaat

Hoewel er meerdere instrumenten beschikbaar zijn om de kwaliteit van het leefklimaat op een betrouwbare en valide manier te meten voor verschillende doelgroepen was dit nog niet mogelijk voor volwassenen met een LVB. De Prison Group Climate Instrument (PGCI; Van der Helm, Stams, & Van der Laan, 2011) is in 2009 ontwikkeld om

het leefklimaat te meten in de residentiële (jeugd)zorg. In hoofdstuk 2 is een valideringsstudie beschreven waarin de PGCI is aangepast met minder complex taalgebruik en een vermindering van het aantal items (van 37 naar 29 items). Zo is de Group Climate Instrument (GCI) ontstaan. In hoofdstuk 2 is de betrouwbaarheid en validiteit van deze vragenlijst in een steekproef van 189 cliënten met een LVB die klinische (forensische) behandeling volgden, onderzocht. Op basis van een Confirmatieve Factor Analyse (CFA) bleek dat er sprake was van een factorstructuur met één overkoepelende leefklimaatfactor en vier afzonderlijke leefklimaatfactoren, namelijk: ondersteuning, groei, repressie en sfeer. De studie verstrekt de eerste bewijzen van de validiteit en betrouwbaarheid van de GCI voor deze doelgroep, waarin ervaren leefklimaat als een multidimensionaal construct in beeld wordt gebracht. Hoewel verdere ontwikkeling van de GCI en replicatie van onze studieresultaten noodzakelijk lijken, is de GCI geschikt om (periodiek) af te nemen bij cliënten met een LVB die verblijven in de klinische (forensische) zorg. De resultaten van de vragenlijst kunnen worden gebruikt om inzicht in het leefklimaat te verkrijgen en, indien gewenst, in te zetten als onderdeel van een verbetercyclus.

Hoofdstuk 3: de relatie tussen leefklimaat, agressie incidenten en de inzet van dwangmaatregelen

In de tweede studie (hoofdstuk 3) werd de GCI gebruikt om de samenhang tussen de kwaliteit van het leefklimaat, de frequentie van agressieve incidenten en de inzet van dwangmaatregelen op de leefgroep te onderzoeken. De steekproef bestond uit 248 cliënten. Uit deze studie kwam naar voren dat een open en therapeutisch leefklimaat, waarin cliënten ondersteuning, groei mogelijkheden en een goede sfeer ervaren, samenhangt met een lagere frequentie van agressie incidenten. Een repressief leefklimaat was daarentegen gerelateerd aan een hogere frequentie van agressie incidenten. Inherent hieraan werd gevonden dat een hogere frequentie van agressie incidenten samenhingen met meer inzet van dwangmaatregelen. Opgemerkt dient te worden dat er geen causale relaties vastgesteld konden worden vanwege het cross-sectionele onderzoeksdesign. De samenhang tussen repressie en agressie enerzijds en agressie en de inzet van dwangmaatregelen anderzijds benadrukken echter het spanningsveld tussen het behandelen en beheersen van agressief gedrag op de leefgroep. Systematische analyse van (onderliggende oorzaken van) agressie en reflectie op professioneel handelen bij agressie incidenten

wordt aanbevolen. Hierbij is het van belang om niet alleen in te zoomen op de persoon die zich agressief gedraagt, maar dient er ook oog te zijn voor de specifieke factoren op de leefgroep waar deze cliënt verblijft.

Hoofdstuk 4: de perceptie van cliënten met betrekking tot het leefklimaat

In hoofdstuk 4 werd de perceptie van 12 volwassenen met een LVB ten aanzien van het leefklimaat kwalitatief onderzoekt. Deze studie beoogde om, in aanvulling op het meten van de kwaliteit van het leefklimaat, leefklimaat te begrijpen vanuit het perspectief van cliënten en inzicht te verkrijgen waarom het leefklimaat als meer therapeutisch of repressief ervaren wordt. De vier factoren van de GCI (ondersteuning, groei, repressie en sfeer) dienden als een raamwerk voor de interviews met de cliënten. In de interviews over de vier domeinen van het leefklimaat (te weten repressie, ondersteuning, groei en sfeer) verschenen vijf overkoepelende dimensies: 1) autonomie, 2) uniformiteit, 3) erkenning, 4) competentie en 5) waardigheid. Deze vijf dimensies komen, afhankelijk van de persoon en de (behandel)context waar binnen deze verblijft in meer of mindere mate, in alle vier factoren van het leefklimaat terug. Door het vergaren van diepte-informatie werden meer details, nuances en context met betrekking tot het leefklimaat verkregen. Ten aanzien van de samenhang tussen de kwaliteit van het leefklimaat en agressie incidenten (zie hoofdstuk 3), gaven de participanten in deze studie bijvoorbeeld aan dat er geen sprake is van een eenduidige relatie tussen het ervaren van repressie en het veroorzaken of meemaken van agressie. De gevonden dimensies brengen hier een belangrijke nuance in aan. De participanten gaven bijvoorbeeld aan dat beperkingen, controle, regels en grenzen van belang zijn, mits duidelijk is waarom en het geen doel opzich is (dimensie autonomie). Daarnaast gaven de participanten te kennen dat de inzet van dwangmaatregelen zoals afzondering gerechtvaardigd vinden om de veiligheid te waarborgen, mits hun gevoel van boosheid of verdriet daarnaast ook erkend wordt door de sociotherapeuten (dimensie erkenning). Dit is een voorbeeld van hoe de link tussen leefklimaat en agressie ingebed wordt in een breder kader.

Geconcludeerd werd dat alle participanten ambivalente signalen gaven over het leefklimaat in het algemeen en de ondersteuning door sociotherapeuten in het bijzonder. Dit resulteert in een complexe opgave voor sociotherapeuten aangezien de participant-

en middels hun non-verbale of verbale gedrag regelmatig signalen afgeven die strijdig zijn met hun behoefte aan nabijheid van sociotherapeuten. Van sociotherapeuten wordt verwacht dat zij de subtiele en ambivalente signalen die de participanten uitzenden, op de juiste manier weten te duiden afhankelijk van de context op dat moment. Dit impliceert dat het leefklimaat een dynamisch concept is waarbij sociotherapeuten hun handelen continu dienen af te stemmen op de ambivalente signalen van cliënten (als op een mengpaneel). Vervolgonderzoek moet uitwijzen in hoeverre de vijf overkoepelende dimensies specifiek zijn voor de forensische zorg voor personen met een LVB of dat deze dimensies in meer of mindere mate ook aanwezig zijn binnen de reguliere zorg voor personen met een LVB of binnen de forensische zorg voor personen zonder een LVB.

Hoofdstuk 5: de relatie tussen het leefklimaat en het werkklimaat

In hoofdstuk 5 wordt een studie gepresenteerd over de relatie tussen het leefklimaat zoals ervaren door cliënten en het werkklimaat zoals gerapporteerd door sociotherapeuten. De steekproef bestond uit 212 cliënten en 262 sociotherapeuten. Het leefklimaat werd gemeten met de GCI en het werkklimaat met de Living Group Work Climate Instrument (LGWCI; Dekker, Van Miert, Van der Helm, & Stams, 2015). De resultaten toonden aan dat wanneer sociotherapeuten meer werktevredenheid ervaren dit samen gaat met minder negatief teamfunctioneren. Daarnaast bleek positief teamfunctioneren samen te hangen met minder ervaren repressie door cliënten. Een hoge werkdruk en negatief teamfunctioneren waren geassocieerd met minder ervaren groeimogelijkheden voor cliënten. Er werden geen significante relaties gevonden tussen de overige elementen van het werkklimaat en de leefklimaat factoren. Hoewel geen causale relaties vastgesteld kon worden benadrukt deze studie het belang van bewustzijn op het gebied van parallelle processen tussen het leef- en werkklimaat.

Hoofdstuk 6: Conclusies en aanbevelingen

In de algemene discussie worden de bevindingen van de vier studies tegen het licht gehouden. De belangrijkste conclusies worden hieronder puntsgewijs weergegeven:

1. Het monitoren van het leefklimaat in de klinisch forensische zorg voor volwassenen met een LVB is mogelijk. Middels afname van de GCI en interviews worden waardevolle inzichten verkregen over de perceptie van het leefklimaat van deze doelgroep.
2. De kwaliteit van het leefklimaat hangt samen met agressie incidenten en dwangmaatregelen op de leefgroep.
3. Leefklimaat is een dynamisch concept waarin sociotherapeuten hun handelen continu dienen af te stemmen op de ambivalente signalen van cliënten.

Alles overziende concludeerden we dat het vormgeven van een therapeutisch leefklimaat dat is ingebed in een gepersonaliseerde klinisch, forensische behandeling een voortdurende uitdaging vormt. Sociotherapeuten hebben een sleutelpositie in de vormgeving van het leefklimaat. Niet alleen dient het leefklimaat te worden afgestemd op de specifieke kenmerken, behoeften, de leerstijl en het functioneringsprofiel van de cliënten, ook wordt beoogd om psychische stoornissen en risicovol gedrag te verminderen waarbij risico's en veiligheid in het oog moeten worden gehouden. Een kwalitatief goede en effectieve behandeling voor deze context afhankelijke doelgroep vereist een integratie van kennis en kunde uit zowel de forensische zorg, psychiatrie als de verstandelijk gehandicaptenzorg op de leefgroep. Tegelijkertijd is er sprake van een kwetsbare context door de landelijke druk op de forensische zorg. Hierdoor is het in de klinische praktijk niet altijd eenvoudig is een therapeutisch leefklimaat vorm te geven. Om kwaliteit van zorg en veiligheid vorm te kunnen geven, die recht doet aan de unieke cliënt in zijn of haar specifieke context, is voortdurend onderhoud nodig in de vorm van het investeren in de kennis, vaardigheden en de attitude van sociotherapeuten ten aanzien van het professioneel handelen op de leefgroep. Sociotherapeuten hebben daarbij, net als de cliënten, recht op een kwalitatief goed werkklimaat met optimale ondersteuning vanuit de organisatie.

CHAPTER 08.

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CHAPTER 9.

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CHAPTER 10.

Curriculum Vitae

Elien werd op 31 oktober 1990 geboren te Drachten. Zij startte haar schoolloopbaan op 't Startblok in Donkerbroek. Na het behalen van haar VWO-diploma aan het Stellingwerf College te Oosterwolde, begon ze in 2009 aan de opleiding Pedagogische Wetenschappen aan de Rijksuniversiteit in Groningen. Hier behaalde ze in 2012 haar bachelordiploma in de richting Orthopedagogiek. Aansluitend koos ze voor de master Forensische Orthopedagogiek aan de Universiteit van Amsterdam. In 2013 studeerde ze Cum Laude af. Tijdens de master schreef zij haar scriptie over het leefklimaat in de residentiële jeugdzorg en liep ze haar klinische stage bij Trajectum, locatie Boschoord. Hier bleef ze na haar afstuderen werken als gedragsdeskundige. In december 2015 is ze gestart met het promotieonderzoek aan het Behavioural Science Institute (BSI) van de Radboud Universiteit te Nijmegen. De aanstelling als promovenda combineerde ze met haar functie als gedragsdeskundige. Bij Trajectum kreeg ze de mogelijkheid om zich verder te ontwikkelen tot gezondheidszorgpsycholoog (2018-2020). Sindsdien werkt Elien als regiebehandelaar bij Trajectum, Klinisch Behandelen Noord te Boschoord.

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