Space between the borders?

ten Brummelaar, Mijntje Derkje Corneeltje

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
2016

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):

Copyright
Other than for strictly personal use, it is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), unless the work is under an open content license (like Creative Commons).

Take-down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from the University of Groningen/UMCG research database (Pure): http://www.rug.nl/research/portal. For technical reasons the number of authors shown on this cover page is limited to 10 maximum.
Chapter Two

Residential child and youth care in the Netherlands: Practices and developments

Parents have a primary responsibility in the upbringing of their children. According to Article 9 (1) of the Convention on the Rights of the Child (CRC), States Parties “shall ensure that a child shall not be separated from his or her parents against their will”. However, when the best interests of young persons are at stake while staying in their family environment, the State has to provide a suitable alternative residence for the young person. Preferably, this alternative residence is with family foster care. If a foster placement is not possible or contra-indicated, a solution might be the placement of the young person in a residential care facility.

According to Article 20 (1) of the CRC, when staying in a residential care facility, the young person is entitled to special protection and assistance provided by the State. Since the ratification of the CRC in 1995 by the Dutch government, the Netherlands has to comply with the requirements set by the CRC. This also applies to young people staying in residential care facilities. We fairly often come across young people such as Mohamed, Cynthia, Melanie or Jeffrey in one of the Dutch residential care facilities.

The Netherlands, with 17 million people residing in an area of 41,526 square kilometres, is one of the most populated areas around the globe. Approximately, 27 percent of the Dutch population is between 0 to 23 years old (CBS, 2014). Within this group of young people over 350,000 young people receive help provided by child and youth care and
treatment services (Knorth, Evenboer, & Harder, 2016). Approximately 11 to 14% of the child and youth care users is assigned to specialized residential care services (Knorth, 2005).

In the Netherlands, every young person between 0 to 18 years old is entitled to help provided by child and youth care services. In some cases, young people up to the age of 23 can also appeal to these services (Harder, Zeller, López, Köngeter, & Knorth, 2013). Over the years, the Dutch child and youth care system has shifted from a traditional facility-centred to a needs-led care system (De Winter, 2002; Metselaar, 2011). The modern needs-led system focuses on outpatient family-oriented interventions (Metselaar, 2011). Despite the focus of the Dutch child protection and welfare system on family preservation and community-based interventions, the number of young people in out-of-home care facilities has increased over the last 15 years (Knorth & Koopmans, 2012).

In this chapter, we will describe the state-of-the-art of the Dutch residential child and youth care practices. With this, we aim to provide insight into the history of these care and treatment practices, and reflect upon the types of residential care facilities and their population. Furthermore, we address the care process of young people, the outcomes of residential care, some ‘good practises’ in this field, and reflect upon developments and future perspectives of Dutch residential care.

**Brief history of Dutch (residential) child and youth care practices**

At the beginning of the 20th century, the establishment of the ‘children laws’ (1905) led to a significant change in the care process regarding neglected and delinquent young people (Hanrath, 2013). Before 1905, certain groups of young people stayed in out-of-home care facilities, such as boarding schools, orphanages, or seminaries, led by Christian or philanthropic organisations. Young people stayed in these types of facilities when their parents were out of sight, or in case of (re)educational purposes (Matthijs & Vincken, 2004). However, there were few judicial measures to protect young persons from abuse and neglect by their parents (Boendermaker & Uit Beijerse, 2008).

In addition, judicial measures for delinquent young people lagged behind. Placement decisions in correctional facilities happened arbitrarily, based on the ability of the young person to distinguish between ‘good’ and ‘evil’ [oordeel des onderscheids]. As the upbringing of a young person was increasingly seen as the main basis for the subsequent behaviour of people, the distinction between the delinquent and the neglected young person began to fade. This movement led to the juxtaposition of these young people in the same institutions. The establishment of children laws in 1905 formed the basis of our current child protection and welfare system, in which the penal law, the civil law, and the civil procedural law all cover an area of legislation (Matthijs & Vincken, 2004).

Despite several positive developments arising from the 1905’s children laws, by the end
of the seventies of the 20th century the Dutch youth care system had obtained a state of fragmentation. There was a strong compartmentalisation between organisations for child protection, child and youth care, and child and adolescent mental health care. Eventually, this fragmented system prompted a profound reform of the youth care system, leading to the implementation of the Youth Care Act \( [\text{Wet op de Jeugdhulpverlening}] \) in 1989 and the establishment of the Youth Care Act in 2005 \( [\text{Wet op de Jeugdzorg}] \) (Harder et al., 2013). Even though the Youth Care Act of 2005 resulted in significant changes ensuring ‘the right’ to high quality care for young people and their families, the system still faced several problems such as the increased use of care, lack of transparency, and unmanageability of the existing care system (Bosscher, 2014).

Currently, the Dutch youth care system underwent major changes: the so-called youth care transition and transformation (Bosscher, 2014; NJI, n.d./a). With this new youth care system, both administrative and financial responsibilities for specialized youth care are transferred from the provinces to the municipalities. As of 2015, the Dutch municipalities are fully responsible for the implementation of the universal, preventive and curative youth care (Evenboer, 2015). This applies equally to the child protection and youth probation services, the secure residential care facilities (with the exception of juvenile justice facilities), the care for youth with mild mental disabilities, and the child and adolescent mental health services. In addition, the transition is accompanied by substantive reforms of the current Child and Youth Welfare and Protection Policy, described in the new Act on Care for Children and Young People, which came into effect in 2015 (Bosscher, 2014). The idea behind the new youth care system is to promote a univocal and integrated approach to youth care, with a further emphasis on the position and self-reliance of children, youth and their caregivers (NJI, n.d./a). For young people such as Mohamed, Cynthia, Melanie and Jeffrey this means that they and their caregivers should have a key position throughout the care process in residential care.

**Types of residential care and its users**

Because the living situation of Mohamed and his brothers was no longer sufficient, they have been placed in an emergency shelter. A placement in an emergency shelter is effectuated when young people cannot stay with their family any longer and are in need of assistance. Young people can stay in such an emergency shelter for a relatively short period of time (approximately four weeks). In this period, all parties involved seek for a sustainable solution for future living arrangements.

Different types of care facilities fall under the scope of residential care in the Netherlands. Generally speaking, young people between the ages of 0 to 23 years old can receive treatment in an out-of-home care facility. Young people staying in residential care show (much) more behavioural problems than their peers, using other types of youth care
services (Knorth, 2005). Over the years, residential care has been indicated more and more as a ‘last resort’ for young people in case other types of care do not seem to be adequate (Harder, Knorth, & Zandberg, 2006; Harder et al., 2013; Hellinckx, 2002).

Residential facilities differ in terms of size, but on average each living group houses four to twelve young people. Within residential facilities, groups can be divided in boys and girls groups. Some facilities do house mixed groups (Boendermaker et al., 2013; Harder et al., 2013). Depending on the needs of the individual young person (and his or her family) the placement can vary from semi-residential care to a continuous stay in a care facility (Harder et al., 2006). Young people stay in a residential care facility based on a voluntary placement or under coercive measures. With regard to the latter, a coercive placement should be imposed by a court order.

Harder and colleagues (2013) distinguish between two broad categories of residential care: 1) residential care for young people who lack a supportive and facilitating upbringing situation, and 2) residential care for young people with severe individual problems, such as emotional and behavioural problems. In the Netherlands, the following types of residential care can be grouped under one of these two categories (see table 1): Residential child and youth care, child and adolescent mental health care, care for youth with mild mental disabilities (all of which are now under the responsibility of the municipalities), and juvenile justice facilities (which remain the responsibility of the State). Young people such as Mohamed, Cynthia, Melanie or Jeffrey are each placed in one of these residential care facilities.

Table 1. Types of residential care facilities and numbers of young people in residential care

<table>
<thead>
<tr>
<th>Type of residential care</th>
<th>Numbers of young people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential child and youth care</td>
<td></td>
</tr>
<tr>
<td>Family Homes</td>
<td>1,362¹</td>
</tr>
<tr>
<td>Emergency shelters</td>
<td>10,697²</td>
</tr>
<tr>
<td>Living and treatment groups</td>
<td>10,906³</td>
</tr>
<tr>
<td>Independent living programme centres</td>
<td></td>
</tr>
<tr>
<td>Secure residential care centres</td>
<td>3,261⁴</td>
</tr>
<tr>
<td>Child and adolescent mental health care</td>
<td>6,073⁵</td>
</tr>
<tr>
<td>Inpatient hospital wards</td>
<td></td>
</tr>
<tr>
<td>Youth psychiatric clinics</td>
<td></td>
</tr>
<tr>
<td>Care for youth with mild mental disabilities</td>
<td></td>
</tr>
<tr>
<td>Orthopedagogical treatment centres</td>
<td>10,493⁵</td>
</tr>
<tr>
<td>Correctional facilities</td>
<td></td>
</tr>
<tr>
<td>Juvenile Justice Facilities</td>
<td>1,844⁶</td>
</tr>
</tbody>
</table>

Mohamed is placed in an emergency shelter, which falls under residential child and youth care. Residential child and youth care, financed by the municipalities, is organised in family homes, living and treatment groups, independent living programme centres, and secure residential care centres. Family homes offer small-scale living arrangements for young people in a family-like care setting. Living and treatment groups are organised in long stay residential groups, offering permanent shelter, care or treatment for young people, and short stay residential groups, such as emergency shelters and observation groups (Harder et al., 2013). Independent living programme centres serve as a bridge between the time in care and the independent living afterwards. Independent living programme centres are often connected to residential care facilities and accommodate four to six young people (NJI, n.d./b). Secure residential care centres [JeugdzorgPlus instellingen] offer the most intensive type of residential child and youth care (Harder, 2011). Secure residential care centres house young people with severe emotional and behavioural problems (Boendermaker, 2008). Young people staying in secure residential care show both severe internalizing and externalizing problem behaviour. In addition, a substantial proportion of the young people come from challenging family environments (Harder, 2011; Van Dam, Nijhof, Scholte, & Veerman, 2010).

Cynthia is placed in a psychiatric clinic, which is part of child and adolescent mental health care. Young people with severe symptoms of psychiatric disorders are assigned to specialized child and adolescent mental health care. These young people can be referred to inpatient hospital wards, or youth psychiatric clinics. The majority of these users have been diagnosed with attention deficit disorders and behavioural disorders, followed by pervasive development disorders (e.g. Asperger, Autism). Most young people residing in residential mental health facilities suffer from comorbidity (GGZ Nederland, 2013). According to Reijneveld et al. (2014) child and adolescent mental health primarily focuses on the individual problems of the young person, and less on environmental factors.

Melanie is placed in an orthopedagogical treatment centre, which falls under care for youth with mild mental disabilities. Young people with mild mental disabilities can stay in residential facilities, varying from open facilities to secure residential care (Harder et al., 2013). Young people with a mild mental disability have a below average intelligence quotient (IQ), accompanied by social adjustment disabilities (Zoon, 2013). They often show comorbidity such as behavioural and psychiatric problems (Došen, 2008). The most common facilities for young people with mild mental disabilities are the so-called ‘orthopedagogical treatment centres’ (Boendermaker et al., 2013). Orthopedagogical treatment centres offer specialized treatment and counselling for young people with mild mental behavioural disabilities often in combination with severe behavioural problems (VOBC, n.d.).

Jeffrey is placed in a juvenile justice facility (JJF). JJFs accommodate juvenile offenders or juveniles who are suspect of a crime. The aim of JJFs is to protect society, prevent future delinquent behaviour, and to rehabilitate the young person so he or she is equipped for
return to society. Often JJFs are grouped under secure residential care (Harder, 2011).

**Background characteristics of youth in residential care**

Cynthia is placed in psychiatric clinic specialized in eating disorders. Cynthia was a cheerful little girl when she was growing up. Her parents described her as ‘someone you would immediately notice in a room full of people’.

However, at age 10 Cynthia is molested by her gymnastic teacher. Hereafter, Cynthia loses her cheerfulness and becomes quiet. Cynthia’s parents seek help for their daughter, but Cynthia refuses to go to these therapeutic sessions. She locks herself in her room mostly every day and uses a lot of pain medicine. Cynthia’s parents are desperate and they finally decide to intervene. Cynthia is diagnosed with a persistent depression.

Cynthia has several aversive experiences prior to her placement in a psychiatric clinic. For many young people a residential care placement is often not the first contact with the care system. Especially when it concerns coercive residential placements, research shows that most young people have a long history of care prior to placement (Harder et al., 2011; Van Dam et al., 2010). A systematic review by Vermaes and colleagues (2014) showed for example that between 93 to 98% of the young people in Dutch secure residential care settings had a history of residential placements. Other characteristics were the presence of externalizing problems (85-99%), often in combination with internalizing problems (36-67%), police contacts (70-72%), abuse of soft drugs (40-65%), hard drugs (18-25%), or alcohol (27-29%), and over 50% had traumatic experiences. Also 75% of all parents experienced moderate to severe upbringing stress prior to placement of their child in a secure residential care facility.

The number of children in residential care as a proportion of the number of out-of-home placed children in the Netherlands is 43% (Harder et al., 2013). Although residential treatment is, according to Whittaker (2015, p. 71), “… the optimal intervention for very high-risk, multi-need youth who have someone in the community who is willing to take them back”, the actual use of this service vastly differs between countries1; the Netherlands show an intermediate position. Knorth (2015) explains these differences between the Netherlands and other countries as the result of factors like 1) child poverty and family deprivation, 2) the interventionist role of the state, 3) the amount of confidence that being in (residential) care can have a positive impact on a child’s life, and 4) the policy orientation of the welfare system: child- or family-oriented.

---

1 In other countries, the number of children in residential care as a proportion of the number of out-of-home placed children varies between 6% (Australia), 8% (Ireland) or 14% (England) on the one hand and 72% (Czech Republic), 80% (Israel) or 92% (Japan) on the other. Big European countries like Germany (54%), Italy (48%), France (37%) and Spain (38%) show numbers in between (Thoburn & Ainsworth, 2015).
The residential care process

It's Monday morning. Melanie's alarm clock goes off at 7.30 am. She snoozes and falls back asleep. A few minutes later she is awakened by Yamila, one of her favorite group care workers. Melanie takes a shower, after which she sits down at the breakfast table with the other young people of her residential group. Melanie has just started picking up her schoolwork again. She is offered a modified school programme alternating with group therapy, individual therapy, or creative therapy. At six o’clock the residential group eats together. Hereafter, there is time for recreational activities. Melanie decides to watch some television. At 9.30 pm she goes to bed.

Depending on the type of residential care facility, specialised treatment and care that is offered is adapted to the group of care users staying in that particular facility. In general all residential care consists of four basic principles: 1) basic care for the child, such as having a place to sleep, receiving adequate meals and drinks, being protected and having access to medical care, 2) upbringing of the child, with the possibilities of education and/or employment programmes, and leisure activities, 3) consistent feedback and individual meetings related to their treatment plan, and, 4) individual or group treatment interventions (Boendermaker et al., 2013). Nowadays, it is more and more recognised that the family and/or the wider social network of a child or young persons should be involved in the treatment process as much and as early as possible (Geurts, Boddy, Noom, & Knorth, 2012; Small, Belloni, & Ramsey, 2015).

The basic care and upbringing mostly takes place at the residential group, as this is also the case for Melanie. Because young people spend a significant proportion of their time on the residential group, group care workers in the Netherlands play a pivotal role in the young person’s life (Bastiaanssen et al., 2012; Knorth, Harder, Huyghen, Kalverboer, & Zandberg, 2010; Van der Helm, 2011). Group care workers are expected to take up both ‘parental’ and educational tasks, but also to manage the residential group, keeping administrative tasks in mind, and collaborating with other care professionals and the young person’s social network (Harder et al., 2006). In most residential care facilities, each young person is assigned to a so-called coach or mentor during their stay, which is one of the care workers of the residential group. This coach or mentor is often responsible for observing the young person and involved in individual treatment planning. Over the years, an increased professionalization in residential care facilities led to a majority of qualified group care workers with higher educational degrees (Harder et al., 2013).

Besides their stay at the residential group, young people also often receive education and/or employment programmes. According to the compulsory attendance law in the Netherlands, young people are required by law to be enrolled in classes until the age of 18 or until they have obtained a basic qualification in secondary education. The education or employment programmes can be conducted within the residential care
facility or outside the facility, depending on the type of residential care that is offered (cf. Harder et al., 2014).

As stated in Article 25 of the CRC, State Parties recognise the right of a child who has been placed in a residential care facility to a periodic review of the treatment provided to the child including all circumstances relevant to his or her placement. In the Netherlands, this right is embedded in the treatment plans, established by the care organisations as the related periodic treatment plan evaluations. These treatment plan evaluations make up an important part of the treatment process, in which the treatment process is discussed. Larger facilities have behavioural specialists, e.g. psychologists or pedagogues with an academic degree, who are responsible for the young person’s care trajectory and/or treatment process. In addition, there are various support staff involved in the treatment process of the young person, such as psychiatrists, specialized trainers, nursing staff, and in some cases security staff.

Various individual or group treatment interventions are available that specifically aim at individual problems of the young people. For instance, Melanie has the possibility to follow group therapy and individual therapy. Just as for education and/or employment programmes, these interventions take place in the residential care facility or elsewhere, depending on the type of residential care that is offered.

**Outcomes of care**

Since Jeffrey is 17 years of age, he is convicted for the crimes he’d committed by the juvenile penal system. Because Jeffrey has developmental delays, in combination with a long history of delinquent behaviour, Jeffrey receives a ‘Placement in Juvenile Institute’ (in Dutch: PIJ) measure. During his stay in the juvenile justice facility, the focus lies on treatment and rehabilitation.

After three years of staying in the juvenile justice facility, Jeffrey is allowed to return to live with his mother under the conditions that he has contact with his probation officer every week, continues his work at the woodworking place, and follows cognitive behavioural therapy.

The first couple of months Jeffrey is able to live up to these set expectations. However after meeting up with some old friends from his past, Jeffrey starts to drink and do drugs again.

Jeffrey’s mother is worried that she loses her son again to bad habits, so she contacts Jeffrey’s probation officer. Together with Jeffrey and his mother, the probation officer comes up with a new plan in which Jeffrey stays in an assisted living facility.

Even though Jeffrey is guided during his transition from the juvenile justice facility, Jeffrey keeps struggling the first years after his release.

Meta-analytic studies show outcomes indicating some progress for children and young people during their stay in residential care. Knorth et al. (2008) report an effect-size (ES) of .60 for behaviour problems in general and externalizing behaviour problems in particular, and an ES of .40 for internalizing behaviour problems. De Swart et al. (2012)
demonstrated that residential care using evidence-based treatment methodologies had better outcomes (ES=.36) compared with residential care ‘as usual’. Cognitive behaviour therapy prominently contributed to the difference in outcomes. Better outcomes are also seen with children who stay in treatment and do not leave care prematurely (Smit, 1993). Like in Jeffrey’s case, not all the children appear to be well-prepared to leaving care and to the transition towards ‘normal’ life (Stein, 2006). Stein (2008) introduced a typology of three groups of care leavers: 1) those moving on, 2) those who survive, and 3) those who keep on struggling. The first group is doing well, feels secure, makes sense of family relationships, etc. The second group experiences more instability, movement and disruption, but these young people see themselves also as ‘more tough’ and ‘having done things off my own back’. The third group is the most disadvantaged one. They had the most damaging pre-care family experiences; their lives are likely to include many further placement moves; they have a cluster of difficulties, including emotional and behavioural difficulties (see also Harder, 2011).

It will not sound as a surprise that aftercare is seen as important for positive outcomes. However, a review by Harder et al. (2011) showed little research evidence for the effectiveness of aftercare services following residential care. The review contained 15 studies of which three were conducted in the Netherlands. Several studies in their review indicate that aftercare can have positive outcomes, but the strength of this evidence is limited because of the weak evaluation methodology applied in the studies. In many studies the aftercare programmes are not accurately described; it is unclear of which components a programme consists and which care factors are associated with positive outcomes. Young people completing aftercare programmes tend to show better outcomes than young people leaving aftercare prematurely. None of the outcome studies focused on both youth and their families in aftercare programmes following residential care, despite the fact that family-focused aftercare especially might improve long term outcomes of residential care.

**Good practices and future perspectives**

A promising development that has emerged in the last couple of years in the field of Dutch youth care is the explicit attention being paid to evidence-based interventions and on ‘what works’ in care in both research and practice (Harder, 2011; Helmond, 2013; Nijhof et al., 2011; Van der Helm, 2011; Van Yperen, Van der Steege, Addink, & Boendermaker, 2010).

Some examples of research on ‘what works’ in residential care, are studies by Nijhof et al. (2011) and Geurts (2010) in which they showed that positive outcomes (e.g., functioning of the young person, treatment satisfactions, realisation of treatment goals) can be achieved in (secure) residential care, when parents are being involved in treatment. Also, during the time in secure residential care a positive young person-staff relationship is associated with higher treatment satisfaction for young people (Harder,
Knorth, & Kalverboer, 2012). Further research on the type of skills for group care workers that influence a positive young person-staff relationship is recommended (Bastiaanssen et al., 2012; Harder, 2011; Van der Helm, 2011).

Since June 2007, two national, independent committees have evaluated specific treatment interventions for youth on their effectiveness. The ‘Youth Interventions Accreditation Committee’ assesses youth care interventions with regard to quality and effectiveness and issues accreditations. The ‘Ministry of Justice Behavioural Interventions Accreditation Committee’ assesses whether behavioural interventions can lead to prevention or the reduction of recidivism (Harder et al., 2013). If an intervention is evaluated as theoretically effective or empirically effective, it is included in the ‘Database of Effective Youth Interventions’, which is a searchable database of interventions in youth care, youth health care, youth welfare and criminal law under supervision by the Netherlands Youth Institute (in Dutch: NJI). Although there are currently 228 interventions included in this database (NJI, 2015), few are specifically developed and applicable to young people in residential care. It is therefore advisable that more attention needs to be paid to individual treatment interventions, besides adequate basic care (Harder, 2011).

**Conclusion**

In conclusion, residential youth care in the Netherlands underwent several positive developments in which the focus increasingly lies on cooperation between system parties, effective treatment interventions, and on the participation of the young person and his/her system (Ten Brummelaar et al., 2014; Harder, Kalverboer, & Knorth, 2012). This is also embedded in the new Act on Care for Children and Young People (2015). Despite these positive developments, we remain cautious how the changes in the youth care system and the related budget cuts affect the final care process of young people like Mohamed, Cynthia, Melanie and Jeffrey. When focusing on this care process and its related outcomes, this should include the acknowledgement of the diversity amongst residential care facilities in the Netherlands.