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Published in:
Residential Child and Youth Care in a Developing World. Volume 2: European Perspectives

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:
2017

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):
Ten Brummelaar, M. D. C., Harder, A. T., Kalverboer, M. E., Post, W. J., & Knorth, E. J. (2017). Residential child and youth care in the Netherlands: Current practices and future perspectives. In T. Islam, & L. Fulcher (Eds.), *Residential Child and Youth Care in a Developing World. Volume 2: European Perspectives* (first ed., pp. 339-355). Article 23 CYC-Net Press.

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Download date: 01-02-2024

Residential Child and Youth Care in the Netherlands: Current Practices and Future Perspectives

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Abstract

Pen picture accounts of four young people in the Netherlands' care system help to focus attention on the needs of young people and their families. This also highlights issues facing the Dutch care system and how it is organised and funded. In one of the world's most densely populated countries, the child protection and welfare system in the Netherlands focuses on family preservation and community-based interventions. However, the number of young people in out-of-home care facilities has increased over the past decade and a half. The New Act on Care for Children and Young People which came into effect in 2015 has made far-reaching changes to Dutch child and youth care policy, and administrative and financial practices that are now re-located to municipalities.

Mohamed

Mohamed (10 years old) comes from a broken home. Mohamed's father is not in the picture. His mother suffers from psychiatric problems. Quite often, she disappears for a couple of days. Following several reports of child neglect, Mohamed and his brothers are placed in an emergency shelter.

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Cynthia

Cynthia (15 years old) suffers from prolonged periods of depression. She refuses any help. Her parents no longer know what to do, so she is placed in a psychiatric clinic.

Melanie

Melanie is a very vulnerable 14 year old girl with below average intelligence. Her parents suspect that she is involved with the 'wrong boys', because she often shows up late at night being stoned. Different boys call to their house and then start to yell through the telephone. Finally, Melanie is placed in an orthopedagogical treatment centre for children with mild mental disabilities.

Jeffrey

Jeffrey (17 years old) is arrested for being involved in an armed robbery of two gas stations. One of the attendants was beaten up during the robbery and now suffers from a serious head injury. Jeffrey is placed in a juvenile justice facility where he awaits trial.

Introduction

Parents have primary responsibility for bringing up their children. According to Article 9 (1) of the UN Convention on the Rights of the Child (CRC), the State "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 they are staying in their family environment, the State must 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. Thus, 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 from the State. Since the ratification of the CRC in 1995 by the Dutch government, the Netherlands has had to comply with the requirements set by the CRC. Young people such as Mohamed, Cynthia, Melanie or Jeffrey can often be found in one or other of the Dutch residential care facilities.

With 16.9 million people residing in an area of 41,526 square kilometres, the Netherlands is one of the most densely populated areas on the globe. Approximately, 27 percent of the Dutch population is aged between 0 to 23 years of age (CBS, 2014). More than 350,000 young people receive help provided by child and youth care services (Knorth, Evenboer & Harder, 2016). Approximately 11 to 14% of the child and youth care users are assigned to specialized residential care services (Knorth, 2005).

In the Netherlands, every young person under the age of 18 years 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 child and youth care services for assistance (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 (Dekker, 2002). The modern needs-led system focuses on out-patient family-oriented interventions (Metselaar, 2011). Despite the focus on family preservation and community-based interventions, the number of young people in out-of-home facilities has increased over the last 15 years (Knorth & Koopmans, 2012).

In this chapter, we first describe the current state of Dutch residential child and youth care practices with the aim of providing insight into their histories and types of services, and about their populations. Then we address the residential care process for young people, the outcomes of residential care, some 'good practice' in this field, and finally consider developments and future perspectives for Dutch residential care.

A Brief History of Dutch Residential Child and Youth Care Practices

At the beginning of the 20th Century, the establishment of the 'child laws' (1905) led to a significant change in the care process for 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 had disappeared, or for (re)educational purposes (Matthijs & Vincken, 2004). However, there were few judicial measures to protect the young person from abuse and neglect by their parents (Boendermaker & Uit Beijerse, 2008).

Judicial measures for delinquent young people also lagged. Placement decisions in correctional facilities happened arbitrarily, based on the ability of the young person to distinguish between 'good' and 'evil'. As the upbringing of a young person was increasingly seen as the primary basis for subsequent behaviour, 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 child laws in 1905 formed the basis of our current child protection and welfare system, in which the penal, civil, and civil procedural law all cover one area of legislation (Matthijs & Vincken, 2004).

Despite several positive developments arising from the 1905's child laws, by the end of the seventies of the 20th Century the Dutch youth care system

had fallen into a state of fragmentation. There was strong compartmentalisation in organisations for child protection, child and youth care, and child and adolescent mental health care. Eventually, this fragmented system prompted a major reform of the youth care system, leading to the implementation of the Youth Care Act [*Wet op de Jeugdhulpverlening*] in 1989 and the establishment of the Youth Care Act in 2005 [*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 an existing care system that was considered unmanageable (Bosscher, 2012).

Recently, the Dutch youth care system has experienced major changes, referred to as youth care *transition* and *transformation* (Bosscher, 2012: 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 services (Evenboer, 2015). This applies to child protection and youth probation services, secure residential care facilities (except for juvenile justice facilities), care for youths with mild mental disabilities, and the child and adolescent mental health services. In addition, this 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, 2012). The idea behind the new youth care system is to promote an integrated, one voice approach to youth care, with a further emphasis on the position and self-reliance of children, youths 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 key roles throughout the whole care process.

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. Placement in an emergency shelter was initiated when young people can no longer stay with their family and are in need of assistance. Young people can stay in an emergency shelter for a relatively short period of time (approximately four weeks). During this period, all parties involved seek to find 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 under the age of 23 years can receive treatment in an out-of-home facility. Young people staying in residential care show (many) 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 cases where other types of care do not seem to be adequate (Harder *et al*, 2006: Harder *et al*, 2013: Hellinckx, 2002).

Residential facilities differ in size, but on average each living group houses four to twelve young people. Within residential facilities, groups can be divided into boys and girls groups although 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 either on a voluntary basis or under coercive measures. In the latter case, a coercive placement should be imposed by a court order.

Harder and colleagues (2013) distinguished between two broad categories of residential care: 1) residential care for young people who lack a supportive nurturing family situation, and 2) residential care for young people with severe individual problems, such as emotional and behavioural problems. 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 each lived in one of these residential care facilities.

Table 1
Types of Residential Care Facilities and Numbers of Young People in Residential Care

TYPE OF RESIDENTIAL CARE	NUMBERS OF YOUNG PEOPLE
Residential Child and Youth Care	
Family Homes	1,362[1]
Emergency Shelters	10,697[2]
Living and Treatment Groups	10,906[3]
Independent Living Programme Centres	-[4]
Secure Residential Care Centres	3,261[3]
Child and Adolescent Mental Health Care	6,073[2]
Inpatient Hospital Wards	-[4]
Youth Psychiatric Clinics	-[4]
Care for Youth with Mild Mental Disabilities	
Orthopedagogical Treatment Centres	10,493[5]
Correctional Facilities	
Juvenile Justice Facilities	1,844[6]

[1] Year 2011, source: Gezinspiratieplein (2014, p. 1). [2] Year 2009, source: Van Yperen & Woudenberg (2011, p. 55). [3] Year 2011, source: Jeugdzorg Nederland (2011, p. 12). [4] No accurate numbers available. [5] Source: Kuunders, De Wilde, & Zwikker (2011, p. 1). [6] Year 2011, source: Valstar & Afman (2013, p. 22).

Mohamed is placed in an emergency shelter, administered by *Residential Child and Youth Care*. Financed by the municipalities, residential child and youth care is organised into 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 organized 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 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 *et al*, 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. Most these users have been diagnosed with attention deficit disorders and behavioural disorders, followed by pervasive development disorders (e.g. Asperger, Autism). Most young people in residential mental health facilities suffer from comorbidity or multiple diagnoses (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). These young people with a mild mental disability have a below average IQ (intelligence quotient) accompanied by social adjustment disabilities (Zoon, 2013). They often show comorbidity or multiple diagnoses such as behavioural and psychiatric problems (Došen, 2008). The most common placement 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 in combination with severe behavioural problems (VOBC, n.d.).

Jeffrey is placed in a *Juvenile Justice Facility* (JJF) which accommodates juvenile offenders or juveniles who are suspected of committing a crime. The aim of JJF's 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 JJF's are grouped under secure residential care (Harder, 2011).

Background Characteristics of Youth in Residential Care

Cynthia is placed in a psychiatric clinic that specializes 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 was molested by her gymnastic teacher. Thereafter, Cynthia lost her cheerfulness and became quiet. Cynthia's parents sought 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 had several aversive experiences prior to her placement in the psychiatric clinic. For many young people, a residential care placement is rarely the first contact with the care system, especially when it involves 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 and 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 care facility.

The number of children in *residential* care as a proportion of the number of out-of-home placed children 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 countries[2]; 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.

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 in her residential group. Melanie has just started picking up her schoolwork again. She is offered a modified school program alternating with group therapy,

[2] 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).

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 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 programs, 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 recognized that the family and/or the wider social network of a child or young person should be involved in the treatment process as much and as early as possible (Geurts *et al*, 2012: Small *et al*, 2015).

The basic care and upbringing mostly takes place within the residential group, as was the case for Melanie. Because young people spend a significant proportion of their time in the residential group, group care workers in the Netherlands play an important role in the young person's life (Bastiaanssen *et al*, 2012: Van der Helm, 2011: Knorth *et al*, 2010). Group care workers are expected to assume both 'parenting' and educational tasks, as well as managing 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, one of the care workers of the residential group. This coach or mentor can be responsible for observing the young person and is often involved in the young person's individual treatment planning. Over the years, an increased professionalisation in residential care facilities has led to more qualified group care workers with higher educational degrees (Harder *et al*, 2013).

Besides their stay in the residential group facility, young people also often receive education and/or employment programs. According to the compulsory attendance law in the Netherlands, young people are required 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 programs can be conducted within the residential care facility or outside the facility, depending on the type of residential care that is offered (Harder *et al*, 2014).

As stated in Article 25 of the UNCRC, the State recognizes 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 and all circumstances relevant to his or

her placement. 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. Most larger scale facilities have behavioural specialists, e.g. psychologists or pedagogues with an academic degree, who are responsible for the young person's care and/or treatment process. In addition, there are various support staff involved in the treatment process, 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 can participate in group therapy and individual therapy. As with education and/or employment programs, these interventions may 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 by the juvenile penal system for the crimes he had committed. 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 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 may lose 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 in 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).

As in Jeffrey's case, not all the children appear to be well-prepared for leaving care and for 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 adolescents 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 (Harder, 2011).

It will not surprise that after care is seen as important for positive outcomes. However, a review by Harder *et al* (2011) showed little research evidence for the effectiveness of after care services following residential care. The review contained 15 studies, of which three were conducted in the Netherlands. Several studies in their review indicate that after care *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 after care programs are not accurately described, so that it is unclear as to which components of a program are associated with positive outcomes. Young people completing after care programs tend to show better outcomes than young people leaving after care prematurely. None of the outcome studies focused on both youth and their families in after care programs following residential care, even though *family-focused* after care might improve long term outcomes of residential care.

Good Practices and Future Perspectives

A promising development to have emerged in the last couple of years is the explicit attention being given 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 *et al,* 2010). Nijhof *et al* (2011) and Geurts (2010) showed that positive outcomes such as functioning of the young person, treatment satisfaction, and realisation of treatment goals can be achieved in residential care, (even secure care) when parents are involved as participants in the treatment. Also, during their stay in secure residential care, a positive adolescent-staff relationship is associated with higher treatment satisfaction for adolescents (Harder, Knorth & Kalverboer, 2012). Further research is recommended to identify the skills that

group care workers should possess in order to develop a positive adolescent-staff relationship (Bastiaanssen *et al*, 2012: Harder, 2011: Van der Helm, 2011).

Since June 2007, two national, independent committees have evaluated specific treatment interventions for youths to review 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 (NJI, 2015). 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).

In conclusion, residential youth care in the Netherlands has undergone several positive developments in which the focus now lies increasingly on cooperation between system parties, effective treatment interventions, and on the participation of the young person and his system (Ten Brummelaar *et al*, 2014: Harder *et al*, 2012). This is also embedded in the *New Act on Care for Children and Young People* (2015). Despite these positive developments, we remain cautious about how the changes in our youth care system and related budget cuts will impact on the final care processes for young people like Mohamed, Cynthia, Melanie and Jeffrey. When focusing on this process and its related outcomes, this should include an acknowledgement of the diversity amongst residential care facilities in the Netherlands.

Questions for Small Group Discussion or Guided Reflection

1. *The Netherlands is one of the most densely populated areas on the globe with approximately 27 per cent of the Dutch population under the age of 23 years with more than 40,000 assigned to specialized residential care services.* How does this number of young people in residential care compare with where you live and work?
2. *The establishment of child laws in 1905 formed the basis of the current* [Dutch] *child protection and welfare system, in which the penal law, the civil law, and the civil*

procedural law all cover an area of legislation. When were child protection and family welfare laws enacted where you live, and what influences shaped these developments?

3. *Two broad categories of residential care were identified in the Netherlands: 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*. How might these categories of residential care placement compare with placement decisions where you live and work?
4. What is an *Orthopedagogical Treatment Centre*, who make up the youth population they serve (check Google if you wish), and how might similar services for similar young people be described where you live and work?
5. *Aftercare is seen as important for positive outcomes although little research evidence in the Netherlands supports the effectiveness of after care services following residential care*. How might you explain the policy and practice differences that are highlighted in this statement?

References

Bastiaanssen, I. L. W., Kroes, G., Nijhof, K. S., Delsing, M. J. M. H., Engels, R. C. M. E., & Veerman, J. W. (2012). Measuring group care worker interventions in residential youth care. *Child and youth care forum, 41*(5), 447-460.

Boendermaker, L. (2008). JeugdzorgPlus; drang en dwang in de jeugdzorg. Nieuw zorgaanbod voor jeugdigen met ernstige gedragsproblemen [Secure residential care centres; pressure and force in care. New services for youth with severe behavioural disorders]. *Jeugd en Co Kennis, 2*(1), 8-20.

Boendermaker, L., & Uit Beijerse, J. (2008). *Opvoeding en bescherming achter 'tralies'* [Educating and protecting young people behind 'bars']. Amsterdam: SWP Publishers.

Boendermaker, L., Van Rooijen, K., Berg, T., & Bartelink, C. (2013). *Residentiële jeugdzorg: Wat werkt?* [Residential child and youth care: what works?] Utrecht: Nederlands Jeugdinstituut (NJi).

Bosscher, N. (2012). *The decentralisation and transformation of the Dutch youth care system*. Utrecht: Nederlands Jeugdinstituut (NJi).

CBS (2014). *Bevolkingspiramide* [Population pyramid]. Retrieved from http://www.cbs.nl/nl-NL/menu/themas/bevolking/cijfers/extra/piramide-fx.html.

Dekker, J. J. H. (2002). Demystification in the century of the child: the conflict between romanticism and disenchantment in (residential) youth care from the 1830s to 2000. In E. J. Knorth, P. M. van den Bergh, & F. Verheij (eds.), *Professionalization and participation in child and youth care* (pp. 11-23). Aldershot, UK/Burlington, VT: Ashgate.

De Swart, J. J. W., Van den Broek, H., Stams, G. J. J. M., Asscher, J. J., Van der Laan, P. H., Holsbrink-Engels, G. A., & Van der Helm, G. H. P. (2012). The effectiveness of institutional youth care over the past three decades: A meta-

analysis. *Children and youth services review, 34*(9), 1818–1824. doi:10.1016/j.childyouth.2012.05.015.

Došen, A. (2008). *Psychiatrische stoornissen, gedragsproblemen en verstandelijke handicap [Psychiatric disorders, behavioural problems and mental handicaps]*. Assen, the Netherlands: Van Gorcum.

Evenboer, K. E. (2015). *A taxonomy of care for children and adolescents with behavioural and emotional problems: development and application*. PhD thesis. Groningen, the Netherlands: University of Groningen.

Geurts, E. M. W. (2010). *Ouders betrekken in de residentiële jeugdzorg: Een onderzoek naar inhoud en uitkomsten van contextgerichte hulpverle*ning [Involving parents in residential youth care: A study of contents and outcomes of context-focused care]. PhD thesis, University of Groningen. Antwerp/Apeldoorn: Garant Publishers.

Geurts, E. M. W., Boddy, J., Noom, M. J., & Knorth, E. J. (2012). Family-centred residential care; the new reality? *Child and family social work, 17*(2), 170-179.

GGZ Nederland (2013). *GGZ Nederland* [Mental Health Care the Netherlands]. Retrieved 16.10.2013 from https://www.ggznederland.nl.

Hanrath, J. J. (2013). *De groepsleider als evenwichtskunstenaar: Het dagelijks werk op de leefgroep in een justitiële jeugdinrichting* [Keeping the balance: On the problem of order in Dutch juvenile offenders institutions]. PhD thesis. Utrecht, the Netherlands: Utrecht University.

Harder, A. T. (2011). *The downside up? A study of factors associated with a successful course of treatment for adolescents in secure residential care*. PhD thesis. Groningen, the Netherlands: University of Groningen.

Harder, A. T., Huyghen, A. M. N., Knot-Dickscheit, J., Kalverboer, M. E., Köngeter, S., Zeller, M. & Knorth, E. J. (2014). Education secured? The school performance of adolescents in secure residential youth care. *Child and youth care forum, 43*(2), 251-268. DOI10.1007/s10566-013-9232-z.

Harder, A. T., Kalverboer, M. E., & Knorth, E. J. (2011). They have left the building: A review of after care services' outcomes for adolescents following residential youth care. *International journal of child and family welfare, 14*(3/4), 86-104.

Harder, A. T., Knorth, E. J., & Kalverboer, M. E. (2012). Securing the downside up: Client and care factors associated with outcomes of secure residential youth care. *Child and youth care forum, 41*, 259-276. doi: 10.1007/s10566-011-9159-1

Harder, A. T., Knorth, E. J., & Zandberg, T. (2006). *Residentiële jeugdzorg in beeld. Een overzichtsstudie naar de doelgroep, werkwijzen en uitkomsten* [Residential child and youth care in the picture: A review study of its target group, methods and outcomes]. Amsterdam: SWP Publishers.

Harder, A. T., Zeller, M., López, M., Köngeter, S., & Knorth, E. J. (2013). Different sizes, similar challenges: Out of home care for youth in Germany and the Netherlands. *Psychosocial interventions*, *22*(3), 203-213.

Hellinckx, W. (2002). Residential care: Last resort or vital link in child welfare? *International Journal of child and family welfare, 5*(3), 75-83.

Helmond, P. E. (2013). *Inside out: Program integrity and effectiveness of the cognitive-behavioral program EQUIP for incarcerated youth*. PhD thesis. Utrecht: University of Utrecht.

Knorth, E. J. (2005). Wat maakt het verschil? Over intensieve orthopedagogische zorg voor jeugdigen met probleemgedrag [What makes the difference? On intensive pedagogical care for young people with behavioural problems]. In E. J. Knorth, A. E. M. G. Minnaert, & A. J. J. M. Ruijssenaars (eds.), *Verschillen onderscheiden:*

Orthopedagogische hulpverlening en begeleiding bij problematische opvoedings- en onderwijsleersituaties (pp. 11-41). Utrecht: Agiel Publishers.

Knorth, E. J. (2015). Prendre une décision en cas de suspicion de maltraitance ou de négligence sur enfant: résultats de la recherche internationale. In G. Séraphin (ed.), *Observer l'enfance en danger: Articuler recherche et pratique* (pp. 31-41). Paris: La Documentation Française Presse.

Knorth, E. J., Evenboer, K. E., & Harder, A. T. (2015). Jeugdhulp, wetenschappelijk verantwoord [Child and youth care, scientifically justified]. In M. H. van IJzendoorn, & L. van Rosmalen (red.), *Pedagogiek in beeld: Een inleiding in de pedagogische studie van opvoeding, onderwijs en hulpverlening* (pp. 193-204). Houten, the Netherlands: Bohn Stafleu van Loghum (third, completely revised edition).

Knorth, E. J., Harder, A. T., Huyghen, A. M. N., Kalverboer, M. E., & Zandberg, T. (2010). Residential youth care and treatment research: Care workers as key factor in outcomes? *International journal of child and family welfare, 13*(1/2), 49-67.

Knorth, E. J., Harder, A. T., Zandberg, T., & Kendrick, A. J. (2008). Under one roof: A review and selective meta-analysis on the outcomes of residential child and youth care. *Children and Youth Services Review, 30*(2), 123-140.

Knorth, E. J., & Koopmans, A. C. (2012). Minder kinderen uit huis geplaatst? [Less children placed out-of home?]. *Kind en adolescent, 33*(1), 45-49.

Kuunders, M., De Wilde E. J., & Zwikker, N. (2011). Hoeveel jeugdigen krijgen zorg in de jeugdzorg. [How many young people receive care in youth care] Utrecht: Nederlands Jeugdinstituut (NJi).

Matthijs, M., & Vincken, M. (2004). *De zorg voor de jeugd. Jeugdzorg in vogelvlucht* [Care for youth. Youth care in bird's eye view]. Utrecht: Nederlands Instituut voor Zorg en Welzijn/NIZW.

Metselaar, J. (2011). *Vraaggerichte en gezinsgerichte jeugdzorg: Evaluatie van het programma Gezin Centraal. Processen en uitkomsten* [Needs-led and family-centered child care and treatment: Evaluation of the program Family in the Centre. Process and outcomes]. PhD thesis. Groningen, the Netherlands: University of Groningen.

Nijhof, K. S., Veerman, J. W., Engels, R. C. M. E., & Scholte, R. H. J. (2011). Compulsory residential care: An examination of treatment improvement of individual and family functioning. *Children and youth services review, 33*, 1779-1785. doi: 10.1016/j.childyouth.2011.05.001.

Nederlands Jeugdinstituut (NJi) NJi (n.d./a). *Transitie en transformatie van de zorg voor de jeugd* [Transition and transformation of the care for youth]. Utrecht: Nederlands Jeugdinstituut (NJi).

Nederlands Jeugdinstituut (NJi) NJi (n.d./b). *Kamertrainingcentrum* [Independent living programme facilities]. Retrieved from: http://nji.nl/Residentile-jeugdzorg-Achtergronden-Voorzieningen-Beschrijving-organisaties-en-aanbod?itemnr=319625.

Nederlands Jeugdinstituut (NJi) NJi (2015). *Databank effectieve jeugdinterventies [Database effective youth interventions]*. Retrieved from: from http://www.nji.nl/nl/Kennis/Databanken/Databank-Effectieve-Jeugdinterventies.

Reijneveld, S. A., Wiegersma, P. A., Ormel, J., Verhulst, F. C., Vollebergh, W. A. M., & Jansen, D. E. M. C. (2014). Adolescents'use of care for behavioral and emotional problems: Types, trends, and determinants. *Plos ONE, 9*(4): e93526. Doi: 10.1371/journal.pone.0093526.

Small, R. W., Bellonci, C., & Ramsey, S. (2015). Creating and maintaining family partnerships in residential treatment programs: Shared decisions, full participation, mutual responsibility. In J. K. Whittaker, J. F. del Valle, & L. Holmes (eds.), *Therapeutic residential care for children and youth: Developing evidence-based international practice* (pp. 156-167). London/Philadelphia: Jessica Kingsley Publishers.

Smit, M. (1993). *Aan alles komt een eind: Een onderzoek naar beëindiging van tehuishulpverlening* [Everything comes to an end: A study on termination of residential child and youth care]. PhD Thesis. Leiden, the Netherlands: Leiden University.

Stein, M. (2006). Research review: Young people leaving care. *Child and family social work, 11*, 273-279.

Stein, M. (2008). Transitions from care to adulthood: Messages from research for policy and practice. In M. Stein, & E. R. Munro (eds.), *Young people's transitions from care to adulthood: International research and practice* (pp. 289-306). London/Philadelphia: Jessica Kingsley Publishers.

Ten Brummelaar, M. D. C., Gerrits, L., Post, W. J., Harder, A. T., Kalverboer, M. E., Pultrum, T. A., & Knorth, E. J. (2014). Perceptions of participation: The views of male adolescents on the care process in a juvenile justice facility. *International journal of child and family welfare, 15*(1/2), 53-75.

Thoburn, J., & Ainsworth, F. (2015). Making sense of differential cross-national placement rates for therapeutic residential care. In J. K. Whittaker, J. F. del Valle, & L. Holmes (eds.), Therapeutic residential care for children and youth: Developing evidence-based international practice (pp. 37-46). London/Philadelphia: Jessica Kingsley Publishers.

Valstar, H., & Afman, T. (2013). *JJI in getal 2008-2012* [JJI in numbers 2008-2012]. Den Haag; Dienst Justitiële Inrichtingen.

Van Dam, C., Nijhof, K. S., Scholte, R. H. J., & Veerman, J. W. (2010). *Evaluatie Nieuw Zorgaanbod. Gesloten jeugdzorg voor jongeren met ernstige gedragsproblemen* [Evaluation of new services. Secure residential care for young people with severe behavioural problems]. Nijmegen, the Netherlands: Praktikon/Behavioural Science Institute, Radboud Universiteit Nijmegen.

Van der Helm, G. H. P. (2011). *First do no harm. Living group climate in secure juvenile correctional institutions.* PhD thesis. Amsterdam, the Netherlands: VU University of Amsterdam.

Van Yperen, T. A., Van der Steege, M., Addink, A., & Boendermaker, L. (2010). *Algemeen en specifiek werkzame factoren in de jeugdzorg: Stand van de discussie [Common and specifc therapeutic factors in child and youth care: The state of the art]*. Utrecht: Nederlands Jeugdinstituut (NJi).

Van Yperen, T. A., & Van Woudenberg, A. (2011). Werk in uitvoering. Bouwen aan het nieuwe jeugdstelsel. Utrecht: Nederlands Jeugdinstituut (NJi). Vereniging Orthopedagogische Behandelcentra (n.d.). *Facsheet orthopedagogische behandelcentra* [Factsheet pedagogical treatment centres]. Retrieved from: http://www.vobc.nu/publicaties.

Vermaes, I. P. R., Konijn, C., Jambroes, T., & Nijhof, K. S. (2014). Statische en dynamische kenmerken van jeugdigen in jeugdzorgplus: Een systematische review [Static and dynamic characteristics of youth in secured residential care: A systematic review]. *Orthopedagogiek: Onderzoek en Praktijk, 53*(6), 278-292.

Whittaker, J. K. (2015). Commentary on 'Needs and characteristics of high-resource using youth: North America' by John S. Lyons, Nicole Obeid and Megan Cummings. In J. K. Whittaker, J. F. del Valle, & L. Holmes (eds.), *Therapeutic residential care for children and youth: Developing evidence-based international practice* (pp. 71-72). London/Philadelphia: Jessica Kingsley Publishers.

Zoon, M. (2013). *Wat werkt bij jeugdigen met een lichte verstandelijke beperking?* [What works for youth with mild mental disabilities?]. Utrecht: Nederlands Jeugdinstituut (NJi).