Hope for ordinary life for children who have not been born under a lucky star

A 'place' for Alicia

Peer van der Helm[1]

This article was published in the Dutch journal 'Jeugdbeleid' ('Youth Policy'), March 2018

The final publication is available at link.springer.com

Resumee

The transition of the Youth Aid Act in the Netherlands where municipalities take over from the provinces is now two years underway and concerns also those children who have the most problems. Their future looks bleak at present: they are put by the municipalities in each year to re-apply 'care-parcels' and are too often transferred from institution to institution, something that worsens their problems more and more. The recent documentary 'Alicia' that shows how Alicia roamed through the youth care landscape is a sad story of human suffering. I detect three flaws in the Youth Aid Act: underestimation of the intergenerational problem transmission in the context of Adverse (early) Childhood experiences (ACES). These adverse childhood experiences lead to intergenerational problem transfer that cannot be solved easily and conflicts with short-term thinking and spending-cuts by municipalities (1). In institutions and mental health care the problem is compartmentalized linear thinking in the organization and treatment (2) and last but not least the current organization (bureaucracy) and funding of youth aid detracts even more money, destined originally for the children(3). For the municipalities there the problems to design realistic solutions for the long term and prevention. For institutions it is imperative to gain insight into what is needed to replace their 'disease' model with an integral pedagogical model, focusing on the development and relationship and learning more from incidents. More institutions should participate in social climate research in the youthcare sector to care for the social living environment in the Netherlands and to create more small-scale facilities and family homes with care and tailor-made (special)education.

[1] G.H.P. van der Helm (PhD) is a lecturer at the Expertise Center for Youth, a consultant at Schakenbosch and head of research at Fier

But given the vulnerability of these small-scale facilities we should also to be cautious to overburden foster parents and family home parents: they are not the drainage of youth aid. We must retain specialist facilities for this, such as Youth Care Plus, institutions for children with a Mild Intellectual Disability (MID) and victims of sexual violence. For society and the towns, the best care for these children is the best way to go for the society. The cutbacks on youth aid in the new law were a mistake: it is time for a change in thinking and better care implementation for those children who are most in need.

Preface

The 2015 Youth Law states that children who can no longer live at home should preferably be placed in a foster family or in a family home. At the moment, the Netherlands has only about 750 family homes, the number of children in foster families is decreasing as a result of the behavioral problems of the children who are registered (NRC, 23-1-2017). At present there are still about 10,000 children in residential institutions and 1700 in youth care plus (secure), based on estimates from Statistics Netherlands and Youth Care Netherlands. Can we do without the secure youth care as the law suggests and can all those children go to foster families and family houses? Are we going to realize this when this youth law also comes with a savings of 200 million and a huge bureaucracy with municipalities and institutions that absorbs further budget and what does this policy take to implement?
On November 30, 2017 I spoke to my university at Leiden University of Applied Sciences with the title 'Hope'. I compared the children who are currently being put away from home with mussels that have lost their grip on the mussel bank with the other mussels, and are drifting up the wide sea of the youthcare. The result is often uncertain: a trip through foster homes, family homes and institutions such as the poignant documentary 'Alicia' showed. But every transfer also means a new school and new friends. The fisherman who would have to bring these mussels back to the mussel bank has a net that has a number of flaws with holes through which the children wash away. With each transfer, the child loses confidence in the care and in itself. It then becomes vulnerable to others who seek, find, exploit and abuse these children with a new 'lost generation', which often generates a generation with many problems. I mention three flaws: the lack of focus on intergenerational problems (1), the compartmentalised treatment vision and linear thinking in youth care (2) and the current organization of youth care, coupled with the funding (3). With a little political will, all these three things could be solved with the aim that no longer let children get lost. This needs a new vision above politics, ideology and money.

1. **Intergenerational problem transmission.**

The new youth law started in 2015 so nicely: every child in the family should be empowered, the problems would decrease (and there was less money needed). Preventive treatment behind the door and if it really could not otherwise be out-of-home placement to a foster family or a family home was the solution, a typical example of linear thinking. But no one

wondered if that was possible. Because a lot of research shows that problem behavior is not a 'broken leg' but has several causes: biological, psychological and social causes, usually in connection with each other. And they can never be solved by a single (short-term) intervention.

Engel (1977) was the first to introduce the 'biopsychosocial' model of psychiatric problems and a lot of research showed that he probably was right about it. Biological causes of problem behavior can be a multitude of factors influencing one another and, in the case of aggressive behavior, these are extensively discussed in the book 'The Anatomy of Violence' by Adrian Raine (2012). Exposure of the mother and / or father to a lot of stress (think, for example, of poverty and debt see box on stress) provides an adjustment ('epigenetic expression') to the hereditary material of the child yet to conceive). This adjustment creates a change in the setting of the stress axis (HPA axis) in the direction of a less social setting and greater susceptibility to reward (material or substance use). The stress axis is discussed further in this article. It is therefore not surprising that dysfunctional externalizing behavioral patterns such as aggression but also substance use are to a large extent inherited. Internalizing problems (depression, anxiety) and specific problems such as autism and a Mild Intellectial Disability (MID) also have a solid inherited component and its effects usually do not pass. Fortunately, we can teach children how cope as they get older.

The consequence of this is that children born from these families are already lagging behind at birth. Then we are not even talking about exposure to harmful substances during pregnancy due to lifestyle and addiction or oxygen shortage during childbirth. The first reception of the baby is often problematic, regardless of whether the child was wanted or not: these children cry more often and are more difficult to comfort. As the occasion arises, the child is beaten, which in turn causes further brain damage, reducing executive functions as a result of micro bleeding in the brain. But reduced contact with caregivers ('attachment') also causes considerable brain damage, especially in the first two years of life. This damage carries the child's with him his whole life.

About the psychological consequences of adverse childhood experiences (beating, sexual abuse, and neglect) a lot of research has been done in recent years (Wolf & Baglivio, 2019). An important consequence of disadvantageous childhood experiences is that they stack: the earlier they take place and the more often the more long-term damage (Mc Laughlin, 2017).

Moreover, adverse childhood experiences psychologically lead to 'negative emotionality' (distrust, depression, low self-worth). With these children, a fundamental distrust arises towards others and towards themselves (low self-esteem) as a result of pain. Anglin (2014) therefore describes their behavior as 'pain-based behavior'. These children, who are often diagnosed with some psychiatric disorder, are usually busier and more aggressive, cannot make good contact with other children and are therefore often socially isolated. Social isolation leads directly to the pain centers of the brain, as modern brain research shows (Macdonald & Leary, 2005.

Social causes go hand in hand with hereditary and psychological causes.

It is these children who are avoided at the nursery by the other children, never invited to birthday parties because of their 'different' behavior (externalizing and internalizing) and remain in the schoolyard if everyone has already found a playmate to play at home.

At home they get a lot of negative feedback from parents because of their behavior (often a lot of shouting at home). But also at school where a teacher has thirty other children and has little time and attention for a busy, aggressive or sad child, they get a lot of negative feedback. This often leads to changing primary schools at an early age. Despite the implementation of the Appropriate Education Act in 2014, after a few schools we see placement in crisis in special education schools, often with a range of diagnoses mostly according to DSM (classification of psychiatric diseases). Last year, these placements increased by 13% (source: Lecso, 2017). Many municipalities often start with a mild form of outpatient treatment and scale up when there is no result and in the meantime the problems worsen, because they are too late: most harm was done in the first years. In many cases, shocked municipal teams look at out-of-home placement, but probably too late because problems started early in childhood and have now grown. Then an out-of-home placement leads to a series of transfers as described earlier and the child continues to drift trough care.

As a teenager, it usually does not get better when the self-control decreases due to hormonal changes in the brain. Boys and girls with deviant behavior often follow different paths. Boys start as a result of their focus on material issues and desire for contact and respect from others which they try to enforce, resulting in aggression and 'small' crime such as stealing. Soon stealing, bagging, extortion and threats are followed by robberies. A while in the juvenile prison increases their status. Then they find out that drug trafficking in the

Netherlands is the most lucrative criminal activity, often combined with arms and human trafficking. Much is known about criminal paths of boys (Raine, 2012). Less attention goes to girls.

Many girls from youth aid, who already have a fragile identity and a shaky self-image because of lack of love, fall prey to criminals who are looking for children from youth aid (Van Dijke et al., 2012). Children with a youth counseling history are more susceptible to sexual abuse in our society. This is because they have been abused in the past and the abuse was not always recognized, not always within youth care institutions. After earlier abuse, the chance of re-victimization is much greater (revictimization, Van Dijke et al., 2012) and their children, who often get them too early follow the same path.

These children often have a disharmonious development profile with a lack of personality development as a result of neglect and abuse and a fragmented existence. This makes it harder for them to say 'no' to others who want to use them. This applies in particular to children with a mild intellectual disability who often have a submissive problem solving style (Van der Helm, van Nieuwenhuizen & Wegter 2010).

In addition, the perpetrators also know that youth aid children are easier to get (grooming): with a little attention, a few expensive shoes and a threat, it often happened that way (Van Dijke et al., 2012). The perpetrators are very refined and exchange girls and young boys, often on the street or via the internet (Dark Web). Usually there are also drugs to pass so that children do not feel the fear and pain:

A girl from a youth establishment: "After three joints it no longer matters who goes over your body".

The long-term effects are often very serious, come on top of an already disturbed development and can lead to depression, behavioral disorders or complex trauma and behavior based on pain. These children need specific trauma treatment (eg cognitive behavioral therapy or EMDR). Because they are hunted by human traffickers and criminals (who are waiting in front of the schoolyard) they sometimes have to go to a secure institution for their own safety. That is why it is so important not to look away or to think that it will fall. It rarely does that.

Research (Van Dijke et al. 2012) has shown that it is more often acquaintances than 'the man in the bushes'. Sports clubs, education, associations, the village, that makes the threshold to be extra alert smaller, but also makes that in case of suspicions often nothing is done. Children often blame their abuses by acquaintances, are ashamed, dare not talk about it, and carry this burden and loneliness with them all their lives.

The great vulnerability of children in youth care means that professional educators must be alert to possible signs of abuse. Generally speaking, signs of physical signs (eg bruises in weird places, pain), behavioral changes (aggression, truancy, walking away), mood changes (depression, withdrawal) and excessive sexual behavior not belonging to the developmental age. The list of signals is long and specific expertise is needed to establish abuse, certainly for MID.

What can you do yourself as a social worker and professional educator? A questioning approach (see Jim van Os, 2015): 'What happened to you' is not easy in the provision of care and we need to pay more attention to that in our courses. "Why so sad, so withdrawn, so quiet or just so screaming, so aggressive?" We must learn to recognize pain-based behavior. Many aid workers are afraid of this when it comes to this theme that is also a burden for them, they mentally do not tolerate the stories and become angry .... At our colleges of higher education, we should pay more attention to the training of future professionals and realize that the future social worker is also someone with a background who sometimes makes it difficult to deal with this adequately, because asking and listening is more difficult than answers give and come up with solutions.

An important advice for assistance is further: always know where your child is and with whom and check that. Invite everyone, also the courtship. Do not be too good of confidence. The outside world mainly hunts these girls (and young boys). A girl who would be with a girlfriend every weekend turned out not to be there. She also appeared too often, without the educators knowing that to be away for a long time in the evening, not a good sign. Besides being 'gone', also know the other signs: hanging around with groups of only boys is not safe and not 'normal' as a girl. Far too old 'boyfriends', not a good sign. Drugs and expensive stuff ('bad clothes', such as expensive dresses and sets of disclosing underwear) will never get you for nothing and who can pay that for their pocket money? But also talk about 'girlfriends' because traffickers put pressure on other girls, often with a youth care past, to recruit girls, even within institutions! Ask where withdrawn behavior, anxiety and

depression come from. Staying with others also belongs to 'normal' life, but sexual abuse is not 'normal' when ‘staying’. Be aware that a child who in youth care is at extra risk, that others know this and can abuse it by offering accommodation. Unfortunately, perpetrators move within the youth aid world. Talk to your child often so that you know when something is going on, ask about place and time. The more vague the story, the more risky. A bleak message? Unfortunately, but it does wake up, the percentage of abuse among children is high, according to Corinne Dettmeijer (former National Commissioner on Human Trafficking)in the Netherlands. Fier is one of the most important knowledge centers for abuse in dependency relationships and can be reached 24/7. Do not look away: traumas, grief and pain never automatically go away with the child.

A family father who takes care of four abused girls and who travels down town and country to bring his children to therapy recently said to me: "I am surrounded at home by trauma". Large themes in the intergenerational problem transfer are therefore stress (often due to poverty and debts), negative childhood experiences and trauma (neglect, abuse, abuse), sensitivity to substance use and LVB.

A good treatment could limit the consequences of these negative childhood experiences, were it not that the most damage is already done in the first two years of life and children. But often they only come into the picture when there are advanced behavioral problems. District teams could change this, but in 2016 and 2017 they saw so many advanced problems that out-of-home placement was often the only remedy (Van der Helm, 2017). When children are removed from their homes, they often come first in a foster family, a single-family home or an institution, where treatment also takes place. However, this treatment is often less effective than expected. The 'treatment landscape' is quite traditional and compartmentalised and therefore lacks in effectiveness.

2. A Clarified treatment vision for children

2.1 **DSM**. In many institutions, the reference point for treatment and funding is called the 'Bible of psychiatry', the Diagnostic and Statistical Manual of Mental Disorders (DSM now: version V).

In this 'bible of psychiatry' all hundreds of psychiatric disorders are neatly lined up. Only a lot of research shows that there is almost never a well-defined disorder in children, let alone a

psychiatric illness. As a rule, there are several problems that often change during the treatment in intensity and often depend on the quality of the living environment (Heynen, 2016, Eltink, Van der Helm & Stams in preparation). Asendorpf, Schneider, Bullock and van Aken (in: Slot and Aken, 2013) found in their large-scale Logic study those hundreds of disorders not back in children but they found an internalizing and an externalizing component (see further on p.12). Recent research by Wolf & Baglivio (2017) shows that there is almost always an internalizing component under an externalizing problem that they call 'negative emotionality' (fear, suspicion, depression, etc.). That is why many youth researchers today rely more on an overall 'Psychopathology factor' ('P' factor). It is expected that modern research will reduce the importance of DSM, at least for young people, in the coming years (Van Os, 2015). Nevertheless, these insights slowly seep through because vested interests depend on mental health care, legislation and funding for a DSM classification.

The treatment landscape for children with serious problems with his emphasis on the DSM V therefore seems to be very similar to a compartmentalized rural village from the last century. A tight compartimentalized hierarchical society with an outwardly expressed unshakeable belief in their own abilities but internally little cooperation and little sensitivity to feedback between the parts. The Mayor and the Doctor determined the village life next to the pastor or the minister. There was seldom room for new ideas because it only caused unrest in the compartmentalized village society and threatened vested interests. In many institutions, the 'mayor and the doctor' is the child and adolescent psychiatrist or the psychologist as main therapist the determining factor (still he / she is called the 'physician-director' in some institutions). This includes psychologists and behavioral experts and specific therapists who look up the Psychiatrist or the GZ psychologist for an example. This therapeutic upper (clay)layer sees the young people at most for an hour a week in a separate room, preferably with their own secretary because that gives status, but they often see the children much less. But they determine the policy staff has to implement. The pedagogical staff, family, parents and teachers from special education come to the bottom. These are the workers and farmers from ‘the village’, who are usually not part of the 'treatment team', but who work with the young people 23 hours a day as supporters, educators and many other tasks. If things go wrong, they catch the aggression or self-mutilation and then have to resume the conversation in the evening with a cup of chocolate

milk. Only they usually do not belong to the ‘treatment team’. No wonder many young people tell us in interviews that they did not receive treatment, if only that one hour in the week in the room with the psychologist counts as treatment. Because 'the treatment team' splits up and down (the living group is usually downstairs and the treatment team has its own rooms upstairs in the building) there is no question of team development. There is mainly a lack of communication, daring and and a lack of being able to give each other feedback and a shared vision. That scours in practice.

When young people go to special education, there is often also a behavior expert or an internal supervisor who usually does not have much contact with the community and their practitioners (Van der Helm & Austman, 2012).

Often the Child Care and Protection Board is also carrying out its own research, guardians from three different national aid organizations decide whether or not to cooperate with the probation service. Furthermore, care providers from the municipality can be involved (Safe Home) who are involved with a family in addition to debt assistance, and the Social Service. Sometimes there are also special municipal teams involved, for example in the framework of the Top 600 or City marines. Maybe I'll forget a few, that was not my intention. Through it Police and Justice and creditors such as housing corporations, public utilities and the tax authorities can cycle with their own policies, priorities and powers, which incidentally do not share all the knowledge. So many social workers lead to what we call a 'diffusion of responsibility'. Diffusion of responsibility according to the Inspection reports (2004) also played a role in the death of baby Savannah and more children such as Gessica in 2007 ('the Maasmaid'). This means that care providers soon think that someone else is taking over this difficult decision. All these emergency services often do not communicate with each other, despite appointments based on privacy, priorities in policy, professional secrecy or an official secrecy and often distrust. If it comes to a case consultation, participants do not always hear relevant facts. If an incident or crisis arises ‘unexpectedly’, someone has to decide quickly, also called 'the jump through the burning door'. Usually a next, heavier care-step is chosen, such as out-of-home placement to a foster family or a family home. The care organizations involved, family householders and special education generally do not receive all the information on time and are sometimes pressured to accept the child quickly. This often goes wrong, usually with a serious incident that damages employees and the child. From the University of Applied Sciences Leiden we investigated such incidents as lack of information

exchange and diffusion of responsibility as the cause, and the conclusion was that when all information had been exchanged and direction had been taken, a different track would probably have been chosen. For the child, however, that failed route meant a new transfer and rejection and failure. Perhaps we should learn more from incidents (framework).

Learning from incidents

In juvenile Care, sensible but bulky reports are often written after each incident, often according to the PRISMA method and it often seems as if the stocking is finished: the issues of the day take over.

But often the problems that gave rise were known for a long time and had important organizational causes that often amounted to interests in the 'village community' and money. All these reports lead to good intentions, which then fail into daily reality again. For learning from incidents, an organization other than the village community is needed where communication and feedback are valued (see below) and village interests are subordinate to the interests of the child.

A practical example: a boy who, although communicative was very strong, but socio-emotionally weak (disharmonious development profile) was placed in a special education system from his place of residence to a higher learning route (5). As a result, he could not get in touch with his classmates, was bullied and eventually caused a serious incident. The boy was rushed from home to a family home in the East of the country without the right information and in special education, cluster 3, placed on learning route two. However, it was noticed that he was very strong communicatively and he was placed in learning route 5. History repeated itself with another serious incident. Research showed that the care organization in the original municipality had chosen not to mention all the information because they were afraid that the boy would not be accepted in the family home and in special education. Incidentally, the same boy is now in a structural class that does take into account his disadvantage in socio-emotional development. He has been doing well at school and in the family home for more than a year. In this case, it had twice been very likely that there had been a crime major crime and this boy had been admitted for years with a PIJ-measure (Placement in a Judicial Youth institution) in a Judicial Youth institution.

In the 'village community' listening to each other, communicating and result-oriented working (the conditions for a starting team according to Hersey and Blanchard, 1995) are often not present. We are also scared to take control in such a complex village community in order not to create conflicts of interest because everybody gets imprinted in the organization that the doctor understands more. The views on treatment can also vary greatly depending on the interests, the framework used by the various aid organization and the policy priorities. The proliferation is large, but ultimately the DSM is the most influential because it depends on funding. What about the knowledge in this field (see History box)?

History DSM

History DSM

1.1 Anyone who wants to look at new insights into child and adolescent psychiatry cannot ignore the history of psychiatry and psychology. In the Middle Ages there was as a rule little compassion with people (and children) who behaved differently. The ruling was that punishment would solve everything (Pinker, 2012) and if that did not help there was always a heavier punishment or execution.

In the second half of the eighteenth and in the nineteenth century the illumination came that many of these people were sick was slowly advancing through, for example, Pinel (1801), and for example Charcot (1868), Kraeplin (1909), but also the work of Freud (1868) changed thinking. When in the First World War soldiers who were exposed to artillery fire for days on end could no longer move - something that was then called 'shellshock' but was in fact a form of post-traumatic stress disorder - this also aroused the interest of psychologists and doctors (and the army). At the same time (1913), in the US (Watson) and in Russia (Pavlov), behaviourism developed on the basis of learning theory with the radical exponent Skinner (1938) who explained all behavior from learning and had nothing to do with thinking or cognition. In the Second World War, the soldiers wanted to train better and gain insight into their behavior, something that grew into a movement that later became known as 'cognitive psychology'. In response to behaviourism, this movement looked at cognitive processes and the role of language (Chomsky, 1958). From the cognitive movement later developmental psychology and social psychology grew. Mental disorders

were also explained more and more from cognitive processes. In the seventies of the last century all the above currents were active, something that led to a huge confusion of speech and competition about disorders. There were also different classification systems for disorders such as the CHAM system, the ICD and the DSM (developed to classify psychiatric problems of soldiers), which made the confusion complete. It is important to realize that these systems did not originate from scientific research but were often compromises between psychiatrists, psychologists and the pharmaceutical industry (Frances, 2012, Van Os, 2015). A disorder was seen as a sort of broken leg that could be repaired. It was a disorder if the problems were present for at least a few months. In addition, there must be a limitation in the functioning and development of the child or the child or the child itself, his parents or the environment suffer (NJI, 2017, www.nji.nl). The medical linear model (disease leads to disorder and cure) was therefore leading in this definition. In the US, the DSM (now version V from 2013) is slowly emerging and as a result of the compromises, more and more disorders were added, making the book thicker and thicker. And child and adolescent psychiatry? In the absence of proper research, the DSM was also declared applicable to children (perhaps with the exception of the then AXIS II personality disorders) but something was found: children were diagnosed (eg 'Borderline' but then with the letter 'io'). -in development- behind it.

In the nineties, in addition to the cognitive movement that began to gain more and more ground as a result of research, we also started research into the role of emotions by Dutch professor Nico Frijda (2013), which also brought attention to relationships: the social-emotional development of children. On the basis of Eriksson's theory, Kroger and Marcia developed research into the personality development that, together with cognitive and social-emotional development, would form important building blocks for a different, more pedagogical view of behavior and development than the DSM classification (Van der Helm et, 2017). The nineties also saw the development of modern brain research. One of the conclusions of this brain research was that many of the DSM diseases could not be found in the brain. Rather, researchers saw general differences between sick and 'normal' people who could just as easily be explained from the consequences of brain damage, the disorder such as stress (see below), a fragmented existence, neglect, abuse and abuse (chicken egg problem). But they also noticed that many patients often had more disorders (co-morbidity)

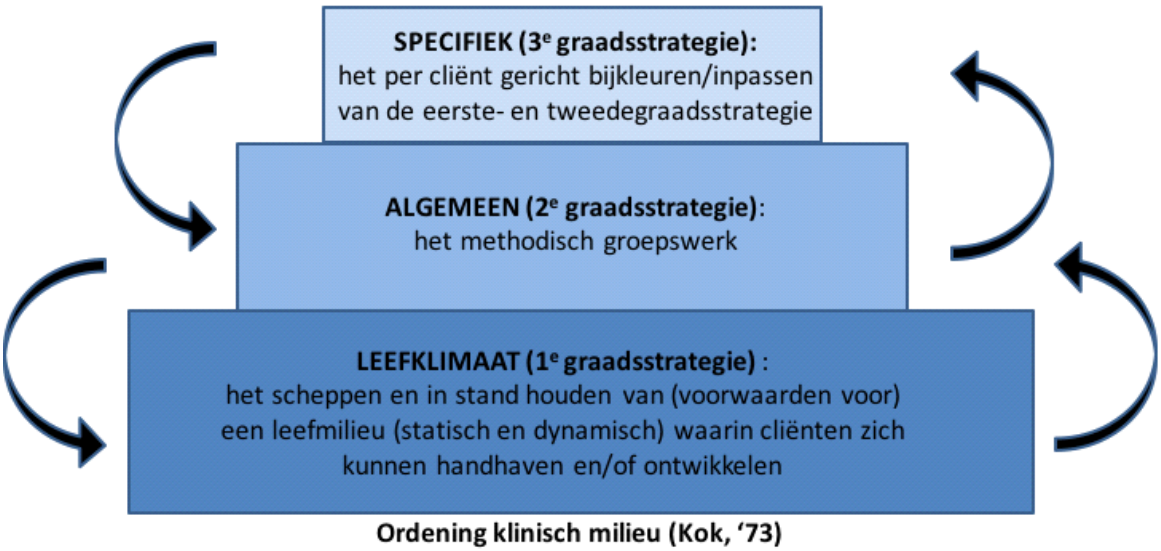
or double diagnoses and that it was sometimes a coincidence what label was stuck on. Furthermore, research showed that the boundaries between different diagnoses in children could not be drawn sharply, for example people with a mild intellectual disability often have characteristics of autism but also of ADHD or dyslexia. Fairchild (2013) showed that there was almost always that general brain damage, especially in criminal and aggressive behavior. The child psychiatrist Frenk Verhulst therefore wrote in 2015 (page 262): 'Nevertheless, scientific research has contributed little to improving the prevention and intervention of psychiatric disorders in children and adolescents. Apparently, the etiological and phenotypic heterogeneity is so complex that the application of new techniques, such as genetics and (neuro) imaging, within child and adolescent psychiatry has not led to the great successes that took place in general medicine. '
But in addition to the DSM, there has been a development in the past 15 years that needs attention: the enormous proliferation of 'proven' methods in Youth Care and Education, mainly brought together in the 'Datebank Effective Jouthcare-interventions' of the Dutch Youth Institute (NJI, www.nji).

2.1 Effective Methods. The idea behind this database is that you can prevent or cure a problem with a child by means of an 'effective intervention', a textbook example of linear thinking. At this moment (state of affairs 1-1-2018) the database 241 contains 'recognized' interventions for help with growing up and bringing up, of which seven with the predicate 'strong indications'. Most interventions, however, do not go beyond 'well-founded' (184), something that for a long time shows no effectiveness. That is why the title of the Effective Youth Interventions Database is somewhat misleading. We also see a strong influence of the medical model in this database. The medical model is strongly focused on linear thinking (reduction through cause-effect) and less on the influence of the relationship between bio-psycho-social factors and intergenerational problem transfer. However, Weisz et al. (2012; 2013) calculated already five years ago that a single intervention can contribute a maximum of 20% to recovery. According to Weisz, the effect of a single intervention in a clinical population is always less than in the general population and some interventions also cause damage (Van der Helm, 2011). We also see that research results into (mainly specific) interventions contribute little to development and recovery.

This even seems to be the case in the 'strong indications' category of the NJI database. When we examine them, it is noticeable that the 'strong indications' do not always apply to clinical groups, or that the studies have been carried out by the inventors of the interventions themselves and have moderate probative value. Examples are that parents did not report any progress ('Incredible Years basis'), the intervention in a problem group did not have the desired effect (' Taakspel '), the study was very limited because there was no control group and the effect sizes were small (' VIPP-SD '). In January 2016, the Pelsser Dietary Diet (RED, ADHD treatment) even silently disappeared from the list after the authoritative magazine The Lancet accused the inventor Trees Pels and her promotor Prof. Buitelaar in 2013 of conflicts of interest in the investigation. The Trimbos Institute was so shocked last year (De Winter, Verhagen & Goossens, 2016) about this kind of conflict of interest in the study of effective youth studies that they published an article in the Psychologist in which they had the high 'Toilet Duck' content ('We of Toilet Duck recommend Toilet duck ") denounced. In 84% one of the authors were not independent, but it was also worrying that in 81% of cases incorrect information was given about the conflict of interest. This is particularly worrying because high amounts of money have to be counted down for many interventions. However, many municipalities require institutions to use effective interventions from the database. For example, institutions are probably forced to buy interventions that do not work for their target group. The reaction of the NJI to this article (printed in the same issue of the Psychologist) was plainly meager and should, in my opinion, be a reason for parliamentary questions.

The idea that a single intervention, especially in clinical groups with many negative childhood experiences and traumas alone cannot be effective was already pot forward in the seventies by the professor J.F.W. Kok (1973). He indicated that treatment could only be effective if there was a good living climate (or a good family climate and learning climate at school). He called that the 'first-degree strategy'. A good climate ensures that the psychological basic needs of the child are fulfilled according to the Self-Determination Theory (Connectedness, Competence and Autonomy, Vansteenkiste and Soenens, 2015), which promotes motivation for behavior and development (Van der Helm, 2017). In addition, the 'second-degree strategy' is based on methodical work, for example on the community, education or in the family home. The specific interventions from the NJI

database usually have a third degree character (see figure 1, Van der Helm, 2017). It is only when the three strategies are combined by a real team (and not a village community) that higher efficacy can be expected. The more important it is therefore to break the compartmentalized treatment landscape and the 'village culture'.



Ordening klinisch milieu (Kok, '73)

2e en 3e niveau zinloos zonder een goed leefklimaat……

3. What now? Contemporary insights

3.1 **P-factor and stress**. There is increasing clarity that most psychological disorders cannot be cured (Van Os, 2015), but that people can learn to live with them and recover from the consequences by building meaningful relationships together with competence and autonomy. This process is beautifully expressed in the book by Toon Walravens ("Toon is recovered", publisher Comtext) and is highly recommended. It is now clear that the traditional medical model and the DSM offer insufficient explanations for recovery, as well as the 241 effective interventions in the NJI database. That is why we are currently thinking in the aforementioned 'Bio-Psycho-Social' model (Van Os, 2015) as the cause and less of a medical disease and linear thinking model. Biological factors (such as genetic vulnerability, but also gender) determine how someone with certain psychological characteristics (eg temperament and 'resilience') together with social factors (stressors) ultimately determine

the behavior and expression of that vulnerability (and resilience). In addition, more attention are to be paid to 'Executive Functions' (what can a child do?) That formed a different, more pedagogical alternative for the medical (disease) model.
Executive functions are about those things that you should be able to participate in society at a certain, age-appropriate level. There is much more attention now than before and then in the medical model. An example: a three-year-old toddler who bites another child in the playgroup because his favorite cuddly toy is taken away (as parents), we do not like it, but we know that in that age the socio-emotional development is not yet ready for stress there is sufficient control (inhibition) to NOT bite. When that child still shows the same behavior at six or eight years and bites or spits other children, we are worried about his executive functions (social and emotional). Look for the excellent documentary 'the children of the Hondsberg' (http://www.npo.nl/ncrv-dokument-kinderen-van-de-hondsberg-2/08-07- 2013 / NCRV_1591071).

Moreover, it often appears that not only the social-emotional development lags behind, but also the personal development (Biesta, 2015), which often has a negative effect on behavior and conscience (Het Morele Kompas, Vansteenkiste & Soenens, 2015). Finally, a lot of behavior is based on pain as a result of traumas from the past that often have a longlasting effect. The Israeli psychiatrist Ariel Shalev expressed this in his 2008 'Anatomic Lesson' as follows: 'trauma etches the mind'. The result is often dysfunctional behavior. Anglin (2014, https://eric.ed.gov/?id=EJ1038559) talks about 'pain-based behavior'. The question is whether such behavior is a psychopathological disorder or simply a reaction to the quality of the environment (the 'living environment').

At the end of the nineties, the Dutch professor Marcel van Aken conducted longitudinal (long-term) research (the "Logic" study) into the prevention of psychopathology in children in Germany and concluded that only 2 forms of problems could be distinguished in children, namely internalizing disorders (inward looking such as anxiety, depression and eating disorders) and externalizing disorders (such as ADHD, rebellious or antisocial behavior). Caspi (2014) added another dimension to his own longitudinal ("Dunedin") research: "thinking disorders" https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4209412/), but concluded that a 'general P factor' (general psychopathology factor) could probably explain the results better. Very recently, Martel and colleagues (2017) conducted research, which

showed that the general P-factor consists of three specific factors, namely anxiety, stress and externalizing characteristics. This P-factor characterizes the psychopathology of a child, which is reinforced by environmental factors and the executive functions of children.

This conclusion therefore points in the direction of the Bio-Psycho-Social model and a general P-factor with internalizing and externalizing problems together with the role of trauma and stress.

There is increasing evidence in the scientific literature that trauma and extreme stress in people's lives have long-lasting consequences even for generations after him. This science is not new: after the First World War we saw soldiers who did not recover from extreme stress, which was then called the aforementioned 'Shell-Shock'. Nowadays we know that this is a Post-Traumatic Stress disorder, that also affects many soldiers who come back from the wars and conflict areas. After the Second World War, it was seen that victims of persecution struggled to pick up their lives again, but that the second generation and the third generation after them also showed signs of disruption. Distinctive here was that the extreme stress lasted for a long time or repeated itself more frequently (for example in case of abuse).

Recent neurobiological animal experiments unravel this mechanism: extreme stress disrupts our stress system and we pass it on for at least two generations (both via the male and the female line). Apparently there is an evolutionary biological adjustment mechanism here. There are, however, large differences between people, we call this phenomenon 'resilience' or resistance, one can handle it better than the other (psychological differences); women react more sensitive to stress and are more susceptible to anxiety and depression, men are more often less socially (biologically determined), but also the social circumstances in which people live determine how you can deal with stress (the so-called 'Bio-Psycho-Social model'). It is important for social workers to be aware of these mechanisms and 'what works' (see Evolution and Biology framework).

Evolution and biology

Stress system and the brain

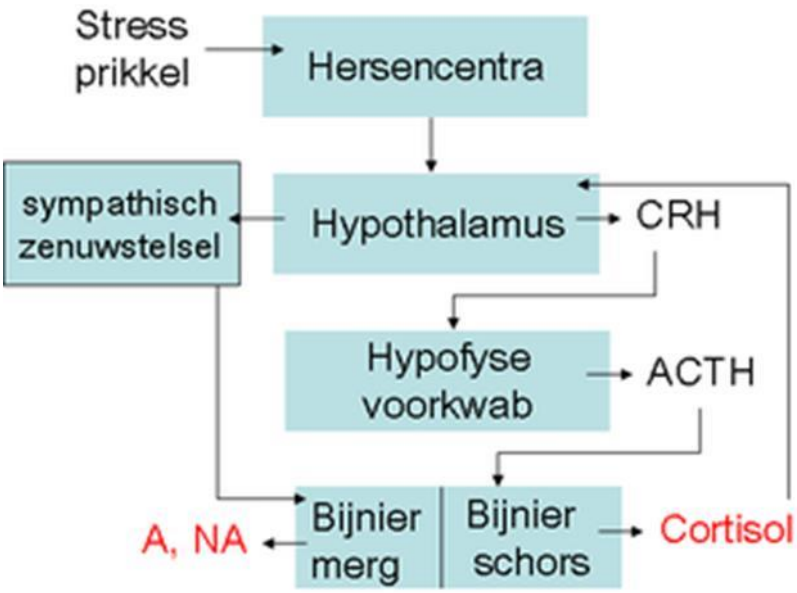
The stress system is a homeostatic system in our body, a balance, where usually 'too' is

never good, such as too little or too much stress.

The balance is controlled by our brains, especially a small organ in the middle of our brains: the hypothalamus. This hypothalamus receives signals from other parts of the brain and sends them to the pituitary gland that releases hormones (CRH and ACTH) in the blood. Those hormones influence small organs on top of our kidneys: the adrenal glands. That is why we speak of the Hypothalamic-pituitary-adrenal axis (HPA axis, see figure below).

Figure 1.

Schematic model of the stress response, A = adrenaline, NA = norepinephrine. Left: fast route, right: slow route (wikipedia.org, 2017)



Our adrenal glands produce stress hormones such as epinephrine, norepinephrine and cortisol that cause more blood to enter our muscles. The function of this is to prepare the body for action (fighting, fleeing or freezing). These hormones affect our brains again, they ensure that we become alert. We have been built in the evolution to deal with short-term stress, but when stress lasts for a long time the system changes (see below) and we also see the other side of this system: for example, cortisol is neurotoxic (eventually breaks down the brain) also has adverse effects on the immune system and our mood. This is especially the case when the stress system is constantly over-stimulated, which is the case with post-traumatic stress disorder. The recurrences and anxiety that are often the result of a prolonged repeated trauma constantly stir up the system and therefore occupy an increasingly important place in memory. The Israeli psychiatrist Ariel Shalev therefore says:

'fear etches the mind' (the hippocampus, a memory center also becomes smaller). That is why the Dutch psychiatrist Gersons found more than 15 years ago that the constant stirring up of memories in therapy and assistance could reinforce symptoms of anxiety and depression. Sometimes the strategy of 'silence' can also mean survival (not constantly recalling memories that further etch the mind).

The survival brain creates reduced cognitive, executive and emotional functioning, as well as aggression and depression. The brain is constantly living in a kind of 'survival mode'; suppressing the trauma costs energy eve as a child. This survival state influences ourselves, our development and how we behave towards others; the executive functions and the empathy deteriorate.

Example

From NRC of Saturday, February 11, 2017 p.24 in which one of the victims of the Utrecht serial rapist told:

"I went to Utrecht to study, fled in the books. I did not have to think about every moment I studied. Until he hit again in 2001. There he was again. There were posters at the University, it was the talk of the day. Then you are busy with it every moment of the day for months. And your fellow students know nothing about it ".

Stress, trauma and social behavior

We live as people around 7-8 million years in groups of hunter-gatherers of about 70-90 people who were not related (risk of inbreeding). Life in such groups was hard, there was often not enough to eat. In order to get enough food, collaboration was necessary. That is why our brains are optimally equipped to read social signals from each other (unconsciously). This happens in parts of our brain that we call the 'social brain'. This social brain takes an estimated three-quarters of the energy that goes to the brain! This social approach is very important to survive: displaying anti-social behavior you were expelled from the group, which meant a certain death. But we are not just social. Aggression was also important to defend yourself and for men to impress the opposite sex. So in the brains there is a balance between social (cooperative) and aggressive behavior (competition).

Social behavior is regulated in our brains by, among other things, the hormones oxytocin and serotonin. But stress hormones (adrenaline and cortisol) are antagonists for oxytocin and

serotonin and also stimulate the production of dopamine and testosterone. Of these hormones we know that dopamine is involved in search behavior but also in craving (the constant appetite for addictive substances). In experiments with monkeys, the 'top monkeys' who had less stress proved to be less susceptible to drugs (cocaine), but under-monkeys much more. However, when a top monkey lost its position (due to a cold virus) and became more stressed, it also became more susceptible to cocaine (Raine, 2012). Long-lasting stress thus promotes addiction behavior.

Testosterone has an influence on dominant and competitive behavior. From long-term stress you become less social and more competitive and dominant! The consequences continue, you also become less sensitive to social correction (punishment) and more sensitive to reward. The survival brain puts the 'I' in the first place by becoming less social. This should be seen as an evolutionary adjustment mechanism in worse times, but in the present time we see this in extreme form back with addicts and for example people who eat a lot (fat). There are differences between men and women who probably have to do with women constantly caring for children. Stress in women translates less due to antisocial behavior compared to men and more to internalizing behavior (depression, anxiety). Women transmit an increased stress or anxiety during pregnancy to their unborn children, who in turn are more susceptible to stress. Men are slightly less sensitive than women and men are also better able to be socially and antisocial at the same time ('dual strategy'). The neurobiologist Keysers therefore thinks that therefore men are often better soldiers (Keysers, 2011).
In our past, bad times could sometimes last a long time: a signal that you had to come up for yourself and because your offspring might also have a worse time to face it was useful to pass this message through the sperm (Micro-RNA) or via the eggs of the mother. This is called epigenetic expression. Epigenetic expression is the change of reading our hereditary qualities. This can be done by DNA modification (metylation), Histones modification (histones are proteins in which the DNA is rolled up) and micro-RNA (genetic messengers). As a result, the DNA itself does not change as much as the ability to read the DNA. Meanwhile, many animal experiments have shown that proteins that code for the setting of the HPA axis can be changed by DNA modification and Histones modification and probably by micro-RNA. This is a signal for the child who has not yet been conceived and who is stuck in the sperm as a message or is hidden in the egg: 'beware of bad times'.

3.2 The relationship: stress due to brain damage, neglect, abuse of the child (trauma)

Children influence their environment and the quality of the environment influences children, this is what we call transactional processes (Sameroff, 2009). When these transactional processes are often negative (abuse, neglect, abuse, bullying, etc.), you build up adverse childhood experiences, but also when parents react very overprotectively, children increasingly feel that they are bad, we call this 'internalizing', resulting in negative emotionality, starting at birth: children with a mild intellectual disability or brain damage, for example due to a fetal alcohol syndrome or lack of oxygen at birth have more stress as a result of adaptation problems and crying for example more often and longer but are also more difficult to comfort, which, combined with possible problems or poor living conditions of parents, causes a lot of stress for parents and children, and this stress often translates into further negative behavior (acting out). This negative behavior further isolates them from peers and adults. Children who come from war situations often also have such an adaptation pattern. Other children often find these children 'weird'. They are often no longer asked to come and are no longer invited to birthday parties and are being bullied because they are 'different'. The resulting social isolation works directly on the pain centers of the brain, as recent research shows, reducing their ability to regulate one's own behavior. Lack of self-control is also often reinforced by brain damage according to neurobiologist Fairchild (2013), sometimes as a result of trauma (birth trauma, violence) or hereditary predisposition or exposure to toxic substances. Several psychological problems (ADHD, MID, OD, CD, anxiety disorders may be the result, according to the American researcher Adrian Raine in his book "The Anatomy of Violence.") In addition, the Dutch psychiatrist Arne Popma has also shown that long-term stress causes that the child's stress system (the pituitary-hypothalamic-adrenal axis) is disrupted The consequences of an altered Hpa-axis activity are that children become less sensitive to punishment and more susceptible to reward and competition do things that seem appealing but also become more sensitive to addiction, smoking, alcohol, substances.). Doing bad things stimulates the reward system in the brain (the dopamine system and the dominance system under the influence of the hormone testosterone). Children are therefore more focused on fun things for themselves and exhibit more dominant (rebellious and hostile) behavior: the survival brain. This goes so far as their social information processing has changed so that they even encode neutral

faces as hostile in the brain (Sato, Unono, Matsuura and Toichi, 2009). Recent research among more than 25,000 young criminals by Wolf & Baglivio (2017) showed that negative childhood experiences led to negative emotionality (low self-esteem, mistrust) and recidivism. In Peer van der Helm's Leiden research into social information processing in children from youth institutions, we saw that this hostile social information processing often led to aggression. The disadvantage of this behavior is that another brain system that is primarily focused on working together and being nice to each other (under the influence of serotonin and oxytocin) can be suppressed. This makes it appear that a child has short-term benefits of his behavior, but in the long term this leads to further social isolation. Children develop antisocial behavior through negative reactions from the environment, are often angry and rebellious, but also calculating and manipulating. This form of behavior is included in the new DSM V as: 'callous and unemotional'. The resulting stress degenerates white matter into the brain, which further reduces the executive functions. The English researcher Graeme Fairchild published a review in 2013 in which he showed that children and adults who showed persistent antisocial behavior always had brain damage, especially in the anterior part of the brain, which provides for impulse control. Is that brain damage permanent? Modern research shows that our brains can grow to old age and change the setting of the HPA axis. However, this requires an environment without too much stress: a good home (living) climate and, for example, a good learning climate at school.

3.3 Recovery An important first example of restoration from extreme conditions were the six orphans who were liberated by the Allies from the Theresienstadt concentration camp and raised by Anna Freud (daughter of) and Sophie Dann. Although they were totally devastated (they only knew German swear words, probably learned from guards) and aggressive towards strangers, they were extremely attached to each other. But over time they began to build up a bond with their caretakers and even passersby who let the dog out. On this example, the assistant of Anna Freud, John Bowlby, later built his attachment theory. When the children were looked up again forty years later, it appeared that most of them had built up a normal existence. The early mutual contact appeared to have protected the children.

In the nineties it was also known that children who grew up with a lot of stress in their environment were more likely to end up poorly (criminal behavior) or become depressed.

Nevertheless, researchers discovered that there were also children who grew up in a bad environment but still ended up well and were less depressed. The differences between children were not only explained by differences in character and resilience. It turned out that children who ended up well somewhere found someone somewhere to take shelter. That could be a grandmother or someone in the neighborhood, but more often that was also at school; a good working relationship with a teacher also turned out to give that 'hiding effect'. An understanding partner also proved to be able to do miracles. A good relationship (secondary attachment) gave stress reduction and made brain growth possible (Raine, 2012). Such a thing is not easy because dealing with others who are anxious, depressed or aggressive can be very difficult and quickly degenerate into conflicts because one person does not understand the other, stubbornness from fear is often mistaken for lack of motivation or lack of realism (see box). for an example).

An example:

When people grow old or when children are very confused often executive functions deminish such as daily actions, remembering things, looking ahead to the future, but also the possibility to control their own thoughts. In people with a trauma from the past, the traumas often reappear in recollections and people with dementia or children who are victims of abuse or abuse sometimes find themselves back in the environment that their mind has etched, such as a camp or an abuse situation. Keeping these memories of which many people are also very afraid of at a distance, requires a lot of energy, something that can reduce daily life and executive functions. People try to survive through a lot of routine and especially not too many new things for fear of not being able to cope with daily life. They prefer not too many changes and large transitions in their own environment and sticking to apparently worthless objects that they have attached themselves to in their lives gives them security. Eating from the old plate, drinking from an old cup and other transitional objects stabilize daily routines in their head. This is not an unwillingness but an attempt to give the fearful brain a hold and structure. For a partner or a family member this can sometimes be very difficult. But also for emergency services. In a rehabilitation clinic where I worked, a woman was admitted with heart failure who had fierce concentration camp re-experiences night in the night and at a certain moment did not want to sleep anymore, something that seriously worsened her condition. In conversation with her

husband I asked how that went home. He always put a certain handkerchief with a little au de Cologne in her bed. But this was not allowed by the nursing because it was unhygienic. After I sent her husband home for the handkerchief and the au de Cologne, she fell asleep.

3.4 The relation: contact as therapy Contact remains the basis of recovery and sociotherapy for children and adults. The American researchers Arden and Linford (2009) therefore recommend in their book 'Brain Based Therapy' that stimulating social contact (in addition to psychoeducation, family therapy and cognitive behavioral therapy with improving self-image and reducing dysfunctional cognitions). However, not all people are able to make contact with others. Sometimes the fear and mistrust are so great that every contact is kept away, sometimes with aggressive behaviour. Recent scientific research has shown that contact with animals, especially dogs (Dutch Celldogs project) and horses (Juzt Jeugdzorg), also called tertiary attachment, can have very good results as a first step towards contact restoration with people.

Recent developments with EMDR are also encouraging because EMDR directly enters the competition with bad memories in the emotion centers of the brain. But EMDR does not work without a safe and structured social environment (without a safe environment many possibilities for re-traumatization). Also recent research by David Bernstein and Marjolein Van Wijk-Herbrink at Maastricht University show the benefits of schema-therapy also for adolescents: changing maladaptive internalized schema's form the past is helping children with severe behavioral problems. One of the main advantages of schema-therapy is that is can also be used by sociotherapist in the social climate (e.g: 'Safe Path' see Marjolein's fresh PhD thesis wicht has recently been approved[2]).

The climate research performed at Leiden University of Applied Sciences in youth institutions, GGZ institutions, TBS and prisons and the learning climate at the special education, where many children are struggling with problems, is therefore aimed at stimulating a good social environment for children and adults with depression or aggression. Stimulating the relationship, the social brain in us could be the key to this 'brain based' therapy.

[2] Van Wijk-Herbrink, M. (2018 in press). Schema-Therapy in adolescents with externalizing behavior problems: bridging theory and practice. Maastricht: PhD Thesis Maastricht University.

In addition, it is important to make the client or child responsible for his recovery. The Utrecht psychiatrist Jim van Os states in his book 'De DSM V over' (2015) that in fact only four questions are needed to make this recovery possible and that the real 'bible' for every care provider should be these 4 questions:

What happened to you? What is your vulnerability and resilience? Where do you want to go? What do you need?

Recovery can be a long way and cost a lot of effort; the Dutch poet C.C.S Crone once said: 'the farther he went, the longer was his way back'. But in practice it appears that a social environment with sufficient possibilities for the relationship, contact, growth, structure and safety can make that recovery possible.

4. The organization and financing of youth aid in the Netherlands

As can be seen from the foregoing, the organization of youth aid is often compartmentalized on the basis of hierarchy, with traditional interests playing a major role ('the village community'). That probably also applies to financing. In the new youth law of 2015, the implementation of the youth assistance, including the specialized youth care, went to the municipality, but with a considerable discount on the total budget of around 200 million euros. The idea behind this was that municipalities with their district teams would sooner identify problems behind the front door and prevented out-of-home placements with preventive ambulance and thus prevent specialized youth care.
Behind this idea, however, there was no scientific research, but probably the wish to cut budgets, according already to many experts in the TV-program "Always What" as early as 2013. Other experts believed that the institutions were greedy and were treating children for too long. That was, of course, a message that appealed to proponents of budget cuts.
In 2015, the number of out-of-home placements and placements decreased slightly, but in 2016 again increased sharply by 15% in institutions and even 25% in family homes (Source: Bureau of Statistics Netherlands). Foster care remained the same, probably as a result of lack of foster parents. Because you cannot just put a child with many disadvantageous childhood experiences into a foster family. A foster parent: 'We had a foster daughter with complex problems, but we were all well on, but we were then put under pressure by the care organization to add another boy. He turned out to have serious antisocial behavior that had

not been told to us and it went wrong with our foster daughter. It took us months and a lot of effort to get the boy transferred'. Approaching motivated foster parents in this way is clearly not the way and my advice is to treat foster parents well.

Moreover, in recent years the care-intensity of the young people who ended up in the specialized youth care and in special education has increased considerably. The combination of less money and an increasing care-intensity resulted in millions of losses for municipalities. Children who depend on youth aid are housed by municipalities as a modern form of horse-trading in 'parcels' that the care provider can bid to without being asked for the place or the fate of the children. Municipalities then shorten tariffs and soon everywhere in the Netherlands care-institutions refuse to treat children at too low rates. At the beginning of November the Journal, 'Domestic Administration' even headed 'chaos in youth care out of hand'. (http://www.binnenlandsbestuur.nl/sociaal/nieuws/chaos-jeugdzorg-lopen-uit-de-hand.9572558.lynkx). How can we explain this?

An important explanation is perhaps the fact that the part of the children who can no longer live at home has very serious problems as stated earlier in this article. They usually do not vanish preventatively or curatively, such as with severe autism or MID and usually there are a combination of several disorders at the same time that cause serious behavioral problems and addiction. We now know from new research that persistent antisocial behavior is often based on brain damage, but also has a strong hereditary component. The adjustment problems that these children have in society are such that we have hardly any control over them. Special education is sometimes unable to cope with this. These disorders do not pass and children have to learn to live with it and that takes a lot of time, knowledge and energy from staff to restore the relationship. Some children are so vulnerable that they will need specialist guidance throughout their lives. Other children have experienced many (early) disadvantageous childhood experiences and are in a phase of life between the ages of 14 and 25 in which they take a relatively high risk and are aggressive. Their social-emotional development and their personality development are lagging behind. We call this a 'disharmonic development profile'. That is also not something you can usually solve quickly with ten sessions of a psychologist or psychiatrist (who are often reimbursed within the youth aid).

In addition, the possibilities to solve problems at home are likely to be overestimated: many parents of children with serious disorders and problems themselves, are sometimes

powerless in the upbringing they sometimes never had and give it from generation to generation through with associated poverty, debts, and addictions. Their possibilities for recovery are often small, let alone their own strength (one of the mantra's in the new Youth Act).
These parents and children have always been there, their number will not lessen so far, but it is probably paradoxical enough to explain the increase in the demand for youth help because district teams do their job well and now see serious problems behind the front door much faster. It is therefore probably necessary to increase money instead of cut budgets because municipalities do their work well. Nobody expected that.

Because we, as a society, have a moral obligation not to let these children out in the cold, and aggression and criminality on the streets ultimately cost society more, the current situation can be improved. There is an urgent need for this. But there is still a second victim of the new law and those are the employees (family parents, pedagogical staff in institutions and teachers in special education) who are confronted with a target group that is becoming increasingly difficult and at the same time having to do it with fewer resources. Then employees report sick, get burn-out and leave. The shortage on the current labor market also makes it possible to leave and earn more elsewhere. Those who stay at work must increasingly do this difficult work with hired temporary employees who do not know the children, which creates unsafe situations. In some cases, staff is replaced by cameras (Trouw, 29 September 2017), leaving vulnerable children alone at night.
Also these employees who continue to do this difficult job with great compassion, day in and day out, with a lot of risk of aggression try to raise children where others have failed and as a reward only get temporary contracts, they too are entitled to our respect and compassion : 'do not let them down'.
To deny children the care they need is not of this time anyway and does not happen when they have cancer or a metabolic disorder. Francien Lamers-Winkelman, emeritus professor of child abuse, once sighed: 'Does the Netherlands still love our children?'
Let us again love children in our society who have been less luckily born and give them the care they need. The 200 million was a mistake: better turned halfway when it is still possible (source: Social issues November, 2017).

5. Consequences for policy, healthcare, education and research. A modern view of treatment and the relationship to prevent children from going adrift into youth care.

The 2015 Youth Law states that children who can no longer live at home should preferably be placed in a foster family or in a family home. The Netherlands currently has some 750 family houses (see box). At the moment to the estimates of Statistics Netherlands and Youth Care Netherlands there are still around ten thousand children in residential institutions and 1700 in youth care plus (secure). Can they all go to foster families and family houses as the law advocates?

We do not know the answer to that question. Not all children are immediately eligible for family homes or foster families. For example, children who show serious antisocial and aggressive behavior disrupt the family home climate and cause damage to other children. Sometimes their behavior is so extreme that the secure youth care (Jeugdzorg Plus) offers a last resort. But also children, for example, who are hunted by loverboys or from honor killings are initially difficult to place. Usually the threat will decrease over time and then they can still be transferred to a family home. There are also specialized family homes in the Netherlands for children who require a high level of care (usually with an intellectual disability), who generally do well. There are, for example, family houses that accommodate young teenage mothers, such as, for example, the Kalor house ('heat' in Latin) in Amsterdam area. In the youth village Glind there is currently a very successful project where children with an authorization for secure youth care are accommodated in two family houses (Bekken & van der Helm, 2016). At Fier, the organization that assists victims of loverboys and honor killings, the first family homes are being prepared. So there is plenty of development in the field.

Framework: family houses in the Netherlands

In 2016, there are a total of 70 (regional) healthcare providers that together offer at least 764 family houses. That is an average of 11.4 family houses per organization. In 2016, at least 2,594 young people were placed in-house in these family homes, with an average of almost 3.5 young people per family home. Most of the placements have a long-term perspective: 89.2%. A much smaller part involved a crisis or temporary placement (respectively 4.8% and 6%). The number of family houses has increased by 30% in the past

two years. As in previous years, there are still providers who only have one or two family houses. On the other hand, in 2016 there are four organizations each with more than 40 family houses in their care offer and another four organizations, each with 20 to 40 family houses.
The number of in-house youths in the family homes has risen by 50% compared to 2014. A significantly larger increase than that of 2012 to 2014; then the number of in-house juveniles increased by 3% (Factsheet Family Houses, the numbers in 2016).

Assuming that 9,000 children are eligible for a family home out of ten thousand residential children, roughly three thousand extra family homes or foster parents are needed in the Netherlands. We will not be able to meet that number for the time being without extra investments. This is because the work as a family home parent or foster parent is not easy. Many children have suffered severe adverse childhood experiences and traumas as a result of neglect, abuse and abuse, often at a very young age, often in combination with a mild intellectual disability. Being removed from the home is another negative childhood experience, and when it is not possible to follow in an institution or foster family, there are usually several follow-up placements that often also change schools (usually special education). When you visit such a child in his room you often see piled garbage bags containing clothes and toys. That says enough about the expectations of the child when only the hugs are unpacked. And with each follow-up placement the behavior deteriorates as a rule and children build up a negative views on others and on themselves. It therefore requires very strong (and well-trained) foster or family parents, good support from behavioral experts and often also pedagogical staff and volunteers ('the supporting network') because you cannot do this work alone. In addition, in the selection of familyhuis.com, only 10% of those interested come through the selection.
And yet it remains worthwhile to strive for more children in a foster family or family home. The permanent presence of foster or family parents, the emphasis on 'ordinary' life has a beneficial effect on the child. Recent research (16 November 2017) from Leiden University of Applied Sciences showed that children experience a better climate in comparison to residential institutions. They experience a lot of support from the parents (solidarity), feel safe, report much to learn (competence) and experience more autonomy (basic psychological needs from Self Determination Theory of Ryan & Deci, 2017). There is now a

lot of empirical evidence that these factors promote motivation for behavior but also the cognitive, social-emotional and personality development. The 'ordinary' that we take for granted is a deep-seated need for these children. That is why foster families and family homes are so badly needed.

During the past life-climate survey at family homes, some children did not even want to fill in the questionnaire because they felt they were living in a 'normal' family and did not want to be found special. This deeply felt desire to be 'normal' can be seen clearly in the beginning of the documentary 'Alicia' of November 17th. Alicia is a girl with MID who wanders from institution to institution. When the teacher tells her that they still have not found a place for her because she is a special child, Alicia answers a crying: 'No, I am an ordinary girl'. After wandering through many institutions, she eventually runs away. Underage girls who are 'away' is not a good sign. If we could have placed Alicia in a family home or a small-scale facility on time, we could have saved her a lot of pain and with her 9,000 other children.

It is an illusion to think that we can do this quickly, but we can try it. This requires money to enable the transition of residential institutions to family-oriented forms of treatment and counseling together with the care institutions. If the government (for example VWS ministry and the VNG) each make a contribution of several millions needed for research, recruitment, selection and start-up of new family homes, foster families for children with many negative youth experiences, small-scale facilities and care institutions can be paid for. That investment will later return in the form of less traumatized children in our society, there is enough scientific evidence for this. Only then will the 2015 Youth Law no longer be a blunt knife and this law will make a serious contribution to better youth care in the Netherlands for those children in the Netherlands who have been born with less luck.

In line with this, treatment for children can probably be significantly improved if all disciplines do not cooperate with each other on the basis of the 'village community' but on the basis as a team, whereby an integration of Kok's strategies (social climate, general methodology and specific treatment). In the community, in the family home and in the classroom of special education, a large part of the treatment takes place by the pedagogical staff. Family householders and teachers form part of the treatment team. There is not so much a need for new 'methods' but for research into their actual effectiveness based on the relationship; there is a need for better frameworks for effective pedagogical action, such as

reducing transfers, for example by improving professional behavior (second-degree strategies, for example Nonviolence Resistance, Van der Helm, 2017).

Consequences for the municipality

First of all, the financing: the 200 million cutbacks were a mistake and are not sustainable, so much is clear now. VNG, take that back from the State and reduce the costs of youth care by letting all those officials who are busy with the bureaucracy to do something more useful, for example, helping children and their parents better. Help the parents who cannot do it on their own, otherwise there will be more children with problems. For children with so many problems, you cannot displace them each year when another care provider offers cheaper care. The most serious problems, based on intergenerational problem transfer, never go away. Vrank Post (Transferium closed Youth Care) rightly proposed to finance this in the same permanent way as the fire brigade: nobody wants to use their services, but we are very happy when they come to help. And we have to stop looking suspiciously at those employees and teachers who risk their health every day to help these young people. Their wages are nothing compared to other sectors and they do not act out of greed but out of motivation.

Therefore, more attention should be paid to the early recognition of early traumatization and intergenerational problems, but also to persistent stress factors such as MID, loneliness, poverty, debt, lack of perspective and associated substance use.

So there should not only be attention for a 'place' for Alicia, but also for her mother, otherwise the problems persist for many more generations.

The stepped care model (from lighter to heavier interventions) does not suffice with regard to this intergenerational problem (and MID) and leads to an escalation ladder of what in psychology is called 'intermittent reinforcement': due to lack of predictability, behavior of the child is becoming more extreme with more and more crises and transfers that further damage the child. Municipalities should impose integral actions of care institutions and education, not only on a DSM diagnosis or a recognized NJI intervention (linear thinking) but more thinking in terms of building stable relationships around the child: stability in life with a good living environment , learning climate at school and adequate staffing. A good working climate includs extra funding to prevent separations and transfers, especially for children

with a high level of care - a principle that was only introduced in care for the disabled, but not everywhere in youth care - should also be introduced for youth care. Then we can also work on restoring contact with meaningful others such as parents and family. Substantive quality requirements should take precedence over bureaucracy. At the fire department, nobody says that a rejected fire hose can last for another ten years?
Furthermore, in medicine, for example the surgery, it has also become clear that not everyone can do everything just as well. In specialized youth care, we also have to recognize and appreciate specialisms high intensive care and high safety (and finance them), but only on the basis of evidence-based quality. Why does the inspections ask for the quality of the living environment, but the municipality does not?

Consequences for healthcare institutions.
Also for healthcare institutions the adage 'First Do No Harm' (Van der Helm, 2011) applies. Our institutions must become safer for the children who stay there. Secondary re-traumatization due to separations, incidents and sexual violence should receive more attention (learning from incidents) and repression should be banned from residential youth care. This is possible, see for example the recent example of Harreveld (Horizon) where, given the latest living climate measurements, a culture change has been achieved with the most difficult children. Who gives Harreveld a medal and who follows? But attention must also be paid to the sufficient effort of educational staff who can fill in the concept of 'relational safety' together with structure and abandon the use of separation rooms, cameras and doors. For institutions and special education, it is important that more circular treatment (instead of linear) work is being done, with a pedagogical vision coming first. This involves a reassessment of the role of the experts, pedagogical employee, family home parent and teacher in special education in order to optimize the quality of the living and learning climate. They too are 'practitioners', also full members of the treatment team within the village community and therefore deserve a good working climate, no temporary contracts and labor market-related salaries. The '' private rooms and secretaries '' of the higher placed villagers (the experts) can make room for rooms for children to play. Instead of problematising behavior through the DSM as 'disease' (linear thinking), we must try to normalize their existence through building relationships with and around the child.
That does not detract from the fact that in recent years major steps have been taken in, for

example, cognitive behavioral therapy, trauma treatment and schema therapy. If these more medically oriented treatments can be combined with an optimal second and third degree strategy, much progress can be expected and recovery for the child.
Where possible, we would have to work towards more small-scale facilities and family houses because the climate is better and more normal, focused on building relationships. But foster parents and family parents are also vulnerable: institutions cherish these people who do this work with a large dose of involvement and above all do not try to see them as a place where you can drop a child in crisis, that will not work. Family homes are already experimenting with a larger role of biological parents and relatives in education.
This does not mean, for example, that secure specialized youth care or specialist facilities are unnecessary. It is an illusion to think that we can do without the Fire Brigade, but we can continue to work on more fire prevention, a better and safer living environment and a view of 'a place' as Alicia articulated so beautifully. Give these children a place under the sun and hope for a normal life.

Consequences for the education that trains for this field of work
Much education at the Universities in the Netherlands (Social Work), but also within the GGZ is still strongly DSM- and the 'method' focused and within many teachers courses there is less interest in the special education, while especially these children need good education. In view of the complex problems of these children, we should educate our best academics students for special education (but the opposite happens). We also have to teach our students to think critically and not to accept everything from the village community. That is why in education it is important to give new insights to our students and to be critical of what is outdated. When we do not, we continue to train them for the 20th century village community. That does not motivate our students.

Consequences for research in the youth sector and beyond
Analogous to the foregoing, a great deal of scientific research into youth aid has been driven by DSM- and methods based on linear thinking. There is currently the most subsidy money available because assessors also think linearly. They therefore prefer to spend money on examining a micro-intervention with n = 150 than looking at a system. We know from research into that micro-interventions in the long run it will not yield much more than

conflicting results. Nevertheless, the big financiers, such as the government, continue to favor micro-research that claims progress in DSM-driven paradigms. The interests of the village community are divided there and the chimney must continue to smoke in the village. That is why the annual 'Youth in Research' congress is a joyous get-together for like-minded villagers with a drink afterwards. But less research is needed into more methods and more research is needed into relationships and the functioning of the system linked to long-term effects of interventions. After all, what is the use for children to improve on a questionnaire like the TRF, the CBCL or a whole ROM while they are transferred to the next place and end up in the jail, social relief or prostitution / crime? Why do we continue to produce and deliver defective refrigerators in youth care?
For the girls from the youth care, Krabbendam and van de Moolen were the only ones to date that examined the effects on the treatment of girls in youth care longitudinally and the results did not make us happy. Therefore this requires a reorientation on research and subsidy. This also requires a changing focus for the village community. This focus could come to less linear micro-thinking and more thinking in relationships. For this purpose multidisciplinary and practice-oriented knowledge and expertise centers could be set up, as has already been done in the medical world.

An urgent need for change or too much to demand?
I understand that the village community continues in youth care with all the interests of the government, financiers, stakeholders, structures, financing problems and organization. However, the inclusion of children with a great need for care in 'parcels' and to auction them at care providers, regardless of where they live or with whom they have already built a bond, is in my opinion abject. With today's knowledge we could better spend the available money by means of less linear thinking, working better together in the relationship to give children a place on the mussel bank and to close the holes in the fisherman's net. All highly motivated employees in youth aid would also be happy about this.
That Alicia had to wander from place to place and could end up in prostitution because of the failure of youth help could easily be prevented or is the latter too much to ask for?

This article was made possible by a Raak Publiek subsidy (‘Met kleine stapjes’, ‘with little steps’)

Some references:

Anglin, J.P. (2014). *Pain, normality, and the struggle for congruence: reinterpreting residential care for*
children and youth. Oxford: Routeledge.

Arden, J. B., & Linford, L. (2009). *Brain based therapy with children and adolescents*. Hoboken: Wiley.

Asscher, J. J., Van der Put, C., & Stams, G.J.J.M. (2015). Gender differences in the association between child maltreatment and adolescent offending. *Journal of Family Violence*. *30*, 215-225. doi: 10.1007/s10896-014-9668

Engel, George (1977), *The Need for a New Medical Model: A Challenge for Biomedicine*. Science, Vol.196, Issue: 4286 (April 8, 1977), pp: 129-136

Fairchild, G., Goozen, S.H. van, Calder, A. J., & Goodyer, I.M. (2013). Research review: evaluating
and reformulating the developmental taxonomic theory of antisocial behaviour. *Journal of Child*
Psychology and Psychiatry, *54*(9), 924–940. https://doi.org/10.1111/jcpp.12102.

Keysers, C. (2011). *The empathic brain*. Social Brain Press: Amsterdam.

MacDonald, G., & Leary, M.R. (2005). Why does social exclusion hurt? The relationship between social and physical pain. *Psychological Bulletin*, *131*(2), 202–223. https://doi.org/10.1037/0033-
2909.131.2.202.

Martel, M.M., Pan, P.M., Hoffmann, M.S., Gadelha, A., Rosário, M.C. do, Mari, J.J.,Manfro, G.G.,
Miguel, E. C., Paus, T., Bressan, R. A., Rohde, L.A., & Salum, G.A. (2017). A general psychopathology
factor (*P* factor) in children: structural model analysis and external validation through familial risk and child global executive function. *Journal of Abnormal Psychology*, *126*(1), 137–148. https://doi.org/10.1037/abn0000205.

Popma, A., & Raine, A. (2006). Will future forensic assessment be neurobiological? *Child and Adolescent Psychiatric Clinics of North America*, *15*, 429–444. https://doi.org/10.1016/j.chc.2005.11.004.

Raine, A. (2013). *The anatomy of violence: the biological roots of crime*. New York: Harper.

Sato, W., Uono, S., Matsuura, N., & Toichi, M. (2009). Misrecognition of facial expressions in delinquents. *Child and Adolescent Psychiatry and Mental Health*, *3*, 27–39.

Slot, W., & Aken, M. van (2013). *Psychologie van de adolescentie*. Utrecht: Thieme.

Spinhoven, P., Elzinga, B. M., Hovens, J. G. F. M., Roelofs, K., Zitman, F.G., van Oppen, P., & Penninx, B. W. J. H. (2010). The specificity of childhood adversities and negative life events across the life span to anxiety and depressive disorders, *Journal of Affective*

Disorders, *126,* 103–112, doi:10.1016/j.jad.2010.02.132.

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

Van der Helm, G. H. P., Matthys, W., Moonen, X., Stams, G. J. J. M., Giesen, N., & van der Heide, E. S. (2011). Measuring inappropriate responses of adolescents to problematic social situations in secure institutional and correctional youth care: a validation study of the TOPS-A. *Journal of Interpersonal Violence*, *28,* 1579-1595. doi: 10.1177/0886260512468322.

Van IJzendoorn, M. H., & Bakermans-Kranenburg, M. J., (2014). Prosocial development and situational morality, neurobiological, parental and contextual factors, in Pathways to Peace: The Transformative Power of Children and Families, The MIT Press, DOI: 10.7551/mitpress/9780262027984.003.0010.

Wikipedia stress systeem tabel. Opgehaald van : https://nl.wikipedia.org/wiki/Stress op 12-2- 2017.