Who Cares?! Baseline profiles and child development in different 24-h settings

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GENERAL INTRODUCTION

INTRODUCTION

The number of children suffering from maltreatment or other adverse childhood experiences is exceedingly high (Gilbert et al., 2009; World Health Organization, 2014). For example, the World Health Organization (2014) estimated that in Europe alone 117 million children suffer from sexual, physical, or mental abuse. Such adverse developmental circumstances have intrusive health and social impacts throughout a child's life-course and result in, among other things, frequent and long-term service usage (Garland, Landsverk, Hough, & Ellis-Macleod, 1996; Gilbert et al., 2009; World Health Organization, 2014). One of the services that is often used for children living in such circumstances is (24-h) out-of-home care (Bhatti-Sinclair & Sutcliffe, 2012; Pinto & Maia, 2013; Vanschoonlandt, Vanderfaeillie, Van Holen, De Maeyer, & Robberechts, 2013). However, a considerable number of children do not seem to benefit from the out-of-home care services provided; this is suggested by the reported number of children who experienced a placement breakdown, which varies from 20 up to even 80% of children who required such services (e.g., Oosterman, Schuengel, Slot, Bullens, & Doreleijers, 2007; Van den Bergh & Weterings, 2010). In addition, the costs of youth care services recently soared to unsustainable levels. Both issues resulted in an urgent call for reform of the youth care system (e.g., Bosscher, 2014; Fegert & Stötzel, 2016; Klag et al., 2016; Menozzi, 2016; World Health Organization, 2014), implying greater emphasis on preventive and in-home (support) services, as well as a reduction in the use of (specialized) out-of-home care and a simultaneous increase in the quality of the remaining specialized 24-h care services (Bosscher, 2014; Courtney, 2000; Hilverdink, Daamen, & Vink, 2015).

One way to increase the effectivity and efficiency of out-of-home care services is to optimize the matching between development-threatening conditions or characteristics at the time of admission, and the ability of the various types of out-of-home care to effectively address these baseline circumstances. This thesis aims to contribute to the optimization of this matching. Its objective is to identify the relevant baseline child and family characteristics of out-of-home- placed children in the various 24-h settings and to link these characteristics to (positive respectively negative) psychosocial development of children in the assigned 24-h setting. Such knowledge can provide building blocks for the development of decision-making strategies to improve matching.

This introduction begins by providing a short overview of the development of child and youth care principles and legislation in European countries in general and the Netherlands in particular. The types of out-of-home care services and their utilization and allocation principles are subsequently discussed. Finally, the model that underlies this thesis is presented, and the relevance, objective and overview of this study are outlined.

DEVELOPMENT OF YOUTH CARE AND CHILD PROTECTING SERVICES

The development of child and youth care principles

In European countries, from the 19th century onwards, the state increasingly assumed responsibility for taking care of children who lacked adequate parental care. Large institutions were established to provide alternative care for poor, disabled, retarded, or mentally ill children and those from dysfunctional families (Costa, 2012; Knorth, Evenboer,

& Harder, 2016). Subsequently, in 1901, the first Dutch Children's Act was adopted, which is often considered to be the foundation of the Dutch youth care and child protection system (henceforth, "youth care system"). The Act enabled governmental authorities to intervene in parental authority in cases of severe child maltreatment or neglect, and it became possible to refer a child to out-of-home care in such cases (Knorth et al., 2016). However, since the emergence of Bowlby and Ainsworth's attachment theory (Ainsworth, 1969; Bowlby, 1952; Bretherton, 1992), large institutions have increasingly become subjects of criticism due to their impersonal nature, their social, emotional and geographical isolation, and the lack of attention that they demonstrate to children's rights and developmental needs (Costa, 2012; Newton, 2017; Van IJzendoorn et al., 2011). Due to their use of 24-h shift staff, these institutions were considered to be unable to meet children's need for stable, continuous, and close relationships with (substitute) caregivers, which are required to develop secure attachment (Bowlby, 1952; Whittaker, Del Valle, & Holmes, 2015). For this reason, but also to reduce costs, from the 1970s onwards, (family) foster care increasingly became the placement of choice. Foster care most closely resembles family-life, and a child has a greater likelihood of developing a continuous and close relationship with a substitute caregiver (Bowlby, 1952;Roy, Rutter, & Pickles, 2000; Whittaker et al., 2015). Along the same lines as this paradigm shift, the United Nations Convention on the Rights of the Child was adopted on 20 November 1989 (United Nations, 1989). This Convention states that every child has the right to grow up in a supportive, protective, and caring environment. Thereafter, in 2009, the United Nations Guidelines for the alternative care of children (henceforth, "U.N. guidelines"), which officially state that a least restrictive and family-oriented setting is preferred in cases of out-of-home placement, were adopted (United Nations, 2009, December 18).

The development of Dutch child and youth care legislation

The aforementioned youth care principles are also reflected in the development of Dutch legislation on youth care services. In 1989, the legal framework for Dutch youth care services was stipulated by the (first) Youth Care Act. A core principle of this Act was the "so-so-so policy," which implied that youth care services should be provided as least restrictive as possible (preferably at home), as close to home as possible (preferably regional), as briefly as possible, and as soon as possible (preferably preventively) (Knorth et al., 2016; Scholte, 2002). This was accompanied by a reduction of appreciation for residential care and a decline in the availability of this type of care (Knorth et al., 2016).

In 2005, the Youth Care Act of 1989 was revised, with the intention of shifting to a (more) client-oriented and coherent approach to providing youth care services by offering one central access point per province. This was intended to support collaboration between provinces, municipalities, youth mental health care services, and child protection services in order to ultimately result in less bureaucracy and greater efficiency (Bosscher, 2014; Ross-Van Dorp & Donner, 2005). Both the preventive (i.e., early intervention, care coordination, and referral to specialized care) and specialized youth care services (i.e., youth care-, mental health-, and child protection services) received central access points. The access points for preventive youth care services were the Youth and Family Centers, while the specialized

youth care services could be accessed through the Provincial Youth Care Agencies. Despite these reformations, the Dutch youth care system remained fragmented, and referrals to youth care services were still provided in different ways, depending on the type of care required (Bosscher, 2014).

For these reasons, a new Dutch Youth Act came into force on 1 January 2015; its objective is to provide one all-encompassing law for all youth care services in order to make the Dutch youth care system more efficient, coherent, transparent, and cost-effective (Bosscher, 2014). Since then, local municipalities have become responsible for the entire continuum of youth care services, ranging from preventive to specialized youth care services for children and families with all kinds of problems. This is described as the *transition* of responsibilities. In addition to this, a *transformation* of the system is sought, including a shift towards emphasizing normal development, the empowerment of children, parents, and their social environments, and preventive and early support instead of an emphasis on the use of specialized youth care services (Bosscher, 2014; Hilverdink et al., 2015).

Despite the fact that providing specialized residential care runs counter to the current objectives of youth care services identified above, it still appears to be a necessary component of (24-h) out-of-home care services, as evidenced by the frequency with which this type of care is used (Huefner, James, Ringle, Thompson, & Daly, 2010; James, 2006; James, Zhang, & Landsverk, 2012). This is particularly true for children with high treatment needs (Butler & McPherson, 2007; De Swart et al., 2012; Huefner et al., 2010). Similarly, the U.N. guidelines state that a (temporary) residential placement can be applicable in ”cases where such a setting is specifically appropriate, necessary, and constructive for the individual child concerned and in his/her best interests” (United Nations, 2009, December 18, par. 21). To provide an overview of the underlying differences between the main types of out-of-home care, the continuum of out-of-home care services is briefly discussed below.

TYPES AND UTILIZATION OF OUT-OF-HOME CARE SERVICES AND THEIR ALLOCATION PRINCIPLES

The continuum of out-of-home care services

Generally speaking, out-of-home care settings can be classified with reference to their underlying principles (family-based versus group-based), levels of restrictiveness, and levels of intensity (Barth, 2002; James, 2006; Petrowski, Cappa, & Gross, 2017). When doing so, a continuum of care services emerges, ranging from the least restrictive 24-h services (e.g., kinship or non-kinship foster care) to alternative family-based group homes (e.g., family-style group care) to several types of more intensive and restrictive residential treatment care (e.g., open residential care or secure residential care) (Barth, 2002; Huefner et al., 2010; Washington State Department of Social and Health Services: Children's Administration, 2014).

In cases of (family) foster care, problematic family circumstances are usually the main reason for a child being placed in a foster family, in order to provide for his or her safety (Strijker, Knorth, & Knot-Dickscheit, 2008). In such a situation, a child will be taken care of by volunteer foster parents, who may or may not be familiar with him or her (kinship or non-kinship foster care). In cases of short-term foster care, the biological parents are supported in

addressing any family issues, with the intention of reuniting them with their child. When reunification is not an option, a child will remain in long-term foster care until the age of 18 (Strijker et al., 2008). In contrast to the foster care process in the United States, adopting a foster child is rather unusual in the Netherlands and other European countries (Holtan, Handegård, Thørnblad, & Vis, 2013).

Family-style group care is a lesser known type of family-based care is. This is partly due to the heterogeneity of terminology used for this setting, such as teaching family-homes, SOS children's village's, family houses, socio-pedagogical homes, and family-type homes (Frensch & Cameron, 2002; Harder, Zeller, Lopez, Köngeter, & Knorth, 2013; Lee & Thompson, 2008; Ringle, Ingram, & Thompson, 2010; Van IJzendoorn et al., 2011; Whittaker et al., 2015). In family-style group care, a child is cared for by pedagogically trained group parents, who live at the setting and provide daily professional supervision to approximately six to eight children (Ringle et al., 2010; Whittaker et al., 2015).

Finally, (therapeutic) residential care encompasses several types of group-based settings which differ in their levels of intensiveness and restrictiveness, ranging from non-secure residential to secure residential to inpatient (forensic) psychiatric care (Barth, 2002). Children are generally referred to residential care when they have, among other things, substantial problems in terms of social, behavioral, and school functioning (Chor, McClelland, Weiner, Jordan, & Lyons, 2012; Whittaker et al., 2015). Residentially placed children are supervised by 24-h shift staff in residential treatment settings, which often feature an incorporated school for special education.

The utilization of out-of-home care services

Globally, approximately 2.7 million children under the age of 18 live in residential care, which corresponds to 120 children per 100,000. No global estimation can be made for foster care due to a lack of sufficiently reliable administrative data on numbers of foster children over the world (Newton, 2017; Petrowski et al., 2017). The preference to refer to a family-based or group-based setting differs between several regions in the world, partly due to differences in historical trajectories and societal views. In African societies, for example, many children are fostered in informal kinship foster care because of a deep-rooted conviction that the care and upbringing of children is a shared family responsibility. By contrast, for Eastern and Central Europe 666 children per 100,000 are placed in residential settings, which is five times more frequently compared to the global average (Petrowski et al., 2017).

In the Netherlands, almost 34,000 children resided in out-of-home care at the end of 2016 (Centraal Bureau voor de Statistiek, 2017); this corresponds to 997 children per 100,000. The majority of Dutch out-of-home placed children under the age of 18 lived in foster care (53%), and a much smaller number (10%) in alternative family-oriented settings such as family-style group care. A significant number (38%), however, were placed in non-secure residential care (Centraal Bureau voor de Statistiek, 2017). In contrast, in the United States, the majority of children were placed in a foster family (75%), while another 6% lived in (family-based) group homes. Only 8% resided in residential care (Child Welfare Information Gateway, 2017).

Closely related to the utilization of the various types of out-of-home care are the principles upon which referral is based, which are discussed below.

Allocation principles in out-of-home care

With regard to the allocation of children to a certain type of out-of-home care, three related underlying issues can be distinguished. At first, as previously outlined, the prevailing view is that, in the case of an out-of-home placement, the setting should be as least restrictive as possible. Today, however, this guideline seems to be overemphasized, resulting in a sense of obligation on the part of child welfare caseworkers to provide the least restrictive type of care first (usually foster care). It is only when such care proves to be ineffective that a more restrictive and intensive setting is perceived as being justified. This "scale-up" principle is referred to as "stepped care" (Van der Feltz-Cornelis, Van Marwijk, Hakkaart-van Roijen, Carvalho, & McIntyre, 2017). The downside of this stepped-care principle is, however, the implication that the least-restrictive guideline should have priority over the specific needs and possibilities of a child and his or her individual situation (Sunseri, 2005; Whittaker et al., 2015). In addition to this, allocation is also affected by other factors, such as resource availability (Broeders, Van der Helm, & Stams, 2015; Frensch & Cameron, 2002; Huefner et al., 2010), or local policy (Barth, 2002; Bhatti-Sinclair & Sutcliffe, 2012; Huefner et al., 2010; James, Landsverk, & Slymen, 2004; Newton, 2017). Third, the absence of clear placement criteria for the various types of (non-secure) out-of-home care hampers a well-informed choice concerning a certain type of care (Chor et al., 2012; Lee, 2010; Strijker, Zandberg, & Van der Meulen, 2002).

All of the issues related to allocation increase the likelihood of a mismatch between baseline child and family characteristics on the one hand and the care referred to on the other, subsequently increasing the risks of placement instability (Chor et al., 2012; Vanderfaeillie, Damen, Pijnenburg, Van den Bergh, & Van Holen, 2016; Whittaker et al., 2015). This placement instability in turn negatively affects a child's development, which further increases the risk of a subsequent unplanned placement breakdown (Webster, Barth, & Needal, 2000). Finally, this negative coercive process heightens the risk of unfavorable placement outcomes (James, Zhang et al., 2012; Newton, Litrownik, & Landsverk, 2000; Oosterman et al., 2007). Based on data from the literature, placement breakdowns are a common phenomenon across all types of care, in which percentages ranging from 20 up to even 80% (Jakobsen, 2013; Oosterman et al., 2007; Van den Bergh & Weterings, 2010; Ward, 2009). This suggests that inaccurate matching likely occurs in all types of out-of-home care.

The principle of matching between baseline child and family characteristics and a certain type of care is known as "matched care" (Boyd, 2016; Williams & Martinez, 2008). An example of a model that uses this matched-care principle is the risks-needs-responsivity (RNR) model developed by Andrews, Bonta, and Wormitmulh (2011), which is used in (forensic) psychiatric care and secure residential care (Buitelaar, Ferdinand, Posthumus, & Buitelaar, 2016; ter Beek, van der Rijken, Kuiper, Hendriks, & Stams, 2017; Vermaes, Konijn, Jambroers, & Nijhof, 2014). Using this model, it is possible to determine who is at risk and should be treated (the risk principle); what should be treated, since it is related to the outcome (the need principle); and how it should be treated (the responsivity principle) (Bonta & Andrews, 2007). The principles of the RNR model are expected to serve well for the

development of a decision-making tool for referral to out-of-home care. By investigating which baseline child and family characteristics (in short "baseline factors") are related to favorable and unfavorable outcomes, it becomes clear which baseline factors (the needs) should be considered at the time of admission. In addition, by specifically linking these baseline factors only to unfavorable outcomes in every type of 24-h care (the risks), it reveals who requires additional specific treatment. Finally, by identifying the relationship between the baseline factors and a favorable result, it suggests which type of care is preferable under certain circumstances (responsivity). In this manner, the baseline factors identified can be used as building blocks for the development of such a decision-making tool for referral to a certain type of non-secure 24-h out-of-home care.

Several attempts have previously been made to develop such a decision-making tool, such as the development of the child and adolescent severity of psychiatric illness (CAPSI) questionnaire (Lyons, Libman-Mintzer, Kisiel, & Shallcross, 1998), the child and adolescents needs and strengths (CANS) algorithm (Lyons, 2009), and the children and adolescent service intensity instrument (CASII) (Fallon et al., 2006). However, according to Chor et al. (2012) there is still much to be learned about referral processes.

RELEVANCE, OBJECTIVE AND OVERVIEW OF THIS THESIS

Relevance of research on out-of-home care

Research on out-of-home care is considered to be important, as evidenced by the many studies that have been conducted on this subject. Nevertheless, a number of issues require ongoing attention. First, out-of-home placement is an intrusive intervention in a child's life and could be traumatic on its own (e.g., Bruskas, 2008; Racusin, Maerlender, Sengupta, Isquith, & Straus, 2005; Schneider & Phares, 2005). It is therefore only justified when other, less intrusive, in-home services or day-treatment programs are considered to be insufficiently able to effectively address risky circumstances (Huefner et al., 2010; Pinto & Maia, 2013; Vanschoonlandt et al., 2013). Second, out-of-home care is a very expensive intervention, especially when it comes to professional family-based or group-based treatment (Barth, 2005). However, the global number of children receiving child-protecting services, and the related costs, continue to increase (Fegert & Stötzel, 2016; Klag et al., 2016; Menozzi, 2016; Withington, Burton, Lonne, & Eviers, 2016). In the Netherlands in particular, the demand for specialized youth care services increases by approximately 10% every year (Hilverdink et al., 2015). A third issue with regard to out-of-home care is the contradiction between the aim of minimalizing or even abolishing the use of residential care and the large number of children who still use this type of care. To reduce the utilization of residential care, it would be helpful to gain insight into the baseline characteristics of children who actually benefit from such services (Connor, Miller, Cunningham, & Melloni, 2002; Klag et al., 2016). Finally, according to the literature data, a significant proportion of children placed in all types of out-of-home care do not benefit from the services received and some even deteriorate during placement (Boyer, Hallion, Hammell, & Button, 2009; Goemans, van Geel, & Vedder, 2015; Lawrence, Carlson, & Egeland, 2006; Van IJzendoorn et al., 2011; Vanderfaeillie, Van Holen, Vanschoonlandt, Robberechts, & Stroobants, 2013). Altogether, these key issues justify the objective of this thesis.

Objective and overview of this thesis

The primary objective of this thesis is to contribute to knowledge on baseline child and family characteristics prior to or soon after admission and their link(s) to children's psychosocial development during the first year of placement. According to the literature data (Anderson, Lyons, Giles, Price, & Estle, 2003; Scholte, 1997; Strijker et al., 2002) and based on the guidelines for reforming the youth care system set by the Netherlands Youth Institute (Bosscher, 2014), obtaining greater insight into these baseline factors would be a first step in supporting the development of well-informed decision-making strategies. The baseline factors related to children's psychosocial development can be used as building blocks for the development of decision-making strategies for referral to out-of-home care and for suggestions for additional treatment during placement. This could improve the match between the attending baseline factors on the one hand and the type of 24-h care assigned, combined with additional interventions, on the other. The improvement of such a match would subsequently contribute to the enhancement of the efficiency and effectiveness of 24-h out-of-home care.

To systemize and summarize the building blocks identified, an adapted version of Kerig, Ludlow, and Wenar's model (2012) is used in this study (see Figure 1).

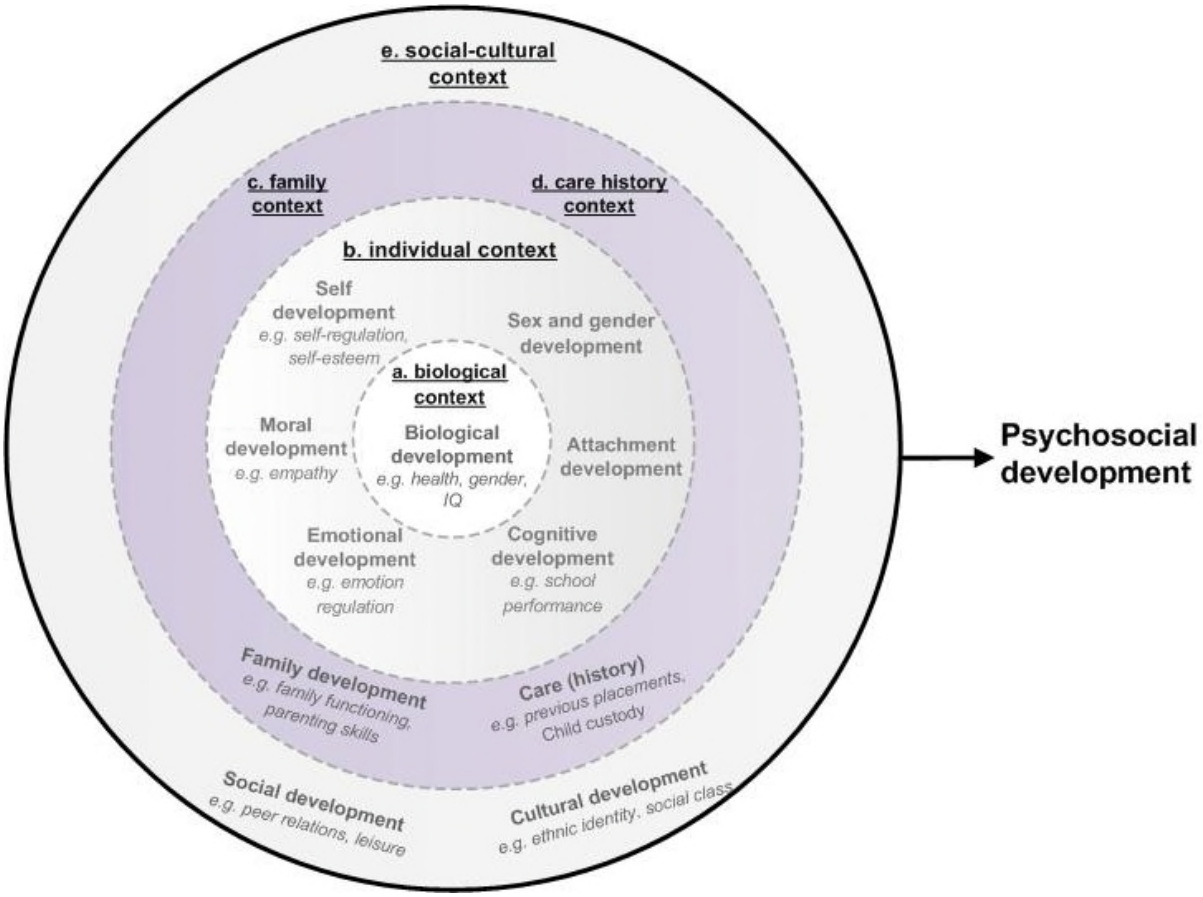

Figure 1. Adapted model of the developmental processes during a child's psychosocial development from Kerig et al. (2012).

The central assumption in the transactional developmental model of Kerig, Ludlow, and Wenar (2012) is that a child's development is determined both by a series of successive developmental processes and the continuous dynamic interaction between that child and his or her developmental contexts during these processes. The model distinguishes between several developmental contexts, namely (a) biological, (b) individual, (c) family, (d) care history, and (e) social-cultural.

For the purpose of conciseness, some developmental contexts are combined in certain chapters. Furthermore, it should be noted that some degree of overlap between Chapters 2 to 5 is inevitable, as each of these chapters is based on a study which can be read separately. This thesis is structured as follows:

Chapter 2 discusses the findings of a scoping review on the baseline child and family characteristics of children placed in foster care, family-style group care, and residential care.

Chapter 3 reports on the findings of a comparison of the child, family, and care characteristics of 200 Dutch primary school-aged children at the time of admission to one of the three main types of out-of-home care distinguished previously. The findings contribute to knowledge of the baseline child and family characteristics of children placed in out-of-home care and, more specifically, provide insight into the similarities and differences between children placed in the three main types of care.

Chapter 4 presents the findings of a study that focused specifically on the similarities and differences in the short-term psychosocial development (internalizing, externalizing, and total behavior problems) of a sample of 121 Dutch primary school-aged children one year after their initial placement in foster care, family-style group care, or residential care. In order to make a sound comparison, the severity of their psychosocial problems at the time of admission is also taken into account in this study. A child's psychosocial development is known to be a central outcome variable in outcome studies (Goemans et al., 2015).

Chapter 5 reports on the findings of a study in which a set of baseline factors is related to favorable or unfavorable psychosocial development of the children in the aforementioned sample during their first year of placement in foster care, family-style group care, and residential care. According to the literature data, the use of a set comprising multiple factors is recommended because of the likelihood of a cumulative effect of baseline (risk) factors being present (Farmer, Mustillo, Burns, & Holden, 2008; Greenbaum et al., 1996).

Finally, **Chapter 6** presents a general discussion of the findings of the empirical studies in relation to the literature data. The baseline factors nominated as building blocks for decision-making strategies are discussed, in addition to their implications for practice and policy. Furthermore, recommendations for future research are suggested, taking into account the limitations of the studies.