Closer Links

Working on an effective system for youth and parenting

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1. Introduction

Research shows that most of the (Dutch) youth are doing just fine. However, some youth are facing one or more serious problems (Van Dorsselaer e.a., 2007). Unfortunately, most reports reveal that only a small portion of these children in need receive the necessary care and relief (also see Zwaanswijk, 2005). Currently, this particular outcome usually leads to the following two conclusions:

- Firstly, professionals working in organizations that are dealing with children and parents or caregivers need to develop and/or adopt efficient tools to recognize early signs.
- Secondly, it is often suggested that referrals to the regional youth care agencies should improve. (Zwaanswijk, 2005).

These are, in fact, fully justifiable statements. However, I do believe that this is only one side of the story. In this article I will introduce a broader perspective. More specifically, I think it is safe to say that - in spite of a possibly imperfect system of early recognition and referral - the use of care services has grown considerably, and that we have to wonder whether our system is operating satisfactorily. In other words, the time has come to reconsider.

2. Increased use of care

Youth care[1]

Anyone who reads the papers knows that –although many young people are doing relatively well - youth care agencies are swamped with cases and clients. In the Netherlands, this phenomenon reached a highpoint in 2004, when the waiting lists for youth care were labelled code red. The number of clients who had to wait five days or more for a first meeting, after reporting in with youth care, increased by slightly over 70% in the period 2002-2003. The number of people waiting for treatment after referral to secondary youth services (the so-

[1] Data derived from: Stichting Registratie Jeugd Voorzieningen (2003); Task Force Wachtlijsten Jeugdzorg (2004); Ministerie van VWS (2005; 2006; 2007); Maatschappelijk Ondernemers Groep (2005; 2007; 2008); Ministerie voor Jeugd en Gezin (2007)

called 'indicated youth care', with the exception of youth mental health facilities) also increased with more than 70%, mostly awaiting day care. Outcomes of the Social Entrepreneurs Association for welfare, youth and child care in 2005, showed that the numbers were continuing to grow. Expectations were that between 2002-2005, the need for specialized care offers facilities would grow up to almost one hundred and fifty percent. The government launched a plan of action and allocated a large sum of money to deal with the problem. As a result, in February 2007 the parliament was able to announce that the waiting lists were virtually solved. Shortly after, the figures of the Branche organization and the Ministry for Youth and Family showed that the waiting lists are once again growing rapidly. The latest reports render mixed messages: on and off the waiting lists seem to be growing longer, while other surveys claim that the situation in under control.

Considering the used definitions and assessment periods, it appears that the general trend is indeed a considerable increase of care users in youth care (Table 1). The production figures indicate that more clients are being served every year (also see de Graaf e.a., 2005). According to the Social and Cultural Planning office (SCP), the number of users of the regionally financed youth care services has increased by 7.4% on average yearly in the period 1997-2007. On top of this, the SCP predicts even more growth in the years to come (Stevens e.a, 2009). This would equal a doubling of the total of provided services in youth care over a period of ten years. The need for care in youth mental health care facilities is also growing, although some of the figures seem to be contradicting each other, depending on the counting method and on developments in the funding principles of the care offer. A careful –unauthorized- estimate warns us for an annual average increase of care users of 12.5%.

Table 1. Increase of specialized service use in the Netherlands

Type of specialized care	Period	Average increase (per year)
Youth care	1997-2007	± 7,4% [1]
Youth mental health	2000-2007	± 12,5% [2]
Special education for children with psychiatric and psychosocial disorders ('Cluster 4')	2003-2007	± 17,5% [3]

1 Source: Sociaal Cultureel Planbureau, 2009
2 Different estimates exist. This one is based on De Graaf e.a. 2005; CVZ & Prismant 2004; Letter of minister Rouvoet to Tweede Kamer (date Nov. 08 2007 and Oct. 10 2008
3 Source: www.cijfers.minocw.nl, 2009 (uncorrected average: 29,1%)

Special educational services

Next to this, a trend that deserves to be investigated is the explosion of requests for special educational facilities for children and youth with psychiatric and psychosocial problems (mainly serious behavioural problems). This so called 'Cluster 4' of special education showed an increase of 55% in applications over the period 2000-2005. In 2006, the Ministry of Education, Culture and Science reported that the realization of one thousand additional

ZMOK positions (for maladjusted children with serious behavioural problems) set off in 2005. Expectations were that in 2006 all of the one thousand positions would be filled. Recent data seems to confirm this: over the years 2003-2007 the department reports a relative increase of the cluster 4 educational programmes of 216 percent, equalling around thirty percent a year (www.cijfers.minocw.nl, *Relatieve ontwikkeling clusters (v)so*, download of 20-02-2009). However, this may be a misleading figure due to the system change in the years 2003-2004. If we correct the growth figures, an average annual increase 17.5% seems likely. If this trend persists, the number of children admitted to the Cluster 4 will double over a period of five years.

In addition, the Rebound-services are coming on strong, i.e. services for maladjusted youth of secondary school age who have dropped out due to serious behavioural problems. According to a leading agency on this matter (the APS), the budget for this facility rose with 33% in the years 2005-2006: from 14,4 million euro in 2005 to 19,3 million in 2006 (www.schoolenveiligheid.nl, download of 22-11-2006). In 2006, the Ministry of Education reported that the Rebound facilities provided 850 positions for over 2.700 students per year. Aim in 2006 was to create 1.500 postitions for 4.500 students (also see De Greef & Van Rijswijk, 2006; Ministerie van OCW, 2006). Recent numbers show that this has been achieved (Van der Steenhoven & Van Veen, 2008).

Looking at these figures, it is clear that we are dealing with an ardent increase of the use of care services in multiple sectors. This is partly due to the number of clients requiring a combination of care from different sectors (for example youth care combined with a cluster 4 programme). Another possibility is that part of the growth is generated by a 'cross-over' effect: young people leaving youth care enter special education programmes (and visa versa). Although there are no exact figures, no one can deny that, as we speak, a fast growing portion of the population is appealing to specialized facilities.

3. What is going on?

How can we explain this increase of care consumption? We can't blame it on the growing number of 0-18 year-olds in the Netherlands, which is less than one percent per year (Stevens e.a., 2009). Also, the huge need for facilities is a rather paradoxical assumption, as one of the outcomes of the research was that the sector still lacks effective early recognition methods. This leaves us wondering what will happen if recognition and reporting practices are improved considerably. Should we expect another explosive increase of the use of care in the years to come?

Maybe the need for care in our present society is growing. In this case the growth figures indicate a positive development: the offer is growing to meet the demand. However, it is important to keep a critical view. From a societal perspective, the increased need for specialized care could also signify some form of social extrusion: anyone who suffers from

anything will have a special facility to go to. Also, the heightened availability of special care services can have a perverse effect: the responsibility for the problems of young people and/or caregivers may be passed on and on until it ends up in the specialized circuit.

However, even though intentions were noble, we have to ask ourselves whether our system of services is all it should be. Does our care system operate effectively? This is what I will be investigating in this article. Looking at the system from this angle I will start by describing four general observations.

Dealing with common parenting issues

Firstly, as much as 36% of parents with children who still live at home report that they have worries about the upbringing or development of one or more of their children at least once during the past year. Sixty percent of these parents ventured outside the family or circle of friends for advice and/or support (CBS, 2008). Apparently, many people are not sure how to deal with the common problems of their children (like refusing to eat or sleep, oppositional behaviour, adolescent behaviour, incidentally drinking too much etc.). A lot can be improved in this field, but this automatically leads us to the following problem.

Locating the 'light services'

There is no clarity on where to find the ´light services´ to smoothly and effectively support the majority of youth and families. Services for light pedagogical support are seriously fragmented. Recommended is:

- A clear positioning strategy on where people can go for light, direct pedagogical support;
- A clear description of the available services, their total offer (who it's for) and the rationale behind it.
- A clear and unambiguous route to contact and mobilize the available services.

Here, an important role may be allocated to the newly planned Centres for Youth and Families.

Measuring effectiveness

Problem number three is the lack of proven effectiveness of the interventions used in the Dutch system. Over the recent years, three large-scale surveys were conducted on the existing light care:

- *Hermanns & Vergeer (2002)* concluded that the quality of the available parenting support is poor and that the services are mostly incompatible and uncorrelated.
- *Verdurmen e.a. (2004)* used foreign studies to illustrate that prevention can be effective, while in the Netherlands there is no clarity on currently used interventions. Furthermore, the authors state that, in general, the effectiveness of interventions is hardly monitored or measured.
- *Prinsen (2006)* reported that Dutch research shows that out of the 55 parenting support interventions in youth care, only three indisputably proved to be (partly) effective. Fifteen interventions seem promising, as their theoretical bases are well grounded, but they have not yet been assessed in terms of effectiveness.

Thus, although we can safely say that prevention is likely to be effective, too few interventions have been systematically assessed in the Netherlands.

If we shift our attention to the effectiveness of youth care we can detect a similar trend. Van Yperen (2005) concluded that the meta-analyses that were conducted during the past years have shown outcomes between .40 and .80 (on the scale Cohen's d). However, most of the treatments from these studies appeared to be fully developed, 'evidence-based' methods, instead of youth care as it is usually practiced ('care as usual'). Furthermore, Veerman & Van Yperen (2007) report that many of the 'evidence-based' interventions are hardly implemented. For the latter category ('care as usual'), Van Yperen (2005) estimates an effectiveness rating of .40. This is as much as saying that, on average, regular youth care merely has a minimal effect, albeit a rough estimation. As we speak, the Netherlands Youth Institute is conducting a large-scale survey to provide a more substantial reflection of the actual situation.

Follow-up support
The fourth problem is the fact that follow-up support after specialized care is not properly organized. The local offer is often positioned as the 'preliminary field', which precedes youth care. I think that this is a rather limited assumption, as the local services can be considered as both the 'preliminary field' as the 'follow-up field'. An important pedagogical task for the local field is to prevent young people and caregivers from relapsing into their problems. This way, they work to sustain outcomes that were achieved through youth care and special education. Strangely enough, in the fields of practice, research and policy this aspect of care is hardly considered, even though it is nothing less than a prerequisite for an effective care system. Needless to say that some serious changes need to be made here.

4. Reconsideration

Looking at the situation now, we find that part of the problems lead to a system that virtually promotes the transition to specialized facilities. At the same time we can observe that the problems are constipating this same system:

- Poor provision of information and support for caregivers with common parenting problems might push them toward specialized facilities sooner than necessary.
- Recognition and identification in the preliminary field without effective early interventions to adequately service most clients, causes the number of referrals for specialized facilities to explode and pile up.
- Admission to youth care without available and workable effective youth interventions leads to a defective system of transferral and a pile up of problem cases in the sector.
- Admission to youth care without a sufficient follow-up system, leads to a stagnation of clients leaving care and a higher risk of relapse in various ways.

Knowing this, it is clear that we need to reconsider the structure and operations of the entire system. We need to formulate an explicit and mutual pedagogic vision to form the basis. In

addition, the positioning and quality improvement of local services for prevention and light care needs to be improved. It is my hypothesis that this will successfully prevent eighty percent of the total client population from having to enter the spectrum of specialized care. For the other twenty percent, two things should be properly organized:

- Investing in specialized care by constantly working on effectiveness and efficiency.
- Investing in the 'aftermath', by providing better follow-up care for young people and their parents that are leaving youth care and/or special education, in order to make sure their positive outcomes are sustained and normalized.

Part of this plea has been buzzing around in the sector for a while now. The reconsideration should focus on concrete descriptions and definitions with regard to risk and problem groups. This is where a change is crucial. Where we used to speak of investing in prevention in general, now is the time to build a chain of services around a specific, common problem or risk group, starting from 'basic' to 'preventive' and 'light' to 'specialized' and back again. Each of these facilities should offer services that are designed to keep clients out of specialized care as much as possible.

5. Changes

In order to achieve the desired demarcations, at least five things need to be realized. I will shortly discuss each of these assignments.

Basis: unity in policy

A truly effective system is based on unity in policy. Tackling the waiting lists in youth care requires more than a policy on waiting lists with specific youth care facilities. It requires an integral policy focussed on decreasing the number of clients applying for specialized services – in youth care as well as in special education – by heavily investing in the education and informing of parents and other (professional) carers and in the local prevention and light care services of youth health care, child day care services, the regular educational system and other relevant bodies. The new Ministry for Youth and Families was erected to create unity in policy. However, in reality the special education facilities for children and adolescents with problem behaviour are still the main responsibility of the Ministry of Education, youth health care still belongs to the Ministry of Health, and the youth probation facilities to the Ministry of Justice. As a result, centrally organizing the desired and valuable collaborations between these facilities is no easy task.

Pedagogical vision

Our system should be grounded on an explicit and evidence-based pedagogic vision. This vision describes the development of healthy youth and the characteristics of a healthy upbringing. In this vision, special attention should be paid to the fact that many problems are completely normal, as we also know from research and literature on pedagogic and developmental psychology. Feeling down, anxiety, hyperactivity and aggression are all common with children. Many of these problems are related to the child's developmental age.

To identify a particular behaviour as a serious problem we need to look at when the behaviour occurs, how long it persists and how intense it is. Figure 1 is an adapted survey from Van Yperen (1994). Many professional caregivers have worked with similar schedules during their training.

Age	Important contexts	Developmental assignment	Parenting assignment	Normal behavioural problems	Examples of behavioural disorders, in terms of timing, duration or intensity
± 0-2 years	Family; Day care	Physiological self regulation; safe bonding; exploration; autonomy and individuation	Easy-going care; offering sensitive and responsive interaction; availability; providing space and support	Feeding problems; sleeping problems; separation anxiety; fear of strangers, of the dark and of sounds	Eating/sleeping disorder; reactive attachment disorder; fussy baby
± 2-4 years	Family; Day care; (Pre)School	Representative skills (e.g. language); constructive relationship with peers; internalisation of demands (like being potty trained); gender-identification	Sensitivity for cognitive level; positive and confirmative parenting; dealing with ambiguity of children; disciplining; genderspecfic approach	Fear of strangers, darkness, sounds; stubbornness; tantrums; aggression; disobedience; restless behaviour/hyper activity; anxiety combined with gender and identity; not toilet trained	Separation anxiety; phobic/social anxiety; speech/ language disorder; locomotion problems; encopresis; ADHD; behavioural problems in the family; oppositional behavioural problems of younger children.
± 5-12 years	Family; School; Peer group; Associations	Decentration; academic skills; industry; peer acceptance	Allowing/ enabling relationships with peers; academic education; validating academic achievements; democratic and warm parenting	Fights; concentration problems; low achievement; refusal to go to school; occasionally stealing or vandalism; ritualistic behaviour	Enuresis; learning disorders; social withdrawal; persistent refusal to go to school; (gender) identity disorders or early delinquency; neurosis and somatoform disorders
± 12-16 years	Family; School; Peer group; internet communities Associations; People at work; Other social-cultural fields	Emotional (and practical) independence; dealing with people from same sex and opposite sex; developing a norm system: personal identity, school, trade and society	Offering emotional support; allowing experiments; offering age appropriate boundaries; setting an example; developing a more symmetric parent-child relationship	Experimenting with drugs or alcohol; doubts about identity, appearance and/or future; problems with authorities; occasional truancy	Problems caused by alcohol and drugs; identity disorder; anorexia and bulimia (nervosa);) problems with sexual maturation or orientation; suicide; adolescent oppositional behavioural disorder (with peers); delinquency ; drop-out

Figure 1. Survey per age stage, normal behavioural problems and behavioural disorders

As many problems are commonplace, dealing with these problems should be part of the regular parenting duties of parents, professional carers (day care nurses, teachers) and communities like the neighbourhood and municipalities. Within the morally and socially acceptable boundaries in our society, each caregiver has his/her own way of dealing with this task. At the same time, they should not stand alone in their quest. Parents, teachers and other (professional) carers should be supported in their duties. This way, there will be less risk that normal problems turn into serious ones and less people will need specialized care. The content of this particular support is based on scientific knowledge on healthy parenting. This expertise offers a great source of different methods for caregivers to help young people overcome many of their 'normal' problems. For example, it has proven very useful to inform parents on effective parenting methods, which will prevent common oppositional behaviour

from growing into serious forms of behavioural problems (Speetjens e.a., 2007). During their training, teachers should be offered the entire scale of parenting skills that are associated with (dealing with) classroom behaviour. [2]

Enhanced recognition and improved referral

Professional carers and professionals with supporting roles have to have access to effective tools for recognition. This is the only way to adequately single out those children and parents that need special services in view of the duration and intensity of their problems. This also requires a quality assessment and improvement of the referral behaviour of professionals by:

- Providing more information on all available services to support young people and caregivers with various problems;
- Offering training in interviewing skills to identify which problems do or do not require specialist care;
- Promoting an appropriate attitude, that is, professionals should respect and really listen to young people and caregivers and feel responsible for helping them deal with their problems.

Institutes can get financial compensation for implementing a serious and clear quality assessment/improvement policy. Likewise, facilities that have no adequate quality policy may be sanctioned.

From recognition/referral to effective interventions

It is not enough to merely improve recognition and referral methods. In fact, this may even lead to an even more cluttered system. There is no use in being extra sensitive or recognizing needs really well if adequate support is not available. We have seen it all before in health care: don't start identifying before you have something to offer your clients. Furthermore, earlier on we concluded that no proper assessments have been conducted on the effectiveness of the existing support. However, we do dispose of a broad scope of useful interventions (see also www.nji.nl/jeugdinterventies), which are hardly used in practice (Veerman & Van Yperen, 2007). In fact, at the moment, a lot is going on in the field in terms of quality improvement.

In youth care, for example, a system is implemented to record the effectiveness of the work more systematically. I am referring to the so-called performance indicators for youth care outcomes (IPO, 2006), as well as to a major project wherein youth care agencies describe their programs, explain why these programs should work, and monitor their effectiveness (see a.o. Veerman & Van Yperen, 2007; Van Yperen & Veerman, 2008; also see www.sejn.nl). What is still missing is a policy to support quality oriented measures by rewarding organizations for developing and applying 'evidence-based' interventions, and sanctioning others who fail to undertake any action in the field of quality improvement.

[2] A similar concept is described in the report of the LCTI to the Dutch minister of education on the reduction of referrals to special education (LCTI, 2006).

Another important quality measure is the introduction of the Centres for Youth and Family. The assignment of these centres is to channel all registration and referrals to more specialized care. To avoid the risk of the Centres of Youth and Families becoming referral robots – leading to even more facilities for specialized care- the recognition of problems is to be linked to a rich offer of effective forms of light parenting and youth support. The centres aim to become the main providers of light pedagogical support for young people and caregivers. If the quality measures are successful, the Centres for Youth and Family will become effective, preventive agencies providing early interventions to clients that would otherwise have turned to specialized care services.

Effectively linking local and specialized care

It is imperative to put the general notion of more cohesion and collaboration between preventive and specialized services to practice by specifically focussing on frequent and 'normal' problems or risks. Every service should aim to keep clients from needing specialized care as much as possible. The core principle of working with this type of so-called 'stepped care' is that recognition and intervention are closely linked and organized by degree of impact and intensity, also known as 'vertical chains', 'a care continuum', or 'managed care' (see for example Tiemens e.a., 2004; Meeuwissen & Van Weeghel, 2003). Various facilities from many different sectors take part in the continuum, offering everything from basic care to very specialized and intense services. Two examples are added to illustrate this approach (figure 2 on the next page; also see Van Yperen & Van der Sar, 2005).

The first example (A) represents the prevention and actions against child abuse. Prevention starts with properly informing the public on effective parenting and the normal problems all (young) parents are bound to encounter. This includes the provision of active and passive information about effective parenting methods to deal with these common and widespread problems (such as fussy babies, sleeping problems, stubbornness, adolescent behaviour etc.). In addition, midwifes need to be trained to be sensitive to young mothers who are expecting their first baby whose situation contains many risk factors that might lead to neglect or abuse of the children after some time (e.g. single parent, no income, and a history of drug abuse). Based on this early recognition, nurses will visit these mothers on a regular basis to offer light support as described in the so-called 'Voorzorg prevention-programme' (based on the North-American program *Nurse Family Partnership / NFP*). Foreign research shows that this type of prevention has proven to be highly successful, the positive outcome being that the problems of a particular group did not develop into serious issues requiring more intense care. However, not all mothers are suited for this type of care. A number of them are 'resistant' in one way or another. This group should be offered a light intensive type of specialized family care. If necessary, additional effective care can be provided by youth care to support mother and child. As soon as the direct need for specialized care is over, youth care will retreat. It could even be useful to use the preventive programme for follow-up care to prevent mother and/or child from redeveloping serious problems in the next phase. As far as I know there is no such follow-up care system. It seems like an obvious choice that this follow-up is developed as soon as possible.

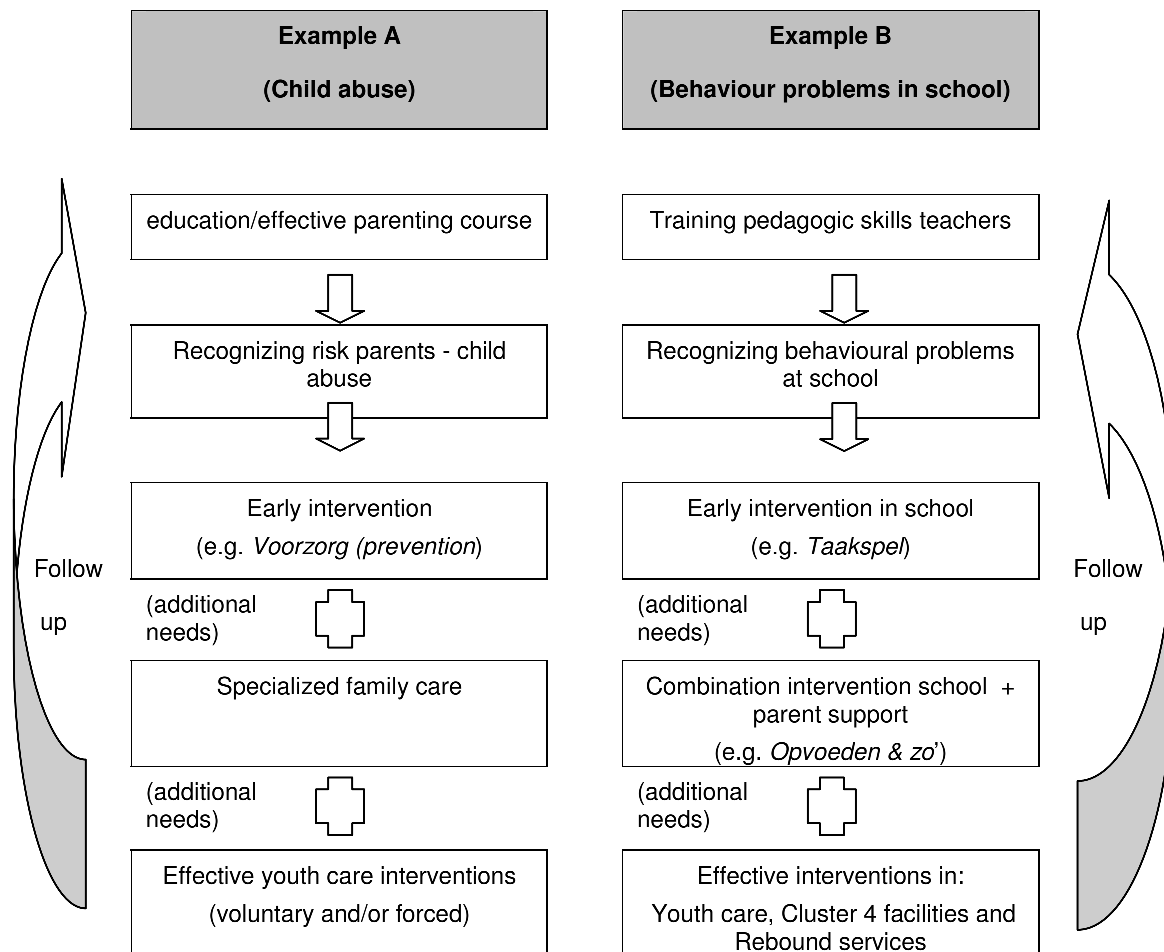

Figure 2. Examples of stepped care

The second example (B), is about youth with behavioural problems at school. The model starts with a description of the necessary basic circumstances for education, being that peace, regularity and safety are prerequisites; including room for both withdrawn and lively children. This entails that teachers should have a good deal of basic pedagogical competences to deal with individual and large groups of children. The key competences are described in many scientific studies. Teachers can be trained in these skills. Also, they will acquire competences to identify children with risk behaviour. Next, they can execute uncomplicated interventions to deal with frequent and common problems at the spot. One of these interventions is *Taakspel* (based on the North-American *Good Behavior Game*). This is a tool for teachers to react to early signs of problem behaviour by setting clear rules and deliberately emphasize positive behaviour. The teachers learn how to apply the key principles of positive parenting to individual children as well as to the group (i.e. the class). Research shows that students will be less inclined to display unruly behaviour, task oriented behaviour improves and withdrawn students manifest themselves more clearly (Van Lier a.o., 2004; Van der Sar, 2004). Again, not all childre are receptive to this approach. This group of

students might benefit from a combined offer of *Taakspel* with the parent support method '*Opvoeden & zo*'. Yet another select group requires a well-designed youth care offer, like the programmes '*Zelfcontrole*' (self control) and '*Minder Boos en Opstandig*' (based on the North-American *Coping Power Program*). If these students do transfer to the cluster 4 or a Rebound facility, a workable, effective specialist offer must be at hand, as well as effective follow-up care to sustain positive outcomes after the children return to their 'normal class'. They might be susceptible now to the positive effects of *Taakspel*.

So this is how its going to be?

Some side-notes have to be made with regard to the stepped care models. Firstly, they do not prescribe a fixed and mandatory route. Any children with a serious high risk of becoming victims of child abuse, or children who are displaying extreme hyperactive or cruel behaviour should quickly be referred to highly specialized care. Without the option for this direct route, young people, carers and the system will be forced to follow all the steps in the chain at all times, which will only cause more stress.

Secondly, there are numerous problems that could do with a chain like these. The question is whether it is wise to invent a chain for every single problem and whether they should all be invented simultaneously. Just realizing a chain of services consisting of prevention, recognition, early intervention, referral, specialized care and follow-up care for the top ten or top fifteen of the most common problems with young people and carers, would represent enormous progress. It would certainly be a huge improvement of the current situation. In addition, it is important to understand that prevention of many different problems mostly comes down to enhancing the basic principles of effective (professional) parenting. In this sense, it might be useful to represent the chains for the prevention and tackling of common problems as a fan, with a nucleus containing the normal (professional) parenting practices, and the sprigs representing the specialized care offers. This is visualized in figure 3 on the next page (figure 3 is rendered without follow-up arrows).

A third additional remark is that the chains might suggest that clients move up from one stage to the next if their problems appear to be more serious: for example, a child with behavioural problems that doesn't respond satisfactorily to *Taakspel* and/or caregivers' parenting training, will move on to youth care, parents and all. This is *not* what the chains are suggesting. The clients are not to be moved on. Or better-said, specialized care is *moving in*, mostly on a temporary basis, while, ideally, the child stays in its familiar school, in its own neighbourhood, with its 'own' Centre for Youth and Families. As soon as possible the specialized services withdraw. To sustain the outcomes of youth care it is crucial to recognise any early signs of a (possible) relapse and implement preventive measures and early interventions to avert additional youth care intervention. This is why it is imperative that, instead of allowing children and families to move on, specialized care is moving in. It is, in fact, the only way to create a seamless chain.

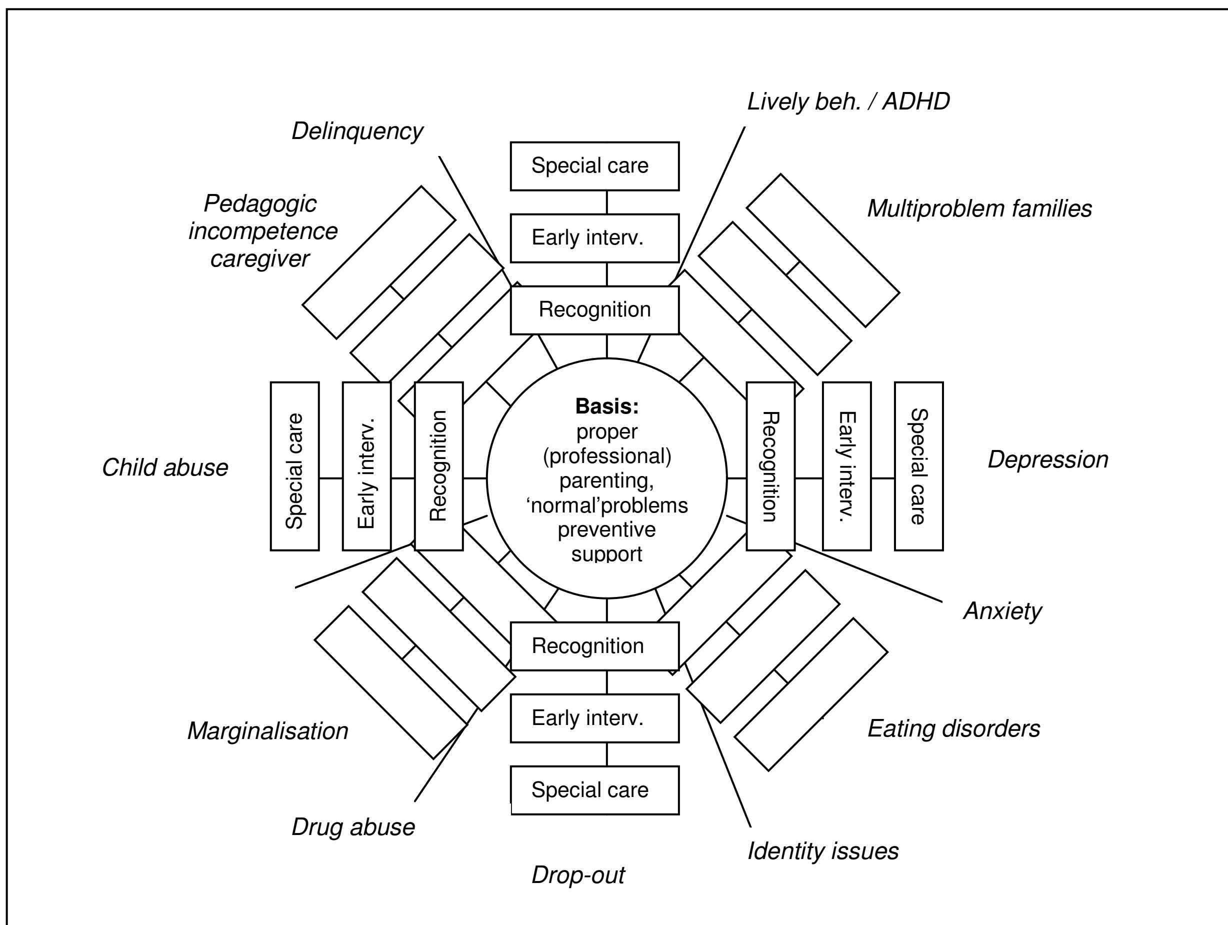

Figure 3. A pedagogic basis with specialized sprigs

Fourthly: experiments in the United States, including the well-known Fort Bragg experiment, have shown that vertical chains do not self-evidently lead to better care (faster intake, less clients in specialized care, cheaper; also see Bickman, 1996; Hoagwood, 1997). In fact, they may just as easily lead to the opposite effect, more people waiting to be served and a dearer offer. This would be true if building this type of chains only consisted of better identification of (risk of) problems and mapping and linking existing services and programs. Achieving more efficiency and more effectiveness is only possible if every part of the chain is trusted with a truly effective offer. Otherwise, the chains won't solve anything. A great deal of knowledge to fill the sections is already available. The tricky part is really using this knowledge to its full effect.

A fifth point that I would like to make is that the ambition of an effective prevention, recognition and (early) intervention should always be shared by all relevant organizations. In practice the chain is usually cut up and divided between the regular educational services (school, day care, social work), youth health services, specialized youth care facilities etc. Each of these services should position itself as an effective part of the chain, aiming to avert the need for (even more) specialized care. This way the number of clients applying for

specialized care should decrease considerably. Obviously, a decrease is favourable from a financial point of view, but it is even more favourable for the youth and carers involved: preventing problems from developing into serious issues requiring specialized care. And this is exactly where facilities should assume accountability. For example, a school that is referring a considerable number of students to the Rebound facilities needs to reconsider its prevention policy. Are the teachers capable of keeping 'troublesome students' with the programme? And municipalities that find that a lot of their youth is applying for specialized youth care should wonder whether their Centre for Youth and Families is equipped adequately. Earlier on I introduced the following assertion: Eighty percent of the people that are currently served by specialized facilities can be 'intercepted' by a quality improvement of local services with regard to prevention and light care. My wish is that schools and municipalities that are responsible for the Centres for Youth and Families formulate similar ambitions: we will effectively serve eighty percent of the young people and caregivers that would otherwise be referred to secondary care services.

6. Conclusion

In summary, we have identified an unfavourable increase of the number of clients in youth care, cluster 4 educational facilities and the Rebound facilities. This outcome should lead to a thorough reconsideration of our system. Cluttering the care and support system can be prevented by:

- Unity in policy;
- Formulating a general, explicit and evidence-based stance;
- Widely implementing recognition tools that are directly linked to a databank of workable effective interventions;
- A well-designed system based on important pedagogic principles with a local offer and special services aimed at commonly identified risk and problem groups;
- Building the system on an accessible, detailed and evidence-based (measurable) care offer.

The overall aim should be that in the near future, a large portion of the young people and caregivers that is currently still referred to specialized care services, is effectively served by a preventive or light care offer, in order to avert the need for further referrals. To achieve this, we need to make use of the very rich source of data, knowledge and expertise that is available to us.

7. Literature

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