

## Different sizes, similar challenges: Out of home care for youth in Germany and the Netherlands

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### ABSTRACT

While there is a large difference in the number of young inhabitants in the Netherlands and Germany, their child protection frameworks are quite similar. In both countries, child protection services are mainly focused on youth aged 0 to 18 and regulations are aimed at clients' responsibility and their active involvement during care. Youth care services consist of community-based services, day treatment and out-of-home care services, which include foster care and residential care. The history of out-of-home care services in both countries is characterized by similar developments. Over the last four decades, similar trends in residential care, towards more small-scale forms of residential care, smaller residential group sizes, and increasing professionalization of staff have emerged. Over the last two decades, a comparable trend towards increasing professionalization can be seen in the context of foster care in both countries. In addition, the number of youths in out-of-home care increased in both countries over the last decade, specifically in foster care. Over the last decade, more studies have been conducted in residential care than in foster care in both countries. Despite similar trends and developments in out-of-home care practice, research mainly shows differences in applied topics and methods between Germany and the Netherlands.

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### Tamaño diferente, retos similares: Medidas de protección a la infancia con separación familiar en Alemania y Holanda

### RESUMEN

A pesar de la gran diferencia en el número de habitantes jóvenes entre Holanda y Alemania, sus estructuras de protección de la infancia son muy semejantes. Los servicios de protección de la infancia en ambos países se centran fundamentalmente en los jóvenes entre 0 y 18 años y la reglamentación va dirigida a la responsabilidad de los clientes y su compromiso activo durante el acogimiento. Los servicios de protección a los jóvenes constan de servicios comunitarios, el tratamiento de día y los servicios de protección con separación familiar, que abarcan el acogimiento familiar y residencial. La historia de los servicios que implican separación familiar en ambos países se caracteriza por desarrollos semejantes. En los últimos cuatro decenios han surgido tendencias semejantes en el acogimiento residencial más encaminadas a modos de acogimiento a pequeña escala, menor tamaño de los grupos residenciales y una mayor profesionalización del personal. En los dos últimos decenios puede apreciarse una tendencia comparable hacia una mayor profesionalización en el contexto del acogimiento en ambos países. En el último decenio se han llevado a cabo más estudios sobre acogimiento residencial que sobre acogimiento familiar en ambos países. A pesar de las tendencias y desarrollos semejantes en la práctica de las medidas de protección con separación familiar, la investigación muestra principalmente diferencias entre Alemania y Holanda principalmente en los temas y métodos aplicados.

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In the Netherlands, the current total population of 16.8 million includes almost 3.5 million people (20.6%) between the ages of 0 to 17 (CBS, 2013). In Germany, the total population is nearly five times larger. Based on the current census, 80.5 million people were living in Germany in 2011, and 8.1 million families had children under the age of 18 (Statistisches Bundesamt, 2013a). In 2010, there were 13.3 million German inhabitants under 18 (16.3% of the population). Within the population of young people aged 0 to 17 in the Netherlands, 16.5% have a non-Western background (CBS, 2013). In Germany, almost one third of those under 20 have what is called a 'migration background' (i.e., living in Germany as first, second, or third generation) (BMFSFJ, 2013).

The most recent figures show that the fertility rate in the Netherlands is 1.7, which is somewhat higher than the rate in the 1980s and 1990s (CBS, 2013). In Germany, the fertility rate has been approximately 1.4 since the 1990s (BMFSFJ, 2013), slightly lower than the rate in the Netherlands. In both countries, the cohort of women who could potentially give birth is continuously decreasing (BMFSFJ, 2013; CBS, 2013).

Germany and the Netherlands are characterized by somewhat different welfare regimes (Gilbert, 2012). In Germany, it is considered to be mainly conservative, with a social-pedagogical tradition. This means that a) generally the services provided are seen as a right which enables people to sustain a living without participation in the market, b) society promotes social solidarity and reduces inequality, and c) the state provides support to the existing structures. In the Netherlands, the welfare regime can be characterized as social-democratic with liberal tendencies. This means that a) there is a high tendency for the services provided to be seen as a right enabling a sustainable living without participation in the market, b) that society highly promotes social solidarity and reduces inequality, but that c) there is also a high degree of stratification, with the aim of freeing up the market and improving individual choice (Stein, 2013). Despite this difference in general orientation, the child-welfare systems in Germany and the Netherlands are considered to be family-service oriented, meaning that the mode of intervention is therapeutic and focused on needs assessment. The state-parent relationship is conceived as a partnership in which the state seeks to strengthen family relationships and voluntary out-of-home placement (Gilbert, 2012). Accordingly, child and youth services emphasize the participation of young people and their parents in decision-making processes (Knorth, Van den Bergh, & Verheij, 2002; Rätz-Heinisch, Schröer, & Wolff, 2009).

Child and youth care services in the Netherlands look after minors from the ages of 0 to 18. In cases where it would be irresponsible to terminate the care process or in the case of a court order, young people from the ages of 18 to 23 are also offered child and youth care services. In Germany, the legal framework pertains to all young people to the age of 21 and can be extended to the age of 27 in any cases involving serious disabilities caused by psychological impairment. In current practice, most care leavers are not older than 18 years (Köngeter, Schröer, & Zeller, 2012).

## The Netherlands

Until the end of the 1960s, youth protection services in the Netherlands were segregated and mostly run by Catholic and Protestant organizations. The dominance of these organizations diminished during the following two decades. From the end of the 1960s until the 1980s, requests for youth protection services showed a considerable decline. During this period, Dutch youth protection services were often reproached for being overly involved in the private lives of children and their parents. There was severe criticism of youth protection services by clients and ex-clients, some professionals, and intellectuals, and also by the Dutch government and politicians (Dekker et al., 2012).

At the end of the 1970s, the fragmentation and compartmentalization of youth care services led study groups to advise that reorganization of youth care in the Netherlands was necessary (Konijn, 2004). The compartmentalization of services concerned the organization of care into three sectors -youth care services, youth protection, and mental health care services for youth. A guiding principle in reframing and coordinating youth care policy was (and still is) that, as far as possible, care services should be non-intrusive, close to a child's home, and of short duration. The previous Youth Care Act [*Wet op de Jeugdhulpverlening*], which came into force in 1989, explicitly implemented this policy principle.

With regard to out-of-home care for youth in the Netherlands, from the end of the 1960s until the 1980s there was an under-utilization and closure of many residential youth care facilities due to severe criticism of these services. This decrease in residential youth care capacity continued until the 1990s. In addition, there was a decline in the number of large facilities, a decrease in the residential group size, and a growth in the number of group care workers for each residential group. New kinds of generally small-scale residential care facilities came into fashion. From the 1990s, there was a restoration of the image of residential services and a slight recovery in residential youth care capacity (Dekker et al., 2012).

Over the course of the last four decades, residential care in the Netherlands has also been undergoing a process of increasing professionalization. During the 1950s, there was a decrease in the appeal of unqualified staff. It became increasingly self-evident that care workers should be educated and certified. The number of higher educated staff in residential care also increased from the 1960s. From the 1990s, an increasing number of positions, including that of group care workers, required a certificate of Higher Professional Education. In 1980, for instance, only 24% of group care workers had a higher professional education degree and none had an academic degree. In 2000, these percentages had risen to 85% and 3% respectively (De Swart, 2011, p. 31). Currently, unqualified and voluntary staff have almost completely disappeared (Dekker et al., 2012).

As occurred in residential youth care, foster care placements in the Netherlands decreased from the end of the 1960s until the 1980s. However, foster care was more likely to be appraised as a less expensive form of child protection service and showed a structural growth in proportion to residential youth care from the 1980s (Dekker et al., 2012). Foster care has been explicitly acknowledged as a separate, independent form of youth care in the Netherlands since 1989, when the previous Youth Care Act came into force. Important foster care provisions were created by that Act, substituted by foster care providers with the passing of the 2005 Youth Care Act [*Wet op de Jeugdzorg*] (Strijker & Knorth, 2007).

Over the course of the last two decades, foster care in the Netherlands has been undergoing a process of increasing professionalization. For example, therapeutic foster care emerged as a new type of foster care during the 1980s (Dekker et al., 2012). During the 1990s, the organization of foster care services radically changed through a disentanglement of the referring agencies from those providing foster care services and an increase in the scale of foster care provision. Increased attention was also paid to improving the quality of foster care referral criteria and to gaining better insight into each child's problems and background in order to respond more adequately to their needs (Strijker, Zandberg, & Van der Meulen, 2002).

### Child protection framework

The most important legislation in the Netherlands on youth at risk and their families can be found in the current Youth Care Act which has been in effect since 2005 (Van den Berg & Vlaardingebroek, 2005). Child day care falls under other legislation, as does legislation regarding education, the juvenile justice system or working

conditions for young people. According to the Youth Care Act, children admitted into care by a Youth Care Agency [*Bureau Jeugdzorg*] can claim their right to actually receive youth care. In the current situation, youth care in the Netherlands is considered to be a market, with a continually growing number of youth care providers who are supposed to operate as market parties (Dekker et al., 2012). The point of departure in the current Act is effective and efficient client-focused and needs-based care (see article 24(1) of the Youth Care Act). In the near future, the current Youth Care Act will be replaced by the Act on Care for Children and Young People (Netherlands Youth Institute, 2012).

The aim of the current Youth Care Act is twofold (Netherlands Youth Institute, 2007): a) to ensure that better care is made available to young people and their parents and b) to strengthen their position as clients in the youth care process. Youth policy in the Netherlands is increasingly focusing on client participation and on the clients' active involvement in the decisions that determine their future (Knorth, 2002), with the clients (i.e., young people and/or their parents) to be at the centre of a more transparent, simpler youth care system. This principle is reflected in five policy objectives (Van den Berg & Vlaardingerbroek, 2005): a) the needs of the client come first, b) clients are entitled to youth care, c) there is a single, recognizable access point to the youth care system, d) other services such as reporting and consulting on child abuse and neglect, guardianship, family guardianship, and youth probation should be integrated, and e) there should be more emphasis on family coaching and support.

Looking at how child and youth care services are organized (see Figure 1), a central organization we come across is the Youth Care Agency (YCA), which is the primary access point to facilities for intensive, specialized youth care.

The YCA works in close cooperation with the Child Care and Protection Board [*Raad voor de Kinderbescherming*]. This organization investigates families and advises the juvenile court magistrate as to legal measures (such as a family supervision order) when a child's physical and/or psychological development is endangered by inadequate pedagogic treatment and it is clear that intervention is required.

Every province has one central YCA as well as a number of regional branches (Knorth et al., 2003). Its primary function is the screening

and identification of problems related to raising children and their development, and –as a consequence of this– advice and referral to intensive or specialized forms of care, such as intensive community-based or home care, day treatment, foster care or residential care. Government policy requires that community-based services (ambulant care) should be considered firstly, day treatment second, and foster care in the third instance. If these care provisions do not seem appropriate or the options are exhausted, residential care will be considered (Strijker & Knorth, 2007). This implies that with regard to out-of-home care placements, foster care should be given preference over residential care. Adoption only occurs when the mother decides to give up her child at birth.

Residential youth care in the Netherlands can be offered by different types of facilities, ranging from small-scale residential groups in residential neighbourhoods to large residential facilities outside residential neighbourhoods. Depending on the type of facility, the residential care environment for young people can be open, semi-secure or secure (Harder, Knorth, & Zandberg, 2006). The residential groups often consist of six to twelve children or adolescents. In many facilities there are separate groups for boys and girls, but there are also facilities with mixed gender groups (Boendermaker, Van Rooijen, & Berg, 2010). Overall, there are four different types of residential care in the Netherlands (see also Figure 1): a) provincial residential youth care (i.e., residential youth care services), b) inpatient mental health care, c) residential care for youth with mild mental disabilities (included in Figure 1 under b), and d) institution-based correctional services.

The provincial residential care facilities fall under the responsibility of the Dutch provinces. Residential care in this context mainly consists of residential groups that are focused on short-term (crisis and observation groups) or long-term stays (treatment and resident groups). In addition to residential groups, residential care is offered by independent living programme facilities and small-scale family homes (College Bouw Zorginstellingen, 2007; Stevens et al., 2009). The family homes, which on average accommodate three to four children in 'normal' houses in residential areas, are quite comparable to services such as Teaching Family Homes, SOS Children's Villages and Multidimensional Treatment Foster Care (MTFC) (De Baat & Berg-le Clercq, 2013). Care in these family homes is provided by

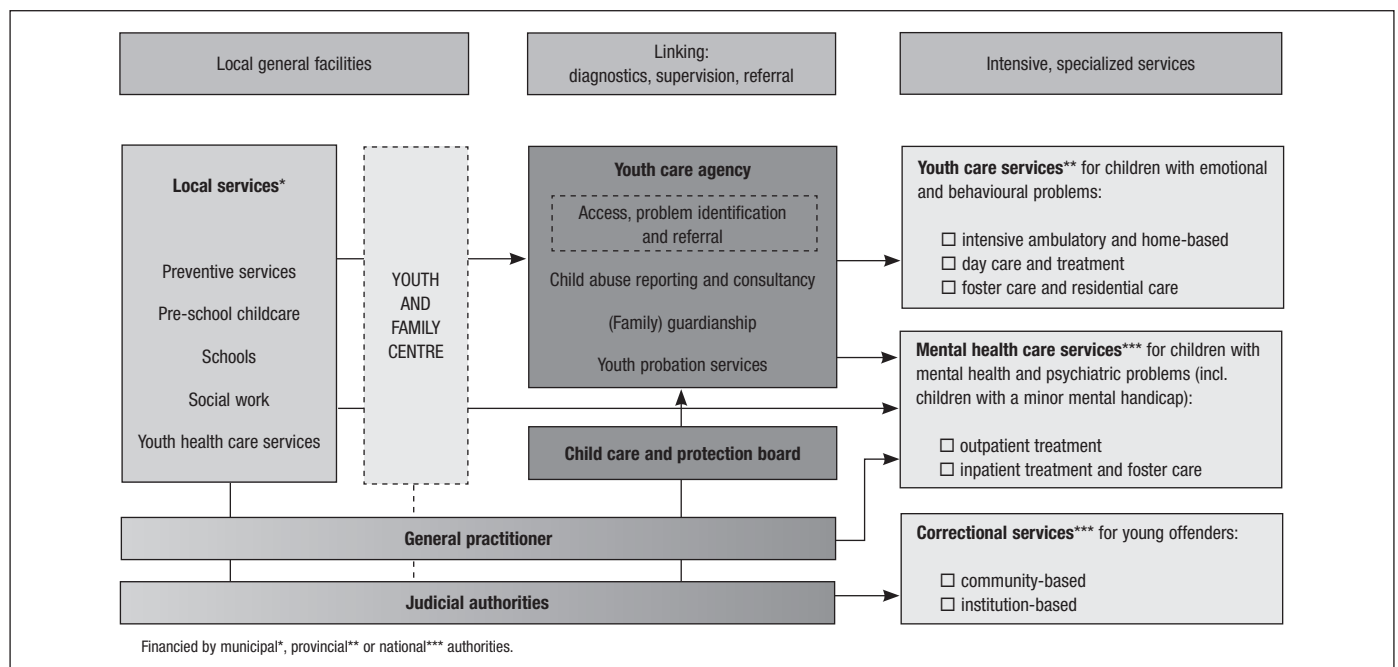


Figure 1. Dutch services and provisions for children, youth, and their families

parents of whom at least one is employed by a care provider or by a national franchise organization. In 2008, secure residential care centres also fell under the responsibility of the provinces. These centres offer care and treatment in a secure environment, and were created as a new type of residential care for young people with the most serious emotional and behavioural problems, who would previously have been placed in juvenile correctional institutions (Harder, 2011).

In the context of mental health care services, residential care is offered in the form of in-patient treatment facilities. There are fourteen mental health care providers for children and young people in the Netherlands, offering inpatient treatment for 3.2% of all children and adolescents that require mental health care services (GGZ Nederland, 2013).

Residential care facilities for children and adolescents with mild mental retardation take the form of 'orthopedagogical treatment centres'. Currently there are fourteen such centres in the Netherlands (VOBC LVG, 2013), offering both open and secure types of residential treatment (Stevens et al., 2009).

Juvenile correctional institutions are locked facilities and can be considered a form of incarceration, although care is also provided during the young people's stay. These facilities function in the context of juvenile criminal law. The rights of young people in juvenile justice institutions are captured in the Dutch Youth Custodial Institutions Act, which came into force on 1 September 2001 (Liefwaard, 2005). In addition to safety, the main points of interest in the Act are the care and treatment of young people in these facilities (see also Bruning, Liefwaard, & Volf, 2004). Currently, there are ten juvenile correctional institutions in the Netherlands (DJI, 2013).

In the Netherlands, there are two types of foster care that can be distinguished –kinship foster care, which includes network foster care, and (family) foster care (Strijker, 2010). Well over one-third (35%) of foster care arrangements concern kinship foster care (Strijker & Knorth, 2007). The quantity of kinship foster care is growing because the policy of foster care providers is focused on searching firstly for foster parents in the direct environment of the candidate foster child. Most common foster care modules are crisis intervention, reunification support, holiday foster care, weekend foster care, day foster care, observation/assessment foster care and long-term foster care (Strijker & Knorth, 2007).

Foster carers are considered volunteers who receive a reimbursement. They are recruited by regional care providers through advertisement or websites. The selection and preparation of foster families is often conducted with the 'STAP programme' (*Samenwerking, Teamgeest Aspirant Pleegouders*) [cooperation, team spirit, prospective foster parents]. Potential foster carers go through an intensive preparation in seven group meetings of three hours each, in which they can reflect on their fostering skills. Kinship carers have no obligation to receive this training programme (De Meyer, 2003).

Most Dutch foster care providers are part of multifunctional youth care organizations (MFOs), which are non-profit organizations that also provide other types of care. There are 32 foster care providers in the Netherlands, including 28 regionally operated foster care providers and four nationally operated providers. Two national foster care providers are Christian-based, one is specialized in the guidance of mentally disabled children and the fourth provides therapeutic foster care (Pleegzorg Nederland, 2013). The current Youth Care Act demands specific requirements be met when determining the suitability of aspirant or current foster parents, obliges foster care providers to offer support to foster parents, and stipulates whether the foster parents should accept the support of these foster care providers (Van Oijen, 2010). The Youth Care Act also includes regulations with regard to contracts between foster parents and foster care providers and the financial compensation for foster parents. In July 2013, a new act came into force that is aimed at improving the legal position of foster parents (Pleegzorg Nederland, 2013).

### Childcare figures

Although children in the Netherlands seem to be the happiest in the world, according to a new report released by UNICEF (UNICEF Office of Research, 2013), this does not imply that young Dutch people are exempt from problems. Between 10% and 15% of minors give cause for concern, and this includes the 5% of youth who give cause for grave concern. This latter group has problems that can be classified as serious to severe and as warranting long-term and intensive care (Knorth, Nakken, Oenema-Mostert, Ruijsenaars, & Strijker, 2008; Schnabel, 2008). Based on the most recent figures, we will mention a few of the problems here (cf. CBS, 2013; Youth Monitor CBS, 2013). For example, 8.8% leave secondary school prematurely, that is, without a qualification, and 30% of those not in school (aged 15-23) in the working population are unemployed. With regard to substance use, 69.8% of adolescents (aged 12-19) use alcohol, either incidentally or regularly, 7.7% actively use cannabis and 3.5% use hard drugs. Furthermore, 2.3% of adolescents (aged 12-25) have had dealings with the police or the legal system. With regard to Dutch families, 13.4% of youth under the age of 25 are raised by a single parent and 11.4% under the age of 18 are raised in a family that can be considered 'poor' (i.e., with an income up to 120% of the legal 'subsistence' level).

This profile of the problems may explain the fact that request for care is constantly on the rise. In 2004 –the most recent year for which dependable data are available (cf. Stevens et al., 2009)– about 205,000 young people (5.2% of children aged between 0 and 19) were being provided with some form of specialized youth care service. The latest dependable figures (Stevens et al., 2009) also reveal that in 2004 over 100,000 young people were registered with the YCA as *new* clients. Taken together, those not living at home –at least 40,000– make up about 1% of children aged between 0 and 19. This means that in 4 out of 5 cases registered with the YCA (79%) the child remained living at home; in 1 in 5 instances he or she was put into foster care or residential care. The direct reasons for admission to out-of-home care can be divided into two broad categories: a) inadequate care and support of the young person in their current social situation, often including the pedagogic incapacity of parents, and b) the individual problems of the young person, such as serious externalizing behaviour problems (Harder et al., 2006; Okma-Rayzner, 2006).

Although Dutch youth care policy concerning out-of-home placements shows a preference for foster family over residential placements, the number of children in residential care was generally larger than the number of children in foster care. However, numbers from 2010 show that there are currently more children in foster care than in residential care (see Table 1).

An increase of 11.5% in the total out-of-home care placements occurred between 2000 and 2010 (see Table 1). The rise in out-of-home placements might partly be explained by the fact that since 2004, youth care became a public issue, with services being accused of responding too slowly and in a limited fashion to children in risky environments. This criticism emerged after the death of a child who was already known by the relevant youth welfare office in 2004 (Dekker et al., 2012). The proportion of residential care in relation to foster care decreased in this period, with a decline of 23.6% for residential care placements and an increase of 72.2% for children and youth placed in foster care. This indicates that foster care placements have continued to be popular over the last decade, which might be due to the fact that it is appraised as a less expensive form of out-of-home care than residential youth care (cf. Dekker et al., 2012).

### Research review

A promising development that has emerged in the last couple of years in the field of youth care in the Netherlands, is the explicit



**Table 1**  
Numbers of children in out-of-home care (OOHC) and newly placed in adoption families: the Netherlands

	2000	2010
	N (%)	N (%)
OOHC: residential versus foster care		
Residential youth care	20,126 <sup>1</sup> (63.3%)	15,372 <sup>2</sup> (43.3%)
Family foster care	11,646 <sup>1</sup> (37.7%)	20,063 <sup>2</sup> (57.7%)
Total OOHC	31,772	35,435
Rate OOHC per 10,000 children	90	99
Family foster care: kinship and non-kinship care		
Kinship care	40% <sup>3</sup>	36% <sup>4</sup>
Non-kinship care	60% <sup>3</sup>	64% <sup>4</sup>
Total family foster care	11,646	20,063
Newly placed in adoption family		
National adoption <sup>5</sup>	42	36
International adoption <sup>5</sup>	1,161	684
Total adoption	1,203	720

Note. The residential youth care numbers do not include youth (0-17 years) in inpatient mental health care/child psychiatric provisions and youth with mild mental retardation in orthopedagogical residential care centres. The total out-of-home care numbers from 2010 do not include youth who were in residential or foster care for a very short period (weekend, short holidays) as the result of a family crisis (this concerns, in total, for all kinds of youth care in 2010, 11,393 children and adolescents).

<sup>1</sup>Sources: Stevens et al. (2009, p. 47); Knorth (2005, p. 16). This number includes 7,495 users in juvenile correctional institutions in 2002 (see Knorth, 2005). <sup>2</sup>Source: Jeugdzorg Nederland (2011, p. 13 ff.). This number includes 1,242 young people in juvenile correctional institutions. <sup>3</sup>Source: Bastiaansen (2001, p. 17). <sup>4</sup>Source: Pleezorg Nederland (2011, p. 3). <sup>5</sup>Source: CBS (2013).

attention being paid to evidence-based interventions in both research and practice (e.g. Van Yperen, Van der Steege, Addink, & Boendermaker, 2010). Following on from the 2005 Youth Care Act, there has been a trend for care providers to describe their interventions in terms of 'modules', so that the YCA is better able to decide what type of specialized youth care services should be brought into action. This has resulted in a large variety of specific youth care programmes (e.g., Loeffen, Ooms, & Wijgergangs, 2004). Since June 2007, these specific treatment modules for youth have been evaluated on their effectiveness by two national, independent committees. The 'Youth Interventions Accreditation Committee' assesses youth care interventions with regard to quality and effectiveness and issues accreditations. The 'Ministry of Justice Behavioural Interventions Accreditation Committee' assesses whether behavioural interventions can lead to prevention or the reduction of recidivism. If an intervention is evaluated as theoretically effective or empirically effective, it is included in the 'Database of Effective Youth Interventions', which is a searchable database of interventions in youth care, youth health care, youth welfare and criminal law (NYI, 2013). Although there are currently 207 interventions included in this database (NYI, 2013), few are specifically developed and applicable to youth in out-of-home care.

The explicit attention being paid to evidence-based interventions and 'what works' in care can be found in several Dutch studies on the outcomes of *residential youth care* undertaken in the last decade (Harder, 2011; Helmond, 2013; Nijhof, 2011; Van der Helm, 2011; Zegers, 2007). Most of these studies apply quantitative research methods, although often including sample sizes of less than 100 young people and/or care workers. For example, a very recently published PhD thesis studied the outcomes of EQUIP, which is a cognitive behavioural programme designed to motivate and teach antisocial youth to think and act in a well-considered manner, combining peer assistance with a skills training approach. The results

showed low to moderate levels of integrity for the EQUIP programme. In addition, EQUIP did not produce the expected positive outcomes for incarcerated youth, with low to moderate levels of programme integrity (Helmond, 2013). Several other studies also showed that effective implementation of new methods in Dutch juvenile justice institutions is difficult (Beenker & Bijl, 2003; Hendriksen-Favier, Place, & Van Wezep, 2010). Different factors, such as the safety and security policy in the centre and the tension between treatment and punishment, can obstruct the effective implementation of treatment programmes in secure residential care settings (Bijl, Eenshuistra, & Campbell, 2010). The lack of programme integrity might also be explained by the tendency of group care workers to rely primarily on their own personal styles and intuition in their contact with youth, which was found in another Dutch study that observed interactions between care workers and children in different residential groups (Van den Berg, 2000).

Several studies suggest that more attention needs to be paid to research on the type of skills that are necessary for group care workers to develop and maintain positive relationships with youth and a positive residential group climate during *residential care* (Bastiaanssen et al., 2012; Harder, 2011; Van Dam, Nijhof, Scholte, & Veerman, 2010; Van der Helm, 2011). For example, a recently completed PhD study showed that adolescents perceived the treatment skills of group care workers and teachers to be highly important for a positive relationship (Harder, Knorth, & Kalverboer, 2012a) and that positive adolescent-staff relationships were associated with higher treatment satisfaction for adolescents in secure residential care (Harder, Knorth, & Kalverboer, 2012b). In addition, in another study conducted with adolescents in secure residential care (Van Dam et al., 2011) and in a study with children in residential youth care (Bastiaanssen et al., 2012) it was found that group care workers exhibited more structuring and controlling behaviour towards youth with externalizing problems and more warmth and support towards youth with internalizing problems. Comparable results were found in other Dutch studies conducted several years ago (Kromhout, 2002; Wigboldus, 2002).

Another topic that emerges from recently completed studies in the Netherlands is the focus on the families of youths in *residential care*. For example, one of the PhD studies showed that positive outcomes can be achieved in secure residential care in terms of the functioning of these young people during care, but that there is little evidence of improvements in family functioning during this care (Nijhof, Veerman, Engels, & Scholte, 2011). Another quite recently completed PhD study showed that residential care can become more family-focused if specific attention is paid to family-involvement in practice. Such family-focused residential care is also associated with better outcomes of care in terms of treatment satisfaction, the realization of treatment goals and the perceived effectiveness of treatment, than the usual methods employed in residential care (Geurts, 2010).

There are fewer studies available within the field of *foster care* in the Netherlands. However, between 2001 and 2010, several empirical PhD studies were published (Strijker & Knorth, 2007). Some of these studies specifically focused on the comparison of foster children or parents with 'normative' children of parents. These comparison studies show that foster parents report higher levels of stress related to care and upbringing than 'regular' parents (Bastiaansen, 2001), that foster children are more likely than biological children to withdraw from conflict situations with their foster parents (Okma-Rayzner, 2006) and that foster children are less able to regulate their emotions and behaviour than children in 'normative' relationships (Oosterman, 2007). Another study showed that the legal positions of foster parents and foster children does not contribute to permanency (Punselie, 2006).

The focus of research in *foster care* has also been assessing the risk of foster care placement breakdown (i.e., premature departure)

(Strijker & Knorth, 2007). For example, one of the studies found that previous treatment of the child increases the risk of an unsuccessful foster care placement (De Meyer, 2003). A quite recently completed PhD study shows that children in foster care regularly (in 45.7% of the foster care placements) experience breakdowns in care (Van Oijen, 2010). These breakdowns were only predicted by foster child characteristics, with a higher age of the child at the start of placement, having received special education, a residential care history, and more serious behavioural problems of the child (as perceived by the foster parents) associated with a higher breakdown rate.

## Germany

Over the course of the last four decades, the residential care system in Germany has been undergoing a process of increasing professionalization. In the 1950s and 1960s, large residential homes were still common, mostly run by the churches, with unqualified staff, poor conditions in terms of food and schooling and very strict rules. At the end of the 1960s, a well-organized and somewhat radicalized student movement started to question the violations of children's rights within residential homes, resulting in major changes to the organization of residential care. From a present-day perspective, residential homes in the 1950s and 1960s are now conceived of as 'total institutions' (Goffman, 1957) and, more recently, care leavers from that time have successfully launched claims for compensation from the German government for the loss of their early years.

After the revelations of the 'Heimkampagne' [Home Campaign], the foundations for reform were laid (IGFH, 1977). Specialization, decentralization, and regionalization were the key concepts that led to smaller groups, family-oriented care and a differentiation of various group-home settings. The education of staff working in the residential group homes was substantially upgraded and consequently oriented to the theoretical framework of social pedagogy, which led to more innovative concepts and methods. At the same time, alternatives to residential care were discussed, and with the amendment of the Child and Youth Services Act in 1990 the idea of providing many different options for child-rearing support was encompassed in the term child and youth services (*Erziehungshilfen*). In addition, different forms of residential and foster care, and various forms of community-based and in-home family support services were also implemented.

In Germany, child and youth services are considered core fields of social pedagogy. The term 'social pedagogy' comprises both the profession and the academic discipline and is only approximately equivalent to the term 'social work' used in North America and the UK (Zeller & Königeter, 2012). Education in its broadest sense stands at the centre of social pedagogy, which in Germany is considered a sub-discipline of educational sciences and "encompasses all elements of living and learning as one unified process of developmental change and growth" (Gharabaghi & Groskleg, 2010).

### Child protection framework

In Germany, residential care provision, and child and youth services more generally, are governed by federal law, the Child and Youth Services Act/Social Code Book VIII (BMFSFJ, 2013), which determines the services and measures provided by the child and youth service system. The organization and implementation of this law, however, is the responsibility of the municipalities, more specifically the Youth Welfare Offices. Specific support is usually provided by not-for-profit voluntary organizations (care facilities). Children with physical and mental disabilities do not fall within the Child and Youth Services Act, but within the Social Code Book IX and the health system. Following the passage of the UN Convention on the Rights of Persons with Disabilities in 2008 a professionally driven

discussion started to create *one* care system for *all* young people (Arbeitsgruppe ASMK und JFMK, 2013).

The Child and Youth Services Act is, moreover, a law inspired by principles of social pedagogy. At its centre lies the concept that the conditions in which a child grows up are to be negotiated by the child or adolescent and their legal guardian. The Child and Youth Services Act ensures that children and adolescents in general receive an upbringing geared towards them becoming a responsible person who can function in the community. Specific assistance starts with support for the parents. Children and adolescents solely have a right to such an upbringing, rather than direct rights to specific services.

In general, there are usually three stakeholders involved in the initial decision-making process: the child, the parents (or the legal guardian) and the professional from the youth welfare office. A fourth stakeholder comes into play once the care facility has been chosen, with a professional from this facility involved in all further decision-making processes. Collaboration among the professionals and the participation of the young people and their legal guardians is obligatory in these processes (§36 KJHG). Once an intervention is in place, the aims of the support must be discussed by all stakeholders and documented in a care plan on a regular basis.

Over the last ten years, child protection has become a public issue, especially following media reports of the deaths of young children, which in one case involved a child who was already known to the relevant youth welfare office. This developed into a scandal (Bremische Bürgerschaft, 2007) and, as a result of the ensuing public debate, the Child and Youth Services Act was amended in 2012, with the focus of these amendments particularly on very young children who require protection from neglect and abuse. Consequently, the collaboration between professionals from various services, such as the youth welfare office, crèches, kindergartens, hospitals and police is now obligatory and the regulations on data protection have been relaxed. Furthermore, the extension of a new type of support, that is 'early intervention' [*Frühe Hilfen*] was initiated by the federal government (Sann & Schäfer, 2011). Here, midwives who have been given a special training play a major role in providing and coordinating support for pregnant women and newborn children who are at risk of growing up in adverse conditions.

The child and youth service system in Germany features a wide range of modalities which in general can be classified into three categories: a) community-based, in-home family support services (ambulant care), b) day groups for children who return to their parents' home for the night, and c) alternative care, such as residential and foster care. With the exception of foster care, the child and youth services system is quite professionalized, with about one third (34%) of the staff having graduated from either college or university. In addition, 87% of staff working in youth welfare offices are also graduates, while other staff have usually completed at least of three years vocational training (Fendrich, Pothmann, & Tabel, 2012).

Residential group care in Germany also features a wide range of modalities, including family-oriented care and a differentiation into various group home settings such as therapeutic intensive residential groups, parent model residential groups (usually staff-supported), children's villages, as well as supervised individual residences for older youth and young adults (Bürger, 2001). Especially the concept of parent model residential groups, which is based on the idea that a couple (one of them being a professional) raises a group of children, shows that the differentiation makes the lines between residential and foster care blur.

Secure care placements have been continuously increasing over the last fifteen years, but remain at a very low level (400 placements across Germany). Just recently, especially due to bad conditions in some secure care facilities and the questioning of how secure care might fit with the social-pedagogical concept, the German section of FICE (IGFH) submitted a petition to the German government asking for the closure of all secure placements immediately (IGFH, 2013).

While over the course of the last decades the residential care sector has steadily progressed in terms of reflecting on concepts and methods, the foster care sector has just started this process. In Germany, being a foster carer has traditionally been voluntary, and foster families used to collaborate directly with the youth welfare office. Only recently has there been a differentiation between 'traditional' foster care families, kinship care and 'professional' foster families (*Erziehungsstellen*), as well as short and long-term placements. In a professional foster family at least one of the foster parents is a qualified social worker, teacher or social pedagogue. Often younger children with special needs are placed in this kind of services. The youth welfare offices, and in some regions also not-for-profit voluntary organizations, have started to offer training, counselling, and workshops for foster parents, and sometimes also for the children to help them cope with their situation (Trede & Winkler 2013). Thus, rather than pushing kinship care, as many countries do (Dill, 2010), Germany is attempting to follow the path of professionalization in the foster care sector.

Some negative after effects of the differentiation, such as that the transitions between different types of support not always running smoothly, have resulted in the development of what are known as 'flexible types of child and youth services' that are oriented to the social environment of individual children or youth and their parents. The goal of this social pedagogical concept is to customize the different types of child and youth services even more precisely to the needs of the children and youth. In this context, 'flexible' means that young people and their families do not have to adjust to the various types of intervention but instead, the intervention must adjust to the needs of children, youth and their families. This framework promotes a personalized approach to service provision that firmly rejects a 'one size fits all' mentality. The orientation to social spaces means that child and youth services are provided regionally and the clients' social networks are included. This implies the consideration of social connections, such as peers, as well as cooperation with relevant institutions located in the neighbourhood, such as schools and kindergartens, as well as recreational and sports associations.

### Childcare figures

Although Germany is considered to be one of the wealthiest countries in the world, during the last ten years child poverty has been discussed and considered a major problem. In 2010, 18% of all children were considered 'poor', that is, growing up in a family with a household income less than 60% of the median of the average net equivalent income. Children in single parent households and children with a migration background in particular have a high risk of growing up deprived (Autorengruppe Bildungsberichterstattung, 2012). Statistical data also indicate that residential and foster care particularly provide support for families in precarious life situations. A disproportionately large number of parents whose children are recipients of residential or foster care are separated or receiving social welfare (Fendrich, Pothmann, & Tabel, 2012).

The explicit reasons apparent in the statistics regarding admission to the alternative care system can be divided into three categories: a) inadequate care and support of the young person, b) precarious life situation of the birth family, and c) individual problems of the young person, such as asocial behaviour, developmental delay or schooling problems. In 2011, approximately 26% of the children placed in residential care were there because of individual problems, 34% because of the precarious life situation of their birth family and 40% because of inadequate care and support (Fendrich, Pothmann, & Tabel, 2012).

In 2011 (Dec. 31, 2011), approximately 65,000 young people lived in a residential group home and approximately 61,000 in foster families, with approximately 13,000 of them living in kinship care (Statistisches Bundesamt, 2012). Additionally, Blandow, and Küfner

(2011) estimate that there are another 40,000 children living in informal kinship care arrangements (Table 2). Altogether there are 112 young people under the age of 21 per 10,000 of the population living in alternative care (residential and formal foster care).

Young people in higher age groups are more likely to be placed in alternative care, with the age group 14 to 18 showing the highest rate: 136 young people per 10,000 of the population. Families with younger children are more likely to receive community-based, in-home family support services (ambulant care) although, due to the new Child Protection Law, the number of under six year olds who were placed in alternative care has slightly decreased recently (Fendrich, Pothmann, & Tabel, 2012), as has the number of removals from custody: in 2011, removal from custody took place in every fifth new case (Pothmann, 2013).

Over the course of the last decade all forms of child and youth services have continuously tended to decrease the length of placement. This is due to a placement policy that is, on one hand, based on the professional reasoning of strengthening the family-orientation and empowerment of parents, but on the other hand also on the limited financial resources of communities (Schilling, 2006). In 2011, a young person might be placed in residential care for about two years on average (26 months) and in foster care for up to five years (57 months) (Statistisches Bundesamt, 2012).

In Germany, adoptions are of secondary importance because even if a child is placed in foster care in most cases the birth parents keep a share of the right of custody and therefore adoption does not arise as an option for foster parents. Only 4,060 children were adopted in 2011 (see Table 2), but more than half of them were either adopted by relatives or step-parents (Statistisches Bundesamt, 2013b). In 2010, only 6% of all the children under the age of three who were placed in a foster family and only 3% of those placed in residential care were adopted by foster parents at a later date (Fendrich & Pothmann, 2011). To date, there is no reliable data regarding international adoptions. In 2011, approximately 400 children without German citizenship were adopted, but this figure is not identical with international adoptions, since in Germany children from migrants often also have foreign citizenship (Statistisches Bundesamt, 2013b).

Between 2000 and 2010 an increase of 9.5% in the total out-of-home care placements can be observed (see Table 2), although due to demographic change fewer young people are growing up in

**Table 2**  
Numbers of children in out-of-home care (OOHC) and newly placed in adoption families: Germany

	2000	2010
OOHC: Residential versus foster care <sup>1</sup>	N (%)	N (%)
Residential care	95,070 (62.2%)	93,785 (56.0%)
Foster care	57,862 (37.8%)	73,692 (44.0%)
Total OOHC	152,932	167,477
Rate OOHC per 10,000 children	83	/
Foster care: kinship and non-kinship care		
Kinship care	11,383	16,181
Non-kinship care	46,479	57,511
Total foster care	57,862	73,692
Adoption		
National adoption	4,482	3,041
Children without German citizenship	1,891	980
Total adoption	6,373	4,021

Note. Data in this table is supplied by the Centre for Statistics on Child and Youth Welfare, University of Dortmund.

<sup>1</sup>Sum of ongoing and completed cases.



Germany. From 2000 to 2010, there is an increase of 1.4% for residential care placements and an increase of 27.4% for youth placed in foster care. One reason for this increasing trend in out-of-home placements could be the public debate on child protection issues that ended in the amendment of the Child and Youth Services Act in 2012. Another interesting trend is that the proportion of those in residential care in comparison to foster care is decreasing. One reason could be that foster care placements have become more popular over the last decade. Another reason could be the ongoing differentiation between the foster and residential care sectors, which make it more difficult to draw a line between the two sectors for statistical purposes (Trede & Winkler, 2013).

### Research review

Although research on residential and foster care has steadily increased in Germany since the 1980s (Freigang, 2003), there still seem to be many gaps. Gabriel (2003) states that these gaps are due to the unsatisfactory funding situation, which allows for very little nationwide fundamental research and almost no longitudinal research. Therefore, most of the research carried out either entails evaluation studies of specific intervention programmes or PhD studies on a wide range of topics.

In contrast to the research situation in the Netherlands, Germany has very few evidence-based interventions in place and research in this area is thus almost non-existent. This is mainly because of the social-pedagogical tradition, which is based on the humanities and social sciences, and which typically criticizes standardized diagnoses and programmes, emphasizing the uniqueness of each case as well as individualized and participatory intervention. Only recently has a debate on what works in residential and foster care begun (Otto, Polutta, & Ziegler, 2010).

One of the few studies in the field of evidence-based research is the evaluation of a national programme that focuses on the effectiveness of the child and youth services system in eleven regions in Germany. Findings of this study suggest that *residential and foster care* are successful if the young people involved have the chance to participate in the decision-making processes and when these child and youth services are organized to support an establishment of a professional working alliance between the young people and their social workers (Albus et al., 2010). For this study the capability approach served as a theoretical framework and as the methodological foundation of measuring successful interventions: the researchers start from the premise that the general goal of child and youth care is to strengthen the young people and their families, "allowing them to live their life self-determined" (Albus et al., 2010, p. 9).

In contrast to this study on the effectiveness of interventions, we can find a range of research projects analysing the subjective perceptions of *residential care*. These subject-oriented research studies generally use biographical research methods. By focusing on clients' learning and development processes this research highlights how young people make sense of their experiences in care and how they are supported in pursuing their own lives in the future (Braun, 2006; Finkel, 2004; Rätz-Heinisch, 2005). The results of studies by Finkel (2004) and Rätz-Heinisch (2005), in particular, show that congruence of biographically developed patterns of actions and child care services plays a crucial role. A recent study by Zeller (2012) using a broad, socio-pedagogical perspective on education and learning, is based on 'biographical analyses' of young women who have left residential care. The results of the study emphasize that opportunities to perform 'biographical work' are essential for learning processes in a broad sense. Furthermore, the results indicate that educational processes, understood in the wide sense of transforming how young people see themselves and the social world, can have positive effects on education in school. In addition to these studies, there are two more recent research

projects that focus only on young women and residential care (Heiland, 2012; Von Langsdorff 2012). Both investigate gender related aspects applied by the child and youth care system in the case of intervention. These studies clarify the statistics, which consistently show that girls on average are older than boys when they enter the residential care system.

One major impulse for research on the child care system was the JULE study (JUgendhilfe-LEistungen, effectiveness of the child care system) (Baur, Finkel, Hamberger, Kühn, & Thiersch, 1998). Findings of this research project revealed that approximately every seventh young person in *residential care* has experienced more than one placement breakdown. Two more recent studies take up this debate on placement stability. While Hamberger (2008) is an in-depth case study which analyses the course of placements from multiple perspectives, Tornow, Ziegler, and Sewing (2012) follow a quantitative approach. Both studies discuss the various factors that lead to the termination of a placement. In addition to termination from the side of the professionals, there seem to be a number of cases that are characterized by the emotional withdrawal of young persons in care who either cannot make sense of the offered services or they feel abandoned by the professionals.

Another major strand of studies focuses on one of the pivotal professional instruments that was implemented in 1990 when the new legislation of Child and Youth Services Act became effective. Since then all child and youth care services have to be planned collaboratively with children, parents and child care service providers. The question of participation and engagement of the clients is intensively discussed and researched (Schwabe, 2005). While many studies focus on child and youth care in general there is one qualitative study analysing the participation processes within four residential group homes (Stork, 2007). The findings point out the difficulties that are connected to creating a (democratic) culture of participation within residential care organisations.

Since Germany has a long standing tradition in the professionalization of residential services research on *foster care* is less developed. However, there is one basic study (Gehres & Hildenbrand, 2008) that contributes to the discussion about whether foster families are replacing or completing the function of birth families. The results of the detailed reconstruction of children's identity processes indicate that foster families and its functions are much more complex than such dichotomous categories suggest. Furthermore, we can identify research studies that focus on the question of how birth parents and foster parents can collaborate (Faltermeier, Glinka, & Schefold, 2003; Sauer, 2008) and how foster children cope with the transition from the birth family to the foster family (Reimer, 2009) or –the other way round– how foster families cope with the return of children to the birth family (Schäfer & Jespersen, 2012).

Only recently, historical issues on residential care facilities are critiqued. Motivated by journalistic inquiries and an ongoing public discourse on residential care in the 1960s and 1970s, care leavers have successfully launched claims for compensation from the German government for the loss of their early years. Following this political debate, some agencies have started research projects to reappraise past practices (Schäfer-Walkmann, Störk-Biber, & Tries, 2011).

### Conclusions

While there is a large difference in the number of young inhabitants in the Netherlands and Germany, there are quite a number of similarities with regard to their child protection frameworks. Child protection services in both countries are mainly focused on youth aged 0 to 18, although the upper age limit is somewhat higher in Germany (27) than in the Netherlands (23). Regulations in both countries are aimed at clients' responsibility and



their active involvement during care. Child and youth services in both Germany and the Netherlands emphasize the participation of young people and their parents in decision-making processes. However, in Germany only the parents have direct rights to receive specific services, while in the Netherlands both the parents and the child have direct rights to receive care services. Youth care services in both countries consist of community-based services (ambulant care), day treatment and out-of-home care services which include foster care and residential care. Youth care policy in the Netherlands is focused on preventing out-of-home placement. With regard to out-of-home care, foster care is preferred over residential care. In Germany, there is no such youth care policy, although over the last decade there has been a trend towards a decrease in the proportion of residential care in relation to foster care.

The history of out-of-home care services in both countries is characterized by similar developments. Until the end of the 1960s, youth protection services in both Germany and the Netherlands were mostly run by churches or religious organizations, with this dominance diminishing during the following decades. At the end of the 1960s, there was criticism on youth protection services in both countries. In the Netherlands, this criticism resulted in a decrease in residential care facilities from the 1960s to the 1980s. In Germany, it resulted in changes to the organization of residential care, in terms of increased specialization, decentralization and regionalization. Over the last four decades, similar trends in residential care, towards more small-scale forms of residential care, smaller residential group sizes and increasing professionalization of staff have emerged in both countries. More recently, over the last two decades, a comparable trend towards increasing professionalization can be seen in the context of foster care.

The childcare figures show that in both countries there was an increase in the number of youths in out-of-home care between 2000 and 2010. In the Netherlands, an increase of 11.5% in the total out-of-home care placements can be observed, despite the focus on preventing out-of-home placement. In Germany, there was an increase of 9.5% in the total number of out-of-home placements in the same period. In both countries, the proportion of residential care in relation to foster care has decreased. In the Netherlands, the number of recipients of foster care services shows a large increase (72.2%) over the last decade, while residential care numbers show a substantial decrease (23.6%). In Germany, there has also been a substantial growth in the number of youths in foster care (27.4%) over the last decade, alongside a small increase (1.4%) in residential care placements.

With regard to research, there has recently been considerable attention to the effectiveness of youth care services in the Netherlands, including residential and foster care. Evidence-based interventions have been the main topic of research over the last decade. In contrast to the Netherlands, Germany has very few evidence-based interventions in place and, consequently, research in this area is almost non-existent, with the debate about 'what works' in residential and foster care in Germany only recently starting. In addition to this difference in focus, there also seems to be a difference with regard to the main applied research approach. For example, in the Netherlands most of the studies seem to apply a quantitative research approach, while in Germany a qualitative approach seem to be more common.

Despite growing numbers of youth in foster care, over the past decade more research has been conducted on residential youth care than on foster care in Germany and the Netherlands. Within both countries, a large variety of topics has been studied in the field of residential care. In addition, the applied research topics in residential care mainly show differences between the countries. In the field of foster care, there also are mainly differences between the countries in research focus, although a similar topic that emerges from both countries is the comparison between foster and 'normative' families.

These findings suggest that, despite similar trends and developments in residential and foster care practice, German and Dutch research studies in out-of-home care mainly show differences in applied topics and methods.

## Conflicts of interest

The authors of this article declare no conflicts of interest.

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