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Ambulant Care for Juveniles 'At Risk'

Summary

The fashion nowadays is to provide care for juveniles likely to develop developmental difficulties in the family home environment whenever possible. In the wake of this, all kinds of family intervention methods have emerged, e.g. Intensive Family Treatment, Video Home Training and Families First. Despite all this, however, the majority of juveniles in ambulant care still get assistance on a traditional or 'classical' basis. This article discusses the empirical characteristics of 'classical' ambulant care for juveniles in the Netherlands. Provisional conclusions are: the level of professional ambulant care that the institutions for voluntary and protected child care can offer is rather low in comparison with the professional care provided by the institutions for mental health care; the professional attitudes and treatment methods in ambulant child care are largely based on psycho-dynamic approaches; and the clinical impressions of care-providers and clients about the results of the care are too positive and in need of correction by objective effect measures.

1. Introduction

A recent trend in the Netherlands - and also in other West-European countries - is to provide the care for juveniles *likely to develop* emotional and behavioral problems as much as possible on an ambulant basis. Instead of placing juveniles out of their original homes and providing the care in residential institutions, the fashion nowadays is to let juveniles stay in the family home environment whenever possible and to provide the care there (Colton, Hellinckx, Bullock & van den Bruel, 1991). In the wake of this, all kinds of new promising ambulant intervention methods have emerged, like Intensive Family Treatment, Video Home Training and Families First. Despite all this, however, most of the juveniles in ambulant care still get assistance on a traditional or 'classical' basis.

In the Netherlands ambulant care has traditionally been provided in three main sectors. In the first place juveniles and their families get help from the Regional Institutions for Ambulant Mental Health Care. Every year about 50,000 juveniles enter this kind of care (Konijn & Swets-Gronert, 1990). In the second place, juveniles and their families get help from Institutions for Protected Child Care. There about 13,000 juveniles yearly receive help related to measures of child protection, while another 5,000 juveniles get custody-related assistance (Department of Justice, 1993). In the third place juveniles and their families get assistance from Institutions who advise juveniles and parents in trouble on a voluntary basis. These organizations are often associated with the institutions for protected child care. However, the

number of juveniles visiting these voluntary institutions is unknown, because in this area a central client registration system does not yet exist. Finally some juveniles receive help from institutions in 'the alternative circuit', like Juvenile Advice Centres.
In this contribution we will explore the characteristics of traditional ambulant juvenile care. To do so we will analyse the care provided by the three major sectors mentioned above, and answer the following questions.

- What are the problems of the juveniles in ambulant care?
- What kind of assistance is offered to these juveniles?
- What is the effect of the assistance given?

2. Theoretical framework

The psychosocial risk model as proposed by Van der Ploeg & Scholte is used as a theoretical framework to describe the psychosocial characteristics of the juveniles in ambulant care. (Van der Ploeg & Scholte, 1990; Scholte, 1991; 1992a; 1992b; 1995).

In this model, the behavioral problems of children 'at risk' are classified into the two main syndromes of *internalizing* and *externalizing* problem behavior (Achenbach, 1985). The first syndrome comprises types of behavior oriented towards the child itself, like loneliness and depression, anxiety, fears without identifiable causes and social withdrawal. The second comprises types of behavior oriented towards the outside world, such as hyperactivity, aggression, opposition and antisocial types of behavior like truancy and stealing.

In the model the internalizing and externalizing behavioral problems are further interpreted as the outcome correlates of transactional processes between risk traits in the personality of the child, and critical rearing and socialization conditions: in the child's primary care environment (e.g. the original family or the primary care environment substitute, like a foster family or residential group home), at school and in the peer/group and leisure time activities.
According to the model, the core risk factors in *the primary care environment* are a family history of personal problems of one or both parents, severe parental and/or parent-child discord and conflicts, poor communication between family members, a family climate generating insecure attachment (e.g. child battering, abuse and neglect), and poor child rearing practices like non-responsive and/or authoritarian rearing behavior, lack of supervision and chaotic rearing.

The core risk factors in the educational situation *at school* include: poor school motivation and academic performance, conflicts with teachers, and a poor school culture with low standards of achievement and undemocratic teaching styles.

The model specifies the following risk factors: antisocial behavior of friends, risky behavior engaged upon during leisure time, like hanging around downtown in combination with alcohol and drug abuse, and relational problems with peers, including severe conflicts or social isolation.

The *personality* traits of the child that increase the risk of emotional and behavioral disorders relate to defects in cognitive-emotional skills, such as poor ego-control (unrestricted control of needs or exactly the opposite: suppression of personal needs), unrealistic self-esteem, unbalanced focus of control and ineffective coping behavior.

3. Population characteristics

The research of Scholte et al (1992) is suitable to describe the three main sectors of ambulant juvenile care mentioned above. This research comprises a random sample of 300 juveniles who got help from Institutions for Ambulant Mental Health Care (MHC), Institutions for Protected Child Care (PCC) and Institutions for Ambulant Voluntary Child Care for Juveniles and Parents (VCC) in a sized and a medium-sized city in the Netherlands.

Table 1 presents the psychosocial characteristics of the juveniles ordered according to the psychosocial risk model for the three main sectors of ambulant care.

Table 1. *Demographic and psychosocial characteristics of juveniles receiving help from Institutions for Mental Health Care (MHC), Voluntary Child Care for Juveniles and Parents (VCC) and Protected Child Care (PCC)*

	MHC (n=98)	**VCC** (n=93)	**PCC** (n=96)
demographic characteristics:			
primary environment:			
- family	94% (32%)	70% (30%)	45% (23%)[3]
- foster family	3%	14%	21%
- residential care	1%	8%	27%
- other	2%	8%	7%
age*	10.5 (4.5)	14.9 (3.2)	12 (4.0)
gender	44%	38%	62%
ethnic background	17% foreign	34% foreign	40% foreign
parental divorce	43%	70%	76%
psychosocial problems			
material problems	20%[2]	40%[2]	48%[2]
internalizing behavior syndrome	59%	68%	68%
externalizing behavior syndrome	37%	46%	62%[2]
personality disorders	45%	48%	64%[2]
family problems	42%[2]	73%	69%
school problems	25%	28%	29%
peer problems	45%[2]	76%	62%

1 means and standard deviations
2 statistically significant difference ($p < 0.05$) between sectors according to Scheffé's Multiple Range Test
3 percentage in parentheses refers to a one-parent family situation

Table 1 shows that the psychosocial characteristics of the juveniles in the three sectors partly overlap, but also significantly differ. The differences lead us to the following conclusions.

Demographic characteristics

Most of the juveniles who get help from Institutions for Mental Health Care (MHC) live in a family environment with both or at least one parent of birth. This is also the case for most of the juveniles in the Institutions for Ambulant Voluntary Child Care (VCC). However, in the Institutions for Protected Child Care (PCC) only half of the juveniles live in the original family of birth. Here substantial numbers of juveniles reside in an institution for residential care or in a foster family. The problematic family background of these juveniles is also reflected in the fact that more than three-quarters of the parents of the juveniles in PCC are divorced. The same applies to juveniles in VCC, while among the juveniles in MHC less than half the parents of birth are divorced.

Further, in VCC the mean age of the juveniles is 15. This is significantly higher than the mean ages of 11 and 12 respectively of the juveniles in MHC and in PCC.

About a third of the juveniles in VCC and PCC have a non-Dutch ethnic background (measured as the mother's place of birth). The juveniles in MHC differ in this respect. Here only a fifth of the juveniles have a non-Dutch ethnic origin.

The table further shows that young women consult VCC relatively often, while boys are more often subjected to PCC. About equal numbers of boys and young women receive MHC.

Psychosocial problems

The following psychosocial problem characteristics can be derived from the table. About a third to half of the juveniles in MHC get help for behavioral, emotional and personality disorders. About a quarter of the juveniles struggle with social-relational problems, in particular in the relationships with teachers and peers. In addition, about half the juveniles have to cope with family problems, mainly consisting of disturbed communication between juveniles and parents. In MHC family problems are much less frequent than in the other two care areas.

In VCC, on the other hand, family problems are a major source of psychosocial stress for the juveniles. The family problems are often expressed as severe conflicts between the juveniles and their parents. They comprise rearing difficulties of parents and individuation problems of juveniles, often related to the process of separation from home. These problems often coincide with behavioral problems like running away from home, material problems like lack of housing and finances, and emotional problems related to the formation of personal identity. In VCC, therefore, the main emphasis is on the problems of adolescence.

The juveniles in PCC show problems at all the psychosocial areas defined by the risk model. The families often have material problems, and the parents themselves often struggle with personal problems and function less than perfect, both personal and social. The family rearing environment is characterized by lack of communication, severe conflicts and insufficient parental guidance of the juveniles. Substantial numbers of juveniles exibit problems, both of the internalizing and externalizing types. At the same time substantial numbers of juveniles

show problems at school (e.g. teacher-pupil conflicts and truancy), while some undergo the influences of adverse socialization conditions in leisure time (e.g. delinquent peers).

In short, the figures presented suggest that of all the juveniles in ambulant care, the juveniles in PCC run the highest risk of following a path of adverse psychosocial development.

4. Frequency and duration of ambulant care

The next subject to discuss is the way the juveniles are guided by the care institutions. In this paragraph we will look at the formal aspects of guidance, like the number of contacts and the duration of the care. In the following paragraphs we will explore the nature of the care.

Contact between the client and the care provider can take place on an individual level, for example between the professional and the juvenile, or between the professional and the parents (as happens with very young children). However, all kinds of combinations are possible, for example individual contacts alternated with family contacts. In addition, other important persons like grandparents, brothers and sisters, other family members or teachers can be involved. Table 2 gives an overview of the contacts with the members of the primary environment of the juveniles.

Table 2. *Care-provider and client contacts in ambulant care*

	MHC (n=98)	VCC (n=93)	PCC (n=96)
contacts with juveniles	91%	96%	91%
contacts with parents	80%	82%	84%
contacts with parents/juveniles together	39%	64%	53%
frequency of contact with juveniles/month	2.2	1.6	1.4
frequency of contact with parents/month	1.2	1.6	1.6

The table shows that most contacts between the care providers and the care takers are of an individual nature. Guidance where the whole primary family system is involved (juvenile and parents) is less frequent. This type of guidance is most frequency applied in VCC (64%), followed by PCC (53%). In MHC contacts with families are fewest (39%).
These findings correspond with the findings for the frequency of contacts. In MHC the frequency of monthly contacts is the highest with the juveniles (2.2), but the lowest with the parents (1.2). In the other two areas the frequencies are almost equal, namely 1.4-1.6 times a month. This corresponds with the findings of other research in this area (Van der Ploeg en Scholte, 1993).

In all the three areas of ambulant care the duration of the contacts is equal: both with parents and with juveniles the contacts take about one hour. However, the length of the care dif-

fers significantly. In MHC and VCC the assistance lasts 11 and 12 months respectively. In PCC it lasts about 20 months.

5. Care objectives

Ambulant care for juveniles 'at risk' is provided because juveniles and their families are in psychosocial trouble. The objective of the care is to resolve this troubled situation. We therefore can get a first impression of the nature of the care by looking at the guidance objectives set by the ambulant care providers. To explore these objectives we used the research questionnaire developed by Van der Ploeg & Scholte (1993). This questionnaire covers the main areas of the psychosocial risk model translated as care objectives. Table 3 shows the results.

Table 3. *Major objectives of ambulant care*

	mean	sd
personality strenghtening	2.77	.83
reduction in emotional problems	2.56	.92
improvement of school functioning	2.31	1.12
improvement of family functioning	2.21	1.03
reduction in behavioral problems	2.09	1.09
solution to material problems	1.76	1.03

The table shows that the 'strenghtening of personality' (e.g. enhancement of self-esteem and self-confidence) is the core objective in ambulant care. A good 'second' is the 'reduction in emotional problems'. These findings suggest that the attention during the ambulant care process to a large extent aims at revolving internalizing or emotional problems.
Improvement of school functioning, improvement of family functioning and reduction in behavioral problems are emphasized to a lesser extent, while the least emphasis is given to the improvement of material problems.

6. Care activities

What kind of activities are done during the care process? With this question we aim to determine the nature of the activities the ambulant care providers apply in order to solve the problems of the juveniles and their families.
Following the Committee for the Restructuring of Juvenile Care in the Netherlands (Commissie Harmonisatie van Normen, 1991) we distinguish the following core activities:

Problem and resolution assessment
In order to be able to provide purpose-oriented assistance, the care provider first must have a

clear picture of the problems of the child and its family. Only then can he/she offer the child the best help available (Scholte, 1995; Van der Ploeg en Scholte, 1995a).
At the beginning of every care distribution, therefore, the care provider must make an analysis of the core problems of the child and its family, and also of the ways he thinks the problems can best be resolved (Faas, 1993).

Test research
Test research is usually applied when the care provider wants more in-depth information about the psychosocial performance of the juvenile than provided by the intake assessment. The nature of this testing can be psychosocial (e.g. vocational interests), psycho-logical (e.g. IQ), psychiatrical, neurological, etc.

Crisis intervention
Sometimes a direct intervention is needed at the intake, e.g. for severe physical or sexual abuse. In cases like this action comes first, and the care provider applies a crisis intervention.

Out-of-home placement
Although the core care policy in the Netherlands is to continue the original family-home environment for juveniles 'at risk' as long as possible by providing ambulant care in the home environment, the primary environment can be so threatening that a temporary or permanent change of primary environment is needed. In those cases, the juvenile is placed out of home in a foster family or in an institution for residential care or treatment.

Case management
Case management refers to the coordination of the individual processes of care. It covers the following activities: the motivation of clients to participate in the care process, referral of clients to third parties, tuning of the various care parts provided by third parties, monitoring of the care process, coordinating evaluation sessions, writing reports etc.

Ambulant guidance
Guidance consists of conversations with the juveniles and/or their parents in which material help, information, advice and/or counseling is provided concerning problems the clients encountered in their daily lives which they could not solve themselves, with the purpose to give the clients instruments to solve these problems after all (NVAGG, 1980). This activity is also named 'basic care or basic family support' (Van der Ploeg & Bonke, 1990).

Ambulant treatment
Treatment refers to those kinds of care activity in which the care provider applies a well defined therapeutic method systematically to resolve the assessed specific social or intra-/interpsychic problems of the client and to enhance his/her self empowerment (NVAGG, 1990). This activity is also called 'intensive care or therapeutic treatment' (Van der Ploeg & Bonke, 1990).

Table 4 shows the extent to which the above core activities are applied in the three main areas of ambulant care.

Table 4. *Core activities of ambulant care*

	MHC (n=98)	VCC (n=93)	PCC (n=96)
problem/resolution assessment	72%	71%	85%
psychological testing	37%[1]	2%	18%
crisis intervention	20%[1]	64%[1]	42%[1]
out of home placement	4%[1]	38%	49%
case management	42%[1]	69%	79%
ambulant guidance	76%	92%	91%
ambulant treatment	46%[1]	3%	8%

1 statistically significant difference ($p < 0.05$) between sectors according to Scheffé's Multiple Range Test

The table shows that in most of the cases and in all three areas a problem and solution assessment is made during the intake. However, the table also shows that in a fifth to a quarter of the cases this assessment is not made. The table further shows that testing mainly takes place in MHC.

Crisis intervention is often applied in VCC (64%) and to a lesser extent in PCC (42%). In MHC crisis intervention is less frequent. This, however, may be because MHC has a separate service for crisis intervention. This service was not part of the present research.

Out-of-home placement is mainly applied by PCC. Here about half the juveniles are placed elsewhere, about equal percentages in foster and residential care. In VCC, too, substantial numbers of juveniles are placed out of the original home environment. In MHC the juveniles are hardly placed outside their original homes.

Case management turns out to be an important core activity in both VCC and PCC. In MHC this activity is less frequent. This difference can be explained by the fact that the Institutions for MHC themselves provide treatment, while the other two institutions call in third parties for this purpose.

The table further shows that the 'real' ambulant care in VCC and in PCC in an overwhelming majority of the cases consists of ambulant guidance (material help, information, advice and counseling). Therapeutic treatment of juveniles and/or their families is provided by MHC in half the cases. For the sake of completeness we can state that in VCC 18% of the juveniles and/or their families are sent to MHC, mainly for the treatment of personality and emotional problems. The corresponding percentage in PCC is 28%.

7. Core activities and problems of juveniles

The above leads to the question of how the core activities of 'ambulant guidance', 'ambulant treatment' and 'residential placement' relate to the problems of the juveniles and their families. We explored this question by linking the multiple risk indicators of table one to these core activities of care, using Scheffé's multiple range test (Scholte, 1994). The following picture emerged:

- ambulant guidance is mainly offered when juveniles and their families have problems in various areas, but only when these problems are relatively small;
- ambulant treatment is mainly offered when juveniles show emotional and personality disorders related to the internalizing problem behavior syndrome. This treatment is offered by the Institutions for MHC, is therapeutic in nature, and both individually and family oriented;
- placement in a residential treatment centre is provided when juveniles show personality and behavioral disorders related to the externalizing problem behavior syndrome.

8. Professional attitude

During the interaction with the client, the professional care provider, usually intentionally, adopts certain attitudes to help the client resolve his problems (Hollis, 1964). For example, he can express understanding, confront the client with his problems, give guidelines about how to handle, arrange tasks etc.

Using a factor analysis of 287 contacts between social workers and clients in ambulant care, Moser & Coelman (1987) find three clusters of attitudes, namely:

- emphathizing (expressing understanding, reassuring and inspiring confidence);
- clarifying (analyzing the problems and giving insight);
- confronting (pointing at the client's share, stressing responsibility, arranging tasks).

This research further reports that the clarifying and empathizing approaches are very strongly accentuated in the counseling contacts with clients, while confronting is far less frequently applied.

9. Effects of ambulant care

Solid figures about the effects of ambulant juvenile care hardly exist, because follow-up research in this area is greatly lacking in the Netherlands. However, some researchers do report effect impressions of clients and care providers. Table 5 summarizes the findings.

Table 5. *The effects of ambulant care in % improvement*

	Total		MHC		VCC		PCC		
% improvement according to:	care-provider	juven.	care-provider	juven.	care-provider	juven.	care-provider	juven.	parents
Scholte e.a. (1992)	-	-	70%	80%	67%	83%	62%	70%	53%
Moser (1992)	78%	85%	-	-	-	-	-	-	-
Moser & Coelman (1987)	-	-	-	-	-	-	67%	87%	61%
V. d. Ploeg & Scholte (1993)	-	-	-	-	49%	-	-	-	-

The table shows that in MHC, VCC and PCC about 60-75% of the care providers and about 70-85% of the juveniles believe that the original problem situation diminished due to the ambulant care provided.

Although this sounds rather promising, we must add some remarks. In the first place the table shows that the parents in PCC are less satisfied with the assistance offered than the juveniles and the care providers. This difference, however, may be caused by the fact that PCC is provided by law. In PCC parents are often seen as 'not fit enough' to raise their children, and the interest of the child (and society) is often placed above the interest of the parents. In the second place Van der Ploeg en Scholte (1993), in their research of VCC, found that the care providers detected progress only in 49% of the cases. In this research the effects were assessed during the process of care, while the other findings refer to a judgement after the process of care was ended. This seems to suggest that the last effect assessments produce flattered pictures.

An additional analysis done by Moser (1992) supports this suggestion. In this research an objective psychosocial effect score was constructed and the effects were assessed by comparing this score at the beginning and at the end of the care. This revealed that only 49% of the juveniles did indeed make progress. This is substantially less than the 78% progress reported by the juveniles.

10. Conclusions

The description of the problem characteristics of juveniles 'at risk' in ambulant care reveals that the various sectors try to solve different kinds of psychosocial problems. In Mental Health Care (MHC) problems associated with the internalizing behavior problem syndrome dominate, while in Protected Child Care (PCC) juveniles struggle relatively often with problems associated with the externalizing behavior problem syndrome. Here family problems are also very frequent, like in Voluntary Child Care for Juveniles and Parents (VCC). However, in VCC the problems of the juveniles often relate to the individuation-separation tasks of adolescence. Young women go to VCC for help more often than boys, who are more often the subject of PCC.

The core activities of ambulant care can be divided into ambulant guidance (material help, information, advice and counseling) and ambulant treatment (therapy). In PCC and also in VCC the care provided mainly consists of ambulant guidance of individual juveniles or of the juveniles and their parents. MHC on the other hand to a large extent offers therapeutic treatment of individual juveniles who have to cope with problems associated with the internalizing behavior problem syndrome. If juveniles in VCC and PCC need a therapeutic approach, third parties are usually called in. The mobilization of third parties to treat the juveniles, however, is relatively rare (at least at the moment of our research). Instead, substantial numbers of juveniles are placed out of their home environment into facilities for residential treatment, especially when externalizing behavioral problems and severe adverse family conditions are involved.

We further find that substantial numbers of juveniles in VCC and PCC express emotional, behavioral, personality and family problems of a more serious nature than in MHC. We also find that the care provided by VCC and PCC mainly consists of ambulant guidance, like material help, information, advice or counseling. This leads to the question whether the institutions for VCC and PCC are equipped well enough to fulfill their task adequately.

When we look at the objectives set in ambulant care, we find that reduction in emotional malfunctioning and personality strengthening are the most popular objectives. Less attention is paid to improving the social problem behavior of the juveniles and to improving the malfunctioning of the families. This is peculiar when we consider that substantial numbers of juveniles express problems related to the externalizing problem behavior syndrome, and that many juveniles also struggle with severe adverse family conditions. The fact that the care providers mainly express a clarifying and empathizing attitude in their client contacts suggests that traditional ambulant care possibly adheres too much to the psycho-dynamic paradigm and too little to the behavioral and/or family-dynamic paradigms to explain the problems of the juveniles and to shape intervention.

The effects of ambulant care, however, seem to tell us something different. At first sight the results look very promising. Huge percentages (70-85%) of the juveniles report improvement due to the care. The care providers are equally positive. Here, too, substantial numbers (60-75%) report improvement due to the care. However, some remarks must be made. The presented figures are based on the subjective judgements of the parties involved and assessed after the end of the treatment. When more independent measures are used, the percentage of juveniles improving turns out to be much lower (50%).

Our findings lead to the following provisional conclusions:

1. The care provided by the Institutions for Protected Child Care and Voluntary Child Care (namely material help, information, advice and counselling) is too restricted to offer adequate help to all the juveniles and their families who enter these institutions for help, especially in those cases where the juveniles have severe multiple psychosocial problems;

2. In traditional ambulant care the problems of the juveniles and their families are too often defined as the internalizing problem behavior syndrome. At the same time, the care provided relies too often on a psycho-dynamic approach alone;
3. The effects of ambulant juvenile care are impressive according to the perceptions of care providers and clients, but less so when we take independent measures. In other words: the clinical impressions of care providers and clients are too optimistic and need to be corrected by more objective results/figures.

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