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From Behind Dikes and Dunes: Communities that Care in the Netherlands

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'A rising tide lifts all boats.' (John F. Kennedy)[1]

This paper will provide a general overview of the implementation of the Communities that Care (CtC) programme in the Netherlands. It outlines the socio-historical development of the initiative and considers the rationale and starting point for the Dutch experiment and the tools used in the process. Attention will also be paid to the implementation of CtC and some of the problems met in trying to introduce the CtC scheme. The final part of this paper will consider the main outcomes of the first (process) evaluation of the experiment.

Introduction

Communities that Care (CtC) is truly a 'crossing border initiative.' This preventive strategy, which aims to attack problem behaviour of young people in deprived areas, neighbourhoods and cities, was developed and first implemented in the United States. Pilots projects are also been undertaken in the United Kingdom (see France and Crow in this issue), Australia and since 1999 in the Netherlands. But not only does CtC cross national borders as a preventive strategy it also crosses the borders between disciplines: science, policy and practice.

Evaluation research of preventive or treatment interventions in the Netherlands is still in its infancy, as is the case in the rest of Europe. One of the main reasons for this is that policymakers and administrators have not seen the usefulness of such research and, as a result, do not require subsidised intervention programmes to be tested on effectiveness. However, in the past decades a number of western countries have shown a clear change in this respect (Sherman and others, 1996). Sherman's report showed that much of what we do in terms of prevention in local communities has no effect whatsoever on the (later) behaviour of young people. But what was clear from his proposals was that if prevention is to be effective then it needs to be coordinated and embedded in the local culture and

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[1]Taken from Bellah and others, 1992.

professional practice. It was this that encouraged the Dutch government to adopt the CTC approach to community-based prevention. CTC fitted in well with emerging efforts of Dutch local authorities to develop prevention strategies in closer collaboration among all youth services, including youth welfare agencies, local schools, the youth protection service and the police.

This article intends to provide a general overview of *CtC* in the Netherlands four years after its take-off. First, we will describe the socio-historical context in the Netherlands that the CTC approach had to engage with. Secondly, we will consider the Dutch experiment and the development of tools that had to take place in the process of implementation. Thirdly, we will discuss the implementation of CtC and some of the problems we met in trying to introduce the programme in local communities. Fourth and finally, we will consider the main outcomes of the first (process) evaluation of the experimental settings. We will then conclude with some observations about future evaluation research.

Socio-historical context

The universal prevention strategy *CtC* has been running in the Netherlands for over four years. Two Dutch Ministries made the translation and introduction of the programme possible: the Ministry of Justice and the Ministry of Health, Welfare and Sports. Interest for this initiative arose in the second half of the nineties. The Minister of Justice at the time was worried about the explosive growth of prisons and juvenile penal institutions. She was interested in alternative ways to deal with serious offenders as well as in looking into the possibility of preventing serious offences. The Ministry commissioned a report that would deal with different options for prevention and *CtC* was presented as a promising approach (Junger-Tas, 1996, 1997). CtC was thought to be one of the more positive socio-political answers to the significant increase of violence and youth delinquency in certain local settings in the Netherlands during the nineties. CtC was seen as a possible structured, community-orientated and effective answer to the social consequences of problem behaviour of young people, which has disruptive effects in a number of Dutch areas, neighbourhoods and cities. A coherent and planned initiative was expected to positively affect different social environments (family, school, community and individual behaviour) and to add a more rationale approach to local youth policy as well as stimulating more effective methods of raising children in these areas.

The originality of CtC lies in its rationale and systematic approach of social and youth problems at the local level. Social change is a very complex process and it requires a well thought through and reasoned approach through knowledge of the problems at hand, reliable organisation and the availability of effective interventions. The roll of the Dutch national state in implementing CtC was substantial, which is in line with the historical tradition of Dutch social policy. It was the state through the Ministries mentioned above that took the initiative of limited trial implementation. This is a fundamentally different approach from countries where the role of the individual and the community is more pronounced than the role of the national state (Waltzer, 1997). However, this approach is also gradually changing in the Netherlands as well.

The Netherlands has 3.7 million children and young people between the ages of newborn to 18 years old. That is approximately a quarter of the total population. One fifth of these are recent or second generation immigrants and belong to an minority ethnic group.

However, most of these live in the large cities meaning that they make up nearly 50 per cent of the youth population. The large majority of the 3.7 million children and young people grow up without serious problems. But some of them (estimates range from 6 per cent to 10 per cent) show problem behaviour, which might pose an immediate or future threat to their own lives or to that of others. These children and young people show (indications of) violent as well as delinquent behaviour, problematic substance use, school dropout and or teen pregnancy, often in different combinations. Of these different kinds of problem behaviours, violence and youth delinquency in particular increased significantly during the nineties. The number of young people interviewed for violent acts more than doubled between 1993 and 2000 (from 4.18 per 1000 in 1993 to 8.77 in 2000). The total volume of juvenile delinquency, including violent acts as well as crimes against property, arson and vandalism increased by 65 per cent between 1980 (2.8 per cent) and 1996 (4.7 per cent), although part of this increase was caused by a change in the police registration system (Van der Laan, 2004). The occurrence of problem behaviour in the Netherlands has traditionally been low. Teen pregnancy, for example, was never seen as real 'problem behaviour'. However, it has recently increased in certain neighbourhoods and among particular groups of the population. The accumulation of problem behaviour among young people occurs primarily in the bigger cities of the Netherlands (Jonkman and Snijders, 2003) a trend policymakers wish to reverse.

There are two more developments which play a key role in why CTC was seen as an important development in the Netherlands. Both are based on a wealth of research outcomes over the last ten to 15 years of studies undertaken in particular in psychology, psychiatry and sociology. These are the growing importance of a developmental perspective in the life of children and the growth of effective preventive and curative interventions. In the nineties there is a clear scientific move towards a more developmental perspective. This happens in different fields such as health (Keating and Herzman, 1999), psychiatry (Achenbach and McConaughy, 1997; Achenbach, 1999; Verhulst, 1999, 2003), economics (Sen, 1999; J. Van der Gaag, unpublished manuscript) and sociology (Elder, 1999; Elder and Conger, 2000; Furstenberg and others, 1999). In psychology the developmental perspective has already been prominent for some time (Vygotsky, 1978; Piaget, 1977; Bruner, 1968, 1983; Erikson, 1987). Moreover, with respect to the question of preventing problem behaviour, there is considerably more emphasis placed on early development, on the upbringing of children and youngsters and on the relationship and interaction with antisocial behaviour (Gottfredson and Hirschi, 1990; Rutter and others, 1998; Tremblay and Craig, 1995; Tremblay, 1999; Junger-Tas, 2001). In addition an important number of studies have been published showing that some preventive interventions are more effective than others (see for example Dryfoos, 1990, 1998; Durlak, 1997; Elliott and Tolan, 1999; Elliott, 1998; Sherman and others, 1996; Greenberg and others, 2001). As a result there was a growing recognition that prevention might have an impact on development of children and youngsters if implemented well. It was this alongside the growing levels of problems that encouraged the Dutch government to adopt CTC as a preventative experiment.

The Dutch experiment

The political context in the Netherlands with concerns about serious public order and crime problems in a number of city areas and the growing evidence base of scientific

developments in prevention cleared the path for CtC. Together they make up the socio-historical context of CtC behind our dikes and dunes. This led the Ministries of Justice and Welfare in 2000 to fund an experiment of CtC in four pilot areas: Amsterdam, Arnhem, Rotterdam, and Zwolle. A commission, including researchers, implementers and civil servants, made the final selection of the four pilot sites. The Netherlands Institute of Care and Welfare (NIZW), a national organisation which collects and develops intervention programmes in justice and welfare, was charged with the implementation and observation of the CtC process. While a contracted agency, the DSP-Group, was commissioned to conduct the process evaluation.

Before the programme could be implemented the American student survey used by CTC USA had to be translated and adapted (as little as possible) to the Dutch situation. Some adaptations had to be made based on cultural differences between the United States and the Netherlands. For example we considered that according to Dutch youth culture there were too many questions on drug use and weapons and too little on protective factors. The instrument was tested and piloted for relevance and comprehension before using it as a research tool. In Holland a lot of diagnostic research has been done on antisocial development and problem behaviour, for the most part on the individual level. A great number of valid and reliable tools are accessible and useful for diagnosis and research. But as far as investigating problem behaviour on the group level (the aggregated level) is concerned the instruments at our disposal are relatively scarce.[2] This is unfortunate because it is clear that we cannot solve all problems on the individual level. So we may learn a lot more by developing tools for social diagnosis. Problem behaviour (violence, delinquency, substance abuse, school dropout and teen pregnancy) accumulates in specific areas and neighbourhoods, frequently combined with other social problems (poverty, violence, social exclusion). We therefore need good tools in order to be able to say something substantial about the development of youth in these areas. Moreover, neighbourhoods and cities need accessible scientific instruments for this task, especially now that the responsibilities of Dutch local authorities for youth policies have been extended. Areas with real problems have to be distinguished from areas with relatively few problems. Developments in problem areas have to be recorded over a period of time and the authorities need solid information on how and where to attack problems and insight into the underlying factors. Characteristic of our CtC research are the four contexts in which young people grow up (family, school, friends and community), the development of children and young people over the years (newborn to 18 years) and the socio-epidemiological toolbox of underlying risk and protective factors.

When the circumstances of youth people in a particular area or neighbourhood have been mapped CtC aims to tackle problem behaviour over an extended period. Within CtC this is done with the use of tested (effective) programmes: well-coordinated and researched based strategies to prevent problem behaviour of youngsters. Scientists, politicians and professionals have come to recognise the advantages of effective preventive programmes. Over the past 15 years evaluation research has been conducted on the effects of programmes. This revealed the criteria of effective preventive interventions, such as a

[2]The researcher of individual children and young people can make use of many different tests (see for the Dutch situation for example F.M.E. Slijper, 2003, blz. 146–157, in F. C. Verhulst and F. Verhey, *Kinder-en jeugdpsychiatrie, Onderzoek en diagnostiek* (Assen.) However, Achenbach developed the Child Behaviour Check List (CBCL) and Verhulst e.a. translated this to the Dutch situation. This instrument can be used on the individual level and also on the group level and is one of the few exceptions to the rule that we don't have many diagnostic instruments at a group level at our disposal in the Netherlands.

focus on underlying factors of problem behaviour, the importance of age adequacy, a clear structure and concrete results, and the scientific determination of the results of interventions (Sherman and others, 1996; Durlak, 1997; Elliott, 1998; Elliott and Tolan, 1999; Posey and others, 2000). Local settings in America are able to work with an effective 'menu' of around 100 effective programmes (Posey and others, 2000). But the programmes in this 'American menu' are not easily transferable to the Dutch context because of differences in culture, language, working methods and organisation systems.

When we started with CtC in the Netherlands no studies of effective programmes had been conducted yet. There were hundreds of Dutch programmes for children and youngsters in areas, neighbourhoods and cities. Only 5 per cent had been evaluated with before and after measurements (Van der Ploeg and Ferwerda, 1998). There was no strong tradition of research on the effectiveness of prevention programmes in the Netherlands and the studies that had been done were not satisfactory in terms of their methodology, the degree of suitability and cost-benefit analysis of interventions (Verdurmen and others, 2003; Bartels and others, 2001). Studies had been conducted on programmes in a specific problem domain as addiction (Bolier and Cuijpers, 2001) and there were a lot of 'best practice manuals' (Van Dijke and others, 1999). But we did not have a 'prevention manual' on effective interventions for children and youth with respect to a number of problem behaviours, over an extended period of time (newborn to 18 years), usable in different contexts (family, school, friends, neighbourhood), and connected to underlying factors. There was no study separating effective programmes from non-effective ones. This was the situation when CtC was undertaken four years ago. Since then we have made some progress.

This year we published the manual *Veelbelovend en effectief*, ('Promising and effective'; Ince and others, 2004), containing all effective and promising Dutch preventive programmes that may be used in local areas to support families, schools, youth and communities. The selection of effective and promising programmes was based on clear criteria: programmes are considered promising when they meet criteria concerning objectives, target group, method and theoretical underpinnings; programmes are considered effective when they also show positive outcomes in scientific research, which meet objective methodological criteria. For this purpose we studied the available literature, standardised all programme descriptions and sent them to programme owners for verification. The selected programmes were divided into four different domains. The result was a total of 31 effective and promising programmes for Dutch children and young people. Five were defined as effective: two in the family domain and three in the school domain. The other 26 programmes were labelled as 'promising'. That does not mean they are not effective but up to this day no high-quality research has been done (with before and after measurement, a control group, and follow-up results after at least six months). Five effective programmes is a poor result compared to the 'American menu' available for local settings. However, these 100 programmes is not the number that a small country such as the Netherlands should strive for. Our country invests a lot in general basic services such as, the public school system, social services and youth health care and also the general level of population health and welfare is quite high. But in the years to come, adding a substantial number of effective preventive interventions should be possible, such as programmes in different contexts, for different ages and dealing with different underlying risk factors. Our study *Veelbelovend en effectief* is limited to universal and selective prevention programmes because these are adequate at the community level. In the next two years we

hope to broaden our selection including effective and promising interventions on indication. In addition, we aim to broaden the CtC concept with programmes addressed to attacking internalising problem behaviour, such as anxiety and depression.

Implementation and innovation

It is important to consider the organisation, planning, management and study of the implementation process. This is where research and practice meet. CtC can be characterised as a complex innovation strategy working with different components, the efforts continue over an extended period of time and many parties are involved (Campbell and others, 2000). But the implementation of this complex prevention strategy raises issues on three levels: the practical, political and the scientific. CtC is an American programme that was 'exported' to the Netherlands in a cultural context quite different from the American situation. As a result there has been some tension in the implementation process over the last four years. We give an example of these tensions for each of the three levels in the programme areas: practice, policy, and research.

At the practical level we have to work with an explicit, comprehensive and research based view of problem behaviour of children and young people and with solid facts. Looking at problems of children and young people in this way is new for people who are working in some neighbourhoods and cities. Although problem behaviour takes a long time to develop we have to tell them that its prevention may take even longer. We have developed different materials for school leaders, workers in the health service, youth workers and community workers to work with over an extended period of time. We train and support them so that they can build up a consistent and shared perspective together, which will organise their practical work. We inform them about what makes programmes effective and how they might improve their effectiveness and, finally, we encourage them to look back at their achievement after a certain period of time (Beumer and Vergeer, 2002). These are important preconditions for successful innovation on the practical level. They are incorporated into the original model as the Dutch CtC concept. But this was not achieved without some struggle. Many Dutch professionals are working with children and youth in local settings. Their workload is heavy and at this moment they are increasingly emphasising the autonomy of their work. There were many questions about their own professionalism, independence and knowledge (see for example, Tonkens, 2003).

We also had to consider the process of innovation at the political level. With *CtC* politicians are able to set the agenda, they can prioritise the programmes they would like to invest in for the coming years and they will evaluate their policies after a certain period of time. With CtC they can hopefully design more effective youth policies. At the political level we often encountered a lot of enthusiasm for this prevention concept, which seemed more rational than policies based on 'good intentions'. However, politicians often hesitate whether to implement a short-term strategy often no longer than the period for which they have been elected or a long-term strategy, which they feel would be necessary ('It is really interesting but how can I sell this to my constituency'). On several occasions we came across this political dilemma.

Finally, there is a clear need in the Netherlands for a more scientific approach to preventive programmes. Knowledge on the prevalence of problem behaviour and effective programmes is scarce. The key question here is: how do we make sure that

effective programmes are being used with Dutch families, schools and communities who need it? CtC as a strategy can be broken up into a number of phases. First, we had to prepare and adapt the theory of social development and underlying risk factors. We had to model the different components of intervention, adapt them to the Dutch context and try them out experimentally. We even examined the question how they might be improved. We had to do three things at the same time: build up knowledge, develop the programme and implement it. A process evaluation has now been completed over a period of four years but an actual comparative evaluation report was not possible before the end of the explorative phase. Products and components were still changing too much. At the time of writing this article (2004) we are ready to compare intervention sites with non-intervention sites in some new settings and to test the theory to reproduce it and control it as much as possible. When this impact evaluation is done we hope that in an international perspective long-term CtC interventions and implementation in different settings over extended periods of time may be possible.

Main outcomes of the process evaluation

Research on the CtC intervention has been going on in the United States for a long period of time (Greenberg and others, 2001; Hawkins and others, 1995). It has also been well reported in the United Kingdom (Crow and others, 2004; France and Crow, 2001). In the Netherlands the evaluation research started four years ago (DSP Group, 2004b). CtC was implemented in four pilot areas (neighbourhoods) in the cities of Amsterdam, Arnhem, Rotterdam and Zwolle. This involved the following tasks:

- The *Decision Determinant Questionnaire* (DDQ) has been used to measure 'readiness' and commitment to CtC of the steering committee and the prevention team.
- In the first months of 2001 the student survey was implemented in a number of schools attended by students living in the pilot areas. The student survey was then repeated late in 2003 its results being compared with the results of the first student survey.
- All local project leaders and local pilot supervisors were interviewed several times during the implementation process of CtC.
- After completion of the prevention plans at the beginning of 2002 the members of the prevention teams were interviewed about their views on the implementation process of CtC.

Each area had its own experience of CTC and as we will see this helps build up a detailed picture of implementation learning.

Amsterdam-Noord

Amsterdam-Noord is a relatively poor urban multi-ethnic neighbourhood. The neighbourhood council had already installed a youth board including its main youth services. This board had introduced a number of prevention programmes in the community. Once CtC started much attention was given to the adjustment and improvement of existing programmes in terms of the major CtC goals. The general results of the student survey show that the situation of young people improved slightly between 2001 and 2003. The following problematic behaviours have been reduced: alcohol

consumption, truancy and school dropout, and community disorganisation. There was also some improvement in family management problems. The general conclusion is that the prevention team judged CtC positively and that continuation of the project has been recommended.

Arnhem

An important problem in Arnhem was the city authorities lack of support for CtC. Related to this was the lack of financial means, which was the reason that large parts of the prevention plan were not implemented. Nevertheless the following conclusions may be drawn. Based on the student survey it appears that the situation concerning problematic youth behaviour improved. The number of smoked cigarettes and the consumption of alcohol both decreased. Furthermore, school absenteeism decreased. All risk factors reduced slightly. However, since other intervention programmes have been interacting with CtC this means that the effect is not necessarily a result of CtC. However commitment to CtC was not very positive. The fact that CtC is not being continued in Arnhem confirms this conclusion.

Rotterdam

The main conclusion drawn from CtC in Rotterdam is that most prevention programmes do conform to CtC norms and that most organisations use CtC as their main guide to formulate their policies. A drawback of the Rotterdam survey is that some schools discontinued their collaboration with the student survey and so the results of the second student survey could not be used. The results of the DDQ indicate that although the overall commitment to CtC slightly decreased between 2001 and 2003 it is still acceptable. The city of Rotterdam has decided to continue CtC at least until 2006 and to implement CtC in other city neighbourhoods as well.

Zwolle

In the city of Zwolle most prevention programmes were already in place but have been adjusted in the selected site to incorporate them into CtC. This means that the same prevention programmes have been used in different ways in the city as a whole. The results of the student survey indicate that problem behaviours in general have not changed. Both risk factors and protective factors remained essentially as they were before the start of CtC except the indicator 'lack of neighbourhood organisation' grew worse. It should be noted that the selected neighbourhood had hardly any real problems to begin with as opposed to the other pilot areas. The DDQ indicates that CtC is positively judged and that the prevention team is optimistic about future developments. Continuation and broadening of the project have been recommended.

It should be recognised however that the interim evaluation of the programme performed by DSP showed interesting results in the short term on information on the possibility of directing, administrating and controlling the operation of relevant organisations and service providers. The DSP report drew several conclusions with respect to the number of

different organisations involved in CtC and the share of social service providers, the extent of mutual collaboration and the degree of support. The study showed that it was considerably more difficult to involve residents and young people in the CtC process. In fact the descriptive output outcomes that were found in the Netherlands are very similar to what has been found in the United States (NIZW, 2003) and the United Kingdom (France and Crow, 2001):

- An increase of the quality of planning and decision taking.
- More collaboration among service providers.
- More coordination in the input in programming of preventive interventions.
- A greater focus of preventive interventions on risk and protective factors.
- More use of demonstrated effective and promising approaches.
- More involvement of young people and other citizens in preventive interventions.

General conclusions

Firstly, with respect to improving existing prevention programmes the implementation of the prevention plans in the four pilot areas went generally well. More difficult was the introduction of projects that were new in the pilot areas and where parts of the project were still not functioning. This was mostly due to opposition of existing agencies in the area to the introduction of projects they had not been running for example in Arnham. Secondly, commitment to CtC as measured by the DDQ survey both at the start of the project in 2001 and at the end late in 2003 appears to show that prevention teams remain considerable in all four pilot areas. Furthermore, all pilots indicate that collaboration on the level of programme execution has increased since the introduction of CtC. Thirdly, the primary goal of CtC is to reduce juvenile problem behaviour by the reduction of risk factors and the reinforcement of protective factors. Whether this goal has been reached is measured by the student survey, which was also done at the start of the project in 2001 and at the end, late in 2003. Complicating factors are small sample sizes and the fact that some schools in Rotterdam decided to discontinue their collaboration. However, the following conclusions may be drawn: In Amsterdam and Rotterdam it appeared that the situation concerning risk factors and protective factors had improved and in Zwolle these factors got a little worse. However, since many prevention projects were already functioning before the introduction of CtC we do not know whether the positive changes that appear from the student survey are due to CtC or to other factors. Fourthly, besides a reduction of risk factors and a reinforcement of protective factors CtC yielded some other positive results. These are mainly related to the improvement of the processes introducing prevention policies in areas where prevention approaches had been low. Finally, the American CtC model had to be adapted to the Dutch culture and social institutions. Instruments such as the student survey and several instruction manuals have been translated into Dutch. When using these instruments there have been some observations on their content and wording. For example, one of the issues was that too little attention was paid to protective factors as compared to risk factors. However, all of these have been dealt with later on in the implementation process. At this moment the instruments are fully adapted to the Dutch situation. We can state that the adoption of the American CtC model took quite a long time but there has hardly been any resistance in the four pilot areas against the American characteristics of the model. During the implementation process the model of risk factors and protective factors became a mutual frame of

reference. Moreover, the clear structure of the CtC process serves as an important guiding principle for participants in the prevention teams. In the first stages of the implementation process CtC was considered a new prevention programme. Later on it became clear that CtC is far more than that; it is a strategy for planning prevention policies and interventions in neighbourhoods. The development of this vision has been of great significance in gaining support for CtC amongst members of the steering committees and local administrators.

Final remarks

CtC belongs to a new generation of prevention strategies in which research, effective programmes, innovation and evaluation are integrated. It has been introduced in very different local settings and in several countries. We are optimistic about the future of CtC in the Netherlands. More and more Dutch cities and neighbourhoods are interested in this strategy including the Dutch Antilles. As of last year and in a new phase CtC has been introduced in two more pilot cities (Leeuwarden and Almere). And from this year on the initiative runs in one of the provinces where it will be set out in seven more cities.

Our policy as the Dutch partner of *CtC International* in this process is trying to keep the middle way between quality-development and control of the fundamental strategy. We also want to expand the strategy to a larger number of cities and neighbourhoods. We feel that CtC will support the build-up of a preventive youth policy, which will increase the effectiveness of Dutch youth policy in general.

But there is still a lot of work to be done in the years to come. We need research so that people can look over our shoulders and assess our work. In addition we have to build up our comparative perspective so that we will be able to compare cities and regions over an extended period of time. We also need more effective programmes that may be used in local settings. And we have to expand our knowledge about innovation. An essential question is how many cities and neighbourhoods use this preventive strategy and tailor it to their local cultural context without losing the essential CtC characteristics? Finally, we need more insight into the effects of this prevention strategy. Next year will see the start of a complete evaluation study in a number of CtC sites. And hopefully in the years to come CtC is this rising tide which lifts all boats behind our dikes and dunes. This should be possible in our low land.

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