18

Kein KIND zurücklassen! Kommunen schaffen Chancen

Making Prevention Work
Case Study Netherlands

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German Research Institute for Public Administration

BertelsmannStiftung

In 2011, the state government of North Rhine-Westphalia and the Bertelsmann Stiftung launched the model project, “Kein Kind zurücklassen! Kommunen in NRW beugen vor” (“Leave no child behind! Municipalities in North Rhine-Westphalia providing equal opportunities for all children”) (KeKiz). The goal of this initiative remains unchanged: To partner with model municipalities in creating opportunities that enable every child and young person – regardless of background – to benefit from a successful upbringing and participate in society. The initiative has been guided by academic research since its inception. Together with its partners from academia, the Bertelsmann Stiftung oversees the research that accompanies the initiative. In partnership with a range of academic collaborators, we will periodically publish the insights and findings from the accompanying academic research on municipal prevention efforts. The “Materials about prevention” series also aims to communicate findings on related issues and the insights gained from taking a broader academic view of the model project.

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Making Prevention Work

As part of a larger project mapping preventive structures and policies for children, young people and families in 12 European countries, the Making Prevention Work study aims to provide a consistent base for developing preventive policies in Europe. It examines approaches across the EU that demonstrate success with local preventive work. The in-depth case study of the Netherlands presented in this publication is one of three published in the context of the Making Prevention Work study.

Making Prevention Work draws on a concept of prevention that is framed in universalist and integrative terms. The concept is universalist in that it addresses all children and young people, even those not seen as being "at-risk." It is integrative because prevention should be organized from a child's point of view, not in terms of administrative responsibilities. As such, this concept targets the establishment of prevention chains that link different institutions over the life-course.

Making Prevention Work includes summary factsheets of the preventive concepts, structures and practices mapped in 12 EU member states (Austria, Czech Republic, Denmark, England (UK), Finland, France, Germany, Ireland, Lithuania, the Netherlands, Spain and Sweden) as well as three case studies (Austria, France and the Netherlands) featuring data from interviews with experts and implementing actors.

Key findings

Varieties of prevention: Despite widespread awareness of the underlying problems and a common frame of reference provided by the European Commission's recommendation

"Investing in Children. Breaking the Cycle of Disadvantage," existing preventive concepts, interpretations and measures vary greatly across Europe.

Universalist vs. targeted approaches: Most countries take a universalist approach that addresses all children and families. The Scandinavian countries are most consistent in this regard, followed by continental European countries such as the Netherlands, France and Germany. Other countries, such as Ireland and England as liberal welfare states, feature prevention strategies that target those in need more specifically.

Integration vs. fragmentation: Whereas some countries aim to integrate different services both across sectors (i.e., health, education, youth welfare) and throughout the life-course, others maintain rather fragmented structures. We see here the Scandinavian countries pursuing an integrated approach, which contrasts with the rather fragmented departmental structures observed in Ireland and England. Countries in continental, east-central and southern Europe are rather inconsistent in this regard, but generally pursue integrated approaches by establishing cross-institutional networks.

Voluntary offerings vs. incentives vs. obligation: How preventive programs are brought to the public differs from country to country. While in some countries programs are provided as voluntary offerings (e.g., early health examinations), other states try to "nudge" people toward participation through incentives (e.g., early child education), whereas others "urge" them to engage through obligation mechanisms (e.g., compulsory education).

Centralization vs. decentralization: The extent to which services are integrated into an administrative architecture depends on a country's broader administrative setting. The three Scandinavian countries of Denmark, Finland and Sweden each have a long-standing tradition of extensive welfare provision and municipalities that are competent in educational, social – and to varying degrees – health matters. Introducing reforms in 2015, the Netherlands has moved toward bundling all relevant competences (excepting schools) for preventive measures at the municipal level. England and Ireland take a more centralized and single-purpose oriented approach in which local governments play a lesser role. The continental, east-central and southern European countries vary in their approaches, but generally aim to establish networks that include actors in centrally governed policy areas (mostly health and employment) and those areas for which local administration bears responsibility.

Financing: Most programs have distributed liabilities with regard to financing. In many countries, budgets are focused on the main responsibilities of the institutions involved. Prevention and other cross-cutting issues often fall outside of these silos. In some cases – once again the Scandinavian countries stand out in this regard – there are additional lines of funding for preventive offers or strategies but, overall, funding for prevention is insufficient.

Making use of additional funding: Drawing on the European Social Fund (ESF) and other European funds to finance prevention remains an exception. Most projects financed with ESF resources target specific groups (e.g., Roma) or transitions (e.g., from school to employment). The "Leave no child behind!" project in Germany's North-Rhine Westphalia is a good example of a universalist and integrated approach that draws on ESF funding.

Leveraging other governance instruments (information, networking and performance management): In addition to funding, governments have other resources to offer. The countries with the greatest degree of centralization provide more materials (e.g., manuals) and are consistent in applying some forms of performance management. Many continental European states by contrast do not issue national guidelines, with the exception of Germany and Austria, where there are forums for a national exchange on their early intervention programs. While information and guidelines are often discussed in voluntary horizontal networks, no binding structures are implemented and, for the most part, performance management is lacking (with some regional or program-based exceptions). In Austria, Germany, France and, to a certain extent, the east-central and southern European countries, **preventive services are arguably under-governed by central actors.**

Country clusters: On a rather abstract level, three different approaches can be identified that reflect geographical lines and welfare state traditions: **The Scandinavian cluster** (i.e., Denmark, Finland and Sweden), takes a universalist and integrated approach to prevention. Responsibilities are concentrated at the level of functionally and fiscally strong local governments. At the same time, the central government supports local governments by communicating good practices and providing (some) financial support. The **Western European cluster** (i.e., Ireland and England) pursues a targeted and segmented approach. The targeting of measures is strongly related to the tradition of the liberal welfare state, where public action requires a special testable need to get things

started. The segmentation of governance is reflective of public administration in England and Ireland where, since the 1980s, single-purpose agency administration has become the norm and local government has lost several competences to specific agencies, Quangos and the private market. In many ways, the **Continental European cluster** (i.e., Austria, France and Germany) falls somewhere in between these two clusters. This stems from the inertia that is a function of their welfare state architecture, which relies on centrally provided and/or financed services as well as decentralized services financed by local governments. Limited in their constitutionally stipulated powers, local governments in these countries have little fiscal leeway to finance tasks that go beyond the tasks delegated by central (and state) governments. In these states, diverse networks that reach across administrative levels, the public sector and civil societies develop innovative preventive solutions. However, these solutions are rarely scaled up across the country. Spain and Lithuania do not fit a specific model, while the Netherlands falls somewhere between the continental and Scandinavian models. The relative dependence of local Dutch governments on the national government, particularly in fiscal terms, is the main obstacle to achieving a successful reform of prevention.

Consequences for Germany and Europe

First, Germany must reform the **design and character of preventive services** in order to reach more addressees of preventive offerings and convince parents to participate in programs at an early stage. This can be achieved by lowering barriers to such services and increasing obligations or nudges to make use of preventive services.

Second, Germany must **enhance cooperation** through networks to compensate for the status quo of fragmented responsibilities. Although local governments are generally tasked with childcare, youth welfare and social services, the federal states are responsible for schools and job training, and the health sector is governed by a complex network of health insurances (financing), free medical practitioners, medical associations *(Ärztekammern)*, and hospitals operated by diverse providers.

Third, given their diverse personnel and financial capacities, local governments – particularly less-wealthy ones – need greater support.

Fourth, given the lack of planning capacities and robust databases for evidence on preventive measures, **more research and data collection are needed to monitor performance and allow for sustainable policy planning.**

The study identifies common **challenges for Europe** as a whole that require stronger EU involvement. Topping the list is the absence of a common understanding of prevention and social investment. Second, there is a lack of a clear will to cooperate calls for greater structural and practical coordination efforts. Third, we need more community-driven, integrated preventive care that brings services closer to people where and when they need it. Fourth, the visibility of such services and general knowledge of them must be strengthened in order to ensure that both professionals and clients are aware of existing services. Fifth, an effort to balance centralized with local adaptation approaches to competences could bring together the best of both worlds. Sixth, budgets for preventive measures follow sectoral lines or are otherwise restricted, which leaves no room for cross-sectoral innovation.

The **European Union** could help strengthen preventive action across Europe. Though a powerful instrument, the ESF is rarely drawn upon for prevention funding in part because the **administrative burden** involved with applying for and managing these funds is too high for many potential users, such as local governments. Lowering these thresholds would mark a step in the right direction.

Within the context of EU discussions already underway regarding "social investment" – also for children (cf. the European Commission's "Investing in Children" recommendation) and the "Child Guarantee" to tackle child poverty, the EU should **promote prevention and preventive measures** as part of this paradigm. This could precipitate the creation of a shared understanding of prevention in Europe while enabling member states to learn more from each other's best practices.

The EU's recently developed **European Pillar of Social Rights,** which includes support for children, is accompanied by a Social Scoreboard that aims to measure member states' performance in different social areas. These instruments should be (and to some extent have already been) included in the process of the **European Semester,** which delivers country-specific recommendations to member states that include possible actions to be taken concerning prevention for children and young people.

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Preface

Since 2012, the Bertelsmann Stiftung has partnered with the German federal state of North Rhine-Westphalia on the **"Leave no child behind!"** (in German: **"Kein Kind zurücklassen!"**) initiative. Together with 40 participating municipalities, we have been united in aiming to **improve children's prospects for development while providing them equal opportunities.** Each municipality involved is creating local prevention chains, that is, systematic and ongoing collaboration between stakeholders in administration, agencies and civil society to improve the effectiveness and efficiency of local support and intervention practices.

Building on this initiative and its research, the Bertelsmann Stiftung, together with the German Research Institute for Public Administration, decided in 2017 to carry out a cross-national study of prevention activities across the EU, titled **"Making Prevention Work – Preventive structures and policies for children, youth and families**" The **case study of the Netherlands**, presented here in this publication, is one pillar of the study's research and offers a deep dive into one country's approach.

What is prevention in a policy context?

Most broadly, prevention refers to efforts designed to ensure the well-being of children and youth so that they can make the successful transition to adulthood. As applied here, our definition of prevention involves mitigating risk factors among children and their families – particularly those most vulnerable – as well as strengthening protective factors and resilience.

Driven by the needs of children and youth rather than institutions per se, this concept of prevention, as a policy objective, seeks to have a direct influence on the behavior of a target group (behavioral prevention) and bring about positive change in the group's environment (setting-based prevention). Prevention encompasses universal offerings (e.g., home visitation programs for families with a newborn) that take effect before risks become problems as well as targeted approaches aimed at those families specifically disadvantaged or in need.

As a policy objective, prevention is highly complex because it involves engaging health, education and child / youth welfare systems – at once. This demands effective coordination and cooperation across different sectors and institutions, which is lacking in many countries, including Germany.

Why are we interested in a cross-national comparison of prevention?

The research accompanying the "Leave no child behind" project initiated in 2012 in Germany highlights both the consequences of segregation on disadvantaged children and their families and the positive impact local support and institutions can have on these children.

Our German research shows that the educational opportunities of disadvantaged children can be improved considerably with just a few good preventive measures, such as improving day nursery attendance in the first three years of life and sports club attendance. Because the preventive services utilization rate is much lower among disadvantaged families, increasing their participation in such services is crucial. Many municipalities demonstrating success have developed and implemented services with a low access threshold, some of which are tailored to the needs of disadvantaged families.

However, our research in Germany shows that municipal "child-centered" policies depend strongly on the political will of municipal decision-makers, stakeholders' abilities to cooperate, and the breadth of local resources, all of which vary among municipalities. Consequently, not all children and youth – particularly those from families in need – are provided the support and care needed to ensure a successful transition into adulthood.

What is the goal of the "Make Prevention Work" study?

In an effort to learn from other contexts, we decided in 2016 to look beyond our national borders in order to identify successful facilities and institutional arrangements with potential applicability for the German welfare system. Although Germany's federalist system and other distinctive features of its institutional architecture may prohibit a direct transfer, factors of success in effective arrangements found elsewhere could nonetheless be adapted in one way or another to the German context.

As a product of this desire to learn from other examples, the study presented here examines prevention activities in the Netherlands and maps their goals, contents and legal basis, as well as their information, financing, organizational and cooperation structures. It provides deeper insight into how cooperation structures work and the daily challenges of preventive work.

What are our key findings?

In addition to providing prevention advocates across Europe with examples of good practices, the the cross-national study on 12 European countries clearly shows the importance of EU funding instruments to fostering inclusive prevention in education, health and social welfare, particularly with regard to youth and children in need. Furthermore, the study shows that an effective local implementation of prevention depends on the following:

- an integrated, cross-sectoral approach involving actors and institutions in health, child welfare and education;
- the promotion of such an approach at the EU level;
- the extent to which the EU fosters prevention locally and its influence on prevention policies in federal states and municipalities.

We are strongly aligned with the European Commission's recommendation on child-friendly investment (Recommendation 2013/112/EU; Investing in Children: Breaking the Cycle of Disadvantage). We therefore find the ongoing initiative to introduce a child guarantee scheme throughout Europe a promising approach. Although this scheme focuses on

the basic needs of children, we see a strong link to the objectives outlined in our study and recommend that it be adopted quickly so that implementation can commence.

In addition, we recommend that the EU draw upon its Pillar of Social Rights and the European Semester process to communicate the urgency of joined-up prevention efforts that link local, regional and national measures. In order to ease local municipalities' access to funding for prevention, we recommend that barriers to ESF funding be reduced. We support European efforts to implement the European pillar of social rights through the Structural Funds and hope that the findings presented here help foster a European-wide discussion on ways to create a better future for expanding generations to come.

A study of this nature requires the efforts and cooperation of many people and institutions. We would like to express our sincere gratitude to **Prof. Dr. Stephan Grohs, Niclas Beinborn** and **Nicolas Ullrich** at the German Research Institute for Public Administration for their outstanding work in conducting the cross-national study. We thank **Niclas Beinborn** in particular for his work on the Dutch case study and **Caroline Vink**, Senior Advisor at the Netherlands Youth Institute, for her ongoing support.

Christina Wieda and Dr. Anja Langness
Bertelsmann Stiftung
"Leave no child behind!" project
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1 Introduction

Prevention for children and young people in the Netherlands has recently gained in prominence due to a decentralization reform in 2015 that shifted all responsibilities in this policy area to the municipal level. Indeed, the entire system of prevention seems to be undergoing a process of transformation process, moving more toward the Scandinavian model of prevention. This makes the Netherlands an interesting case, with much potentially to be learned from the experiences of the municipalities in particular.

In investigating this promising case, this publication takes a deeper look at the general prevention system in the Netherlands, focusing specifically on the level at which preventive policies are actually implemented – that is, within the municipalities. We have conducted interviews with officials from three municipalities with different characteristics in order to analyze their respective approaches, gather information on their successes, and learn about potential problems and challenges. To complement this picture, we have additionally interviewed national experts from the Dutch Ministry of Health, Welfare and Sport, the Association of Netherlands Municipalities (VNG), the Netherlands Youth Institute (NJI) and an education cooperation network. As will be shown, there are indeed differences throughout the Netherlands; however, each approach has its merits and shows potential for transfer to the German context. Nevertheless, as the reform process is still underway, a further and careful observation is highly advisable.

The case study is structured as follows: First, it will shed a light on the general structural setting for prevention, meaning the overall government architecture; the structure of the health, education and social security system; recent reforms; and the local-government structures. Second, we will detail exactly what we mean when discussing the term "prevention," and take a general look at prevention-related programs. The third

part takes a look at the implementation of preventive policies, while contrasting the different approaches taken in three municipalities. Part four critically evaluates these preventive approaches along with the factors that make prevention possible, and the final section offers a summary of conclusions drawn.

2 Basic information

2.1 Overall government architecture

Formally, the Netherlands is a constitutional monarchy with the queen or king serving as head of state. In practice, however, it is a representative democracy organized as a decentralized unitary state. The Netherlands has three administrative layers: The central administration, 12 provinces that serve as regional administrations, and 355 municipalities (as of January 2020) that function as local-level administrations. Being a decentralized unitary state, the central government is responsible for legislation in all areas relevant to this report's research. The lower two levels of government do not have legislative powers; however, they are important as implementing bodies. The heads of the provincial assemblies (king's commissioners) and municipal mayors are neither directly nor indirectly elected, but are nominated by the minister of the interior and appointed by the king or queen to six-year terms. Since 2001, however, provincial and municipal councils have had an important say in their selection by recommending potential candidates to the minister. To understand the municipalities' role in the Dutch administrative system, it is important to note their historical role and self-understanding. Dutch municipalities have a strong conception of themselves as being the vital foundation of the governmental structure. This is reflected in their desire and right to execute their tasks without close supervision by the national government. Usually, no more than the basic elements of tasks are defined and supervised by the national government, with the majority of implementation responsibility remaining at the discretion of the municipalities.

Today, preventive services for children and young people are largely implemented by the municipalities and several non-binding intermunicipal cooperation bodies. The central government does not hold relevant implementation responsibilities; the provinces

did until 2015, but their former tasks in the area of children- and youth-related services have been handed over to the municipalities. This decentralization process has not been limited to children- and youth-related administrative tasks; other issues such as long-term care and income support have also fallen to the local level. Today, the provinces hold implementation competences in the area of traffic and transport, environmental protection and nature policy, regional economic development, spatial planning, recreation, culture and heritage. Moreover, they hold administrative and financial supervisory powers over the municipalities, and are important entities with regard to vertical coordination.

For their part, municipalities have a wide range of responsibilities, with their list of assigned tasks growing in recent years. Municipal tasks presently include:

- Youth care
- Primary and secondary education (specifically with regard to school building maintenance, as school buildings are always municipal property)
- Local healthcare and social care
- Provision of social security, and reintegration of unemployed people
- Culture, sports and leisure, tourism
- Public order and safety (including fire protection)
- Spatial planning and urban development (municipal plans are the only ones that are legally binding)
- Housing policy
- Environmental issues and sewage services
- Waste collection and disposal
- Local economy permits and accessibility
- Local public transport, municipal roads and harbors
- Registry
- Local taxation (mainly property tax)
  (cf. VNG 2018: p. 11f.)

2.2 Health system

The Dutch health system is built on four national healthcare-related acts: The Health Insurance Act, the Long-Term Care Act, the Social Support Act and the Youth Act. Before 2015, a different regime was in place. The primary difference relative to the old system

is the devolution of responsibility for social support and youth health issues from the provinces to the municipal level. To understand this system, it is important to differentiate between general health services for children and social care or child-protection services. General health services for children are provided by medical doctors or specific municipal-level providers (centers for youth and family (CJG) or local neighborhood teams (*wijkteams*)), depending on the issue and the parents' preferences. Health-related services associated with social care or child-protection functions are provided exclusively by the municipalities.

Most health policy issues are governed by the Health Insurance Act. This obliges everyone who lives permanently in the Netherlands to purchase a basic insurance package from a private insurance company; insurance programs have to accept everybody regardless of age, gender, health status or other personal aspects. This basic insurance package covers the vast majority of medical services. The national government defines the contents of the insurance package, as well as the price, which is currently set at about €1,200 per year. Additionally, an income-related portion is paid by the employer. The national government pays these fees for all residents under the age of 18, so that they can be insured without further costs. In addition to the mandatory basic insurance package, most people (about 90%) in the Netherlands have a privately financed medical-services insurance plan that extends beyond the regular services (e.g., including dental care or homeopathic treatments).

Elderly people and others with a permanent need for care are insured under the Long-Term Care Act. Insurance is mandatory for all residents, is organized by the national government and is financed through income-dependent shares of the income tax.

Medical services for disabled people and children are regulated under the Social Support Act and the Youth Act. These allow for municipal-level service delivery, but are not structured around an insurance-like model. Instead, the national government uses a tax-financed municipal fund to provide all necessary funding to the municipalities, which then organize the services. This system is also used for mental-health care for children, which is a municipal task under the terms of the Youth Act. Medical services for children and youth are one aspect of the multidisciplinary neighborhood teams' work.

The primary anchor point in the provision of medical services is the general practitioner (GP). These physicians are usually self-employed, and act as gatekeepers providing referrals to visit specialists and hospitals. The GP is also a key provider of individual, health-related preventive services for children and adults. In addition to the GP, municipal entities (centers for youth and family, and local neighborhood teams) also provide medical services of all kinds to children.

The vast majority of hospitals in the Netherlands are run privately (usually organized as foundations) but not for profit. They are financed through payments provided by the health-insurance entities.

Under the terms of the Public Health Act (WCPV), public health is a municipal task. The municipal-level public health services (GGDs) are responsible for carrying out activities in this area. The 355 municipalities have formed 25 GGDs, which are major actors with regard to health-related preventive services for children and adults. The main tasks of the GGDs are:

- Child healthcare
- Environmental health
- Socio-medical advice
- Periodic sanitary inspections
- Public health for asylum seekers
- Medical screening
- Epidemiology
- Health education
- Community mental health

2.3 Social security systems

Most aspects of the Dutch social security system are based on mandatory insurance programs organized by the national government. Some parts are mandatory for all residents, while others are only applicable to (and also mandatory for) employed persons.

Social insurance programs for all residents are financed in part by general taxes and in part by contributions (from those employed). These include:

- Pension system *(Algemene Ouderdomswet, AOW)*
- Child benefit program *(Algemene Kinderbijslagwet, AKW)*
- Survivor benefit program *(Algemene nabestaandenwet, Anw)*
- Long-term care program *(Wet langdurige zorg, Wlz)*

Social insurance programs specifically for employed individuals are financed by contributions and include:

- Unemployment benefits *(Werkloosheidswet, WW)*
- Sick leave *(Ziektewet)*
- Disability benefits *(Wet Inkomen en Arbeid, WIA)*

Under the terms of the Participation Act *(Participatiewet)*, everyone who lives legally in the Netherlands and has insufficient means to maintain themselves is guaranteed a minimum income. People who are not medically unable to work have to do everything possible to find work. Parents of children up to five years old can request an exemption from the obligation to work, but have to attend training courses.

There are a number of social-policy measures for children and their parents on the national level. Some of the most important are:

- 16 weeks of fully paid (based on the individual's net income in the 12 months before giving birth) maternity leave, paid through the General Unemployment Fund *(Awf)*.
- 26 weeks of parental leave for both the mother and father; individuals must have been employed by the same employer for at least a year before the birth of a child. Parents can take this leave at any time during the child's first eight years. This time is generally unpaid, but many employers voluntarily pay around 50 % of the regular wage based on individual agreements with the parents.
- General child benefit *(Kinderbijslag)* and benefit for families with low incomes *(Kindgebonden budget)*: Every child of a resident in the Netherlands receives a monthly child benefit (between about € 200 and € 300, depending on the child's age). In addition to the general, non-means-tested child benefit, there is an additional benefit for families with low incomes. This is also financed by the national government through taxes. Families must have low incomes and a limited amount of savings to be eligible for this program; the amount of the benefit depends on the family's actual income. The maximum payment for parents with

a combined income of less than ca. € 27,000 per year is about € 1,000 per month for the first child, € 500 for the second child, € 200 for the third and € 100 for any additional children.

- Childcare benefit *(kinderopvangtoeslag)*: If both parents are working legally in the Netherlands and one or more of their children attend a childcare facility (daycare, extracurricular care or childminder service), the parents can receive a childcare benefit. The amount of the benefit depends on the parents' income and the type of childcare facility, but covers most of the childcare costs.

2.4 Educational system

The Dutch daycare / preschool system is well established and widely used. Many children attend daycare facilities. Municipalities are responsible for providing such services, receiving grants from the national government for this purpose. Parents (and their employers, if relevant) also pay a share of the cost, depending on their incomes. On average, 65 % of these costs are financed publicly; for families with low incomes, the costs may be nearly completely publicly financed. There are two main types of daycare:

- Private daycare centers *(kinderdagverblijven)*: Care for children up to four years of age.
- Public pre-kindergarten facilities *(peuterspeelzalen)* or playgroups: A more formal type of care for children two or three years old.

Responsibilities for the different types of daycare facilities are split between two ministries: The Ministry of Social Affairs and Employment *(Ministerie van Sociale Zaken en Werkgelegenheid, SZW)* is in charge of general offerings for children up to the age of four, while the Ministry of Education, Culture and Science *(Ministerie van Onderwijs, Cultuur en Wetenschappen, MoECS)* is responsible for targeted care programs for children from disadvantaged backgrounds for children aged from 2.5 to four years, and for preschools for children aged four or five. The municipalities' public health services are in charge of monitoring the structural quality of all childcare facilities.

School entrance is possible at the age of four. Approximately 95 % of all children start school when they turn four years old. Entrance is possible at any time; usually children start on the day after their birthday. Children in the Netherlands must attend school

on a full-time basis (five days a week) from the age of 5 until the end of the school year in which they turn 16. Between the ages of 16 and 18, there is the qualification requirement for all young people lacking an initial qualification. The goal is to provide all young people with at least a certain amount of secondary-level education. An important characteristic of the education system, as described in Article 23 of the Dutch constitution, is the principle of the freedom of education – that is, the freedom to found schools, organize school curriculums and determine the principles on which schools are based. This means that people have the right to found schools and provide teaching based on religious, ideological or educational beliefs, and that they are entitled to determine how they wish to organize and design their educational programs. Most of these special schools *(bijzondere)* are Protestant Christian or Catholic, and are financed by the national government in the same way as the public schools *(openbaar)*. About two-thirds of children in the Netherlands attend special schools. Since these schools are usually governed by a foundation and a board, the national government and municipalities have limited influence. The national government does prescribe and monitor the basic structure and contents of teaching and pupil assessment, but has little control over schools' day-to-day business. Numerous practitioners interviewed for this study cited this as an obstacle with regard to establishing comprehensive nationwide preventive programs. However, a variety of actors mainly at the municipal level, including schools, school boards and municipal staff, have recently established a political coalition pushing for strengthened education-sector and youth-welfare-sector cooperation within 11 pilot regions *(inspiratieregios)*. These cooperative programs build on the already established cooperation in the special-education sector *(speciaal onderwijs)*, as an official of one of these regions told us. While this process is meant to inspire the rest of the Netherlands, backers also hope the government will draft regulations based on these experiences (Political Coalition Education-Care-Youth, 2018).

2.5 Recent reforms of the municipalities' structure and competences

In recent years, the number of municipalities has decreased, mainly due to mergers between small municipalities (for comparison, there were 467 municipalities in 2005, and 355 in 2020). Nevertheless, the size of the individual municipalities varies considerably, from approximately 950 residents in Schiermonnikoog to about 850,000 in Amsterdam, with most populations falling between 10,000 and 30,000 people. Thus, municipalities' administrative capacities are very disparate.

The Netherlands has also sought in recent years to decentralize service provision from the national administration to the provinces and the municipalities, as well as from the provinces to the municipalities. This is also the case for child and youth policy and its implementation, both of which have been subject to substantial reforms. The Dutch youth care and welfare system basically consists of three different services: universal services, preventive services and specialized services. Examples of universal services include youth work, childcare and schools. Preventive services include child healthcare, general social work and parenting support. Examples of specialized services include youth care services, mental-health services for youth and child-protection services. Until 2015, the municipalities were responsible for universal services and preventive services, while the provinces were responsible for the specialized services. Since that time, all the provinces' responsibilities with regard to children and youths have been transferred to the municipalities. The goal here was to concentrate all related responsibilities in a single administrative body, enabling multidisciplinary teams to take care of the entire spectrum of children's needs. Several key goals of the new Youth Act are to decrease the number of children in specialized care, increase preventive and early intervention support, and promote the use of social networks within children's immediate environments.

2.6 Municipal financial capabilities

Dutch municipalities have very little of their own tax revenue (approximately 10 %[1] of their spending). The majority of their revenues come from grants provided by the national government and the provinces (approximately 70 % of their spending) and other revenues like fees (approximately 20 %). Intergovernmental financial relations are regulated by the 1996 Financial Relations Act. Transfers to municipalities can take several forms, including general grants (through the Municipalities Fund / *Gemeentefonds*), decentralization grants (with sources including a new fund for social affairs), integration grants and specific grants covering the expenses for obligatory delegated tasks. Municipal Fund grants consist of a lump-sum payment. This funding channel has a strong equalizing function, with numerous criteria used in its allocation. Municipalities also receive transfers from provinces (e.g., investment grants for roads and public transport).

1 All data in this section taken from OECD (2016).

The financial and economic crisis of 2007 – 2008 and the subsequent years presented Dutch municipalities with budgetary challenges (Porth 2019). Budgets for social services came under particular pressure. Nearly all the municipalities contacted for this study reported that they had made cuts in their social budgets and / or experienced rising expenses. Additionally, the national budget for child and youth matters was cut by 15 % in 2015 as part of the decentralization campaign. This combination of budgetary challenges forced many municipalities to devote virtually all of their budgetary resources earmarked for children and young people to the provision of obligatory services. As a result, many made cutbacks in the area of preventive services, as these were not obligatory.

2.7 Cooperation between government administrations and other actors

As noted in section 2.1, Dutch municipalities generally have significant leeway to make their own decisions, even with regard to implementing national regulations. This means that cooperation between municipalities and higher government levels, and even with other municipalities, is rarely enforced. Rather, municipalities cooperate on a voluntary basis and make decisions on cooperation formats independently of the national government or other superior structures. This has led to the development of numerous different cooperation models that reflect individual municipalities' administrative choices, and which are adapted to individual policy areas. In the social-services domain, cooperation between municipalities was strong under the pre-2015 legal framework (see section 2.1 for further information about the reform), as all municipalities at that time followed a similar approach to youth and family centers. For example, coordinators met on a regular basis to exchange information. In the first phase after the 2015 reform, cooperation virtually disappeared. However, as initial implementation of the reform measures slowly comes to an end, people have had more time to reach out to contacts in other municipalities and reestablish cooperation. This has been especially true in the larger cities, where key program managers have created informal channels for the exchange of information and insights.

Because Dutch schools are often privately operated, cooperation between the municipally dominated social sector and the education sector is also an important task. However, actual success varies in this regard (see chapters 3 and 4 for details).

On a more abstract level, three basic types of intermunicipal cooperation can be distinguished (Schaap 2017: 4, see Table 1). In brief, we can identify these as networking models, the division of labor between different municipalities, and the integration of different municipalities' services. In the context of municipal services for children and young people, two of these can be found in practice. First, we can see the presence of loose network structures such as the *Zorglandschap Specialistische Jeugdhulp*, which is a network including various municipalities, private providers of youth welfare services and the national government devoted to the exchange of information and experiences around the topic of youth welfare services. Second, a far-reaching integration model is evident in the centers for youth and family *(Centrum voor Jeugd en Gezin, CGD)* and social neighborhood teams *(wijkteams)*, today found in most municipalities. These integrated approaches will be detailed further below.

TABLE 1: **Administrative types of intermunicipal cooperation in the Netherlands**

Types	Main characteristics
Networking / network model	Local officers informally sharing knowledge and expertise. The officers continue to act in a local capacity but collaborate in a structural way.
Division of Labor / matrix model	The partner municipalities specialize in one or more policy fields and perform tasks in their field(s) of expertise for the other partners, thus acting as administration for the others. Municipalities therefore no longer hire personnel for all topics. Decision-making remains at the separate city-halls.
Integration / integration model	Merger of offices into one larger intermunicipal bureaucracy. This joint organization works for all the partner municipalities, based on specific contracts. This merger can take shape as a concentration of personnel in one municipality (usually the larger city), or as a separate shared service center (delivering services to all partners), or as a fusion of almost the entire organizations of the partner municipalities.

Source: Schaap 2017, p.4

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3 Prevention and preventive policies

3.1 General understanding of prevention and the locus of prevention

There is no common, universally shared understanding of prevention in the Netherlands. This is in part due to the large number of actors involved, including the 355 municipalities as the focal point of prevention, as well as other actors including the national government, privately run schools, care providers, foundations, research and knowledge-provision institutes (e.g., the NJI), physicians, midwifes and health-insurance providers.

Nonetheless, there is a long tradition of social, health and education services that have a preventive character. In general, prevention in the Netherlands is framed mainly in terms of health, and is divided into universal or general prevention services and special (often compensatory rather than preventive) care. This health-oriented focus is also evident in the national prevention program *(Nationaal Programma Preventie, NPP)* adopted in 2014, which had the subtitle "All about Health" *(Alles is Gezondheid)*.[2]

On the municipal level, prevention is usually conceived more broadly, tending to extend into the social-services sector and sometimes into the educational sector as well. The approach taken to prevention at this level tends to have a universal thrust, aiming to reach all children and young people rather than focusing only on the worse-off. Due to the municipalities' considerable policy independence, differing administrative and financial capabilities, and differing local problem constellations, ideas and definitions of prevention vary considerably, as do the measures ultimately adopted.

2 https://www.allesisgezondheid.nl/english/

3.2 Policies / programs with an overall preventive approach

As previously noted, prevention in the Netherlands is mainly a task that falls to the municipalities. Given the high degree of autonomy in the provision of municipal services for children, it is difficult to produce a summary of existing prevention activities valid for the whole country. However, some programs and policies based on national regulations are established nationwide. Thus, the most important preventive programs on the national and municipal levels are described in the following.

3.2.1 Social policy

To ensure pregnant and working women do not have to work in the weeks preceding their childbirth, thereby unnecessarily endangering the unborn child, every woman giving birth in the Netherlands is entitled to 16 weeks of fully paid maternity leave (based on the individual's net income in the 12 months before giving birth). This benefit is paid through the General Unemployment Fund. A total of four to six weeks of the leave have to be taken before the birth, and the remaining weeks afterward, with the goal of allowing the newborn babies to develop a healthy relationship with their closest caregivers. Fathers have a right to one week of leave (fully paid by the employer) during the first six weeks of the child's life.

After this period, mothers and fathers are each entitled to 26 weeks of parental leave if they have been employed at the same employer for at least a year before the birth. Parents can take this leave any time during the child's first eight years of life. This time is generally unpaid, but many employers voluntarily pay around 50 % of the regular wage, based on individual agreements with the parents.

Every child of a parent in the Netherlands also receives a monthly child benefit. This is financed by the national government and paid to the parents by the *Sociale Verzekeringsbank (SVB)*, an organization that implements national insurance programs in the Netherlands. In addition to the general, non-means-tested child benefit, there is an additional benefit for families with low incomes. This is also financed through taxes by the national government, but is paid by the national tax administration. To be eligible for this benefit, families must demonstrate that they have low incomes and a limited amount of savings. The amount of the benefit depends on the family's actual income.

The "Promising Start Action Program" *(Actieprogramma Kansrijke Start)* is a new preventive program aimed at infants and young children. This universal service provides support to parents and children from the beginning of pregnancy until the end of the second year of life, with the goal of preventing detrimental effects on children's' health and development. The program is financed by the national government and private foundations, with a budget of € 41 million between 2018 and 2021. It started with a small number of pilot-test municipalities in late 2018, and has mainly sought to enhance cooperation and ease information exchanges between local actors in the social services, health and early-education sectors. Unfortunately, because the program was launching just as the data collection for this study was winding down, it is too early to report on its actual implementation and potential successes.

A number of different specific prevention measures exist on the municipal level. One feature established in virtually all municipalities is a generalist approach. This approach was originally initiated and funded by the office of the Program Minister for Youth and Family[3] in 2007, and refers to a method or variety of methods in which (child and family) support is provided to the clients. By 2011, every municipality was obliged to have at least one such CGD or center for youth and family in place. The generalist teams, which include child healthcare workers, social workers, psychologists, GPs and others, aim to provide early and direct support. In addition, they help empower families in finding their own solutions to parental and care issues, and to coordinate among each other more effectively. Generalist teams can work within the preventive field, but generalist models are also used to provide care to families facing multifaceted problem situations. In some municipalities, the generalist teams are organized within specialized centers for youth and family as mentioned before; however, in most municipalities, they are today constituted as social neighborhood teams *(wijkteams)* with responsibility for all age groups.

Many municipalities also have school care and advice teams. These groups organize assistance and help for students with psychosocial problems, seeking to encourage balanced development and prevent them from dropping out of school. School care and advice teams work closely with the centers for youth and family and the social neighborhood teams.

3 Refers to a minister with a dedicated portfolio and budget, but without his or her own organization. The minister used the staff of the Ministry of Health, Welfare and Sports (which is where his office was located) and that of the Justice and Social Affairs and Employment ministry. This position existed from 2007 to 2010; in 2010 it was abolished and the competences were transferred to other ministries.

The *Zorglandschap Specialistische Jeugdhulp* is a cooperative network that includes municipalities, private providers of youth welfare services and the national government, with the goal of enhancing the general quality of youth welfare services. It facilitates the exchange of information and experiences and enhances cooperation between the members. Participation is voluntary.

3.2.2 Education policy

Because of the constitutionally guaranteed freedom of education and the consequent organization of schools, it is not easy for either the national government or the municipalities to work directly within the schools. This presents an obstacle to the establishment of comprehensive nationwide preventive programs, as many practitioners interviewed for this study noted. However, one example of success in the early-education field has been the establishment of targeted childcare/preschool programs *(voor en vroeg schoolse educatie, VVE)* for children from disadvantaged backgrounds between the ages of 2.5 and four. The VVE are special programs intended to enhance children's language, socio-emotional, cognitive and motor development. The aim is to avoid or mitigate deficits before the children enter primary school. VVE programs are provided in regular daycare centers and preschools by specialized personnel. Responsibility for the programs rests with municipal authorities, which also determine which children are eligible. Referral usually takes place via infant and toddler clinics, often in cooperation with the centers for youth and family or the social neighborhood teams.

3.2.3 Health policy

The first health-related preventive measure in a child's life is the provision of free and extensive midwife counselling during the mother's pregnancy. The midwife is seen as a key actor during pregnancy who serves as a central point of contact for any issues during pregnancy. Midwifes work closely with other medical professionals, but also refer women needing non-medical help and guidance to municipal services such the centers for youth and family or the social neighborhood teams.

For 10 days after their child's birth, parents have the right to receive support by a public maternity nurse *(Kraamverzorgster)*, a service provided all over the Netherlands. The nurse visits the parents at home every day and answers all questions regarding the newborn baby and other related issues. If problems arise, the nurse can refer the parents

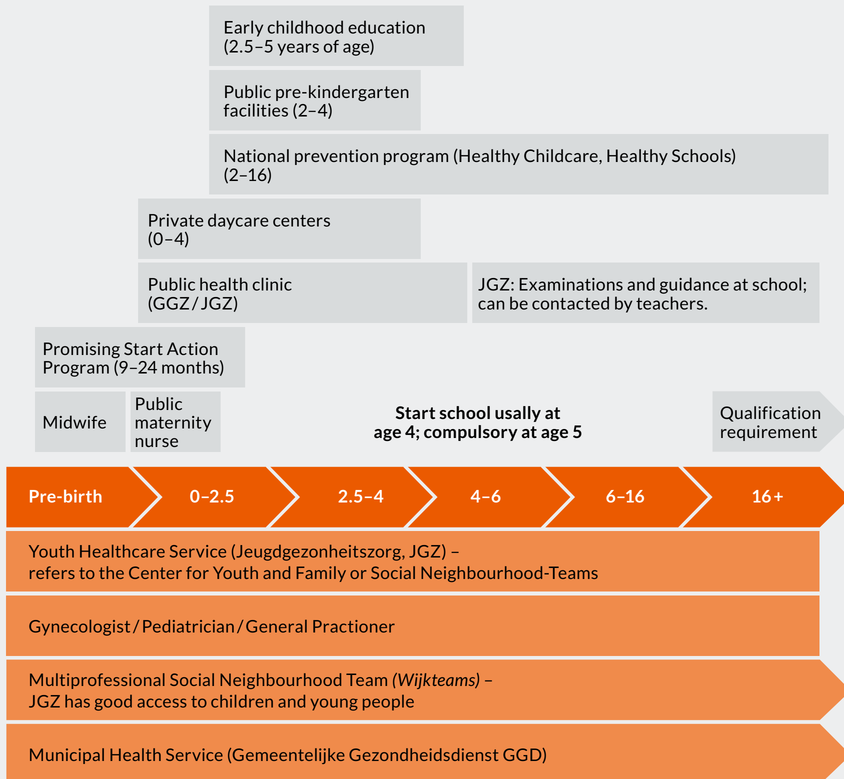
to a doctor, the local center for youth and family, or a social neighborhood team. Most costs associated with this service are paid by the health insurance, with only a small fee usually paid by the parents. However, the service is not mandatory.

Once a child is born, it is automatically registered with the public health clinic *(Consultatie-bureau)*. These clinics will contact the parents and invite them proactively to participate in regular examinations and vaccinations during the first four years of the child's life. In addition, parents can visit these clinics with any other questions or problems they may encounter. All services are free of charge for the parents; they are paid for mainly by the municipalities, with some participation by the health-insurance providers and the national government. Examinations and vaccinations are not mandatory, but show very high usage rates (>90 %), as society views them as standard aspects of the child raising process.

The National Prevention Program *(Nationaal Programma Preventie, NPP)* is a nation-wide health-oriented prevention program that is not focused on children in particular. Launched in January 2014 by the Ministry of Health, Welfare and Sport, the program is today a joint effort involving six ministries, municipalities, businesses and civil society organizations. The NPP covers five domains: school, work, living environments, health-care and health protection. Child-related aspects include the following:

- Prevention in primary care: The main aim here is to connect public-health professionals with general practitioners. Priority is given to helping primary care professionals – and especially GPs who function as linchpins – improve preventive policies intended to influence lifestyles. Knowledge and online materials are shared in regional meetings and personal advisory courses.
- Healthy School program: The Healthy School Manual contains information, resources and support for health-promotion and educational professionals. The resources can be used in primary and secondary schools, as well as vocational-education schools.
- Healthy Childcare program: A Healthy Childcare Manual has been developed for professionals working in nurseries and kindergartens. The goal is to help create a structural approach promoting the health of young children.

FIGURE 1: **The prevention chain in the Netherlands**



Source: Authors' illustration

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3.3 Recent reforms

The current structure of child and youth policies in the Netherlands, along with the associated administrative architecture, is of quite recent vintage, goes back to an extensive reform in 2015. Since the beginning of 2015, the new Youth Act has given the 355 Dutch municipalities responsibility for the whole continuum of care for children, young people and families in need of help. That means that the municipalities are now responsible for a wide range of services for children and families, ranging from universal and preventive services to specialized (both voluntary and compulsory) care for children and young people up to the age of 18.

Before 2015, universal and preventive structures were also the responsibility of the municipalities. However, the 12 provinces were assigned primary responsibility for the youth care system. The shift of all preventive and care programs for children, youth and families to municipalities has entailed a correspondingly huge shift of administrative and financial responsibilities to the local level.

The reasons behind this reform were diverse. Over years of discussion about the administrative structure for the provision of child and youth-related services, a number of problems with the old system had been identified. As reported by the Netherlands Youth Institute, they can be summarized as follows (cf. Netherlands Youth Institute 2015: 4):

First, there was an "imbalance in focus," meaning that specialized care – compensatory services – received too much funding compared to preventive services. Second, the system of child and youth care was overall rather fragmented, with critical actors sometimes organizationally distant from one other. This was seen as a hindrance to innovation. Moreover, there were too many services that were too specialized. Children and young people were therefore often transferred from one service to the next, with different and complicated admission procedures taking considerable time. This in turn led to increased demand for and usage of care services, even though the total level of problems had not significantly increased. This finally led to growing unmanageability, especially in terms of funding, with a feedback effect in the rising cost structures.

3.4 Influences from other countries and the EU

Both the national and municipal levels regularly seek lessons from other countries to improve prevention in the Netherlands. Our interviews indicated that the Scandinavian countries have traditionally been the preferred source of inspiration. Indeed, the strengthening of the municipalities' social-services role in the context of the 2015 reform came in part from this source. The concept of bundling social-policy responsibilities at the municipal level was in large part inspired by the Scandinavian countries' traditionally strong and universally competent municipalities. However, there are still major differences with regard to general government architecture, the resulting role of the municipalities and society's tolerance for state intervention that make a direct transfer of concepts difficult. Therefore, the view has widened to take in experiences in other countries in recent years. For example, Germany (with the concept of the municipal youth welfare office or *Jugendamt*) and Iceland (with its prevention programs focused on youth crime, addiction and unemployment) are regarded as potential models.

EU funding is used rather sparsely for preventive purposes in the Netherlands. Official documentation of European Social Fund (ESF) funding in the Netherlands shows very few projects that have a direct link to prevention measures for children and young people. Two projects can be viewed as exceptions, however. One of these has sought to enhance nursery school teachers' role in the integration process by improving their skills in teaching Dutch (€12 million allocated in 2014–2020). The other project has focused on training special-needs school teachers (€150 million allocated in 2014–2020). Some additional projects have focused on integrating young people into the labor market, which is one of the current ESF's main goals. However, such projects generally have only a weak (primary) prevention component. In the interviews conducted for this study, we found that officials from all levels of government reported a rather limited use of EU funding for preventive purposes. Municipality representatives often reported that they lacked adequate knowledge regarding the possibility of EU funding, and were additionally reluctant to use EU funding due to fears of bureaucratic hurdles.

4 Preventive policies in the local context

In general, prevention in the Netherlands is understood mainly in terms of health, and is divided between universal or general prevention programs and special (generally more compensatory than preventive) care. Programs in the former category have long been a local-government responsibility, while responsibility for the latter was transferred to the municipalities in 2015.

Preventive work is carried out mainly by the so-called youth healthcare service (*jeugdgezondheidszorg, JGZ)*. Under the provisions of the public-health law, JGZ services must be offered to children and young people by every municipality in the Netherlands. The list of mandatory basic services *(Basispakket JGZ)* was reformed and updated in 2015, in parallel with the transition of special youth care to the municipalities. This basic services list differentiates between different phases of young people's lives, beginning at birth.

As soon as a child is born and registered with the municipality, the municipality will give notice to a branch of the local municipal health service *(the Consultatiebureau, CB*), which is basically a JGZ-affiliated clinic for children up to the age of four. CBs can be run by the municipality or by a private sector provider, but is always financed by the municipality. It is staffed by nurses and doctors, and sometimes even special pediatricians, and offers services such as routine examinations and vaccinations for the child, as well as counseling for the parents. Visits to the CB are free of charge, even if the parents do not have health insurance or are illegally in the Netherlands. Parents and their child are invited to visit the CB for routine check-ups several times during the first four years of the child's life, but such visits are not mandatory. However, according to officials in the municipalities interviewed for this study, most parents take the opportunity to visit

the CB, as the examinations are viewed within Dutch society as being quasi-obligatory. According to officials, this is partially due to the fact that there is no risk of the child being taken away from the parents if severe problems are identified, which may not be the case in the specialist-care institutions. Thus, many parents would rather visit a CB for assistance. Furthermore, if CB representatives see that a family needs some practical help at home, the clinic often has people on staff able to visit the families and provide help. If these individuals see a need for more extensive intervention, they can send the child to special youth care. If a CB refers a child or a family to special care, the individuals are obliged to follow this direction. However, according to municipal officials interviewed for this report, CBs are in some cases not strict enough in this regard, and should be more willing to intervene if a child/family at a check-up obviously needs more (specialized) help.

As soon as the child starts attending school – usually at the age of four – the JGZ offers examinations and guidance in the schools. Every school has JGZ staff, sometimes based in the school itself and sometimes elsewhere, that performs medical check-ups and monitors children's development. These staffers also discuss youth-related problems and difficulties with the young people. Again, use of this service is not obligatory, and parents have to give their consent. The JGZ staff also cooperates with the schools, so teachers can contact the JGZ if they see that a child is having particular troubles, or if there are more general problems in class that might be solved with the help of JGZ staff or other associated organizations.

All information concerning the child's health is stored in a special digital JGZ file up through the age of 18. Only JGZ staff members are authorized to read or add to this file. If a family moves from one place to another, parents have to give their consent to move the file to their new local JGZ organization.

JGZs are financed by the local municipality. However, municipalities receive government funding intended to cover a variety of duties, and can decide on their own how to spend and distribute it. Due to recent budget cuts, municipalities have generally found it harder to fulfill their obligatory tasks; our interviewees noted that this has often led to decreases in funding for preventive measures.

JGZ organization varies across the Netherlands. Most municipalities contract for their JGZ services from a municipal health service (GGD) that typically serves a number of municipalities at once. As of 2018, there were 25 so-called GGD regions in the Netherlands. Representatives of one of our interviewed municipalities indicated that they had elected to drop out of an established GGD area and instead organize their JGZ services jointly with seven other municipalities. Our interviewees noted that these municipalities had felt that their former GGD had focused too much on one comparatively large city at the expense of the other participating municipalities.

In addition to prevention within the health sector, the Netherlands also features some social sector prevention, for example in the form of counseling for young people or their families. As responsibility for such services also falls to the municipalities, there is again no single model for such programs. The most common institutional approach today is the so-called social neighborhood team. The neighborhood teams consist of experts drawn from several different areas, including district nurses and social workers, for example. The teams work with a number of different organizations, and often help connect people in need of specific assistance with experts who can offer this help. Some municipalities have special teams for issues relating to children and youth, while others have more general teams covering several different demographic groups. The teams' services are usually quite easily accessible, so people can seek assistance with any problem they encounter and get help or a referral to another expert; for example, this may be an expectant mother seeking counseling and guidance, or a young person with questions of a sexual nature. The neighborhood teams also work very closely with the JGZ, so if a JGZ staffer identifies a problem best handled by the team, the staffer may proactively reach out to the neighborhood team (and vice versa). A minority of municipalities have instead created CJG centers for youth and family that can be visited by parents and their children.

However, most municipalities use the neighborhood-team approach. In our interviews, we got the impression that municipalities generally regard this model as being more effective with regard to promoting the welfare of children and youth, as the teams are more flexible and have a more direct relationship with their potential clients. By contrast, centers for youth and family focus rather narrowly on issues having to do specifically with children; however, given that most problems faced by children are ultimately family-related, the multidisciplinary strategy pursued by the neighborhood teams allows for a more nuanced approach.

As one official in a municipality that switched to the neighborhood-team model told us, cooperation between different municipalities was more robust when most were using the center for families and youth model for their preventive programs. The coordinators of these centers routinely visited one other and exchanged knowledge on topics such as best practices or common problems. After 2015, these contacts broke down, as many centers were shut down and replaced by neighborhood teams, and it proved initially difficult to locate the relevant contacts in other municipalities. Very slowly, however, contacts and cooperation between municipalities on issues of prevention are being reestablished, in part to the realization that economies of scale are possible in financing preventive measures. As the official said, "learning spaces," or less formal fora for officials to exchange information, are now being established as a nationwide trend.

Municipalities are free to offer additional preventive services and establish additional organizational structures beyond these two primary models. In the following section, we will report on the findings from interviews conducted with officials of three different municipalities in the Netherlands. The three municipalities have each pursued different prevention models, with different environments and different sizes. Municipality A is a rather big city with around 100,000 inhabitants, and is located in a still-bigger metropolitan area. Municipality B is a mid-sized city (around 40,000 inhabitants) in a smaller metropolitan area. Municipality C is a rather small city of 20,000 inhabitants in a largely rural area. All interviews were conducted in October 2018.

Municipality A is one of the few cities that retained the center for youth and family (CJG) model. As our interviewee told us, the municipality's decision-makers did not "believe in the sense of social neighborhood teams," and therefore elected to stick with the CJG, even expanding its responsibilities. This municipality developed a special prevention approach, and differentiates between three prevention types: universal prevention, risk-oriented prevention and problem-oriented prevention. Universal prevention is essentially everything the municipality does to prevent children and young people from "getting into trouble," mainly through the services contained on the basic list of JGZ services. By contrast, problem-oriented prevention covers all measures employed by the special youth care organizations that are implemented when a young person already has certain, often severe problems. Risk-oriented prevention falls somewhere between the other two types, focusing on risks likely to be encountered by certain groups and trying to deal with them before problems arise. A particular goal here is to prevent situations in which children need to be brought into special care. As the municipality's

social-services providers are aware of the difficulties in targeting only those children in the community that are exposed to such risks, they instead address all children with their measures. Currently, they are running a pilot project in a neighborhood that is home to many at-risk children, working jointly with a primary school and a team of researchers. For the first step in this pilot, the group identified potential risk factors, and then in a second step designed measures to tackle those risks. The model for this approach was taken from Sweden; indeed, the municipality even brought officials and practitioners from Sweden to meet with people from the Netherlands to exchange ideas and potential policy designs. The idea behind the project is that if children are successful in school, they will also be more empowered and have greater self-esteem in other areas. As the project has shown initial success, there are plans to expand it, with several principals from other schools having signaled an interest. This risk-oriented preventive strategy is classified under the municipality's non-obligatory tasks; as noted, the law only prescribes some basic tasks, leaving the municipality freedom to pursue more measures if its decision-makers are willing to spend the money.

Another program in this municipality focuses on young children having difficulties in learning to speak properly, this time involving cooperation between two organizations. In this case, the municipality has partnered with a center that specializes in children's speech difficulties; if the JGZ or CB identifies a child with speech issues, it can send the child to the privately run center, which will provide specialized assistance. This "Behind Language" program is financed by the municipality, once again as a non-obligatory service.

This municipality is also worthy of notice for the way in which its JGZ health service functions. Usually, a JGZ has two different levels: a basic level for (mainly) child-related problems, which handles individual and generally relatively simple cases, and a more general level (the "social team") that handles several problem areas. Most municipalities use the general team for initial interactions with clients, even if the case appears to be relatively simple; however, this municipality sends clients initially to the lower-level prevention team, activating the generalist team only in the case of families or cases with multifaceted problems. This is very similar to the way youth care facilities work, as it allows case workers to address a problem from multiple angles; however, JGZ care is not mandatory, so many people prefer to try this avenue of assistance before reaching out to institutions that may have a more intrusive approach.

Municipality B has switched to the neighborhood-team approach in recent years. According to an official from the municipality, this was due to the fact that the CJG model focused too narrowly on children's issues, and the municipality wanted to broaden its approach. The connection to other thematic areas in particular has been of great importance; the municipality's decision-makers wanted to create a more unitary approach, connecting different organizations and actors. The underlying mode of governance was described by one interviewee as "no-management" (sic), meaning that every actor depends on the other actors, with everybody "managing" the others. Under such a system, it is vital to remove barriers between different sectors and areas. To ensure that staffers adopted the necessary mindset, the municipality changed practices within the administration itself; for example, all persons concerned with children/youth issues now gather in weekly sessions to "pitch" what they are working on, identify what they want to change and describe how this could be accomplished by coordinating with other actors. This is already showing initial results, with a new way of thinking taking root, the interviewee said.

Secondly, according to the official, all municipalities have had access to youth care data since the transition in 2015. This data provides information on how much money is spent for whom and what in youth care. This data can be used to gather information about events that have led cases to be escalated into the youth care system. This knowledge may in the future make it easier to prevent such events from taking place in young people's lives, and thus prevent others from being taken into the special-care system. As previously noted, municipalities are required to pay for every case in youth care, while preventive measures apart from JGZ are generally implemented on a voluntary basis. Consequently, a rather significant proportion of available funding goes into youth care, while the budget for prevention is generally much smaller. According to the interviewee, effective prevention could lead to fewer cases being escalated to the special-care system, which in turn would enable the municipality to spend more on comparatively less invasive services. The municipality is therefore developing a so-called integrated approach that would combine and coordinate preventive and invasive services by taking advantage of this newly available youth care data (an evidence-based measure). This approach also coordinates different municipal departments and addresses multiple life phases, leading to a rather holistic prevention policy.

Municipality C is a rather special case. While its features differ somewhat from the other cases, it nevertheless lends itself to some interesting findings. The share of the population represented by children and young people here is very high, with nearly 50 % of the inhabitants under the age of 25. Moreover, churches and religion play a big role in local residents' lives. The municipality has retained the CJG approach; however, according to the official interviewed, churches also engage in significant preventive work outside the context of "official" services. In many cases, the municipality is unaware of such activity until a case comes to need special care, which is the duty of the municipality. However, the relationship between churches and the municipal administration is currently undergoing change; for example, a voluntary care foundation, which provides prevention services and cooperates closely with the municipal government, has installed a contact person within the community and has plans to refer problematic cases to the municipality. This will give the municipality's social services an early awareness of social problems, enabling them to take the measures needed. For their part, the churches too have also acknowledged their special role within this social-services constellation, and want to use their influence to support prevention.

In addition, the municipality has recently initiated a so-called productive partnership with primary and special-care providers, with the aim of bringing them all together to exchange insights and information on various aspects of care twice a year. According to the official interviewed for this report, prevention will be one of the topics addressed. The municipal administration acts as a facilitator for these meetings. Additional meetings between the various providers may also take place on an informal basis.

The education sector is viewed as a considerable problem in this municipality. On the one hand, many local children do not attend preschool due to widespread religious influence. Parents often prefer to care for their children at home, but typically lack the pedagogical capacities needed. To change this, the preschools are currently trying to involve parents directly by, for example, providing them further information that could motivate them to bring their children to the schools. According to the local official, this approach seems to be successful. The municipality has also started a program for children who speak only the local dialect, allowing them to attend preschool classes. On the other side of the educational age spectrum, many children and young people drop out of school before receiving a qualification of any kind in order to go to work. The municipality is home to several large industrial employers that are always on the hunt for new workers. The municipal administration has sought to mitigate this trend in cooperation

with the churches, asking them to encourage young people to finish their school career. The municipality itself offers support in helping young people find another school or vocational-training placing, but needs the churches' help in order to get in contact with the relevant individuals.

As of late 2018, this municipality was also exploring an approach "imported" from Iceland. The goal of this policy is to "make policy out of figures" – that is, by designing preventive policies on the basis of the observation of actual needs. To begin, the municipality sent out questionnaires to local children and young people to obtain information about their needs, wishes and problems. With this information, municipal decision-makers believe they will be able to better tailor their measures to local residents' needs. Generally speaking, this municipality heavily emphasizes evaluation; administrators meet with care providers four times a year to get feedback on what is going on, what has changed, and so on.

In general, all interviews conducted with municipal officials strengthened the impression –further validated by an official from the Netherlands Youth Institute (NJI) – that the biggest problem in the Netherlands with regard to prevention is the fragmentation of task responsibilities at the local level, which is facilitated by the high degree of independence accorded to the municipalities. There is no common organizational principle; a fact that has only been exacerbated by the 2015 policy transition. This has led to disparities between the large cities, which always have cooperated with other municipalities and the provinces, and comparatively smaller cities, which have been overwhelmed by the reform and the new tasks assigned to them. Nevertheless, all municipalities seem in general to be pleased to have gained the new responsibilities, in part due to the generally strong belief in the value of local autonomy. This is why the NJI has argued that cooperation between different sectors, especially between schools and municipal administrations, is a promising approach. To support such efforts, the NJI has sought to provide localities with relevant know-how. On their own, municipalities are likely to be unable to establish such cooperative ventures; the national level can offer valuable assistance in this regard.

However, as we were told by officials in the Dutch Ministry of Health, Welfare and Sports, the national administration has very few "buttons to push" in the municipalities. This is also why there are very few government-led programs aimed at strengthening particular prevention services. However, according to the ministry, such programs are

in fact neither necessary nor useful, as the municipalities are closer to the people who need this kind of service. In fact, before 2015, when the provinces were still in charge of youth care, there was little contact between youth care services and the schools, whereas today the municipalities and the schools are in frequent contact and cooperate in many areas. National cooperation also exists in the educational sector; in some cases, for example, school associations work with the Association of Netherlands Municipalities (VNG) and the ministries of health, welfare and sport and education, culture and science to strengthen cooperation on the local level, according to the NJI. And, as noted above, a political coalition made up of a variety of different actors is currently seeking to strengthen cooperation between schools and youth care services in 11 pilot regions; this bottom-up process, as one expert involved told us, is expected to lead to similar such projects across the Netherlands.

A VNG official responsible for special care told us that schools often hesitate to cooperate closely with special care providers, as they are fearful of the stigma that might result; however, such cooperation could be useful, as special care providers are able to gain valuable insights into problems at an early stage, potentially allowing for less-invasive measures to be taken rather than bringing a child into the special care system. Actors within the municipalities are only slowly becoming conscious of these advantages.

According to the NJI, care providers can cooperate on the national level on an informal level via board meetings; in so doing, they can exchange information and insights regarding best practices. The NJI, along with certain ministries and the VNG, is working to facilitate this exchange. However, there is a considerable amount of fragmentation in the care sector, meaning that professionals often take quite different approaches to problems due to the lack of cooperation. National support would be helpful in overcoming this situation, the NJI official said.

Although the government provides no direct financial incentives to strengthen prevention policies, the municipalities ought to be able to see the advantages offered by effective prevention policy. For example, special care services consume a huge amount of money, even though they are not always successful. According to our interviewees, preventive measures could help avoid such problems, even if benefits may become visible only after several years. However, municipalities are paying attention to the Scandinavian countries and can see the results achieved there; according to officials in the municipalities, this evidence has proved increasingly convincing for the politicians.

5 Evaluation

All in all, the picture of preventive policy in the Netherlands is a differentiated one. Prevention is entirely the responsibility of the municipalities, which are able to act quite independently of each other and the national government. By law, the municipalities have to fulfill certain tasks and provide certain services; however, these mandates leave considerable leeway for individual interpretation and additional voluntary action. Health services are more extensively regulated than other areas thanks to the mandatory list of basic JGZ services that applies nationwide. Moreover, these services have a low threshold for access, with preventive health services being viewed as virtually obligatory for parents and their children, especially at young ages. However, other aspects of prevention policy lack this degree of commitment. This is in part due to the fact that although municipalities have today been assigned the full spectrum of responsibility in children- and youth-related areas, only health issues are regulated in detail by the national government. The social-services sector in particular has little in the way of nationally valid regulations, with most details left to the individual municipality. This produces a considerable degree of variation. By law, the municipalities are obliged to provide basic / general preventive social services, but are free to decide on the model and organizational structures employed. Since the 2015 reform, two basic models have been in place, respectively focused around the neighborhood teams and the centers for youth and family. The latter was the dominant model prior to 2015; however, our research showed that many municipalities decided to switch over to the neighborhood-team approach due to its greater flexibility. However, use of such services is ultimately voluntary, so local residents are free to choose whether they want to consult a neighborhood team or youth and family center if they have a problem.

The quality and intensity of cooperation between municipalities differs depending on the policy area. In the social-services domain, cooperation was strong when all municipalities followed the center-based approach, as policy coordinators would regularly meet to exchange information. When the neighborhood-team model rose in prominence, there was less clarity regarding potential contacts in other municipalities, so cooperation diminished substantially. However, as the initial reform period has come slowly to an end, administrative and social-services staffers are once again finding time to seek out contacts in other municipalities and reestablish a form of cooperation. This has evidently taken place more consistently in the larger cities, where policy directors told us that they have developed informal channels for the exchange of information and experiences; in general, we got the impression that large cities have weathered the reform process more easily, while smaller municipalities have found themselves somewhat overburdened. In smaller municipalities, the role of individual persons in youth-policy departments is comparatively far more important. In such areas, proactive departmental leaders, as long as they are paired with mayors and councils open to new preventive approaches, have been able to find promising ways forward. However, the opposite appears to have been the case rather frequently as well.

Due to the budget cuts that came along with the shift of responsibilities in 2015, municipalities have had to balance funds available for their new range of tasks very carefully. As a consequence, obligatory tasks such as special youth care programs receive more money than do the mostly voluntary preventive tasks. This financial shift has been accompanied by a shift in general awareness toward compensatory aspects of care; as special care measures come with a high price tag, many municipalities have sought to redesign them in a more cost-effect way. For example, they have created informal geographical areas in which the various municipalities work together to coordinate their special care services. However, awareness of the potential benefits associated with preventive measures is rising. The main driver in this regard is usually the issue of cost; municipalities hope to lower the costs of special care by reducing the number of people in need of special care – according to our interviewees, the underlying logic is that early and preventive measures might prevent people from falling into difficulties resolvable only through compensatory special care. As logical as this argument appears to be, many representatives of local youth-services departments reported that their heads of local government have demanded data-based evidence indicating that investments in prevention would save money in the future.

Finally, in the health sector, there are several geographical areas in which municipalities are working together to fund the services to be provided by the JGZ. However, decision-makers from one of the interviewed municipalities reported that they had found this model to be ineffective; consequently, they had organized their commissioning of JGZ services differently, cooperating with a different grouping of surrounding municipalities. Our research indicated that similar shifts have taken place elsewhere as smaller municipalities have seen their interests take a lower priority as compared to those of larger cities in the cooperation zone.

The character of cooperation within municipalities, especially between the various entities active in the field of prevention, is also very mixed. The social neighborhood-team approach is promising, as it allows different actors from different sectors to work together to find the best solutions to problems. However, barriers between the social-services, health and education domains typically remain. Nevertheless, according to one official in a municipality that has switched to this approach, coordination and cooperation are slowly increasing, with the administration itself taking promising first steps. It will clearly take more time before the prevention-policy sector can be fully restructured around this team logic, as the major reforms initiated in 2015 remain relatively fresh. In the municipalities we visited, certain semi-formal or informal exchange platforms had been established with the goal of bringing together actors in the children and youth-services sector. However, we got the impression that officials in these municipalities also hoped that actors would develop the habit of exchanging information on their own, outside of venues organized by the municipality. Our interviewees noted that it was common to have several preventive projects running in parallel without knowing of each other's activities. Exchange fora could help to better coordinate actors working on preventive projects.

Cooperation with the educational sector presents another problem. Due to the constitutionally mandated freedom of education, it can be difficult for municipalities to establish working relationships inside or with the schools beyond the context of JGZ services. However, in one of our focus municipalities, a promising pilot project is underway that is bringing together actors from a school and actors working in prevention in other sectors. Our interviewee told us that more schools are interested in adapting the measures being tested in the pilot project. A similar approach is currently being developed by political coalitions in 11 regions, which aim to improve cooperation between schools and further actors. Furthermore, representatives of the VNG indicated that there are

plans to integrate actors from the special care services into schools; the goal here would be to use their expertise to prevent children from being placed into special care in the first place. However, schools have shown some hesitation in allowing this, fearing that it would stigmatize both the schools and the pupils.

The exchange of information between actors engaged in prevention, whether across sectors or between different municipalities, is not generally regulated even when a specific individual's information is involved. The only exception here is the health sector, where digital JGZ files are created for each child and young person, which can be assessed by a variety of medical staffers. In other areas, we got the impression that individual actors rarely have a good idea what counterparts in other sectors or geographical areas are doing; indeed, when communication does exist, it tends to be of a general nature, talking about general problems rather than individual cases. The neighborhood-team approach seems to be an appropriate means of overcoming this situation in the long run, at least if it is adapted consistently and lends itself to the development of truly cross-sectoral networks. In the municipality that shifted from the youth and family center model to the neighborhood-team model, we got the impression there is still much work to do. However, this is also the municipality that is currently experimenting with a data-driven approach to prevention; here, data on the special youth care services should help to identify and address risk factors that appear in different life phases. This approach seems to be promising, as all municipalities have had access to this kind of data since 2015, and could use it to develop integrated, evidence-based prevention policies that improve the situation of children and young people. Another of our example municipalities has developed a risk-oriented approach with a similar logic, which tries to identify risks or potential risk factors and then seeks to address these with general policies that benefit all children.

6 Conclusion

It is probably too early to evaluate the success of the prevention policies currently being implemented in the Netherlands. The 2015 reform shifted all responsibilities relating to children and young people to the municipalities, providing them with the opportunity to use this new constellation to expand preventive measures. In many Dutch municipalities, this was achieved through the introduction of the social neighborhood teams; these multidisciplinary teams bring together professionals from different policy areas to build networks and find the best solutions possible for problems faced by mothers, children or young people. However, apart from the nearly completely centrally regulated health services, most preventive measures are still implemented by the municipalities, which act independently. This has led to a patchwork system, with extensive preventive measures evident in large and wealthy municipalities, and no more than basic services in other municipalities, sometimes even lacking significant public sector participation (as seen in one of our example municipalities). The independence built into the educational system represents another hurdle to the establishment of comprehensive prevention measures. The constitutionally guaranteed freedom of education, which has meant that most schools are not operated by the public sector, has hampered information exchange and cooperation between municipalities and schools.

The Netherlands' current prevention-policy landscape and its ambivalent features are illustrated in our case scenarios (see info box) from the core inventory included in our comprehensive report "Making Prevention Work. Preventive structures and policies for children, youth and families. A comparative study in 12 European countries." Especially in the early years, we find a significant degree of convergence: the primarily health-centered services in the first two scenarios are more or less equivalent between the municipalities. For instance, expectant mothers seeking counsel during their

Info box: Case scenarios

Scenario 1) Pregnancy: Midwife, regular examinations
Scenario 2) Issues of special concern in the first 12 months of age: Municipal health service (*Consultatiebureau* of the GGD)
Scenario 3) Infants (1–6) with behavioral problems: Daycare facility, municipal health service (*Consultatiebureau* of the GGD)
Scenario 4) Children (6–12) with behavioral problems: School psychologists and social workers, often in "school care and advice teams" from the municipal multidisciplinary social neighborhood team *(wijkteam)*
Scenario 5) Youths (12–18) with violent behavior: School psychologists and social workers, often in "school care and advice teams" from the municipal multidisciplinary social neighborhood team *(wijkteam)*
Scenario 6) Family filing an application for social assistance: Depends on the municipality; multidisciplinary social neighborhood team that brings municipal actors from different services together might offer further services

pregnancy, or whose children are showing certain abnormalities, will consult the JGZ-affiliated health clinic. The institutional structure used to deliver such services varies – while most municipalities are part of larger groups of municipalities that contract for these services with a central body, some organize it differently. Nevertheless, the basic package of services is legally prescribed by the government and is binding in all municipalities. However, with regard to the education and social-services sectors, municipalities are more independent, showing what can be great variation with regard to the content and structure of their preventive services, as evident in scenarios 3 to 6. This can be seen, for example, in the differences between municipalities A and B: while the former stuck with the "old" center for youth and family structure (and even expanded the center's responsibilities), the latter locality has adopted the neighborhood-team model, and is working to enhance its preventive services through analysis of case data. The approaches taken by these two municipalities to the definition and delivery of prevention also differ. Municipality A uses a so-called risk-oriented approach addressing every child, seeking to reduce risks for all children, while municipality B takes a more integrated approach, combining preventive and more invasive corrective services with the use of big data. Thus, it can be seen that children, young people with problems (and also families filing applications for social assistance, for whom *wijkteams* could offer

certain additional services) are treated rather differently across the different municipalities, depending on the policy structure and prevention approach.

Overall, it appears that the success of preventive policy in the Netherlands largely depends on three factors:

- Financial resources. The recent budget cuts in particular have resulted in a heavy burden for the municipalities.
- Consistent cooperation within the local administration, and with key entities in the healthcare, social-services and education sectors. This is most obvious within the social neighborhood teams. Cooperation between municipalities is also of importance especially for the smaller localities; these entities have struggled to implement the 2015 reform, and have thus had little ability to design new prevention-policy architectures.
- Administrative personnel committed to the cause of prevention. This may be the most of the factors; such staffers are able to organize and facilitate the cross-sectoral exchange of information, and can help coordinate preventive measures.

The combination of extensive municipal task responsibility in areas having to do with children with multidisciplinary teams in the municipal administration certainly holds the potential for transfer to the German context or to other European countries. The Netherlands' 2015 reform showed that in principle, concentrating all services for children and young people at a single administrative level can enhance information flow and cooperation between different services. However, the reform also showed how organizational reforms combined with budgetary cuts can place local administrations under severe stress. This stress made the actual work more difficult; moreover, preventive services lost priority during the course of the reform. Thus, the new structures and responsibilities have only slowly begun to demonstrate their true potential and yield benefits in practice. It will be interesting to see how the different systems perform in the next years, how they might change and if there will be learning (and convergence) processes between the municipalities. Another lesson from the Dutch case is that it is much more difficult for the municipality's preventive services to maintain contact with children, and to detect needs at an early date, after they start school. This is an issue specific to the structure of the Dutch education system, and could not be solved with the 2015 reform. However, keeping track of older children's needs is a common problem for prevention policies in many European countries, and should be taken under consideration in further discussions of reforms.

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Making Prevention Work – Comprehensive Report Preventive structures and policies for children, youth and families

This publication features research for use in developing prevention policies. Drawing on a universalist and integrative concept of prevention, the study summarizes and compares prevention structures and practices in 12 EU member states: Austria, Czech Republic, Denmark, England (UK), Finland, France, Germany, Ireland, Lithuania, the Netherlands, Spain and Sweden. It identifies potentially transferable practices as well as the common policy challenges facing all European countries. Making Prevention Work also features case studies of prevention systems in Austria, France and the Netherlands that offer relevant findings for policymakers and prevention professionals across Europe.

Making Prevention Work – Case Study Austria

As a supplement to the "Preventive structures and policies for children, youth and families" study, the analysis of Austria presented here examines how prevention is implemented in Vienna, Graz, rural Styria and through the country's Early Prevention initiative, offering insight into the potential transfer of measures. Two further analyses of prevention are also available for France and the Netherlands.

Making Prevention Work – Case Study France

As a supplement to the "Preventive structures and policies for children, youth and families" study, the analysis of France featured here offers a close look at prevention chains in France and the competences, institutions, services and networks promoting equal opportunities for children throughout their life course. Two further analyses of prevention are also available for Austria and the Netherlands.

As part of an exhaustive cross-national study of prevention activities across the EU, this publication offers a close analysis of how prevention works in the Netherlands and of the structures of cooperation driving it forward. It explores the factors contributing to sound implementation through the 2015 reform that shifted all competences regarding family affairs to municipalities.

The examples presented in this close-up look at the Netherlands illustrate how regulatory authorities and preventive measures work along the life course of a child. The inclusive access to prevention through the public health sector is a major asset, as is the country's neighborhood-centered approach that is carried out by teams of professionals from various fields or family centers.

This publication is one of three case studies featured in the four-part cross-national study "Making Prevention Work" conducted by the Bertelsmann Stiftung in cooperation with the German Research Institute for Public Administration. Designed to identify facilities and institutional arrangements with positive impact in 12 EU countries, the study aims to facilitate an exchange of good practices with potential applicability for welfare systems in various national contexts.

Making Prevention Work draws on research findings associated with the German initiative "Leave no child behind!" ("Kein Kind zurücklassen!") that show how local support mechanisms and institutions can have a positive impact on disadvantaged children and their families. The initiative demonstrates just how effective a few good preventive measures can be in improving the educational opportunities of disadvantaged.

In addition to the close-up look at the Netherlands presented here, Making Prevention Work features two further case studies – Austria and France – as well as the comprehensive report "Preventive Structures and Policies for Children, Youth and Families."

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