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MENTAL HEALTH, YOUTH CARE, AND CHILD PROTECTION IN THE NETHERLANDS
SYSTEMIC CHALLENGES, INSTITUTIONAL ACCOUNTABILITY, AND THE EXPERIENCES OF FAMILIES

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INTRODUCTION

Mental health is integral to personal and social health and wellbeing and impacts on psychological, emotional and social development throughout the lifespan. Mental health is especially important for children and adolescents as it affects their educational, relationship, physical health, and adult functioning. Youth-care and child-protection services are frequently involved in supporting and protecting vulnerable children when they experience psychological stress, family strife, abuse, and/or neglect, or when they live in a socially unstable environment. But the success of these systems is dependent on not only the provision of services, but on professional accountability, evidence-based decision making, recognizing family rights and having effective processes for challenging decisions.

Youth care and child protection in the Netherlands is provided in a multi-layered institutional system where social workers, mental-health professionals, municipalities, certified child-protection organisations (Gecertificeerde Instellingen), the Child Protection Board (Raad voor de Kinderbescherming) and the courts play a role. Since the decentralisation introduced by the Youth Act of 2015, municipalities are primarily responsible to organise youth care and certified institutions are responsible for carrying out compulsory care measures, like supervision orders (ondertoezichtstelling) ordered by a judge. These institutions have a lot of power; they can have children supervised, limits on parental access, or the child removed from the home. The process that leads to decisions, the evidence on which they are based and the means of contesting them are legitimate issues of public concern because they may have long-term effects on children and parents.

The key issues that have been found in comparative studies of child protection systems are problems with professional judgement, differential communication with families, differential access to timely help and harm arising from over or under intervention. Transparency and independent oversight are especially critical because families are often highly distressed when they feel their concerns are not being listened to or when the information upon which decisions are based or inconsistent.

In this article, these dynamics are explored from the perspective of the Netherlands and in relation to the interplay between mental health, youth care, social work and child protection. It focuses especially on institutional accountability, the accuracy of professional reports, family separation, concerns for safety, and the psychiatrist's role in the treatment of children and adolescents with psychiatric medication. Several types
of evidence for the study are presented, including official evidence from the inspectorate, child and parental accounts of their experiences, and research findings; here the accounts from parents and children are presented as one source of evidence and are used to understand how youth-care processes are experienced, not as independent evidence of fact, and are discussed alongside official evidence from the inspectorate and research findings, not as evidence in themselves.

Another theme is the risks associated with children taking psychotropic drugs. Claims of psychiatric drug risks are well documented and peer reviewed, or they are more speculative claims that have not been substantiated in the scientific literature. The discussion should be responsible, clearly differentiating between the two and basing it on systematic reviews and regulatory information, not on anecdote or extrapolation.

The general conclusion of the article is that for effective youth care to take place, children must be safeguarded from real risk, there must be procedural justice, accurate documentation, meaningful consultation with the child and their parents, professional accountability, and independent review of the outcome of the consultation. The mental-health context for Dutch youth, the institutional context of youth care and child protection, issues of accountability and reporting, issues of family separation, concerns about safety, psychiatric drugs and potential reform directions are explored, one by one. The author's perspective is informed by more than 20 years of professional experience working within organisations connected to mental-health and related services. This experience has shaped the author's concerns regarding institutional practices, psychiatric treatment, accountability, and the effects of interventions on individuals and families. These experiences are presented as

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part of the author's perspective and are considered alongside independently documented evidence, published research, official reports, and other available sources.

MENTAL HEALTH AND YOUTH WELLBEING IN THE NETHERLANDS

Mental-health difficulties among children and adolescents are common and, on several measures, increasing. The TRAILS cohort study of Dutch adolescents found that by late adolescence a substantial share of young people had experienced a diagnosable mental disorder at some point, with anxiety disorders the most common but generally the least severe, and mood and behavioural disorders less common but more often severe (Ormel et al., 2015).

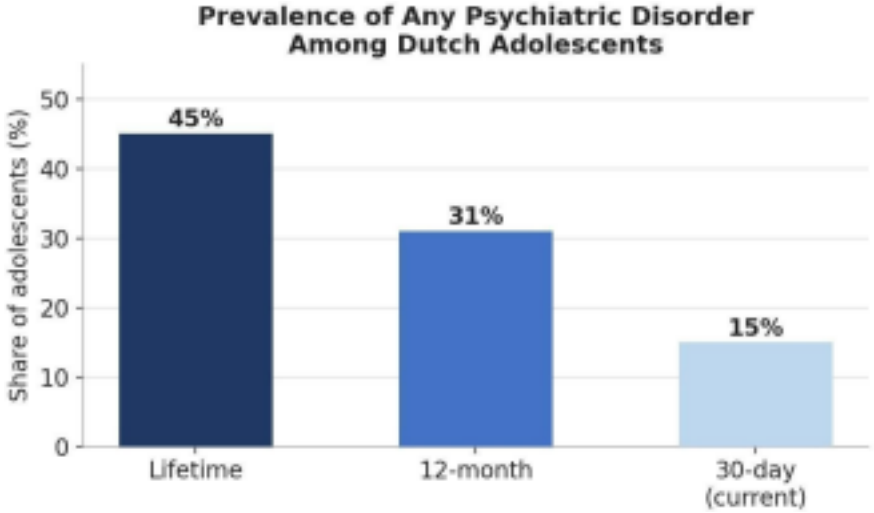

Figure 1. Prevalence of any psychiatric disorder among Dutch adolescents by time frame. Source: Ormel et al. (2015), TRAILS.

A large-scale burden-of-disease study covering nearly 54,000 Dutch secondary-school pupils found that anxiety and depression, including depression accompanied by suicidal ideation, represented a substantial source of disability among adolescents aged 13 to 15, with the burden concentrated disproportionately among girls (Klaufus et al., 2022).

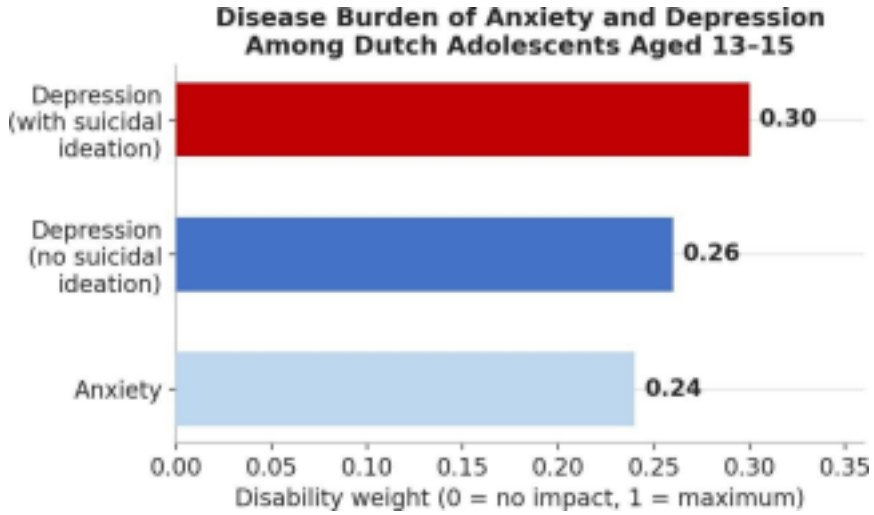

Figure 2. Disability weight of anxiety and depression (with and without suicidal ideation) among Dutch adolescents aged 13–15. A higher weight reflects a greater estimated impact on functioning. Source: Klaufus et al. (2022).

Research using Dutch general-practice records has similarly shown a rising incidence of recorded anxiety problems among children and adolescents, with the highest rates among adolescent girls, and a meaningful proportion of these

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children receiving referrals to specialist mental-health care or a prescription for psychiatric medication within the first year of presentation (van Dijk et al., 2022).

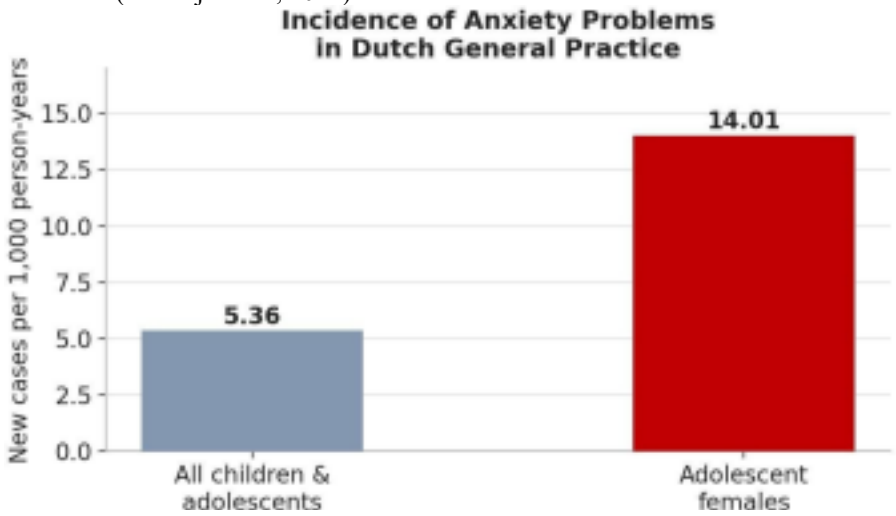

Figure 3. Incidence of anxiety problems recorded in Dutch primary care, overall versus adolescent females specifically. Source: van Dijk et al. (2022).

These patterns are part of a broader global phenomenon that mental-health problems tend to manifest in early adolescence, and also have implications for the Dutch youth-care system. Along with the increasing demand for youth mental-health services, the number of youth accessing youth care has also increased: According to national statistics used in health-system reviews, around 23 per cent of young people in youth care services were in care between 2015 and 2022, with waiting times for care increasing to approximately 10 months in some regions (Eurohealth Observatory, 2024). This growing need puts pressure on an already fragmented system, and, as noted below, several inspectorate assessments show that the system is under-resourced.

Mental-health difficulties among children and young people are seldom unrelated to their social and family environment. Emotional and behavioural difficulties may occur in association with family conflict, parental psychological difficulties, substance misuse within the family, socioeconomic disadvantage, school-related stress, and exposure to maltreatment. These factors should therefore be considered when understanding children's behaviour and wellbeing rather than interpreting behaviour exclusively through a disease-based framework. The interaction between psychological wellbeing, family circumstances, social conditions, and youth-care involvement is particularly important when considering decisions concerning children and their families.

It provides a solid base for early identification of difficulties (as summarised in the Bocca-Tjeertes literature on child and youth health care prevention) and is offered to 18. Yet there is a need for further enhancements in health literacy, consistency of specialised support for children in disadvantaged situations and the integration of data across services, which are also likely to help enable better, child-centred and coordinated youth care decision-making.

The collection of evidence as a whole suggests that the need for mental health services among young people in the Netherlands is significant and, in certain aspects, is increasing at a quicker pace than the services that are available to address this need. The context is necessary to understand the pressures that are experienced within youth-care institutions and the experience of families who interact with them is explored in the sections to follow.

YOUTH CARE AND CHILD PROTECTION: INSTITUTIONAL FRAMEWORK.

The organization of youth care and child protection in the Netherlands is done in a distributed institutional structure instead of a national authority. There are several hundred municipalities, each with a statutory role in organising and funding youth care, and replacing a previous system in which care was organised and funded by provincially organised Bureau Jeugdzorg offices. In this context, different types of institution have different roles. Families usually reach out to a municipality or neighbourhood team (wijkteam) as their first point of contact for voluntary assistance. Youth mental-health services (jeugd-GGZ) offer therapy for those with a diagnosed psychological disease. Concern about children's safety is reported to and evaluated at Veilig Thuis, the regional reporting centre for domestic violence and child abuse. The Child Protection Board (Raad voor de Kinderbescherming) conducts investigations of cases referred to them and may ask the court to take a compulsory

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measure for the child's protection. An order by a court to make such a measure is usually a supervision order (ondertoezichtstelling) and is implemented by a certified institution (Gecertificeerde Instelling), usually via a designated family supervisor (gezinsvoogd or jeugdbeschermer).

This configuration can lead to a family having a number of disparate experiences with youth care services each in turn, and, in practice, each with its own workload stress. If a concern is raised about a child, professionals are expected to use the standardised risk-assessment tools and to record this in a way that can, if Where necessary, need to be reviewed by court. The process should be transparent to the family, so that parents and, as the child grows, children are informed of concerns raised, heard in the course of an assessment and present at case conferences at which decisions are made regarding the care of the child. However, studies on child participation in Dutch youth care have revealed that the participation of children and young people is not always well realised in practice; in some cases, children and young people are consulted on decisions without fully informing them of these decisions (as was found in the research into children's participation in youth-care practice). Judicial supervision is supposed to be an extra security check. A supervision order is only given by a children's judge (kinderrechter) and is based on a request from the Child Protection Board and an evaluation of the evidence available. Parents can get legal representation and appeal decisions. However, in practice, youth-care professionals' reports and recommendations play a significant role in decisions, and the accuracy, comprehensiveness, and even-handedness of professional reporting goes to the heart of decisions, as explored in the following section.

It has also undergone a continuous process of reorganization. Further reform has followed reform as the current national effort, the Reform Agenda Youth 2023-2028 (Hervormingsagenda Jeugd), was agreed upon between the national government, municipalities, providers, professional associations and client organisations in June 2023, with the specific goals of enhancing the quality of care and achieving financial sustainability
(VNG, 2023). The frequency of reform itself is instructive, as it is a sign of a system's institutional design that has not been able to keep up with the increased demand, staffing problems and financial pressures at the municipal level, which ultimately impact the consistency and reliability of decision making, as discussed in the subsequent sections.

INSTITUTIONAL ACCOUNTABILITY AND PROFESSIONAL REPORTING

Because compulsory child-protection measures rest heavily on professional assessment, the accuracy and reliability of that assessment is central to the legitimacy of the system. Reporting failures can, in principle, run in either direction: a professional report may understate genuine risk to a child, or it may overstate risk, rely on incomplete information, or fail to adequately capture a family's own account of events. Both types of error carry serious consequences, and both have been documented in the Dutch context, though through different channels of evidence.

Official supervisory bodies provide the most reliable, independently verified picture of systemic weaknesses. The Health and Youth Care Inspectorate (Inspectie Gezondheidszorg en Jeugd, IGJ), working alongside the Inspectorate of Justice and Security, has published a series of newsletters and reports since 2022 documenting serious and persistent problems within the child-protection chain. In September 2022, the inspectorates formally warned the responsible ministers that their own instruments for intervening in the system were exhausted, and that the most vulnerable children were being put at further risk as a result (IGJ, 2023). Subsequent monitoring found that, as of January 2024, roughly 1,500 children subject to a court-ordered protection measure had no permanently assigned family supervisor, despite an increase in staffing at certified institutions between mid-2023 and early 2024; only four of thirteen certified institutions were able to operate without a waiting or throughput list for children awaiting a supervisor (IGJ, 2024). A 2025 regional inspection report similarly found that the timeliness of appropriate help for children and parents under supervision was, in the inspectorate's own assessment, largely inadequate, with families frequently waiting months between a court hearing and their first substantive contact with an assigned professional (Inspectie Gezondheidszorg en Jeugd & Inspectie Justitie en Veiligheid, 2025).

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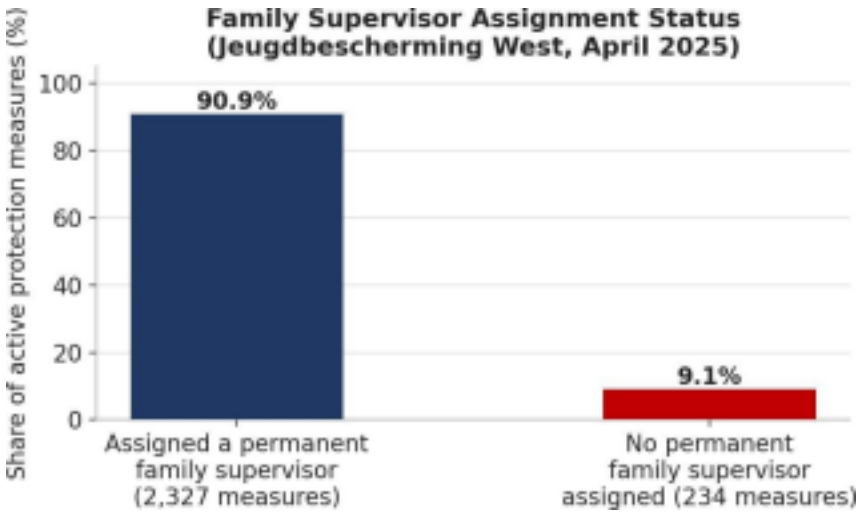

Figure 5. Share of active child-protection measures with and without a permanently assigned family supervisor, one Dutch region, April 2025. Source: Inspectie Gezondheidszorg en Jeugd & Inspectie Justitie en Veiligheid (2025).

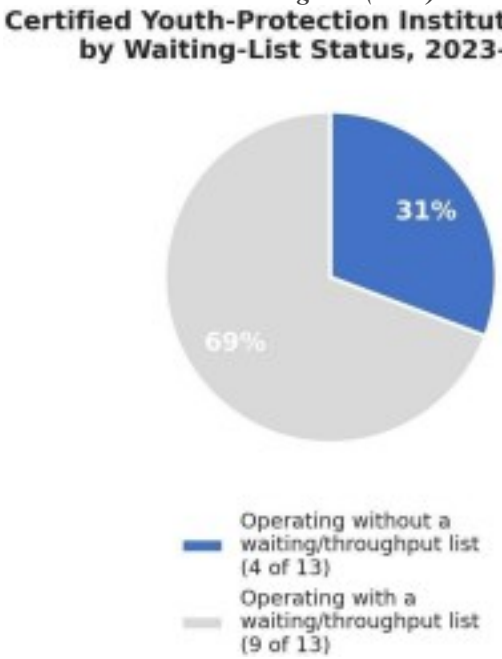

Figure 4. Certified youth-protection institutions (GI's) operating with versus without a structural waiting or throughput list for assigning family supervisors. Source: Health and Youth Care Inspectorate (IGJ), 2024.

These findings are directly relevant to issues of accountability and reporting errors. A system where caseworkers rotate jobs often, cases sit out of supervision for long periods of time, or caseworkers don't have time to collect all the information is a system where the risk of incomplete, outdated, or poorly substantiated reporting also can increase not because of any one caseworker's competence or intentions. This is exacerbated by financial constraints: average profit margins of youth-care providers were down to only 0.1 percent in 2023, resulting in youth-care facilities being shut down and a growing waiting list, in at least one documented case in Friesland, the closure of a youth-care institution and the relocation of youth, sometimes across their home province (A-Insights, Defence for Children, 2024). Individual families have already experienced a systemic risk, even if their individual case has not been investigated independently, when they report that a professional assessment was wrong, or the decision is based on a one-sided account. At the same time, alleging that a specific report was deliberately fabricated, or that a specific institution was involved in a cover up, is a separate, more serious claim, which can

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only be substantiated based on case specific and independently verified evidence: findings by the Inspectorate, a court, the disciplinary body Stichting Kwaliteitsregister Jeugd (SKJ), or the National

Mechanism	What it handles	Who can use it
Institution's own complaint procedure	First step for dissatisfaction with a family supervisor or caseworker's conduct or decisions	Children, parents, carers
SKJ (Stichting Kwaliteitsregister Jeugd)	Disciplinary complaints against an individual registered youth-care professional	Children, parents, carers
National Ombudsman (Nationale ombudsman)	Complaints about compulsory (court-ordered) youth-protection measures	Parents, children (via representative)
Children's Ombudsman (Kinderombudsman)	Complaints concerning children's rights specifically, across care, education and youth services	Children and young people primarily
Jeugdstem (trusted-person service)	Independent support and advice when raising or pursuing a complaint	Children, young people, parents, carers
Courts / judicial appeal	Formal appeal against a supervision order or other compulsory measure	Parents, with legal representation

Table 1. Formal accountability and complaint mechanisms available to children and parents in the Dutch youth-care system. Source: compiled from Nationale ombudsman (2026) and Kinderombudsman (2026).

Ombudsman prior to being considered established. It is important to differentiate these two levels of claim and the first one is well supported by data from the inspectorate across the sector, the second one can only be true in certain cases and would require a case by case assessment. There are a few formal accountability processes for families who challenge a decision or a professional's actions. Any complaints against the behaviour of an individual practitioner can be made to the appropriate disciplinary body of that practitioner or to the SKJ. First complaints related to the handling of a case may be addressed to the institution, and if this is not the case, to the National Ombudsman (Nationale ombudsman), who has jurisdiction over complaints about compulsory measures for child protection; complaints about children's rights specifically may be addressed to the Children's Ombudsman (Kinderombudsman) (National Ombudsman, 2026; Kinderombudsman, 2026). Jeugdstem is also an independent trusted-person service, available for parents and children and young people to raise concerns. The avenues for redress are meaningful, but depend on families being aware of them, having the resources and support to access them and on a timely response — which is not always the case in light of the pressures on the workforce and capacity observed by the inspectorates. Another structural issue is that the same certified institutions that are relied upon to implement the compulsory measures are also the ones court systems are hinging on as the primary source of information regarding a family's situation. The increased importance of independent verification of professional reports

and the increased opportunities for families to challenge the factual part of a court report in a court are in line with the larger international literature on procedural fairness in child protection and are also concerns that have been raised by the Dutch policy makers and inspectorates. The loss of family togetherness and the experiences of children and parents. If compulsory measures lead to a change of the child or young person's placement, the impact can be significant and enduring for children and parents alike. There is a long history of research on family separation published since the Second World War that has consistently shown an increase in mental health issues, disrupted attachment, changes in stress reactivity and social functioning among children when separated from their families (Society for Research in Child Development, 2018). The effects were seen to be detrimental in a recent review of separation in various settings, including the separation of children from their parents due to child abuse and neglect, adoption, parental incarceration and immigration enforcement, and included increased risk of psychiatric disorders, academic delay, and behavioural problems such as anxiety, depression and self-harm (IntechOpen, 2023). Studies that explore this literature also warn that it is difficult to distinguish between the impact of separation and the impact of the maltreatment that frequently follows, so that not all of the harm experienced can be attributed to separation alone (American Bar Association, 2020). This is significant in that it does not diminish the actual harms of separation, but rather is important to recognise that in some situations, removal can not be the only or main cause of poor outcomes, especially when a child already has a significant amount of adverse experience prior to their removal. Children are not the only ones to suffer psychological effects when they are taken away from their parents, and those effects are often not recognised as serious. Studies of parents of children placed in foster care have shown that parents are at higher risk of depression, grief, social

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isolation, stigma and, in some studies, alcohol or substance use after forced separation (see 2025 study in Children and Youth Services Review). This distress seems to be exacerbated by communication problems with institutions – in several studies, parents reported that they were not given enough clear and consistent information about why a decision had been made, the They felt that they were left out of a process that deeply impacted their families and had the means to disagree with this process or to work toward reunification. Not only does the removal experience affect the child but also the way removal is dealt with, such as whether the child maintains contact with parents and siblings, is informed about and consulted and whether placements are stable or repeatedly disrupted. Although the participation of children in decision-making about their own care is a principle of the 2015 Youth Act, meaningful involvement is not a consistent phenomenon in all municipalities and across all case types, as Dutch research on participation in children's decisions about their own care shows. This can exacerbate the emotional impact of the separation when the decisions made are made 'to' children, not ‘for' them.

CONCERN FOR CHILDREN AND YOUNG PEOPLE'S WELL-BEING ACTIVITIES THAT MIGHT INVOLVE CHILD ABUSE, EXPLOITATION OR SAFEGUARDING CONCERNS.

Ensuring that children are free from abuse and exploitation is a cornerstone to youth care, and the Dutch system has also been the focus of extensive, independent historical research on its history of effectiveness in this regard. Two main national commissions are pertinent. The Samson Commission, headed by former Deputy Public Prosecutor Rieke Samson-Geerlings, investigated sexual abuse of children from 1945 to 2010, and presented their final report in October 2012. The commission concluded that children in youth-care institutions had approximately a 2½-fold higher risk of sexual abuse than children in their own homes and that prior to 1975, the perpetrators of sexual abuse had been placed in these institutions.

In later years, abuse was more commonly committed by peers in institutions, and were more often group-home staff or foster father (as summarised by Justice Initiative, Samson Commission 2012). The other, wider investigation, headed by Micha de Winter, a professor in pedagogy, looked at physical, psychological and sexual violence in the entire Dutch youth-care system from 1945 to the present, and published its final report, "Onvoldoend beschermd" ("Insufficiently protected"), in June 2019. It found that approximately 75% of the children placed in Dutch youth care between 1945 and the present day had suffered from, or observed, physical, psychological or sexual violence during their youth care experience, and that the supervisory authorities did not take sufficient steps to prevent this (Commissie Onderzoek naar Geweld in de Jeugdzorg, 2019; NSCR, 2020).

Institutional Naming and Historical Context

An additional question concerns the historical naming of residential children's institutions in the Netherlands. Names such as Het Bosje, Kleinwoud, and Schakenbosch may invite questions about the origins, symbolism, and historical development of institutional naming practices. Further archival research would be required to determine whether these names have any common historical significance or whether their use simply reflects geographical, cultural, or institutional naming traditions. The question is nevertheless relevant to understanding the historical identity and development of residential youth-care institutions.

INSTITUTIONAL ACCOUNTABILITY AND ALLEGATIONS OF CONCEALMENT

The history of Dutch youth care demonstrates that serious failures within institutions have not always been identified or addressed promptly. Independent investigations have documented repeated failures to protect children from physical, psychological, and sexual violence. These findings raise important questions about institutional accountability, transparency, reporting practices, and the extent to which concerns raised by children, parents, and staff are properly investigated.

Where families allege that institutions concealed wrongdoing or discouraged reporting, such allegations should be investigated independently rather than automatically accepted or dismissed. Effective accountability requires accessible complaint procedures, protection for people who raise concerns, independent investigation, and transparency regarding the outcome of complaints.

A related sector study, commissioned by the commission and carried out by the Netherlands Institute for the Study of Crime and Law Enforcement (NSCR), focused on the experienced forms of violence in closed judicial youth institutions and on how former residents experienced the violence within these institutions, which informed the commission's recommendations to strengthen regulation, increase intensive supervision, continue staff training, and reduce the punitive nature of residential youth institutions (NSCR, 2020).

The findings are of interest in the current talk in two ways. First, they conclude, after a comprehensive and independent historical inquiry, that the Dutch youth-care system in the past and in the future has at times and on a repeated basis failed to protect children from serious harm that has taken place in its care, and that that it has not always been able to function properly. Second, they show that the worry expressed by an individual about

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exploitation and/or abuse related to a youth-care setting should be taken seriously, and not ignored, even if a specific allegation has not yet been substantiated in an independent investigation. Historical evidence of failure from previous decades, however, does not, by itself, point to the accuracy of any assertion of the present day, such as allegations of trafficking or exploitation linked to any particular organisation, and further investigation would have to be made by the appropriate authorities, which are the police, the Inspectorate, or Veilig Thuis, the national reporting point for domestic violence and child abuse, before such allegations could be considered substantiated.
Today, in the Netherlands, the responsibility of ensuring children's safety is shared between various bodies: the reports of suspected child abuse or neglect are received by and assessed by Veilig Thuis, the Inspectorate monitors the quality and safety of the care offered in care institutions, and the Child Protection Board and courts are consulted when compulsory protective measures are considered to be necessary. It is clear from the history that independence, resourcing and responsiveness to children, parents and frontline staff are what make these mechanisms effective, not their existence.
They work as they are designed to work. Independent monitoring of residential and foster placements, having accessible and trusted avenues for children to voice concerns, and maintaining institutional cultures where concerns about abuse are taken seriously, but not trivialised, are still key areas of unmet needs in the Dutch system, and as demonstrated by the De Winter Commission, are not fully addressed.
Particular attention should also be given to the safety and continuity of accommodation for women and children involved with institutional services. Disruption of accommodation or support can expose already vulnerable families to homelessness, instability, and additional psychological stress. Where families report being discharged or excluded from services without adequate alternative accommodation or support, such cases should be independently documented and investigated. Safeguarding responsibilities should extend beyond the immediate institutional intervention to include continuity of care, accommodation, family stability, and protection from further harm.

MENTAL HEALTH SERVICES AND MEDICINES.

Children and adolescents may be treated with psychiatric medication for depression, anxiety, attention-deficit/hyperactivity disorder (ADHD) and, less frequently, for psychotic and mood disorders. This is a very sensitive area to use in this population both due to the immaturity of the brain in youth and because a lot of evidence supporting the use of these medications was generated in adults and then subsequently in paediatric populations, with the evidence in paediatric populations being either not available or less so. Systematic, peer-reviewed evidence is therefore essential for a responsible discussion of risks and benefits, whether supported by individual reports or unverified claims, and whether documented adverse effects are taken seriously or not.
To date, the most comprehensive evidence-based study is a large systematic, metareview by Solmi et al. (2020) which combined data from nine network meta-analyses, 39 metareviews and 78 pre-specified adverse effect categories across 80 psychotropic medications and more than 337,000 children and adolescents. This review showed there was a significant difference in the frequency and severity of adverse effects across and within drug classes.
Researchers found that nausea, vomiting and side effects were the most common issues encountered with antidepressants, and escitalopram and fluoxetine had relatively lower rates of side effects than some of their alternatives, such as venlafaxine, which they said was a “wild card.” The most common issues noted included sedation, extrapyramidal symptoms (EPS) and weight gain; olanzapine was associated with a higher risk of these side effects compared to other medications like lurasidone. The most frequently reported problems with medications used for attention-deficit/hyperactivity disorder were appetite reduction and insomnia, and methylphenidate was found to be more tolerable than atomoxetine or guanfacine for sleep and appetite. Sedation and weight gain were the most common concerns among mood stabilisers, with valproate listed as being more risky than lithium (Solmi et al., 2020)

Medication class	Comparatively better-tolerated options	Options flagged with greater concern	Most common adverse effects
Antidepressants	Escitalopram, fluoxetine	Venlafaxine	Nausea/vomiting; discontinuation due to side effects
Antipsychotics	Lurasidone	Olanzapine	Sedation; extrapyramidal symptoms; weight gain
Anti-ADHD medications	Methylphenidate	Atomoxetine, guanfacine	Anorexia; insomnia
Mood stabilisers	Lithium	Valproate	Sedation; weight gain

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There are also concerns regarding the possible effects of psychiatric medications on cells, brain tissue, and genetic material. From the author's perspective, the potential for psychiatric medications to produce cellular or neurological harm deserves greater independent investigation, particularly where medications are prescribed repeatedly or for prolonged periods during childhood and adolescence. Questions concerning whether medications can influence genetic or cellular processes should not be dismissed solely because definitive clinical evidence of permanent DNA damage is limited. Instead, these questions warrant further independent laboratory and clinical research examining cellular effects, neurological changes, oxidative stress, and possible effects on genetic material. The distinction between an absence of conclusive evidence and evidence that an effect cannot occur is important when evaluating such claims. The interpretation of psychiatric-drug evidence should also take account of potential conflicts of interest. Researchers, universities, healthcare institutions, and pharmaceutical companies may have financial or professional relationships that can influence the design, reporting, interpretation, or dissemination of research. Such relationships do not by themselves demonstrate that research is false or deliberately misleading, but transparent disclosure and independent replication are important safeguards. Greater support for research conducted independently of pharmaceutical interests would strengthen confidence in evidence concerning both the benefits and potential harms of psychiatric medication.

More recent studies, based on actual prescribing and adverse event data, have confirmed some of these conclusions and provided additional information. An analysis of the U.S. Food and Drug Administration's Adverse Event Reporting System (PMC, 2025) identified almost 10,000 relevant adverse-event reports for the three drugs, fluoxetine, escitalopram and sertraline, and examined patterns of association between specific medications and specific adverse effects in children and adolescents aged 6-17 from 2014 to 2023. The body

of research also confirms a specific finding that has been established by regulators: in 2007, the US Food and Drug Administration mandated a black-box warning on antidepressants stating that they may increase suicidal thinking in young people, especially within the first few months of treatment or after the dosage is changed — an actual and documented risk, the attention of which is expected to be carefully monitored during the first couple of months of treatment and after changes in dosage.

It is also important to recognise that official reports and regulatory information may not capture every concern associated with psychiatric medications, particularly potential long-term effects that may be difficult to identify through routine monitoring systems. In addition, some psychiatric-drug research is conducted with financial support or other relationships involving pharmaceutical companies. Such relationships do not automatically invalidate research findings, but they represent potential conflicts of interest that should be disclosed and considered when evaluating evidence about the safety and effectiveness of psychiatric medications.

Concerns have also been raised regarding possible neurological and cellular effects of psychiatric medications, including potential effects on brain cells and DNA. However, these concerns should be evaluated on a medication-specific basis and supported by appropriate experimental, clinical, and peer-reviewed evidence. Claims that psychiatric medications directly destroy brain cells or cause permanent DNA damage should not be presented as established facts unless the available scientific evidence clearly supports them. Further independent research is therefore needed to examine potential long-term neurological and genetic effects, particularly in children and adolescents.

A balance argument is the appropriate conclusion: There are documented and real risks associated with psychiatric medications used in children and adolescents, and these risks vary significantly across drugs, and across individuals, and should be carefully prescribed, carefully informed, and carefully monitored; and at the same time, the most dire warnings that occasionally are promulgated about these medications are not substantiated by the peer-reviewed literature, and shouldn't be taught as gospel. The need for families to have this information presented clearly, fairly and balanced, and then to have the chance to talk to a prescribing clinician about concerns, is a benefit to having this evidence available.

SYSTEMIC CHALLENGES AND AREAS FOR REFORM

The evidence in this article suggests a series of related systemic issues, rather than a single problem. One of the key issues is capacity, with inspectorate reports of thousands of children not having a permanently assigned family supervisor, waiting lists for most of the certified providers, and provider profit margins now dangerously low (IGJ, 2024; Defence for Children, 2024). This will need to be resolved through sustainable funding models between national government and municipalities, which is one of the two key targets of the current Reform Agenda, along with quality improvement (VNG, 2023).

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The second is related to professional training, caseload and documentation standards. In cases where caseworkers have high caseloads, are rotating their cases more often or don't have enough time to fully assess the case, the danger of incompleteness or poor substantiation increases. This risk would be mitigated by the ability to have a more consistently constructed documentation process, and in conjunction with manageable caseloads, would also allow the independent bodies to review contested decisions on the basis of a clear evidentiary record.
Third, independent review and complaint mechanisms are a challenge. Concerns have also been raised about the ability of people receiving psychiatric care and their families to express disagreement, challenge professional decisions, and make complaints without fear of negative consequences. Reports of people feeling censored, silenced, intimidated, or discouraged from contacting external authorities raise important questions about procedural fairness and the independence of complaint mechanisms. Such allegations require careful case-by-case investigation, but they underline the importance of ensuring that patients and families can communicate concerns freely, obtain independent advocacy, access legal representation, and report suspected wrongdoing to appropriate authorities without retaliation.
There are several facilities for complaints in the Netherlands, including the professional disciplinary facility of SKJ, the institutional complaint facility, the National Ombudsman and the Children's Ombudsman; but making use of these facilities and making a complaint effectively requires the family to be aware of them, supported in a way so that it is accessible (such as the Jeugdstem trusted-person facility), and to have a realistic expectation of when their complaint might be addressed. Strengthening
The introduction of independent verification of professional reports before they lead to compulsory measures and the provision of timely, substantive responses to complaints by families would make a positive difference to the sense of fairness as well as to the actual fairness.
The fourth challenge is regarding the involvement of family members and children. Although this is a declared principle of the 2015 Youth Act, evidence suggests involvement of children and their parents in decisions that affect their care and development is not always effective. Incorporation of structured, well resourced opportunities for meaningful participation (not just notification) in all municipalities would further help to ensure that practice meets the intention of the law.
A fifth challenge is related to the coordination between the youth mental-health care and youth care services provided by municipalities, which is commonly identified as a failing in various reform agendas in the Netherlands' health care system. Greater integration would help minimize the risk that families are referred back and forth without the continuity of information and care, especially since there is a high prevalence of youth mental health problems and youth contact with child protection services, as revealed in Section 2.
Lastly, the recommendations from the Samson and De Winter Commissions suggest that there is a need for ongoing independent and external monitoring of residential and foster placements in particular, as there is a historical record of inadequacies in protection of children in institutions set up to protect them. While all these reforms are essential, each requires ultimately the funding and staffing capacity that the current Reform Agenda is trying (with uncertain success to date) to achieve.

DISCUSSION

From all the evidence examined in this article several conclusions come into mind. The need for mental-health care of children and adolescents in the Netherlands is also large and has increased at a higher rate than the services available to address this need, leading to a system that is under significant strain. Independent inspectorate results from 2022 to 2025 support this and show that this strain has been realised in terms of real, significant harms: children lacking a supervisor, delayed support after court orders and financially precarious providers. They are not just individual administrative errors and may reflect structural deficiencies and have direct consequences for the reliability of the professional judgement on which compulsory measures are based.
The history, however, also shows that the Dutch youth-care system has, in a more basic manner, been less successful over the long run: that it has not always fulfilled its mission of keeping the children it takes in to prevent them from experiencing the very harms it is supposed to prevent.
This history is relevant in understanding how families of children who have experienced problems with YCIs may not accept official assurances and why independent oversight is more than just a bureaucratic formality; it is a real protection against reoccurrence.
The study of family separation has added another important dimension: While a protective intervention may be merited, it can be costly, and that cost may be borne by the child as well as the parent. This does not negate the importance of protective intervention when a child is genuinely at risk, but it does highlight the importance of the least intrusive effective intervention, of family participation and transparent communication as a protective factor

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in its own right, and of recognising that distress of parents after separation is a well documented and legitimate clinical and social concern, not a by-product of a simple process.

When a person is on psychiatric medication, the evidence suggests there is a middle ground between two extremes about psychiatric medications: first, that they are generally safe and that the risks are exaggerated; and second, that they cause serious, unproven harms, like genetic damage. The documented risks, such as the black-box warning on the FDA label regarding suicidal risk in youth, side effect profiles specific to the medication, and the fact that many medications are prescribed off label, are substantial enough that patients should be carefully, individually prescribed and monitored, even though these risks may not be exaggerated to make unsubstantiated claims.

There is a major gap of knowledge with regard to the extent of disputed decisions, or contested decisions, about the placement of young people in Dutch youth care, in other words, how many families who object to a professional placement are subsequently found, independent of their professional assessment, to be right in part or in full. Past inspectorate reports have tended to concentrate on the capacity and process of the system and not on the accuracy of the substantive risk assessments. More independent research in this specific area –
possibly using information from SKJ disciplinary cases, National Ombudsman case outcomes and court appeal statistics – would help to clarify how many times the accountability issues identified by families, when considered independently, are substantiated.

CONCLUSION

The evidence examined in this article indicates that the Dutch youth-care and child-protection system is experiencing serious and documented structural failures. These include inadequate capacity, delays in care, weaknesses in professional reporting, insufficient family participation, and historical failures to protect children within some institutional settings. These failures can have consequences that extend beyond individual administrative problems, affecting the psychological wellbeing of children, parents, and families.

The evidence on family separation further demonstrates that interventions intended to protect children can themselves have significant psychological and social consequences when they are poorly managed or unnecessarily prolonged. Separation can disrupt family relationships, increase distress, and contribute to negative health and social outcomes. The evidence therefore supports the conclusion that the system fails in important aspects of its responsibility to protect children while also preserving family wellbeing.

From the perspective of affected families, the repeated nature of these problems can create the perception that the system is structured in a way that permits harmful outcomes to continue. Some families may therefore argue that the system is not simply failing in practice but is, in important respects, designed in ways that make failure more likely. However, the stronger claim that the system was deliberately “designed to fail” would require direct evidence of intentional institutional design and should therefore be presented as a critical interpretation rather than an established fact.

The central issue is that child protection and mental-health intervention should not come at the unnecessary expense of family integrity or health. Effective reform must therefore strengthen independent oversight, professional accountability, accurate documentation, meaningful participation by children and parents, transparent decision-making, and careful monitoring of psychiatric treatment. Protecting children and preserving family wellbeing should be treated as complementary objectives rather than competing ones.

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