centrum voor consultatie en expertise

Safe Haven

Working together to create an unconditional home

This publication is about the concept of Safe Haven. It describes what the Centre for Consultation and Expertise (CCE) means by this term based on what we have observed in our consultation practice.

What does CCE mean by ‘Safe Haven’?

‘Safe Haven’ means living in an unconditional home - a place where you are allowed to stay, no matter what. Everybody deserves to have this; people with complicated, incomprehensible or challenging behaviour in particular.

CCE is committed to supporting healthcare providers in providing Safe Haven for all clients in all sectors. We do this by sharing knowledge, expertise and doing consultations — working in tandem with everyone who wishes to contribute to providing an unconditional home for people in complex care situations. Because we know that involuntary transfers reinforce challenging behaviour.

In practice, helping to prevent these people from being moved again and again (via involuntary transfers) often proves to be quite difficult. Their care comes under pressure, while care provision is operating at near full capacity, and then the situation becomes untenable. A common response is to then transfer the client. So, creating a sustainable environment for people with complex issues is complicated.

A joint effort

Achieving Safe Haven requires the cooperation of all those involved in a client’s care. Providing Safe Haven requires a joint effort: it requires carers to observe their clients closely and know exactly what their clients need in order to create an unconditional home. It requires recognition and support for carers in the complex care situations in which they find themselves. It requires an enlightened stance on living situations on the part of organisations, directors and managers.

Researchers, knowledge centres and CCE can identify what is (not) working and what is needed. Policymakers and politicians can also contribute by means of laws, regulations and funding which will enable carers to facilitate Safe Haven. Together, we can form an interwoven network which lays the foundation for unconditional homes.

1 Sometimes, a different residence can be a better fit for a client. ‘Safe Haven’ is most expressly not about these cases.

In practice

To better understand what it takes to provide that foundation, CCE conducted exploratory research in our consulting practice. Because CCE is only called in when situations involve an inability to respond to challenging behaviour (around 1,900 cases annually), our perspective of Safe Haven is very specific, but definitely valuable. We have observed that a lot is already being done to create Safe Haven and prevent the involuntary transfer of clients. When Safe Haven is compromised, it is often not as a result of 'not being willing', but of 'not knowing how'. But at the same time, we have also seen that when carers cannot resolve the issues involved in a client's challenging behaviour, the inclination to transfer that client can be strong. In consultations, CCE works with carers to answer the question of what should be done in the context of care, so that a client can stay and that it is clear what carers need to achieve this. During these consultations, we looked for possible patterns as well as any approaches that might help when dealing with complicated situations and thus avoid involuntary transfers.

The purpose of this publication

In this publication, we briefly describe the observations from our field review which underpin CCE's interpretation of 'Safe Haven'. We detail cross-sectoral observations, zooming in on hindering factors in the context and helpful elements in practice. In this way, we can articulate both the background and our mission to provide unconditional homes in a joint effort with care partners. In conclusion, we identified some relevant, sector-specific characteristics regarding the occurrence of involuntary transfers and obstacles to providing Safe Haven. These (and other) sector-specific observations from exploratory research in our consultation practice are detailed in the following sector chapters (in Dutch):

- Safe Haven in the Youth and Education Sector (hereafter: Youth)
- Safe Haven in Mental Health Care (hereafter: Mental Health)
- Safe Haven in the Disability Sector (hereafter: Disability)
- Safe Haven in Care, Nursing and Home Care for the Elderly (hereafter Elderly Care)

Preface

This exploratory study is based on 24 interviews with CCE consultants, 4 group discussions with 12 CCE coordinators, 1 meeting with the project leader of the consultation request team, and interviews with 4 sector work-groups between February and December 2023. CCE discussed and documented examples of (potential) involuntary transfers, and the hindering and helping factors for Safe Haven by sector. The results are described in sector-specific documents for the Youth, Elderly Care, Disability and Mental Health sectors. This publication is based on findings from these sector papers, including quotes from the interviews and discussions, with all results anonymised.

It is important to note that the situations in which CCE is involved are not representative of the Dutch healthcare sector as a whole. CCE works in tandem with carers in complex care situations where carers are at risk of gridlock and clients' quality of life is seriously compromised. Our findings therefore focus specifically on these complex care situations and should not be regarded as a portrait of Dutch healthcare as a whole. Nevertheless, providing Safe Haven is still a daily challenge within the Dutch healthcare system, and we hope that our findings will make a positive contribution to addressing this challenge.

What do we see across all sectors?

Providing a sustainable home where you can stay, is challenging in all four of the sectors in which CCE is active. Each sector experiences feelings amongst carers of 'this client doesn't fit here' and 'we can't handle this'. These feelings of inadequacy, frustration about 'not succeeding' and worries about clients' wellbeing can be found everywhere. All sectors also share helping factors.

In our consulting practice, we see several mechanisms at work:

Greater pressure
When carers cannot resolve client care issues, pressure mounts across the board. Providing necessary care is made more difficult, caring for other clients becomes compromised, and feelings of frustration, fear and doubt rise. This results in an increased pressure. A client transfer can sometimes feel like the only solution, but this could also cause moral stress and anxiety, and result in feelings of failure.

Task perspective
The sector perspective on the task of carers plays a role here. It is important whether the focus is on providing care (as in Elderly Care), guidance (e.g. in the Disability and Youth sectors), or treatment (Mental Health and Youth sectors). In Elderly Care, the caring role may come under pressure due to specialist care needs, which may trigger the desire for a transfer. If clients in the Mental Health or Youth sectors do not benefit from treatment, this can lead to the conviction that the client is a better fit elsewhere and nothing more can be done.

Perspective on living conditions
Safe Haven depends on the perspective on living conditions: do carers work where people live, or do people live where carers work? The former creates more of an unconditional home, while the latter often means rules are the guiding principles in a home and you are allowed to live there (i.e. conditionally) as long as 'you're a good fit'. This can result in situations in which clients are living in certain residences due to their behaviour, but then must leave precisely because of it.

Vicious circle

A (wish to) transfer often stems from challenging behaviour, which can cause a vicious circle: challenging behaviour leads to the wish for a transfer, resulting in the client feeling unwelcome and unsafe, which in turn leads to an escalation of their challenging behaviour and then a heightened desire for a transfer. In the Mental Health and Youth sectors, an unsuccessful treatment outcome can also be a reason for transfer: if the client does not improve, it is concluded that they are out of place, which can reinforce feelings of futility as well as exacerbate the client's challenging behaviour.

Tensions

When providing Safe Haven fails, we see a number of tensions such as those between the client's care needs and the means available, or those between the need for unconditionality and the conditionality of care (home) supply. Also: the greater the lack of intimacy with a client, the greater the lack of focus on that client; the greater the emotional distance, the greater the desire for a transfer will become. Working counterintuitively by offering intimacy is difficult and requires a lot from a team that is already under pressure due to staff shortages, for example.

Different ways of looking at things

There are no standard solutions when a home is not providing Safe Haven, but there are a few different ways of looking at this. Providing Safe Haven depends largely on how challenging behaviour is approached and understood within its context. Reflecting on the origins of the behaviour, its impact on the team and the role of internal systems can provide a new perspective.

How do involuntary transfers occur?

‘He’s not a good fit here’

The question “Does this person fit in here?” plays a role in a large proportion of the 1,900 consultations CCE does each year. A desire for a transfer is almost always preceded by a situation involving challenging behaviour, in which carers and the team no longer see any possibility of improvement despite their many efforts. Their explanations vary: ‘too complex’, ‘we feel powerless’, ‘we fall short’, ‘we can no longer cope as a team’, ‘we don’t have enough carers’, ‘fellow residents suffer too much’ and/or ‘there are others who can do this better’.

“You really want to get a grip on the situation and help people, with your carer’s heart. By definition, that leads to powerlessness, because you cannot resolve things. It takes a lot from carers to let go of that need for control, precisely because of their large carer’s hearts.”
- Youth sector

Repetitive actions

What happens next is that clients who are transferred might have fallen out of the frying pan and into the fire. In their next home, a repetition of treatment will escalate their challenging behaviour. Clients have to get used to a new place while they’re experiencing rejection. Clients internalise the idea that there is no solution, that it is all their fault - which can reinforce their challenging behaviour. Meanwhile, their new carers are hitting a wall because whatever is at the root of the initial challenging behaviour is not clear. This can lead to a reactive approach, focusing on the client’s (challenging) behaviour rather than their needs. Then you get statements like ‘she does it on purpose’. Thus, the vicious circle perpetuates itself.

“My case concerns a man in his 40s who has already lived in more than 40 places.”
– Disability sector

‘We are not equipped for this’

Teams and professionals who experience the feeling of ‘he’s not a good fit here’ will look for explanations. A common analysis is that, for example, the team is insufficiently equipped to (continue to) provide good care. ‘We cannot provide this specialist care’, ‘we are not trained for this’, ‘we fall short, for both the client and their fellow residents’; statements that recur in all sectors. Providing adequate care to clients with complex needs is a challenge for carers in all sectors. If carers are not adequately equipped, it can result in feelings of anxiety, and sometimes even illness or not wanting to work ‘when that one client is there’. Especially when a client demands a lot and/or a team has little experience, concerns arise about fellow residents.

The behaviour of one client can affect the safety and wellbeing of others, and this is weighed when considering whether or not the residential placement is appropriate.

“There was also a lot of staff turnover due to intensity and complexity in working with this one client; some people worked in the group for a single day and then left immediately afterwards. The team is disintegrating because of this.”
- Disability sector

Relationship carers - loved ones

In practice, we regularly see that the relationship between carers and relatives comes under pressure when a transfer is considered because the expectations and ideas of those involved can differ greatly. This can lead to conflict and reduced trust between family and carers, resulting in a tense relationship. Accusations fly back and forth and all have feelings of shame and inadequacy. Both carers and relatives may feel unable to take any action as a result and find it hard to discuss sensitive issues, which can then lead to unspoken feelings of frustration and disappointment. This disagreement can actually prompt transfers - to create an unconditional place to live, it is crucial that family, loved ones and carers are all on the same page.

“Yes, but you said she could live here until she died.”
- Elderly Care sector

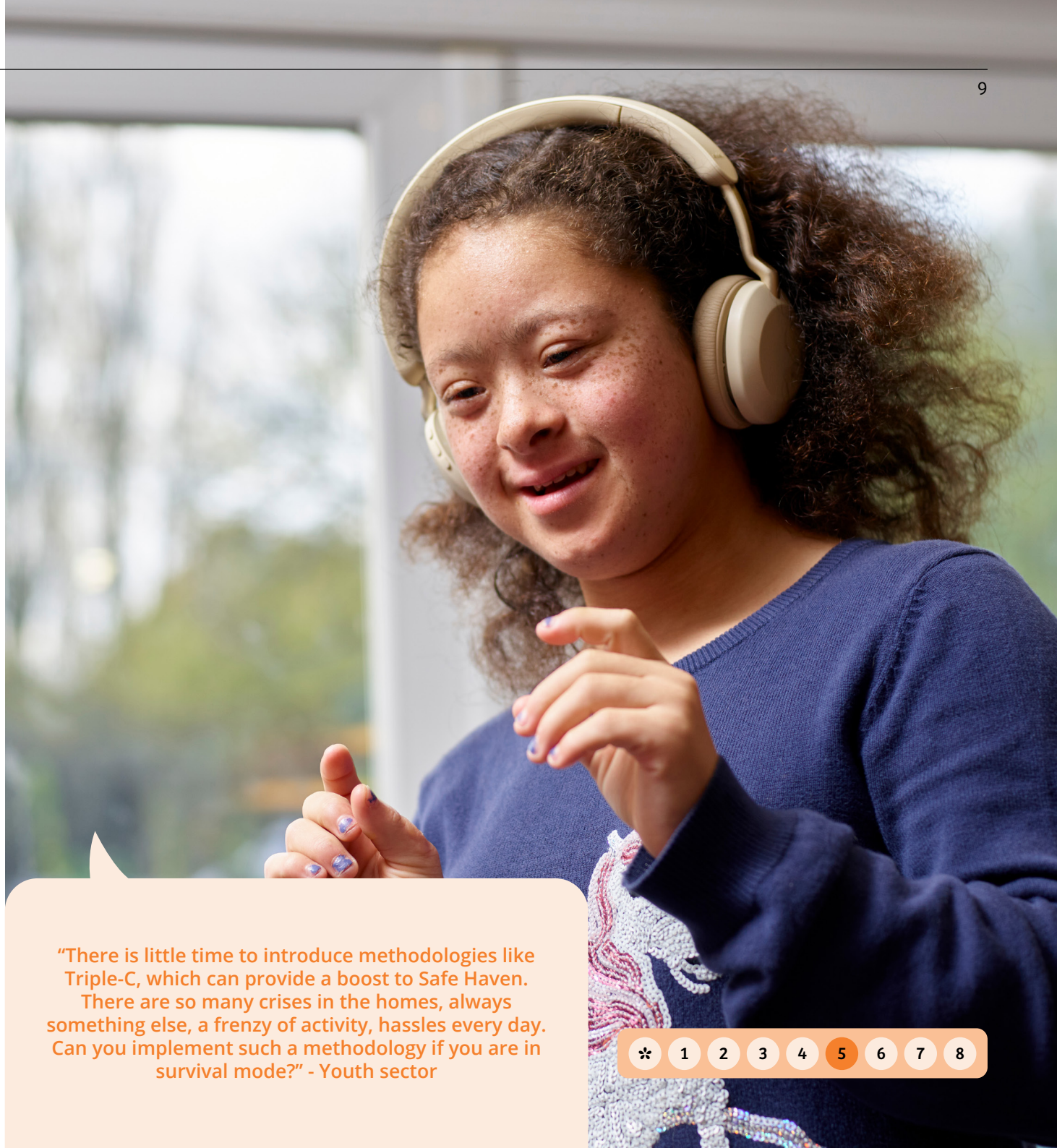
An imminent transfer does a lot to a person

An involuntary transfer has a negative impact on the person in question. It can lead to feelings of unworthiness and powerlessness. It is common for healthcare organisations to impose conditions to ensure safety, for example. But in fact, this also means that being able and allowed to live there is conditional, because: 'if you don't follow the rules, you can't stay here'. Such conditionality can lead to feelings of rejection, sometimes resulting in a client's challenging behaviour intensifying. In response, rules become even stricter, the situation escalates and transferral is accelerated. The situation or the behaviour the person needs help with thus becomes a contraindication. This can lead to thoughts like 'apparently there is no way anyone can work with me', 'I am worth nothing', or: 'everyone around me has given up'.

"If it doesn't work, you have to leave; the contract or the care relationship will be terminated. It's up to you."
- Mental Health Care sector

What are the hindering factors in the context?

Teams under pressure
Staff shortages hamper teams and organisations in their ability to provide care for people with severe challenging behaviour. They result in many staff changes and less stable teams, which complicates healthy attachment and adequate care for clients. Sometimes, teams can do little more than keep putting out fires, leaving carers unable to initiate new measures. They would like to fall back on their team - but team spirit is precisely what has come under pressure due to staff shortages. Under pressure, teams do not feel validated, especially if management is only 'conditionally available'. This places even more pressure on staff and can mean they make more demands of clients to keep functioning. These dynamics are not always plainly visible. In addition, teams now regularly face tougher issues than they did in the past, for which they are sometimes inadequately equipped. This may lead to the conclusion that the team is unable to help certain clients, resulting in transfers. Under pressure, it is difficult for teams to reflect and to introduce new methodologies or ideas to improve care.



"There is little time to introduce methodologies like Triple-C, which can provide a boost to Safe Haven. There are so many crises in the homes, always something else, a frenzy of activity, hassles every day. Can you implement such a methodology if you are in survival mode?" - Youth sector

An imperfect understanding
In many cases, there doesn't appear to be a working understanding of the clients who are frequently transferred. This can lead to incorrect estimates of the care needed upon transfer, resulting in the new team stalling out when they are unable to provide appropriate care. This can (yet again) create the feeling that 'this person is not a good fit here'. For example, a flawed understanding can occur due to a lack of insight in the client's emotional developmental age or insufficient knowledge of the client's wants, needs and life story.

Hindering factors in care organisation
Various factors at the organisational and societal levels can also form an obstruction to creating Safe Haven. For example, when sectors such as the Mental Health and Youth sectors are more focussed on temporary care and treatment, rather than on unconditional residence. This focus gets in the way of working towards an unconditional home. In crisis situations, crisis wards are sometimes used for placements, even if this does not seem appropriate for a specific individual. Financial considerations may also play a role in the search for another residence for a client. Conversations about transfers are sometimes more influenced by resource availability than by client needs. Good care in complex situations also requires cooperation between disciplines and sectors, but this is often under pressure. Especially in the Mental Health and Youth sectors, there are barriers between disciplines and institutions. Moreover, the way Youth Care is funded complicates cooperation, with children sometimes bouncing back and forth between different Youth Care divisions 'like a ping-pong ball'.

"Carers find sexually transgressive behaviour difficult to handle in the group. However, there doesn't appear to be much of a file on the client and how to deal with the behaviour."
- Disability sector

"You often see people in Youth Welfare focussing on a single type of problem. If other things then turn out to also be in play, there isn't a good fit and someone has to be transferred, either residentially or in counselling or treatment, which doesn't help much either."
- Youth sector

What are the helping factors?

"A team that is permanently attentive to the client's needs, that sees challenging behaviour as a signal rather than as 'we should be well shot of this', time and space to puzzle it out. What needs lie underneath this behaviour, what makes him so angry and where are the hindering factors."
- Disability sector

Validating and supporting teams
Teams that deal with complex client behaviour face major challenges. When they are heard, acknowledged and have room for reflection, carers experience the security to share what they need in order to care for these clients. Resilient teams that are valued and enjoy doing their work are better able to provide an unconditional home and meet clients' needs. In addition to self-care and room for reflection, teams also need practical support, such as accommodations to deal with certain behaviours, deploying specialists within the organisation and inter-professional cooperation.

Read more on this (in Dutch): Artikel: Kijken naar perspectief bij vastlopendesituaties in de ggz

"The moment we can shift our focus in care to the context and get it right, that context can provide Safe Haven for the client." - Elderly Care

A perspective on housing
Working together to create an unconditional home starts with a clear perspective. An organisation should project: "You are unconditionally welcome here, this is your home and we will not let you go." This provides a solid foundation for everyone to work toward Safe Haven. It requires tolerance when things don't go well and transparent expectations about the care needed and who can provide it. Cooperation agreements with fellow organisations are helpful here: who can provide what care? You can commit to that as an institution and as a professional in that institution.

Read more on this (in Dutch): Artikel: Misschien wel beter dan ooit - werken in een kleinschalige woonvorm

"Nowadays, when the girl walks away and comes back, she gets a cup of tea and they tell her 'how nice that you are here again'. Instead of 'what did you do, how stupid of you'."
- Youth sector

A good understanding and focus on the client's life history
A good understanding of the client is essential to shift the focus from "Does this person belong here?" to "What does this person need in order to be here?" This requires a taking broad view, and not simply managing challenging behaviour. Understanding the client's unique context is crucial to providing Safe Haven. Carers can see more opportunities to help clients when they know them well. Finding out the client's life history is important here, as (challenging) behaviour often reflects experiences and traumas. Mapping the emotional developmental age is also a part of this process. This helps to anticipate behaviour and prevent escalations. Carers can benefit from tools that help them to tailor their approach to the client's emotional developmental age.

Listen, read and watch more on this (in Dutch):
Podcast: Expert Tales - Vertragen en Verbinden, Mensgerichte Zorg bij Probleemgedrag
Boek: Gedragen – Mensgericht samenwerken rondom dementie
Video: Trauma en lichaam: onlosmakelijk met elkaar verbonden
Video: Gedrag als signaal – traumasensitief werken in de vvt

Cross-sector learning
Cross-sector learning is essential to promote Safe Haven. Each sector and organisation has unique expertise to offer: the Disability sector focuses on lifelong care and the meaning of behaviour, the Mental Health sector has experience with psychiatric conditions and treatment strategies, the Youth sector has a family and developmental approach, and the Elderly Care sector is experienced in analysing people's pasts. There are good examples of Safe Haven in all sectors which can provide valuable learning opportunities. CCE facilitates cross-fertilisation between sectors and encourages dialogue to promote Safe Haven.

Knowledge of organisational dynamics
Sometimes it remains unclear where behaviour comes from, or it is attributed solely to the client's limitations or disorder ('he doesn't belong here'). Dealing with challenging behaviour then stalls and the severity of the behaviour increases. Once the cooperation between those involved in the client's care then (logically) suffers small fractures, for example due to stress or feelings of powerlessness, a negative spiral is imminent and improving the situation becomes increasingly complicated. It is then helpful to look at the broader, more abstract context that affects clients' behaviour. The main issue is what the dynamics are like in that wider context. When all those involved are able to analyse what is happening in the dynamics between them and a client, new insights can emerge that can help improve a situation, allowing them to provide a client with Safe Haven. When relationships between them are strained, it is therefore important to look systemically and validate everyone's perspective. This helps keep the dialogue going.

Learn more on this (in Dutch):
Masterclass: bewegen bij probleemgedrag
Spel: 't 7-Krachtenspel

Fresh eyes during consultations
A fresh perspective from CCE in a consultation can provide support in creating Safe Haven. By using this outside view, momentum is created and people feel there is now room to identify the causes of problems instead of simply reacting to behaviour. Consultations involve delays and necessary extra time, which can help to prevent overly hasty transfers. Room can be made for looking at what might still be done in the current residence. Finding lasting solutions often requires more thinking time and space for in-depth questions, such as the underlying reasons for wanting the transfer and what is needed in order to allow someone to stay. This deeper view can result in reducing the need for a transfer.

Read more on this (in Dutch) Consultatie: samen zoeken naar perspectief

What do we see per sector?

We see hindering and helping factors that are present in all of the sectors in which CCE is active. There also are a number of relevant, sector-specific features with regard to the occurrence of involuntary transfers and the obstacles to providing Safe Haven. Different factors play a role in different sectors, particularly in the run-up to an involuntary transfer. The nature of care provision is also different in each sector. Some of the results of sector-specific studies are described below. For the full story, we refer to the (Dutch-language) individual sector papers.

Vicious circle in the Youth sector
In the Youth sector in particular, we see a vicious circle of involuntary transfers. Children experience multiple moves between departments and institutions, which makes them believe 'I'm a complex case, it's my fault'. This feeling, together with needing to adapt to new environments and existing complex problems, results in behaviour for which the child needs help. But if the (behaviour of the) child is rejected, this exacerbates the situation, resulting in escalation. Carers and family feel powerless, leading to the child being transferred yet again and the cycle repeating itself. The internalised feeling of having unresolvable issues reinforces this pattern. An additional factor is carers' fear of coming under fire, leading to risk aversion and increased control within the organisation. This results in imposing rules and restricting freedoms for children, which again rejects them and leads to escalating problems. This reinforces the feeling of 'you don't belong here', where the problem lies with the child, and the cycle begins again.

The Youth sector in the Netherlands includes several sectors, such as Education, Youth Aid, Youth Mental Health and Youth Protection. These sectors do not always work well together, they are fragmented and have different perspectives. For example, Youth Mental Health focuses more on temporary treatment and stays, while Youth Care has an education-oriented view with a focus on behaviour. These differences and the lack of cooperation mean there are challenges in organising long-term care in the right residence.

Transfers are systemically built into the Youth sector. When children are removed from their homes, they do not usually end up in a residence where they will remain for a long time. It may be a crisis placement, a short-term treatment placement or a temporary out-of-home placement with the goal of returning home (which is not always possible). Children are also sometimes scheduled to be transferred to another group because of their age.

The Mental Health System is more focused on treatment than long-term residence

Providing an unconditional home is not a natural objective in the Mental Health sector. Most institutions focus on treatment and short-term stays, with the expectation that clients will go home or go on to assisted or sheltered housing after treatment. This can become a problem if clients do not recover sufficiently, deteriorate rapidly at home or are not self-reliant enough. Finding a suitable place for people who need intensive mental health care and counselling is difficult.

For clients whose mental wellbeing fluctuates widely, it is also difficult to find Safe Haven because different institutions have their own expertise. This may result in a transfer if the necessary expertise is not available. This also means that as the Mental Health sector comes under pressure, compromises are made such as accepting a crisis placement even if it is not the best solution for the client.

Some clients thus end up on a 'carousel' of relocations because there is no suitable facility where they can continue to live. Sometimes these transfers are even agreed upon in advance, for example for a temporary admission of three months with the condition that the client can be placed elsewhere afterwards.

In the Mental Health sector, more often than in other sectors, we observed that the request for a transfer stems from a fear of client aggression. Carers feel responsible for preventing serious incidents, such as violent incidents involving injuries.

An imperfect understanding in Disability Care
Of the four sectors in which CCE is active, the existing systems and structures in the Disability sector seem to facilitate Safe Haven the most. This is partly due to the permanence of care: care for people with intellectual disabilities is often lifelong and the focus is on ordinary life: on care rather than cure. This already involves looking at the meaning of behaviour and connecting to someone's needs, and the sector is 'accustomed' to providing tailor-made care - something people with intellectual disabilities and challenging behaviour often need.

Despite the permanent nature of care in the disability sector, an incomplete understanding of who the client is can still be formed. For instance, their emotional developmental age is not always clear, which can lead, for example, to discussions about whether a client is under or overstimulated. A lack of clarity on these points can result in the mistaken idea that 'the client is doing it on purpose' or 'doesn't belong here'. If this is regarded as the truth, the topic shifts to the client no longer fitting in, rather than focussing on what their needs are. If a transfer is then discussed, the carers' relationships with family or loved ones also comes under pressure. Family members' ideas about what might be possible or good for the client do not always match with those of carers. Mutual (unreasonable) expectations then arise which can result in mutual recriminations, conflict and reduced trust in the other. And precisely because of the long-term nature of care, a good relationship with family and loved ones is important. Stress in that relationship could result in a transfer

Learn more on this (in Dutch): Leertraject: Emotionele ontwikkeling in relatie tot probleemgedrag

Unequipped for increasing complexity in Elderly Care
Our ageing population is accompanied by the trend of people living at home for a much longer time before moving to a nursing home. As a result, those who end up in elderly care often have more complex problems than in the past, such as advanced dementia. This makes elderly care more complex, while care staff are often not adequately trained to deal with these challenges. The feeling of being insufficiently equipped to deal with complex behaviour is reinforced by the fact that management and specialists are often more remote. This leads to feelings of inadequacy on the part of carers regarding residents, relatives and fellow residents. A desire for a transfer may arise from their hope of creating a better situation and freeing up more time for other residents.

In addition, efficient work processes are often the guiding principle in nursing homes. This leaves little room for variation or reflection, which is exacerbated when staffing is tight. Moreover, carers often work at nursing homes for far longer than residents stay there, making it difficult to see a nursing home as a home for the elderly rather than primarily as a workplace.

The relationship between carers and family in Elderly Care has its own dynamics, especially as it concerns a client's final stage of life. In addition, emotions such as grief, loss and shame can each play a role. Family members' expectations can vary greatly, with some assuming that elderly clients can stay until end of life. The message that an elderly client has to move out, for example due to overly complex problems, can therefore be extra painful especially if residing in the nursing home was seen as the final stage of life.

Learn more on this (in Dutch): Leertraject: Samenwerken rond probleemgedrag in de ouderenzorg

And now: We must work together to create unconditional, permanent homes

This publication, based on CCE's exploration of Safe Haven in our consultation practice, is just a start. It is a call to work together to translate the idea of Safe Haven as much as possible into actual unconditionality. In this endeavour, all those involved with clients, residents, children and young people have a role to play. Safe Haven requires something from all of us. It requires us to learn from each other, identify good examples and give them a platform, and look beyond the boundaries of one's own domain.

Based on this exploration, CCE believes the important first step is to find answers and insights to the following questions:

- What do clients need to experience Safe Haven?
- How does Safe Haven benefit clients' quality of life?
- What do healthcare providers and healthcare organisations need in order to provide more access to Safe Haven?
- How do you create unconditional living spaces in sectors focused on temporary stays?

CCE would like to pick up this gauntlet, together with all of the participants in the field.

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