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Needs-led child and youth care: Main characteristics and evidence on outcomes

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ABSTRACT

Needs-led child and youth care has three main characteristics: a continuous focus on clients' needs, client participation in the care process (including decision making), and practitioners' displays of needs-led attitudes and skills. The primary aim of this review was to establish whether there is evidence for using a needs-led approach when working with children and families in need. We performed a literature search to find reviews and outcome studies of child and youth care for school-aged children and their families which included the core characteristics of needs-led care, and related them to outcome measures. Only a few studies attributed positive outcomes of care to the attention given to clients' needs and goals. Most studies referred to participation in terms of clients' involvement or engagement. Higher levels of participation were associated with positive changes in child behaviors and parenting stress, client satisfaction, higher completion rates, safety for children, feelings of well-being and empowerment, and better service coordination. Significant professional attitudes and skills included listening to clients and working in active partnership with them. There is some proof for the relevance of core characteristics of needs-led child and youth care, although that evidence is limited by the lack of rigorous studies. This study indicates that needs-led child and youth care can make a difference. Future research should pay attention to the intertwinement of the characteristics of the needs-led approach in care.

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1. Introduction

Since the 1980s, professional organizations have advocated needs-led care for children and families. Stroul and Friedman advocated a care system that is driven by the needs of the child and his or her family, asserting that services should be provided in an environment and a manner that enhance the personal dignity of children and families, respect their wishes and individual goals, and maximize opportunities for involvement and self-determination in the planning and delivery of care (Stroul & Friedman, 1986, vi). Although the importance of a needs-led approach is rarely discussed, it is not evident what actually works in such an approach. Moreover, there is no unequivocal definition of the concept of needs-led care (Trivette, Dunst, Boyd, & Hamby, 1995).

With regard to intervention practices, it is helpful to define the term “need” (i.e., to make a distinction between “concerns” and “needs”). Dunst and Deal (1994) defined a “concern” as the awareness of a family and its members that the situation they are in is different from what they want it to be. They used the words “worry,” “problem,” “difficulty,”

and “uneasiness” as equivalents to “concern.” These terms all reflect the discrepancy between what is and what ought to be. They defined a “need” as a judgment that a resource is necessary or desired in order to achieve a goal. The words “goal,” “desire,” “aspiration,” “priority,” “want,” and “aim” are often used to mean the same thing. The terms reflect efforts to minimize concerns (Dunst & Deal, 1994).

The aim of this study is to clarify the concept and define the core characteristics of “needs-led care,” which, in turn, function as key variables in the search for evidence for the effectiveness of these elements. After clarifying the concept, we will review studies into the effectiveness of needs-led care, offer insight into the focus of these studies, and discuss the core elements' impact on the effectiveness of care.

2. Needs-led care: three characteristics

A comparison of descriptions of a needs-led approach derived from professional and scientific literature brings out similarities resulting in three defining characteristics: focus on clients'¹ needs, client participation, and needs-led attitudes and skills of practitioners.

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¹ “Clients” refers to children and/or their parents and families taking part in child and youth care.

2.1. Focus on clients' needs

First of all, many authors consider the clients' needs to be the central reference point of the care process; needs take an important stand throughout the care trajectory (Baartman, 2003; Dronkers, 2002; Knorth, Bolt, Van Bommel, Tacq, & Verkerk, 2003; Pool, Mostert, & Schumacher, 2003; Van Beek, 2004; Van Burik, Kayser, & Van de Mortel, 2001; Van der Steege, 2003; Van Yperen, 2004; Verbeek, 2003; Welling, 2000). This is – by definition – the prime focus of needs-led care.

In this context, Dunst, Johanson, Trivette, and Hamby (1991) defined four classes of family intervention programs with an increasing focus on clients' needs. In *professional-centered* programs, professionals are seen as experts who determine a family's needs from their own perspective rather than that of the family. In *family-allied* programs, families are seen as barely capable of independently effecting changes in their lives. In these models, families are seen as the agents of professionals. In *family-focused* programs, families and professionals collaboratively define what the families need to function in a healthier manner. Although families are seen in a more positive light, they are generally viewed as needing advice and guidance from professionals. Finally, *family-centered* models are defined as programs in which families' needs and desires determine all aspects of service delivery and resource provision. Professionals are seen as the agents and instruments of families, and intervene in ways that maximally promote families' decision making, capabilities, and competencies. Intervention practices are almost entirely strength- and competency-based, with the provision of resources and supports primarily aiming to strengthen a family's capacity to build informal and formal networks of resources to meet needs (Dunst et al., 1991).

2.2. Client participation

Client participation is considered to be another important component of a needs-led approach (Doğan, Van Dijke, & Terpstra, 2000; Knorth et al., 2003; Kramer, 2004; Van Burik et al., 2001; Van der Laan, 2002; Verbeek, 2003; Welling, 2000). The concept of "participation" in the context of youth care was well defined by Thoburn, Lewis, and Shemmings (1995), who described nine increasing levels of participation in the "ladder of participation",² displayed in Fig. 1 (also see Knorth, Van den Bergh, & Verheij, 2002). The four aforementioned classes of family-oriented programs (Dunst et al., 1991) have been inserted in this figure because of their striking resemblance to Thoburn et al.'s (1995) participation ladder.

The ladder shows different "degrees" of agency or participatory engagement, but it should not be interpreted to mean that the higher rungs of the ladder are always superior to the ones beneath (Hart, 2008); full participatory roles and responsibilities are not feasible or necessary for every task or project (Head, 2011; Shier, 2001). According to Hart (2008), it is important to communicate that participants have the option of operating with these "higher" degrees of engagement. The thought behind the ladder is to fully recognize participants' potentials and allow them to participate at the highest possible level (Hart, 2008). Shier (2001) considered the first two levels of this ladder to be non-participation or false types of participation. He thinks the minimal level of participation should be "(young) clients are listened to". According to Knorth et al. (2002) this corresponds with Level 3 of the ladder. Informing and listening to clients is a necessary condition for all other forms of participation.

Participation should not be taken for granted. For instance, in a study on the implementation of the principle that local authorities should work "in partnership" with parents (UK Children Act 1989), Sinclair and Grimshaw (1997) concluded that parents were ill-informed by social services, involvement of fathers was low, attending meetings was not the norm, and parents were not actively involved in decision making. Knorth et al. (2002) found that only Levels 3 through 7 of the ladder

were applied in Dutch child and youth care practice. More specifically for children in the out-of-home care system, Molin and Palmer (2005) referred to the danger of foster parents and birth parents being overlooked or excluded during their children's treatment. These feelings of exclusion can have a strong negative effect on the treatment process (Molin, 1988). Minimizing participation by exclusion can also undermine parents' sense of responsibility for and importance to their children (Molin & Palmer, 2005). Vulnerable or hard-to-reach groups may be overlooked regarding participation (Head, 2011).

As a consequence of accentuating the importance of participation, Knorth et al. (2003) emphasized that the professional and client share responsibility for the care process and are equal partners working together (also see Janssens, 2003; Shier, 2001). An explicit commitment to sharing power is necessary. In the collaboration between professionals and clients, Baartman (2003) focused on reciprocal action. In this way, both the professional and the client use their own expertise to contribute to the care process (Baartman, 2003; Doğan et al., 2000; Pool et al., 2003; Prakken, Van Dijke, Van der Steege, & Terpstra, 2002).

2.3. Needs-led attitudes and skills

The third common characteristic in the descriptions is the principle that a needs-led approach requires professionals to put attitudes and skills into practice with respect, empathy, flexibility, a focus on family strengths, and a focus on activating the client and delegating power (Van Burik et al., 2001; Welling, 2000). A needs-led professional should show positive and proactive behavior characterized by respect (Park & Turnbull, 2002; Schippers, Wehman, & Hermanns, 2005; Van Yperen, 2004), equality and understanding (Schippers et al., 2005), and modesty and sincerity (Van Yperen, 2004). Janssens (2003) referred to these skills in terms of establishing a functional working relationship. Friesen, Koren, and Koroloff (1992) found certain professional behaviors that most parents considered to be very important concerning the relationship with parents of children with emotional disorders, in particular honesty, a non-blaming attitude, supportiveness, and inclusion in decision making. Families of children in a psychiatric facility described a "good" service provider as someone who listens well, helps them to establish concrete and workable goals, respects them, includes them as treatment partners, provides clear and meaningful information, and demonstrates clinical expertise in helping them solve their problems (Solomon, Evans, Delaney, & Malone, 1992).

In connection with needs-led attitudes and skills, the interaction between practitioners and clients can be characterized as a continuous *dialogue* (Baartman, 2003; Doğan et al., 2000; Dronkers, 2002; Kramer, 2004; Pool et al., 2003; Tonkens, 2003; Van Beek, 2004; Van Burik et al., 2001; Van der Steege, 2003; Van Yperen, 2004). Janssens (2003) emphasized the importance of a dialogue between professionals and clients, as it can take some time to thoroughly assess a client's needs. In this respect, embedding the care trajectory in the context of clients' *everyday surroundings* is also considered to be important (Doğan et al., 2000; Pool et al., 2003; Schippers et al., 2005; Van Beek, 2004; Van Burik et al., 2001; Van der Laan, 2002; Van Pel, 2002; Verbeek, 2003); help should be offered where problems occur (Garfat, 2003; Post, 2001). Professionals should also respect family members' schedules, work together with other partners (e.g., school and neighbors) who deliver care (Post, 2001), and use daily life events for therapeutic purposes as they occur (Garfat, 2003).

All in all, a needs-led approach means that: (a) clients' needs are the main focus, (b) clients participate in the care process, including decision making, and (c) care workers display needs-led attitudes and skills. It is generally assumed that by adapting the aforementioned characteristics, outcomes of care and treatment are maximized in child and youth care programs. This leads to our main question: Is there empirical proof that working according to a needs-led approach leads to positive outcomes?

² Originally formulated by Arnstein (1969), used by Hart (1992), and tailored to the child and youth care context by Thoburn et al. (1995).

Fig. 1. The participation ladder (Thoburn et al., 1995) and the four classes of family-oriented programs (Dunst et al., 1991).

3. Method

We performed a literature review of outcome studies. We searched the psycINFO, ERIC, and Medline databases for Dutch and international peer-reviewed studies that used empirical evidence to prove the assumption that the three characteristics are core elements in maximizing the outcomes of child and youth care. We used the following search terms: family, participation, needs-led, centeredness, effectiveness, efficacy, child, youth, care, and school age. Outcome studies of child and youth care interventions for school-aged children and their families were included, provided that they were published between 1990 and 2013. Non-experimental and experimental studies were included in the review. The first type of studies was included for the same reason that Hoagwood (2005) included a group of non-experimental studies examining key processes of involvement: mediating processes may become key targets for the development of future family-focused interventions. Some of the studies gave us reasons to include a few additional studies, for which we manually searched.

Following the example of Vis, Strandbu, Holtan, and Thomas (2011), the results of the literature search are presented in Table 1. It resulted in 29 studies. Nine of these were reviews (including two focusing on controlled trials). The other 20 were individual studies (including six with an experimental design). The child and youth care which was the subject of the 29 studies consisted of residential or in-patient child care ($n = 7$), and ambulatory or home-based care ($n = 22$).

4. Results

Only a few studies ($n = 3$) focused on clients' needs (Table 2a). Most studies ($n = 18$) related to client participation. Regarding this concept, we distinguished between studies on involvement/engagement ($n = 13$) (Table 2b) and on participation ($n = 5$) (Table 2c), which, respectively, refer to the Levels 5 and 6 on the ladder of participation (Thoburn et al., 1995). Studies referring to "involvement" and "engagement" of clients in care were covered by the collective term "involvement"; studies referring to "active involvement" or client "participation" were covered by the collective term "participation."

Table 1
Literature search results.

	Studies included N	Studies excluded N
Identified through database searches	1366	
Duplicates removed, not meeting inclusion criteria after abstract screening		1266
Retrieved for full text screening	100	
Not meeting inclusion criteria after full text screening		74
Meeting inclusion criteria	24	
Duplicates with included reviews removed		2
Included through manual search	7	
Included in the review	29	

We finally found eight studies about the needs-led attitudes and skills of practitioners (Table 2d).

4.1. Focus on clients' needs

Research shows that positive outcomes were generated by focusing on the needs of families (Conoley et al., 2003; Simeonsson et al., 1991) and by tailoring the intervention to the families' needs and goals (Connell et al., 2008). In practice, this could be realized by honoring clients' implicit and explicit wishes to look for solutions together instead of studying their problems in depth (Conoley et al., 2003), by determining treatment targets and doses collaboratively with each family (Connell et al., 2008), and by involving clients in the identification and prioritization of care and treatment goals (Simeonsson et al., 1991).

4.2. Client participation

4.2.1. Involvement: reviews

The overview of studies on participation starts with several reviews that pay attention to client participation on the level of *involvement*. Studies of family-focused interventions centered on specific modes of involvement. Only a few controlled studies were found that directly examined outcomes associated with interventions that included families in the role of co-therapists (Hoagwood, 2005). The range of outcomes was considered to be narrow; factors such as therapeutic alliance, family perspectives in treatment planning, parental perceptions of continuity and support, and issues of trust were rarely measured in treatment outcome studies (Hoagwood, 2005). Nevertheless, indications of the value of (family) involvement can be derived from the reviews.

In *home-based services*, ADHD and the child externalizing symptoms were positively affected by family involvement at a low-to-moderate level while internalizing symptoms were positively affected at a moderate level. Furthermore, the child's academic performance and the family's functioning might benefit from family involvement (Corcoran & Dattalo, 2006). Client involvement improved retention in services, client satisfaction, and active participation in service planning (Hoagwood, 2005). "Reminder calls" were an effective intervention strategy for increasing engagement among adolescents and young adults in mental health services at the individual level. In addition, family intervention increased initial and ongoing attendance. Effectiveness varied depending on the clients' developmental age, family context, history, and mental health difficulties (Kim et al., 2012).

Programs in *residential settings* that use engagement strategies resulted in positive outcomes (e.g., shorter stay, positive change in behavior, decrease in "support room referrals" and "safety holds"), which were mediated or moderated by other variables (e.g., family functioning) (Affronti & Levison-Johnson, 2009). Involving families by including parenting education or family therapy (Affronti & Levison-Johnson, 2009), or frequent family visits and participation in family therapy (Hair, 2005) were associated with successful outcomes. Geurts et al. (2012) suggested that family involvement in residential care is important because of benefits in terms of child functioning (e.g., child behavior) and family functioning (e.g., skills, parenting stress, family

Table 2a

Reviewed studies about focusing on clients' needs (n = 3).

Authors	Intervention	Method	Sample	Measures and instruments ¹	Results
Conoley et al. (2003)	Solution-focused family therapy (SFFT)	N = 1 multiple baseline	N = 3 (families with children aged 8–9 years)	Parenting (PDR) Child behavior (BASC)	SFFT focusing on positive goals can be effective in working with elementary-aged children who have problems with aggressive and oppositional behavior. At the three-month follow-up, changes were maintained and had generalized to other areas of the child's functioning.
Connell et al. (2008)	Family check-up (FCU)	Random controlled trial (RCT)	N = 731 (mother–child dyads; child aged 2–3 years)	Problem behavior (CBCL)	FCU affects the likelihood of youth transitioning out of early problem behavior classes and into more normative symptom profiles over time. Family-centered interventions are important for reducing problems with anxiety and depression in youth.
Simeonsson, Bailey, Huntington, and Brandon (1991)	Family-focused early intervention	Evaluation	N = 23 (infants and their families)	Goal attainment (GAS) Family needs (FNS) Impact on family (IFS)	Two-thirds of child and family goals were attained at the expected level or better. Total attainment was at comparable levels for child and family goals. Comparison of initial and follow-up scores revealed that changes in goal attainment scores were paralleled by a reduction in family needs' scores and by a decreased impact of a disabled child on family life.

¹ Adherence questionnaire (AQ); Anxiety disorders interview schedule for DSM-IV (ADIS); Behavior assessment system for children – parent rating scale (BASC); Barriers to treatment participation scale (BTPS); Beck depression inventory (BDI); Child behavior checklist (CBCL); Center for epidemiologic studies depression scale (CES-D); Clinical global impressions (CGI)-improvement scale; Coder impression inventory (CII); Dyadic parent–child interactive coding system—revised (DPICS-R); Eyberg child behavior inventory (ECBI); Family-centered practices scale (FCP); Family engagement questionnaire (FEQ); Family needs survey (FNS); Goal attainment scaling (GAS); Connors rating scale (IA Crs.); Impact on family scale (IFS); Inpatient parental satisfaction index (IPSI); Multidimensional anxiety scale for children (MASC); Parent daily report (PDR); Parent motivation inventory (PMI); Parenting stress index (PSI); Research diagnostic interview (RDI); Hopkins symptom checklist (SCL-90); Therapeutic alliance scale for children (TASC); Treatment evaluation inventory (TEI); Treatment improvement scale (TIS); Working alliance inventory (WAI).

relationships). They also found higher completion rates for family-centered residential interventions.

4.2.2. Involvement: single studies

In the non-residential context, *engagement* was defined as the number of parent training sessions attended, the percentage of homework completed, and a rating of the mother's engagement in group discussion made by the program's group leader (Reid et al., 2004). *Involvement* was the research subject of seven single studies we found. In the context of residential care, this concept was defined as both the number of family contacts per month (Robst et al., 2013) and as a much broader concept than family contacts. For instance, in their definition, Tam and Ho (1996) included parents exercising their authority and signing consent for treatment, supplying pocket money, or taking their child home for the weekend or on long holidays. Brinkmeyer et al. (2004) defined family engagement as alliance (e.g., willingness of the child to interact positively, frequency with which the parents visit the residential unit and participate in family and treatment sessions, and openness of parents to discussing family problems with unit staff) and, in the opposite direction, as hostility (e.g., toward unit staff).

Outcomes, related to involvement and engagement, included positive changes in child behaviors (McKay et al., 2011; Reid et al., 2004; Robst et al., 2013; Wood et al., 2006), positive changes in parenting stress (McKay et al., 2011), discharge of the child from residential care back to the family (Tam & Ho, 1996), parental satisfaction (Brinkmeyer et al., 2004; Thompson et al., 2009), and increased retention in treatment (Thompson et al., 2009). Brinkmeyer et al. (2004) noted that motivational interviewing is a process variable capable of influencing engagement and client satisfaction. In the study by Thompson et al. (2009), the experiential activities made family members participate actively which, in turn, helped to increase their willingness to openly discuss difficult topics.

4.2.3. Participation

In the second subcategory of studies, referring to Level 6 of the participation ladder, five studies (one of which is a review) shed light on

the potential impact of client participation on intervention outcomes. Participation was defined as the active engagement of clients (Littell, 2001; Nix et al., 2009) and their involvement in treatment decision making, in planning coordinated services, and in assessing how well services work together (Koren & Paulson, 1997). In comparison to involvement in terms of attendance, attending training sessions alone is not sufficient to speak of "participation"; the quality of participation is decisive (Nix et al., 2009).

A study by Vis et al. (2011) indicated that participation in treatment planning and decision making in home-based care can potentially have a positive impact on children's health in several ways, although it does *not automatically* benefit children (Vis et al., 2011). Vis et al. (2011) described the need for children to be given the opportunity to successfully form relationships with someone who can give information, who explains what is happening, and who is open to the children's own agendas. In those situations, participation may have the power to increase children's safety, the success of care arrangements, and the children's feelings of well-being (Vis et al., 2011). The studies that presented outcomes of participation-enhancing interventions focused on compliance rates (Littell, 2001), empowerment (Singh & Curtis, 1997), service coordination (Koren & Paulson, 1997), and treatment response (Nix et al., 2009).

Caregivers' participation in treatment planning predicted better compliance with program expectations. In turn, compliance was related to positive outcomes for child welfare (Littell, 2001). Participation also had a positive effect on the families' empowerment status (Singh & Curtis, 1997). Families with higher degrees of participation tended to view services as more coordinated, which in turn meant higher satisfaction rates (Koren & Paulson, 1997). Parents who were most actively engaged in the activities achieved the greatest treatment response (e.g., change in parental perceptions of the child, warmth, use of physical punishment, school involvement) (Nix et al., 2009).

4.3. Needs-led attitudes and skills

In their review on attendance and adherence to outpatient treatment, Nock and Ferriter (2005) pointed out that the relationship

Table 2b
Reviewed studies about clients' involvement (n = 13).

Authors	Intervention	Method	Sample	Measures and instruments	Results
Hoagwood (2005)	Family-based services	Review	Studies (N = 40)	Studies of families as recipients or co-therapists in service delivery and studies of core processes of involvement (therapeutic alliance; engagement; empowerment; expectancies and choice)	The scientific evidence centers on studies of specific modes of involvement. Few controlled studies have examined interventions that include families in the role of co-therapists. There have been too few well-conducted studies of family-based services to conclude that these interventions decisively improve youth clinical outcomes. The range of outcomes is too narrow to afford an adequate view of the impact of family-based interventions. Involvement can improve retention, satisfaction, and active participation in service planning. Family involvement has a low-to-moderate effect on ADHD and externalizing symptoms. Family involvement might benefit children's academic performance and positively affect family functioning.
Corcoran and Dattalo (2006)	Treatment for ADHD	Meta-analysis	Studies (N = 16)	Studies of parent-involved psychosocial treatment for ADHD (children aged 0–18 years)	Reminder calls are an effective strategy for increasing engagement at the individual level. Family level interventions increased initial and ongoing attendance. Focusing on potential barriers to engagement can increase attendance at initial appointments and ongoing service engagement. The approaches varied in effectiveness depending on the clients' developmental age, family context, history, and mental health difficulties.
Kim, Munson, and McKay (2012)	Interventions on engagement in mental health services	Review	Studies (N = 13)	RCT's of interventions designed to increase engagement	Programs that actively partner with families, subscribe to a system of care philosophy and the wraparound approach, use strategies to reduce initial barriers to engagement, or include parenting education/treatment or family therapy result in positive outcomes. The outcomes of family engagement strategies are mediated or moderated by other variables (e.g., family functioning).
Affronti and Levison-Johnson (2009)	Residential treatment	Review	Studies (N = 34)	Studies into engagement practices in residential settings	Frequent family visits and participation in family therapy are associated with successful outcomes. Residential treatment that includes family involvement combined with accessible aftercare and continued education is associated with success after discharge. Family involvement is important and can have benefits in terms of a range of child outcomes.
Hair (2005)	Residential treatment	Review	Studies (N = 18)	Outcome studies into residential treatment	
Geurts, Boddy, Noom, and Knorth (2012)	Residential treatment	Review	Studies of residential care	Studies of residential care in which family-centered factors are associated with positive outcomes and studies involving residential care with explicitly family-centered approaches	
Tam and Ho (1996)	Residential care	Comprehensive study	N = 877 (children mean (M) = 6.9 years)	Child's physical and behavioral–emotional adjustment, placement planning, and service strategies (structured questionnaire)	Placing siblings in the same facility inhibited the children's return home. In deciding whether a child should return home, the workers emphasized the degree of parental involvement instead of the state of the family's material and psychosocial circumstances or the child's behavior and emotional problems.
Brinkmeyer, Eyberg, Nguyen, and Adams (2004)	In-patient psychiatric care	Single group design	N = 47 (child and adolescent patients aged 7–17 years)	Problem behavior (CBCL); Family engagement (FEQ); Parental satisfaction (IPSI); Follow-up situation (follow-up questionnaire)	Families with a history of in-patient hospitalization participated less meaningfully in current treatment (rated by therapists at discharge) and rated themselves as less satisfied with treatment. The parents' report of satisfaction with their child's earlier in-patient treatment was highly predictive of their satisfaction with current treatment. Effect sizes suggest that the nine-month outcomes are related to poorer engagement and greater dissatisfaction with the hospitalization experience. Therapist ratings of parent engagement are related to parents' satisfaction with care. Externalizing behavior problems do not affect the child's ability to become involved but are markers for poorer outcome.
Reid,	Incredible years	RCT	N = 882 (86% of	Child behavior (ECBI); Parent–child	Program engagement reduced conduct problems

Table 2b (continued)

Authors	Intervention	Method	Sample	Measures and instruments	Results
Webster-Stratton, and Baydar (2004)	parent training program		the children under the age of 5 years)	interaction (DPICS-R); Coder impression inventory (CII); Program engagement; Program attendance	(as detected by observers but not by mothers). Program engagement had a positive impact on prosocial behaviors. The shared opinions of mothers and observers regarding conduct problems significantly predicted program engagement: mothers whose children exhibited more conduct problems were more likely to become engaged in the program. Effects of training differed depending on initial levels of conduct problems and critical parenting. Changes in conduct problems were related to maternal engagement in the intervention and to whether mothers reduced their critical parenting.
Wood, Piacentini, Southam-Gerow, Chu, and Sigman (2006)	Family-focused cognitive behavioral therapy	Experimental (pre-, mid-, and post-treatment)	N = 40 (clinically anxious youth aged 6–13 years; M = 9.13 years)	Anxiety disorders (ADIS-C/P); Clinical improvement (CGI); Anxiety (MASC)	Both treatment groups showed improvement on all outcome measures, but family CBT may provide additional benefits over and above child-focused CBT. Family CBT was associated with greater improvement on independent evaluators' ratings and parental reports about the child post-treatment.
McKay et al. (2011)	Multiple family group (MFG) service delivery strategy	RCT	N = 312 youths (aged 7–11 years) and their families	Attendance; Youth oppositional behavior (IA Crs); Parenting stress (PSI)	MFG participants improved their oppositional behavior at a significantly different rate and manifested a greater decrease in parenting stress over time than participants in a control group. There was a substantial drop in ODD symptoms and a greater decrease in parenting stress from baseline to follow-up.
Robst et al. (2013)	Residential treatment	Single group design	N = 1649 (youth age: M = 13.5; SD = 2.6)	Parental involvement; Contacts with extended family; Type of involvement; Method of contact; Problem behavior (CBCL)	Family involvement was associated with improved outcomes. Involvement by extended family was not associated with improved outcomes. Type of involvement was associated with outcomes. Youth with families that had more in-person interventions, phone interventions, treatment planning contact, and therapeutic home passes had greater improvements in outcomes. Involvement over the phone had positive effects similar to in-person involvement when parents live farther from the RTC.
Thompson, Bender, Windsor, and Flynn (2009)	Home-based family therapy	Quasi-experimental	N = 83 (families with children aged 12–17 years)	Retention (number of sessions completed); Engagement (CEST)	Adding creative experiential activities to home-based family therapy significantly increases retention in treatment. Participants who received home-based family therapy with experiential activities remained in treatment longer than those in the control group. Parents in the intervention group reported greater satisfaction and better rapport with their counselor. No differences were found on levels of session participation. Active participation helped to increase family members' willingness to openly discuss difficult topics.

between client participation and outcome is not a simple and linear one. According to these authors, facilitative and supportive behaviors by the therapist (e.g., expression of empathy, encouragement of motivational self-statements) increased clients' motivation to participate in therapy and decreased non-adherence.

The non-linearity of the relationship between practitioner behaviors and outcomes was further clarified by Dunst et al. (2002, 2007). They made a clear distinction between *relational* help-giving practices (e.g., active listening, empathy, respect) and *participatory* help-giving practices (e.g., flexible, responsive to family concerns and priorities, informed choices, family involvement). Parents involved in family-centered programs were more likely to indicate that practitioners employ help-giving behaviors and styles that promote active participation of parents in resource and support mobilization. This, in turn, was related to improved parent and family functioning (Dunst et al., 2002). Both types of family-centered practices were associated with more positive

and less negative parent, family, and child behavior and functioning, but participatory help-giving practices were a more important determinant of positive outcomes compared to relational help-giving practices. Family-centered practices were not directly related to child development outcomes but were indirectly mediated by self-efficacy beliefs of parents (Dunst et al., 2007).

In addition to improved parent and family functioning, other outcomes were found. Encouragement of participation related positively to family caregivers' treatment satisfaction (Kruzich et al., 2003), treatment attendance, motivation, and readiness to change (Nock & Kazdin, 2005). Barriers to participation in children's out-of-home treatment were the lack of open communication and the lack of opportunity or encouragement for families to participate in the child's treatment. Supports of participation were notifications when something was wrong or when there were health or other concerns involving the child, followed closely by providing a contact person (Kruzich et al., 2003).

Table 2c
Reviewed studies about clients' participation (n = 5).

Authors	Intervention	Method	Sample	Measures and instruments	Results
Vis et al. (2011)	Participation in decision making	Review	Studies (N = 21)	Studies that related health and participation of children (aged 0–18 years)	Participation has the potential to promote children's health. Participation does not always have an automatic benefit for children. The relationship with the social worker and the way in which the participation process is tailored to accommodate children's expectations and abilities are important. Greater collaboration in treatment planning predicts better compliance with program expectations. Early maltreatment and placement events affect collaboration and compliance. The FPS workers' views of compliance affect both placement and reunification decisions. Participation in parent support groups had a positive effect on the empowerment status of families with children who have emotional and behavioral disorders. Mothers reported higher levels of family empowerment than fathers. A number of demographic characteristics were associated with the empowerment status of families.
Littell (2001)	Intensive family preservation services (FPS)	Single group design, with multiple observations over time	N = 2194 (families, of which 56% had at least one child under 2 years of age)	Participation in developing the service plan, agreement with the plan, contact initiatives, attendance, adherence (service summary form); Child abuse and neglect	Parents considered services to be more coordinated to the extent that they were involved in developing the primary plan for their child. Parents considered children's needs to be well met to the extent that they were satisfied with individual services and viewed services as coordinated. A significant inverse relationship was found between the severity of children's behavior problems and service coordination. Families with higher participation viewed services as more coordinated. Service coordination showed a stronger relationship to overall satisfaction than family involvement and satisfaction with individual services.
Singh and Curtis (1997)	Parent support group	Single group design	N = 228 (parents of children (M = 13.3 years; SD = 4.5) with SED or SED and ADHD combined)	Family empowerment (family empowerment scale)	Family characteristics (demographic attributes, stressful family circumstances, severity of children's behavior problems) were related to quality of participation and unrelated to attendance at parent groups. Quality of participation was the consistent predictor of treatment response (change in the child's perceptions, parental warmth, use of physical punishment, school involvement).
Koren and Paulson (1997)	Social service	Empirical exploration	N = 266 (children aged 5–18 years (M = 11.7), emotionally disturbed, DSM-III-R diagnosis)	Child's services and activities, satisfaction, extent to which each service met the child's needs, parental participation in planning (interview); Service coordination (service coordination scale); Satisfaction (client satisfaction questionnaire); Problem behavior (CBCL)	
Nix, Bierman, and McMahon (2009)	Parent management training	RCT	N = 891 (families with children aged 6 years: M = 6.47; SD = 0.48)	Stressful life events (developmental; history/life changes interview); Parental depression (CES-D); Social support; Quality of home environment; Neighborhood quality; Child home behavior (oppositional and aggressive behavior scale of the PDR); Child school behavior; Attendance and quality of participation; Parenting	

Clients were more likely to explore new ways of interacting, the more therapists listen to clients and understand clients' feelings (Hammond & Nichols, 2008). A collaborative relationship requires not just empathic comments from the therapist but also sustained respect for clients and working in active partnership with them. The term “alliance” refers to the quality and nature of the interaction between the client and therapist, the collaborative nature of that interaction on the tasks and goals of treatment, and the personal bond or attachment that emerges in treatment (Horvath, 2001). The more positive the alliances were, the more therapeutic changes were seen in the children, the fewer barriers to participation in treatment were perceived, and the more parents and children viewed the treatment techniques as acceptable (Kazdin et al., 2005). The quality and nature of the interaction between children, parents, and therapists and the collaborative nature of that interaction on the treatment tasks and goals were positively related to therapeutic change in terms of positive changes in child behavior, parenting skills, and interaction in the home (Kazdin et al., 2006).

5. Discussion

5.1. Summary of findings

The aim of this study was to clarify the concept of a *needs-led* approach in child and youth care, and to establish whether there is evidence that working according to such an approach leads to positive outcomes. An unequivocal definition of needs-led care is difficult to develop. After exploring several points of view and reflections, three central characteristics remained: a) clients' needs take a central position during treatment; b) clients are invited to participate in the treatment process, and c) care workers show needs-led attitudes and skills.

Studies that focused on the first characteristic found that positive outcomes were attributed to the attention practitioners pay to the needs and goals of clients during treatment. Most of the studies related to the second characteristic, participation, thereby referring to clients' “involvement” or “engagement” in the treatment process (the middle rung of the participation ladder). Both the reviews and single studies

Table 2d

Reviewed studies about practitioners' needs-led attitudes and skills (n = 8).

Authors	Intervention	Method	Sample	Measures and instruments	Results
Dunst, Boyd, Trivette, and Hamby (2002)	Family-oriented programs	Single group design	N = 221 (mothers and fathers of children with or at risk for developmental delays from birth to 6 years) and N = 45 (mothers of children with or at risk for developmental delays from birth to 3 years)	Help-giving practices (HPS); Family-centered practices (FCP)	Help givers in professional-centered programs were judged poorly in terms of use of relational and participatory practices. Help givers in family-allied programs were judged better in use of relational practices than in use of participatory practices. Help givers in family-centered programs were judged "good" on the use of both relational and participatory practices. Participatory help-giving practices (but not relational help giving) varied as a function of the degree of family-centeredness of early intervention programs.
Dunst, Trivette, and Hamby (2007)	Family-centered help giving	Meta-analysis	Studies (N = 47)	Studies that related variations in family-centered help giving to variations in parent, family, or child outcomes	Relational and participatory family-centered practices were related to parent, family, and child behavior and functioning. Parents' judgments of their child's behavior are influenced by family-centered practices.
Nock and Ferriter (2005)	Child psychotherapy	Empirical review of research on attendance and adherence to child therapy	Studies (N = 12)	Controlled trials on attendance and adherence to child therapy	No standard measures are available for assessing treatment adherence and treatment motivation in child therapy. Barriers to treatment participation are associated with less favorable attendance and treatment outcomes. Motivational techniques (e.g., facilitative and supportive therapist behavior) increase parent motivation and participation in child therapy. Younger children and children in facilities closer to home had more contact with their families. Caregivers with less total contact reported less satisfaction with the amount of contact. The most frequent barriers were distance to service providers and lack of communication between staff. The most frequently mentioned support was the provision of a contact person. Reports of more barriers were associated with less total contact with the child, a lower rate of participation in treatment planning, and less satisfaction with the amount of contact.
Kruzich, Jivanjee, Robinson, and Friesen (2003)	Residential care	Cross-sectional study	N = 102 (parents/caregivers of youths aged 0–20 years (M = 14.1; SD = 3.1) who received in-home treatment or out-of-home treatment for emotional, behavioral, or mental disorders)	Family participation in children's out-of-home treatment, including contact between parents and children and caregivers' involvement in educational planning and service or treatment planning (questionnaire); Family caregivers' satisfaction	PEI was associated with greater parent motivation, greater treatment attendance, and higher parent and therapist-reported quantity and quality of treatment adherence. PEI parents reported significantly greater readiness and perceived ability to change parenting practices through participation in PMT and greater motivation overall. PEI parents attended significantly more sessions than parents in treatment as usual. The more therapists demonstrated an effort to listen to and understand clients' feelings, the more likely clients were to explore new ways of interacting. In cases in which therapists challenged clients before showing empathy for their perspective, the clients resisted the therapist's efforts and little therapeutic change was seen. A collaborative relationship requires sustained respect for clients and working in active partnership with them, not just empathic comments.
Nock and Kazdin (2005)	Participation enhancement intervention (PEI)	RCT	N = 76 (children (M = 6.7 years; SD = 2.3))	Parent motivation (PMI); Treatment attendance; Adherence (AQ)	PEI parents attended significantly more sessions than parents in treatment as usual. The more therapists demonstrated an effort to listen to and understand clients' feelings, the more likely clients were to explore new ways of interacting. In cases in which therapists challenged clients before showing empathy for their perspective, the clients resisted the therapist's efforts and little therapeutic change was seen. A collaborative relationship requires sustained respect for clients and working in active partnership with them, not just empathic comments.
Hammond and Nichols (2008)	Structural family therapy		N = 24 families	Empathy (therapist collaborative empathy scale); In-session change (change in the core problem dynamic scale)	The more positive the child-therapist and parent-therapist alliances were during treatment, the greater the therapeutic changes of the children, the fewer perceived barriers to participation in treatment, and the more acceptable parents and children viewed the treatment techniques. The predictors were generally supported across all raters, although more consistent and stronger relationships were evident for child and parent rather than therapist evaluations of
Kazdin, Marciano, and Whitley (2005)	Problem-solving skills training (PSST) and parent management training (PMT)	Evaluation	N = 185 (children aged 3–14 years (M = 7.2; SD = 2.6))	Therapeutic alliance (TASC); Working alliance (WAI); Improvement (TIS); Barriers to treatment participation (BTPS); Treatment evaluation inventory (TEI, children and parents); Family level of educational and occupational attainment	The more positive the child-therapist and parent-therapist alliances were during treatment, the greater the therapeutic changes of the children, the fewer perceived barriers to participation in treatment, and the more acceptable parents and children viewed the treatment techniques. The predictors were generally supported across all raters, although more consistent and stronger relationships were evident for child and parent rather than therapist evaluations of

(continued on next page)

Table 2d (continued)

Authors	Intervention	Method	Sample	Measures and instruments	Results
Kazdin, Whitley, and Marciano (2006)	PSST and PMT	Survey	N = 77 (children aged 6–14 years (M = 9.6; SD = 1.8))	Therapeutic alliance (TASC); Working alliance (WAI); Depression (BDI); Symptoms (SCL-90); Parenting stress (PSI); Conduct disorder symptoms (RDI)	alliance. The better the quality of the child-therapist and parent-therapist alliance, the greater the therapeutic changes in the children. The better the quality of the parent-therapist alliance, the greater the improvements parents made in their parenting skills and interaction in the home. Child and parent evaluations of alliance produce more consistent and robust findings than the therapist evaluations of each alliance in relation to outcomes.

included in our overview related “involvement” and “engagement” to positive changes in child behaviors and parenting stress, reunification of the child with the family, client satisfaction, and increased retention in treatment and higher completion rates.

Only a few studies focused on “active (family) participation” in treatment (the rung above “involvement”). Positive outcomes were found for safety for children, the quality of care arrangements, children's feelings of well-being, compliance rates, feelings of empowerment, service coordination, and treatment response. “Involvement” and “participation” were therefore mainly associated with complementary instead of similar outcomes.

From the outcome studies concerning the third characteristic – needs-led attitudes and skills –, it became clear that facilitative and supportive behaviors by the practitioner appear to be pivotal. These help-giving practices were indirectly mediated by self-efficacy beliefs and were associated with positive changes in parent, family, and child behavior and functioning. In addition, client satisfaction, treatment attendance, increased treatment motivation, and readiness to change were also found to be related to needs-led professionals' attitudes and behavior.

5.2. Reflections

Listening to clients, respecting them as team members and decision makers, and working in active partnership with them can be considered to be important aspects of needs-led attitudes and skills. As to what the actual practitioner skills or help-giving practices should be, only limited benefits should be attributed to “relational practices” such as active listening, empathy, and respect. Participatory help-giving practices (Dunst et al., 2002) and working in *active partnership* with clients, that is, not just empathic comments from the therapist (Hammond & Nichols, 2008), seem to be more important. For active partnership allows clients and practitioners to share responsibility and work together as equal partners (Janssens, 2003; Knorth et al., 2003; Shier, 2001).

The *non-linearity* in how the characteristics of a needs-led approach relate to outcomes can be seen in the participatory help-giving practices and encouragement of families to participate (e.g., by motivational interviewing; Brinkmeyer et al., 2004). Child development outcomes due to family-centered practices appeared to be mediated by self-efficacy beliefs (Dunst et al., 2007). Furthermore, facilitative and supportive practitioners' behaviors were associated with clients' increased motivation to participate and diminished levels of non-adherence (Nock & Ferriter, 2005). Client participation, in turn, was related to outcomes often measured in terms of positive changes to child and parental behavior.

We might conclude that, in great part, practitioners facilitate clients' participation in the treatment process, using their skills to focus on client needs and to invite children and parents to participate. Although, as Hill (2005) describes, therapist techniques, client involvement, and the therapeutic relationship are inextricably intertwined variables in treatment processes, our review suggests that practitioners can use

techniques to positively influence this involvement and relationship, leading to enhanced outcomes.

5.3. Strengths and limitations

A strength of this study is that it thoroughly researched a concept that is often used in daily practice, but for which a solid empirical basis and well-ordered knowledge was not available. This study furthers our knowledge about this concept.

Our review has some limitations. First, the majority of studies included had a non-experimental design. Therefore conclusions can only be drawn with great caution.

Second, some of the studies were unclear about what “involvement” or “participation” entailed: some gave a clear description (e.g., McKay et al., 2011; Nix et al., 2009; Robst et al., 2013), while others were less clear (e.g., Corcoran & Dattalo, 2006). In the latter case, it was uncertain whether “involvement” or “participation” meant more than just attendance. Therefore, we included some studies based on the assumption that they used the same meanings of involvement and participation as did studies that presented more detailed definitions. This assumption might be correct, but we cannot ignore the possibility that it is not, in which case our conclusions could underestimate the importance of these factors.

Third, an overall limitation of this study is the fact that the concept of needs-led care refers to a broad category that is related to comparatively broad concepts like child and family-centeredness of care. To deal with this phenomenon, we unraveled the concept by identifying three core characteristics, which helped to clarify how these characteristics may relate to each other, creating opportunities for future research into effective mechanisms of child and youth care.

5.4. Implications

Even in one of the studies about lower levels of participation (involvement/engagement), it was noted that there needs to be a shift toward considering families to be *partners in care* instead of the source of children's problems (Kim et al., 2012). Interventions should not only focus on children, but also on parents and families as a whole. Professionals need to be trained and supported to incorporate needs-led attitudes and skills (also see Baker, Heller, Blacher, & Pfeiffer, 1995). It is not enough to propagate a needs-led or family-centered approach without emphasizing the main characteristics that need to be present in the practitioner's attitudes and skills. Additionally, based on our findings and following Head (2011), we stress the importance of clarity about the aims, methods, and processes in care to ensure that the benefits of client participation are made more explicit.

The evidence base for the outcomes presented is limited by a lack of rigorous studies. Only two of the reviews and one-third of the single studies we looked at included experimental designs. Based on the findings from our review, Hoagwood's (2005) conclusion still holds: only a few controlled studies directly examined outcomes associated with

interventions that included families in the role of co-therapists. Therefore Hoagwood's suggestion still stands that a more extensive effort to improve the *science of family involvement* is needed. Specifically on the involvement of children, Gal and Duramy (2015) state that it is not a question of whether children should participate in decision-making processes affecting their lives. The question is *how* children should take effectively part in such processes. An ecological model, in which several variables of child participation are being mapped (Gal, 2015), might be of use in investigating child participation in practice and policymaking.

5.5. Conclusion

More research is necessary to discover the core influences of needs-led child and youth care on outcomes of interventions in terms of positive changes in the lives of families making use of child and youth care. From the studies presented, it can be concluded that there is evidence for the relevance of the three characteristics mentioned. This review indicates that needs-led child and youth care can make a difference. It shows the benefits of a needs-led child and youth care approach to secure clients' needs, participation and workers' needs-led attitudes and skills in daily practice. Because of the importance of these elements for the outcomes of care, additional research is needed to confirm these indications. Future research should especially focus on how intertwined elements of a needs-led approach relate to outcomes. Our expectation is that results of such research will inspire daily practice, in favor of children and families in need.

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