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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.

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.

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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 Bemmel, 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 accenting 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).