Indications for treatment in child and youth care: Results from two complementary empirical studies

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Abstract

The central issue in this contribution is the analysis of indications for treatment (IFT) in Dutch child and youth care. In the Netherlands under the new Youth Care Act, clients can only obtain intensive forms of child and youth care on the basis of a so-called written IFT-statement. Two studies are presented: one investigating the general quality of the IFT-statements (N = 270), the other focusing in more detail on the quality of IFT-statements (N = 227). The main question in both studies is to what extent IFT-statements meet the basic requirements that represent a well-founded and explicit decision. The first study reveals that the assessment of IFT-statements by a committee of experts yields the verdict 'agreed' in only two out of three cases. Some IFT-statements receive the stamp 'agreed' even though the case is insufficiently substantiated. In the second study IFT-statements are being assessed by applying objective standards, as well as by consultation with case managers and clients themselves. It turns out that the assessment of the IFT-statements by use of the objective standards paints a more disadvantageous picture than consulting the case managers. The latter, in turn, are more critical about the IFT-statements than the clients. The authors advocate to make IFT-statements more explicit and, by doing so, to contribute to an increased transparency of the decision-making process at the entrance into child and youth care services.

Key words: child and youth care, indication for treatment, decision-making, youth care office

Introduction

Steven is a 15 year old juvenile whose parents were divorced under fierce conflicts. He now resides with his mother. The problem is that he refuses to listen to her. His behaviour is oppositional, offensive and rebellious. His mother's plea for counselling is: help us to make Steven's behaviour less problematic. According to Steven, his parents made a terrible mess of their separation. This is seriously troubling him. He vents his aggression by hurling objects about and by extreme verbal aggressive reactions towards his mother. He recently threatened her with a knife. Steven does agree that

he should contain his temper. He has no real friends at school and his truant behaviour increases. He roams all over town with other boys. His mother wonders if he is using coke. What to do?

This last question, alternatively formulated as: 'What kind of help or treatment would be most suitable to diminish or dissolve the presented problems?', represents a search for *indications for treatment* (De Bruyn, Pameijer, Ruijssenaars & Van Aarle, 1995). This search is crucial (Rispens, 1996; Heinrich, 2002), because the outcome is (or should be) decisive for the type of help that will be offered. It demands that a *choice* is being made, for there are many options in dealing with the situation of Steven and his mother, for instance:

- mother could be eligible for support by a family counsellor, giving her advice how to cope with Steven's behaviour;
- Steven could participate in a behavioural therapy in order to master his aggression ('anger coping');
- Steven could be referred for treatment in a day care centre, offering temporary relief for mother, and focusing on Steven's aggressive behaviour, school results and his contact with his peer group;
- Steven and his parents could participate in systems therapy, to work on Steven's role and emotions concerning the divorce;
- it could also be considered to perform an in-depth diagnostic assessment first in order to map out more precisely the situation of Steven and his mother.

Setting the 'indication for treatment' (abbreviated as: IFT) refers to the process of a *professional decision-making* about the intervention or a combination of interventions considered optimal. This decision should hold the prospect that the problematic situation of a child and his family will (eventually) improve as much as possible.

In the Dutch youth care system, the setting of IFT's has become of crucial importance. Under the new Youth Care Act, that will come into effect in 2005,[1] clients can only obtain expensive forms of child and youth care on the basis of a so called *IFT-statement*, a document that is the result of the professional decision-making on the optimal intervention. This document gives clients a *statutory right* to the care/treatment modality that is recommended (cf. Eijgenraam & Konijn, 2003). This puts a heavy demand on the quality of IFT-statements: offering clients a legal right to receive a certain type of care is only sensible if the decision for this care is grounded on rational and explicit arguments. Therefore, an IFT should include:

- a careful assessment of the problems and assets of the child and its parents;
- an in-depth analysis of the needs of the client for support or treatment to solve the problems or to cope with the problems more adequately;
- a consensus between the client and the professional on the goals to be served by the treatment;
- a consensus on the means and arrangements that lead to the attainment of these goals.

Moreover, IFT-statements imply that the decisions on the goals and the means of treatment are rationally and explicitly related to the problems and needs of clients. Without these relations, an IFT is no more than a random decision.

The purpose of this contribution is threefold. First, we briefly elaborate on the new situation in the Netherlands that puts the IFT-statement in such a central position. Then, we focus on two studies that pertain to the issue to what extent IFT-statements meet the basic requirement of being a rational and explicit decision. The purpose of the first study is to determine the degree to which IFT-statements in practice show logical and systematic connections between the type of problems assessed on the one hand and the type of treatment advised on the other. Furthermore, it investigated the general quality of the IFT-statements. The second study focuses in more detail on the quality of IFT-statements, regarding the explicit formulation of goals and means and the justification for selecting these goals and means.

Child and youth care and indications for treatment in The Netherlands

During the first half of the 1990's, research showed that an explicit IFT-statement often was missing in the reports of referring agencies (Bullens, 1995; Faas, 1993; Inspectie Jeugdhulpverlening regio Zuid-West, 1992). In other words, it was not clear why professionals opted for intervention A and not for intervention B or C.[2] Furthermore. it appeared that, once an IFT for a certain type of help was pronounced, this offered no guarantee that the client would actually receive this help (or any help). Emans and Robbroeckx (1997) established, for instance, that quite a number of children who were landed with the indication 'family foster care' ended up in residential facilities and – conversely – a number of children without such an indication were put into foster care (see for residential care Knorth & Dubbeldam, 1999; Knorth & Van Woensel, 2000). Studies also revealed that youth care shows a high rate of drop-out, partly due to the fact that clients or professionals conclude that the wrong treatment was initiated (see e.g. Van der Ploeg & Scholte, 2003). Therefore, based on research and treatment theories (De Bruyn et al., 1995) as well as on policy and legislation (Smit, Knorth & Klomp, 1997), it was urged that indications for treatment should be made as explicit as possible, and should provide a solid basis for the actual assistance to children and their families.

Several attempts have been made to increase the quality of IFT-statements and the underlying decision-making process. In some places, the use of assessment committees or *expert teams* is being explored, their task being to ascertain whether or not the indication for placing children and adolescents in out-of-home care was sufficiently substantiated, for in these cases it does involve the most 'intrusive' decisions. The value of these testing bodies or expert teams, however, has been questioned (cf. Oudenhoven, 1997; Pijnenburg, Vennix & De Bruyn, 1998; Van Dam & Ten Haaf, 1999). Another way is to guide the decision making by a *protocol* that prescribes the factors that should be taken into account and outlines the subsequent steps that should be followed in making the decision.[3] However, decision making on the optimal treatment is a complex process (Knorth, 1991; Lindsey, 1992). Because our knowledge on 'what works with which problems' is limited (Rispens, 1996; Ten Berge, 1998; Van Yperen, 2003), and it remains the question if this knowledge – if available – is applicable in the *individual* case (Kok, 2002), the issuing of an IFT-statement forms a telling example of 'deciding in uncertainty' (Knorth & Veerbeek, 1999). Protocols can reduce this uncertainty to only a very limited degree. Yet, daily, hundreds of these decisions are being made in our country, be it implicit or explicit. It takes simple arithmetic to know that on an international scale this involves, day after day after day, thousands of these kinds of decisions (Knorth, 1998).

The Youth Care Office and the access to child and youth care

During the second half of the 1990's, the government instigated a reorganisation of the Dutch Youth Care system. The main goal was to realise more cohesion in what was being regarded as a hotchpotch (Dutch Government, 1994). Pivotal was the foundation of the so-called Youth Care Offices (YCO's), intended as the central entrance to all kinds of child and youth care, and the Multi-Functional Organisations (MFO's), that should offer a 'continuum of care' or a comprehensive range of care programmes (Notten & Elling, 1998; Smit et al., 1997).

To date, all organisations that play a role in providing access to child and youth care programmes are being integrated in YCO's. These offices are easily accessible institutions where children and their parents, as well as youngsters and young adults, can obtain advice

about issues of everyday life which they cannot resolve themselves, nor with the help of general youth services. The main function of the YCO can be divided into two domains.

- Client registration and intake, screening, and provision of basic, short term, ambulatory care (in medical settings named as: outpatient care).[4] Access to this type of care can be gained without extensive diagnostic assessment.
- If more intensive forms of treatment are to be considered, YCO's perform diagnostic assessment, decide on what is the most appropriate treatment strategy, and, by means of an IFT-statement, formally assign young clients to various child and youth care programs/centres in the region. In other words, YCO's form the exclusive entrance to most of the specialised child and youth care facilities. Their task is to refer children and their families to these special child and youth care programmes in different sectors, like youth welfare, mental health care, child protection and care for children and adolescents with mild cognitive impairments. In most YCO's, a team of experts evaluates the draft IFT-statement (the *IFT-proposal*), before it is documented as an official IFT-statement.

Additionally, the YCO is charged with the task of case management. This implies supervision of the entire care/treatment process, and accompanying clients throughout their care trajectories (Kauffman & Pijnenburg, 1999).
The line of action of the Youth Care Offices can be visualised as follows (see Figure 1, derived from Nota, Van der Schaft & Van Yperen, 1997).

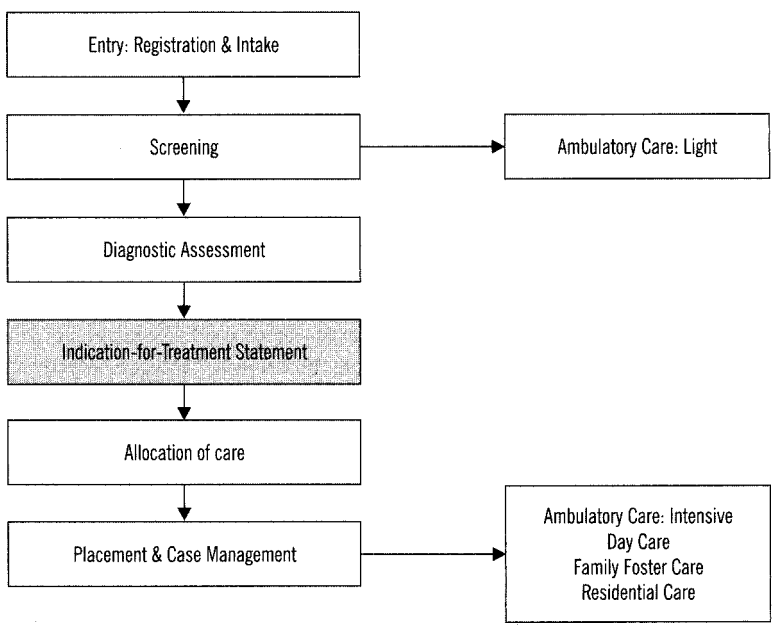

Figure 1
Basic Model of Access to Child and Youth Care

In this model, the 'indication phase' takes a prominent place. It forms the 'hinge' between the analysis of the problem and the need for help on the one hand and the suggestions for support

or treatment on the other (see also Heinrich, 2002). The idea behind this model is that no child ends up in a facility for youth care without a rational, explicit, well-documented, written IFT-statement. Additionally, there is the assumption that the care trajectory will proceed more successfully and more efficiently, because in the IFT problems are properly analysed, a diagnosis is made, short and long term goals are set, and the most appropriate care/treatment is selected – all done in consultation with and by consent of the children and parents involved.

Against this background we will now present the results of two empirical studies. The aim of the first study was to investigate the relations between the problems of the children who have been referred to the YCO on the one hand, and the types of help that are being advised in the IFT-statements on the other, and to establish the quality of the IFT-proposals as assessed by an expert committee of the YCO. This study was performed by the Section of Child and Youth Care, Department of Education, Leiden University. The second study focused on the quality of the IFT-statements as assessed by independent experts. It was performed by the Expertise Centre for Child and Youth Care, The Netherlands Institute for Care and Welfare (NIZW) in Utrecht.[5]

The Leiden study: Problem characteristics and indications for treatment

Methods

The Leiden study was performed at the Youth Care Office which serves the northern part of the province of South-Holland, a densely populated region with some 1.5 million inhabitants.[6] The subjects comprised a random, systematically drawn sample from the youth population referred to the YCO during the period of February-December 2000 (11 months). The population counted over 2.400 referrals; every eighth referral was selected, resulting in 300 cases. Due to attrition the actual sample consisted of 270 cases (90% response-rate).
A *case-file survey* was carried out by using the *RED-form*, a tested inventory for mapping out personal and problem characteristics of children or adolescents and their families (Van Vianen, Baarda & Ten Berge, 1996; see also Verheggen & Van Yperen, 1997). In this survey, data were also gathered on the type of help that was advised by the YCO-worker, and whether the expert committee approved or disapproved of the IFT-proposals (cf. Josias, 2002; Noom, Knorth & Josias, 2003).

The sample comprised of 54% males. Approximately a third of the sample in our study had a non-Dutch cultural background. The age distribution of the subjects was: 0-6 years: 18%; 7-11 years: 31%; 12-18 years: 46%; older than 18 years: 5%. This proportional increase of children that find their way to youth care as they grow older is a finding that comes across in other studies also (see for instance John, Offord, Boyle & Racine, 1995).[7]

Results

Table 1 presents which type of behavioural or emotional disturbances were manifested by the children, as well as to what extent parental behaviour was assessed as problematic.

As the Table shows, a slight majority of the youth (52%) showed predominantly externalising behavioural disturbances (such as aggressive behaviour, oppositional behaviour or excessive

boisterous and attention demanding behaviour). In 23% of the cases a combination of externalising and internalising problems was found, whereas in 20% there were predominantly internalising behavioural problems (such as depressive symptoms, anxiety disorders or somatoform disorders).
As to the parental behaviour, in four out of five cases (83%) various problems were observed, such as setting ambiguous rules, inconsistent parenting, insufficient stimulation of the child, or child neglect or abuse. Striking is the number of case-files (102) that contained insufficient reliable information on this issue.

Table 2 presents which type of intervention was advised by the YCO-worker.

The table shows that outpatient (ambulatory) youth care was the most frequently advised type of care (64%). In 24% this outpatient help was brief and non-intensive; 40% was referred to intensive care such as long-term home-based care, functional family therapy, or individual

Table 1
Behavioural problems child and parenting behaviour

	Frequency	Percentage
Behavioural problems child*		
Externalising	136	52
Internalising	52	20
Mixed Externalising/Internalising	58	22
Other	4	2
No behavioural problems	10	4
Total	*260*	*100*
Parenting behaviour**		
Problematic	141	83
Uncomplicated	27	17
Total	*168*	*100*

* number of missing data = 10; ** number of missing data = 102

Table 2
Types of intervention suggested by care worker (IFT-proposals)

	Frequency	Percentage
IFT-Proposal*		
Ambulatory Care Light	62	24
Ambulatory Care Intensive	101	40
Out-of-home Placement [unspecified]	31	12
Day Care	7	3
Family Foster Care	8	3
Residential Care	7	3
Further Diagnostic Assessment	38	15
Total	*254*	*100*

* number of missing data = 16

behaviour therapy. In over a fifth of the cases (21%) a counselling outside the family, either during daytime (day care), or day and night (family foster care, residential care) was advised. Note that in one out of seven cases (15%) the YCO-worker stated that more diagnostic exploration was advisable before formulating an IFT-statement.

Our analysis also reveals that the expert committee that assessed the IFT-proposals agreed in two-thirds (66.7%) of the YCO-worker's proposals, whereas in almost a quarter of the cases (23.3%) the proposals were turned down. In about half of these refusals (11.2%) the committee deemed that the content of the IFT-proposal was incorrect or insufficiently substantiated. The other half (12.1%) were disapproved because the information provided was inadequate to make a well-founded decision. Notable is the number of cases (10%) in which the committee's decision was undocumented. The graphic representation of the procedure can be visualised as follows (see Figure 2).

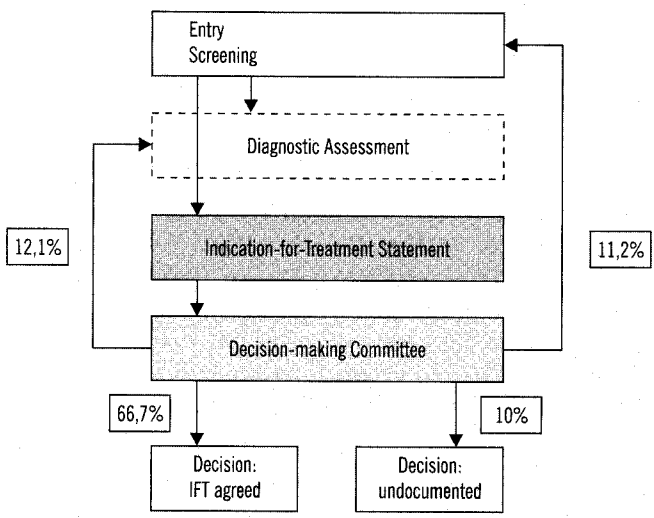

Figure 2
Evaluation of IFT-statements by Youth Care Office (N = 270)

We also examined the relation between the personal and problem characteristics on the one hand (Table 1) and the IFT-statements on the other (Table 2). Inspection of cross-tabulations revealed some interesting results.
Looking at the type of *behavioural problems* of the children, youth with predominantly internalising problems relatively often receive the indication 'ambulatory care: intensive'. Children with externalising problems or a combination (both externalising and internalising) of problems are comparatively frequently found in the categories 'day care' and 'residential care'. The IFT-statement 'family foster care' involves a relatively large number of children without behavioural problems, whereas the advice 'further diagnostic assessment' is more often found in cases with predominantly externalising behavioural problems (Chi-square: 127.1, df = 24, p = 0.00).
As to the *decision-making process* of the expert committee, our analyses showed that the committee always agreed on day care, family foster care or residential care, whereas it often disagreed on 'ambulatory care: light' (Chi-square: 11.4, df = 6, p = 0.07, 2-tailored).

In 30% of the cases the committee made a critical comment on the submitted reports that contained the IFT-proposals. If we consider the fact that almost 25% of the information items in the RED-inventory showed a 'substantial' amount of missing data (i.e., in more than 50% of the cases), we notice that the committee was actually mild in its comments on the reports.

The NIZW study: A closer look at the quality of IFT-statements

Methods

We randomly selected five of all Multi Functional Organisations (MFO's; see also p. 169) that receive IFT-statements from YCO's. At each of these five institutions we analysed the quality of the IFT-statements (i.e., IFT-statements that passed the expert committees of the YCO's) from three different points of view: objective standards, the opinion of professionals, and the opinion of clients.

Objective standards. In order to assess whether the written IFT-statements by youth care workers meet objective standards, we developed the *Checklist of Quality Standards* (Konijn, Metselaar & Stoll, 2002).[8] This Checklist contains items pertaining to:

- referral information and problem analysis;
- diagnosis;
- goals to be attained by treatment;
- most desirable forms of treatment;
- minimal needed forms of treatment.

Many of these items cover the quality standards set by the new Youth Care Act. The Checklist focuses on how well the treatment proposal is motivated and how well the views of the client is described separately from the views of the YCO-worker, and whether the client agrees upon the goals that are set and the forms of treatment that are proposed. In total we analysed 227 written IFT-statements using the Checklist of Quality Standards. The sample comprised of 72% males.

The opinion of professionals. To complement the outcomes based on objective standards, we asked case managers what their opinion was on the IFT-statements. Here, we used a questionnaire with 11 questions examining the extent to which a clear description of the problematic situation of the client is given and to which the situation is properly being examined. Some of these questions deal with how well the IFT-statement matches the problematic situation of the client. In addition, the case managers were asked to give the IFT-statement a mark on a scale ranging from 1 (complete lack of quality) to 10 (excellent quality). Of all professionals we approached, 90 returned the questionnaire (78% response).

The opinion of clients. We also developed a written questionnaire to get the opinion of the clients (i.e. the parents of children in the age of 0 to 12 years and young people older than 12 years). Here, two matters were of special interest: their opinion on (1) the quality of the IFT-statement, and on (2) the process they had to go through before they received their IFT-statement from the YCO-worker. The questionnaire consisted of 14 items on the extent to which the YCO-worker paid enough attention to the client, performed a thorough assessment, and provided the client with sufficient information on treatment options.[9] As in the questionnaire for professionals, the clients were asked to give the IFT-statement a mark on a

scale from 1 to 10. All clients in our study (N = 227) were contacted to fill out the questionnaire. 83 Forms have been returned (37% response).

Results

Table 3 gives an overview of the results if the quality was assessed using objective standards. It shows that there is a lot to improve on the quality of the IFT-statements. They clearly do not meet the quality standards set by the Youth Care Act. The IFT-statements in our sample as a whole answer to 31% of the quality standards. The average score (the right-hand column in Table 3) is referring to the percentage of quality indicators met by the IFT-statements. For instance, the score of 34% on 'problem analysis (according to the worker)' [with 7 indicators] means that on average 2 to 3 of the quality indicators are met in the IFT-statements, whereas 4 to 5 indicators are not met.

Table 3
Quality of Indication-for-Treatment statements

Clusters of quality aspects [between brackets: number of indicators]	Average score (%)
1. General information (bio/demographic client data) [11 indicators]	37
2. Specific information (the question that prompts the client to call upon child and youth care; former diagnostic assessments; information on risk and protective factors in social environment of the child) [15 indicators]	40
3. Problem analysis (according to the client) [10 indicators]	41
4. Problem analysis (according to the worker) [7 indicators]	34
5. Diagnosis [5 indicators]	13
6. Client needs (taking problems, talents, impairments and wishes of the client into consideration; arguments re indication-for-treatment proposal) [4 indicators]	37
7. Goals of possible care and treatment [8 indicators]	32
8. Most desirable care and treatment [11 indicators]	51
9. Minimal needed care and treatment [11 indicators]	15
10. Band width (variation in possible care and treatment in terms of function, location, duration, type of care, term, goals) [7 indicators]	11
11. Signature of the client [1 indicator]	30
Total score	*31*

The care assigned to the client according to the IFT-statement (one of the items in the cluster 'most desirable treatment') is in most cases (90%) written down. However, the score on 'most desirable treatment' is only 51%, because in many IFT-statements it remains unclear whether the client approves the treatment that is suggested (one of the other items in this cluster).
The problem analysis in the IFT-statements meets only 40% of the quality standards. In most cases (60%), the problems in the home situation are being described, whereas information on the school situation, functioning in leisure time, functioning with friends, and the social circumstances is often lacking. As a result, it is unclear which domains of functioning are intact or affected. This makes it difficult to understand why a client cannot solve a problem (partly) by himself, using his natural resources. The same counts for the quality standards on the opin-

ion of the client on the problem: in many cases it is not clear to what extent the client thinks that (s)he can contribute to solving the problem.
As the Table shows, foundations for the requested treatment are often lacking. In most cases it is not clear for what reason the requested care and treatment is chosen. This is also the case for the description of the short term and long term goals. Although one or two goals of the treatment are written down in 82% of the IFT-statements, it turns out that in only 29% of the cases these goals are clear enough to give direction to any treatment. In only 30% of the IFT-statements, we found a signature of the client. Therefore we draw the conclusion that only one third of the clients has read the IFT-statement and has agreed on it explicitly.

Seventy percent of the clients were satisfied with the way the YCO-worker supported them. They were relatively content with the assessment of their problems by the care worker: he or she took the time to listen to the clients. Less positive are the clients' comments about information they received from the youth care worker, the understanding of the situation and the way in which they had a say in the treatment chosen. Nevertheless, the clients mark their IFT-statement with an average 7.6 on the scale of 1 (complete lack of quality) to 10 (excellent quality). Of all clients we asked, 60% has read the IFT-statement and a majority of these clients considered it to be clear and well-defined. Compared to the outcomes of the Checklist, this percentage is two times higher than the percentage of IFT-statements (30%) that is signed by the clients. This indicates that some clients may have read the statement but were not asked to put their signature.

Compared to the opinion of the clients, the case managers are less content: they mark the IFT-statements on average with a 5.7 on the scale of 1 to 10. Nevertheless 84% is content with the IFT-statements: in their opinion the proposed treatment is the right one. Most of the critics by the case managers concern the foundations of the IFT-statement: neither the problem analysis nor the goals of the treatment are adequately written down. Moreover, the client's perspective on his or her needs is also lacking, according to the case managers. The case managers' mark is statistically related to particular qualities of the IFT-statements: the mark correlates positively with the quality of 'general information' ($r = .34$, $p = 0.005$), the specification of 'goals of possible care and treatment' ($r = .26$, $p = 0.03$), and the designation of 'the most desirable treatment' ($r = .26$, $p = 0.03$). According to the case managers these very same aspects are the most crucial ones for an IFT-statement of high quality. The results of this study may be summarised as follows: the case managers agree on the IFT-statement, but the motivation or – to quote Backe-Hansen (2003) – the 'justification' the YCO-workers present is found to be poor.

It is important to bear in mind that the IFT-statements we analysed 'already passed the test' of the expert committee of the YCO. Many of these cases were assigned to intensive types of youth care, like residential care, despite the poor quality of the IFT-statement.
Apparently, the expert committees failed to note the poverty of argumentation, or accepted the low quality of the IFT-statements. Research confirms this hypotheses: most of these committees throughout the country check the IFT-statements on the quality of the *procedure* that leads to the statement, more than on the content of this statement (Booy, Cohen de Lara-Kroon & Van Yperen, 2002). In addition, it is important to note that we only analysed IFT-statements of clients who were receiving care at the moment of our study, whereas clients who received these statements but dropped out before our study began were not included. So the results shown here may be positively biased.

Conclusions

Looking back on the Leiden study, we discern a pattern that was also found in other studies (Festen & Verburg, 2003; Konijn & Schuur, 1992; Van der Ploeg, 1998):

- externalising behaviour problems can most frequently be found in children and adolescents who are referred to psychosocial youth care;
- the parental performance is often qualified as problematic by the care workers;
- the most often proposed types of help involve ambulatory or outpatient youth care in more or less intensive form; out-of-home placement is only advised in a minority of the cases;
- The IFT-statement 'ambulatory care: intensive' is significantly more often issued with young clients with internalising problems, whereas children with externalising problems or a combination of internalising and externalising problems receive comparatively more often the advice 'institutional care' (day care, residential care).

Intriguing is the finding that the need for 'further diagnostic exploration' evidently most often occurs with young persons presenting *externalising* behavioural problems. These youth tend to display a so-called external 'locus of control' (the tendency to attribute problems to others), show less evidence of introspective orientation and are more often difficult to approach in personal relations (Van der Ploeg, 1998). The result could be that care givers with the YCO get the feeling that they have too little 'grip' on these clients, which might account for the need for further diagnostic assessment.

The assessment of the IFT-statements by the committee of experts yields the verdict 'agreed' in only two out of three cases. So quite some fault can be found with the IFT-statements submitted for assessment. Moreover, some IFT-statements receive the stamp 'agreed', even though the case is insufficiently substantiated. In the NIZW-study this subject was taken much further. Conspicuous is that the assessment of the IFT-statements by use of the objective standards clearly paints a more disadvantageous picture than consulting the case managers. The latter, in turn, are far more critical about the IFT-statements than the clients. What could have brought this about?

In an attempt to explain the difference between the outcome of the Checklist of Quality Standards and the opinion of the case managers and clients we first take a closer look at the Checklist. One of the reasons for the low score on this list could be its strictness. The items are rooted in the new Youth Care Act. The Checklist represents the ideal way in which an IFT-statement should be written out. Therefore it is aiming at the highest level of quality. Considering the fact that the Youth Care Act is not in use yet, at the present it might be aiming at too high a level. Nevertheless, the Act will become into force in January 2005 and the Checklist has already been considered to be a useful instrument for quality-focused policy (Heinrich, 2002). Therefore we do not want to detract from its outcomes for the moment. But in the future maybe we should develop a set of 'good enough' standards.

Secondly, the case managers do not think highly of the IFT-statement (mark 5.7) although they do say the assigned treatment, which is being carried out, is the right one. They criticize especially the items 'client's perspective on needs', 'problem analysis' and 'goals of possible treatment'. Additional research points out that the YCO-workers come to the same conclusion if they are asked which aspects need attention in improving the quality of the IFT-statements (Metselaar, Stoll & Konijn, 2003).

Thirdly, the opinion of the clients on the quality of the IFT-statements is more positive than the opinion of the case managers. According to Jumelet et al. (2002) in the long run by far the most clients are glad to have received some sort of care. This creates a bias: invited to give their opinion on the trajectory *in retrospect*, clients often assess the IFT-statement positively. We assume that their opinion would have been less positive if we would have asked them in previous months, for instance while they were still waiting for care.

In general, we can ask ourselves why IFT-statements and decisions in child and youth care evoke so many critical remarks – both in The Netherlands (Knorth, 1998) as in other countries (cf. Gleeson, 1987; Jones, 1993; Lindsey, 1992; Packman, 1989). In the Netherlands, this is a hotly debated issue.

One position in this debate is that giving a scientifically sound IFT-statement is essentially impossible (cf. Kok, 2002): there exists too little knowledge about types of help that prove to be effective with various types of problems and, moreover, there is the fact that in individual cases very little use can be made of general knowledge and insights. In line with this view, it has been proposed to 'abolish' the professional IFT-statements as a basis for care planning, and to give the clients main responsibility for decisions of relevance. In this context, much is expected of the Family Group Conference model (cf. Lupton & Stevens, 1998; Sundell, Vinnerljung & Ryburn, 2002).

Another position holds that our knowledge of more and less effective interventions as to various types of problems is certainly expanding (cf. Konijn, 2003; Scholte & Van der Ploeg, 2002; Shadish, Matt, Navaro & Phillips, 2000; Van Yperen, 2002; Weisz & Jensen, 2001) and this knowledge could in a heuristic sense play a role as a decision support device.[10] In addition, skilled care givers have a lot of 'practice know how' at their disposal, from which children and their parents can benefit. The profession would take a step back if it fails to put these various fountains of knowledge to good use.

In our opinion, every process of care giving implies by definition that choices as well as decisions have to be made, so IFT-statements (by whomever) are in fact unavoidable (Van Yperen, 2003). Instead of concluding that professional IFT-statements should preferably be omitted in the future youth care – given the points of criticism that also arise in our study – we would like to advocate to work on reaching the optimum effect, i.e. making the IFT-statements more *explicit*, thus contributing to an increased *transparency* of the decision-making processes in child and youth care. Given the results from the NIZW study, it is most advisable that the client, in his capacity as both co-investigator of the problem situation and – even more so – as a real discussion partner in elaborating a possible approach, will play a far more important role (cf. Berben, 2000; Hermanns, 1995). This has been visualised in Figure 3 (see next page).

From research projects we know that there is a demand for *in-service training* in this context amongst child and youth care workers (Metselaar et al., 2003; MO Groep et al., 2003; Stoll, Metselaar & Konijn, 2003). Assuming that this kind of training indeed will take shape, we deem working with IFT-statements in child and youth care – as of this moment – as a promising practice. Further research will have to reveal whether or not our prognosis is correct.

Notes

1. The new Youth Care Act was planned to come into effect by the start of 2004 but will actually come into effect in 2005. In spite of this delay, in practice many agencies are carrying out their working processes according to the new Act.
2. Faas (1993) ascertains for instance that in an dossier survey of 112 children placed in care, in only 39% of the cases a written IFT-statement is present. Furthermore, he concludes that in 70% the quality of the statement is sadly falling short. Bullens (1995) establishes that in the 84 diagnostic reports made in 1993 by the ABJ – a well respected diagnostic research centre in The Netherlands – in which the placing in care of a youngster is advised, in 49% of the cases a clear indication for treatment is missing.
3. See for instance Knorth, Van den Bergh & Smit (1997) or Van Yperen & Pameijer (2000).
4. This term covers forms of help like 'community based care', 'home based care', 'non-residential care', et cetera.

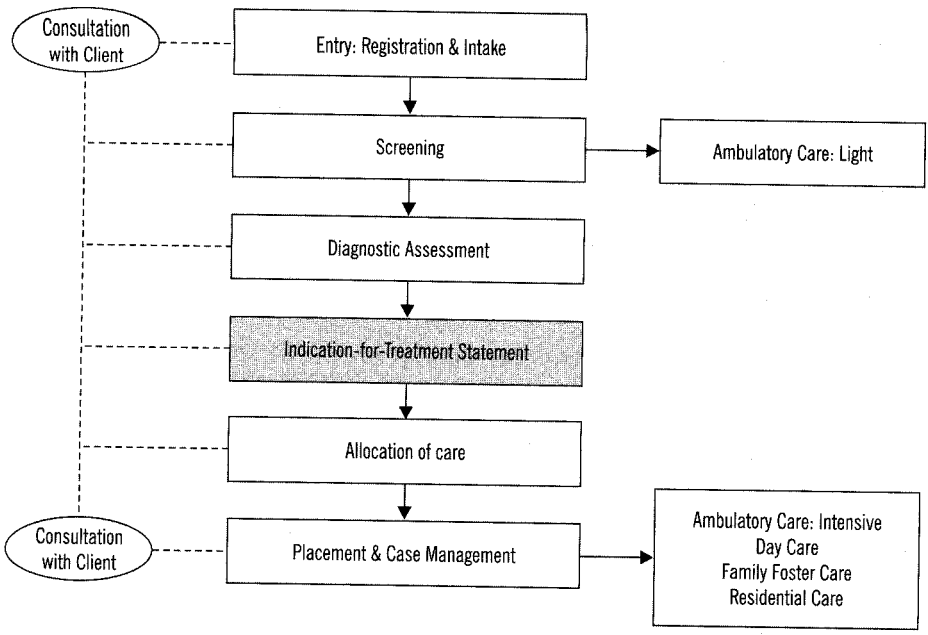

Figure 3
Adapted Basic Model of Access to Child and Youth Care

5. This study was financially supported by a grant of the National Child and Youth Care Platform (Landelijk Platform Jeugdzorg) and formed part of a broad monitor concerning the quality of child and youth care (see Delicat & Pijnenburg, 2002; Konijn, Metselaar & Stoll, 2002; Kwakkelstein & Groen, 2002; Jumelet, Jurrius & Bruggeman, 2002; Van Beek, 2002).
6. The whole province of South-Holland has over 3.4 million inhabitants (as recorded March 1st, 2001).
7. The age distribution of the first three groups in the general population in The Netherlands (up until 23 years) is approximately the same, notably 26%, 26% and 24% respectively (SRJV, 2001, p. 41).
8. The initial Checklist originated from a former research project in Amsterdam (Eijgenraam et al., 2001a, b). This Checklist was updated with criteria from the most recent version of the Youth Care Act and other more recent national guidelines.
9. In both questionnaires (for professionals and for clients) the respondents could answer on a scale from 1 to 4: highly sufficient, sufficient, insufficient, and highly insufficient respectively. They have additionally the 'don't know' option.
10. Scholte and Van der Ploeg (1999), for instance, give – based on empirical research in The Netherlands – the following, general decision heuristics for allotting youth to various types of youth care:
    - '*Foster Care* is suggested when severe personal problems of parents threaten the – still unproblematic – development of the child;
    - *Family Guidance* is suggested when the psychosocial situation of the juvenile is problematic in several respects, yet these problems only are moderately serious;
    - *Residential Care* is suggested when the children's situation also is moderately problematic, whereas there are serious personal, relational and educational problems in the family;

- *Residential Treatment* is suggested when there are serious emotional, behavioural and personality problems of the juvenile of an aggressive and/or hyperactive nature, together with serious disturbances in family-functioning...' (p. 125).

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