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One size does not fit all
The need for treatment tailoring in youth and family services

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Chapter 7

Summary of Main Findings and General Discussion

Dissertation Objective

Child maltreatment affects millions of children around the world (Stoltenborgh et al., 2015), and is associated with serious short- and long-term consequences, such as depression, substance abuse, post-traumatic stress symptoms, and aggression (Cicchetti & Handley, 2019; English et al., 2005; Gilbert et al., 2009; Stoltenborgh et al., 2015). Unfortunately, programs aimed at reducing child maltreatment show only small to moderate overall effects (Euser et al., 2015; Van der Put et al., 2018a; Vlahovicova et al., 2017). An explanation for these results may be that interventions provided by youth and family services are insufficiently personalized to the individual risks, needs, and characteristics of families at risk. In the criminal justice system, a widely used approach for providing personalized interventions to criminal offenders is applying the principles of the Risk Need Responsivity (RNR) model (Andrews et al., 1990). Although the RNR model was specifically designed for preventing recidivism of criminal offenders, it seems very promising to apply the RNR principles to other domains as well, such as the child welfare domain, that addresses (risks for) family problems and child maltreatment (Van der Put et al., 2015; Van der Put et al., 2018a). This idea is promising because the etiology of both delinquency and child maltreatment can be explained by the interplay of risk factors (e.g., psychopathology) and protective factors (e.g., social support) across various social systems, such as the family, school, and neighborhood (see Belsky, 1993; Bronfenbrenner, 1979). Further, the occurrence of delinquency and child maltreatment are both determined by the balance between risk and protective factors (Belsky, 1980, 1984; Cicchetti and Carlson, 1989; Cicchetti and Rizley, 1981; Folger and Wright, 2013; Smith et al., 2009; Stouthamer-Loeber et al., 2002).

Implementing the RNR model in youth and family services to prevent adverse outcomes in families at risk implies that interventions should be delivered following three core principles: (1) the *risk principle* is about matching an intervention's intensity to a family's risk for (recurring) child unsafety; (2) the *need principle* indicates that interventions should target unique dynamic criminogenic risk factors (i.e., needs) of families to successfully reduce the risk of child unsafety, and (3) the *responsivity principle* refers to tailoring interventions to specific abilities and characteristics of families. In recent years, the implementation of the risk principle has already proven to be beneficial for improving the quality of assessment procedures in child welfare agencies (Van der Put et al. 2018; Van der Put et al. 2016; Vial et al., 2021). However, research

on the implementation of the need and responsivity principles in youth and family services is not yet available. Therefore, this dissertation aimed to extend the research on implementing a comprehensive RNR approach in youth and family services. Below, the dissertation's contributions to the research, strengths and limitations, suggestions for future research and practice, and final conclusion are discussed.

Summary of Main Findings

Chapter 2 featured a meta-analysis on the effects of adhering to the Risk, Need, and Responsivity principles in family interventions aimed at reducing criminal recidivism of delinquent youth. We chose to critically re-evaluate the effectiveness of adhering to the RNR-principles in family interventions specifically, as the risk factors that are targeted in these type of interventions (e.g., harsh parental discipline and poor parent-child-communication) have been associated with both youth delinquency and child maltreatment. A three-level random-effects meta-analytic model was used to synthesize all effect sizes and to model effect size dependency that arose from the fact that more than one relevant effect size could be extracted from individual primary studies. The meta-analysis of k = 31 studies reporting on 71 effect sizes revealed an overall small and significant intervention effect on criminal recidivism of youth (d = 0.382, $p < .001$). However, the results revealed that none of the RNR principles significantly moderated the overall intervention effect, meaning that we did not find significant differences in effects between interventions adhering to the RNR principles and interventions not adhering to the RNR principles. We suggest that the absence of convincing empirical support for the effectiveness of applying the RNR principles is likely to be driven not by a lack of relevance of these principles for practice, but rather by a limited implementation of these principles in primary research on intervention effectiveness. More specifically, we urge future primary researchers to explicitly and thoroughly describe whether and how RNR principles were implemented in studies on treatment effectiveness. Further, we emphasize the importance of using valid and reliable instruments for risk, need, and responsivity assessment so that treatment can be tailored to needs and circumstances of individual clients.

The study in **Chapter 3** assessed the clinical value and usability of a needs assessment tool (ARIJ-Needs) in the decision-making processes of practitioners choosing an appropriate intervention for families that are involved in child protection services. ARIJ-Needs is a Dutch computer application designed to support practitioners in

adhering to the Needs principle of the RNR model, through assessing treatment needs of individual families, and in selecting interventions that best target those needs (Van der Put et al., 2018). Semi-structured interviews were conducted with fifteen practitioners (n = 12 women and n = 3 men) who had a variety of child protection-related occupations, such as family social workers and psychologists. First, the semi-structured interview started with questions about the current practitioner's decision-making process for selecting appropriate interventions. Next, a vignette that described a (fictitious) child protection case with a variety of family problems was presented. Practitioners were asked to identify any care need in the vignette, and to indicate which intervention would be appropriate to address the needs that they identified. Third, ARIJ-Needs was introduced and explained to each participant, after which practitioners were asked to perform a second needs assessment using ARIJ-Needs. Last, questions were asked about the user experiences of the instrument, after which the practitioners evaluated the results of their needs assessment with the instrument. The results revealed that practitioners identified significantly more needs in the vignette when they used ARIJ-Needs compared to their unstructured needs assessment without using the instrument. In particular, family- (e.g., domestic violence, and financial difficulties), parent-, (e.g., criminal behavior) and parenting-related (e.g., a problematic parent-child relationship) needs were more often assessed by practitioners using the instrument, which is an important finding given that these factors are the strongest predictors of child maltreatment (see, for instance, Assink et al., 2019; Mulder et al., 2018; Stith et al., 2009). These findings indicate that ARIJ-Needs seems to support practitioners in identifying relevant treatment targets in families at risk for child maltreatment that otherwise may be overlooked in unstructured needs assessments.

Although a growing body of research has appeared on how child protection can benefit from principles of the Risk-Need-Responsivity model, no attention has yet been paid to the implementation of the responsivity principle in child protection. Therefore, in **Chapter 4**, the clinical value of applying the responsivity principle in child protection services was examined. Put simply, the responsivity principle states that interventions must be tailored to specific characteristics of clients to optimize its effectiveness (Bonta & Andrews, 2017). For identifying relevant responsivity factors, a literature review on components of (forensic) responsivity and treatment readiness assessment instruments (N = 19) was performed. Based on the results of the review, an

overview of responsivity factors primarily related to caregiver characteristics in child protection services was drafted. Next, the overview was presented in semi-structured interviews to 14 professionals working in the field of child protection – specifically in health care institutions offering care to families – to evaluate the clinical relevance of tailoring treatment to each responsivity factor. In addition, practitioners were asked to provide clinical treatment suggestions for tailoring treatment to each of the identified responsivity factors. The results derived from this study support child protection practitioners in identifying core responsivity factors (e.g., problem denial, cultural background, and practical barriers such as financial problems) that may interfere with caregivers' abilities to succeed in treatment, and in providing tailored care to enhance caregivers' treatment engagement.

In **Chapter 5**, gender differences in criminogenic risk factors between male and female domestic violent perpetrators were examined. Although many studies have concluded that men and women engage in domestic violence at equal levels, existing studies have hardly focused on gender specific risk factors for domestic violence perpetration. Therefore, this study aimed to examine gender differences in criminogenic risk factors between Dutch male and female forensic outpatients who were referred to forensic treatment for domestic violence. Clinical structured assessments (using the RAF-MH, Van Horn et al., 2012) of criminogenic risk factors were retrieved for 366 male and 87 female outpatients. Gender differences in the prevalence of criminogenic risk factors measured with the RAF-MH were determined, and for men and women separately, the associations between risk factors and treatment dropout were examined. To examine the interrelatedness of the risk factors for male and female outpatients, statistical networks were created to model the interactions between risk domains. The results revealed gender differences in not only the prevalence and interrelatedness of criminogenic risk factors, but also in associations between criminogenic risk factors and treatment dropout. In domestic violent men, risk factors related to the criminal history, substance abuse, and criminal attitudes were more prevalent than in women, whereas socio-economic risk factors (e.g., education/work and finances) were more prevalent in domestic violent women. Further, having criminal friends, having a criminal history, and drug abuse were associated with treatment dropout in men, whereas a problematic relationship with family members, housing instability, a lack of personal support, and unemployment were associated with treatment dropout in women. The results provide important insights into gender specific differences in

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criminogenic risk factors for domestic violence, which support clinical professionals in adhering to the needs principle of the RNR model, by tailoring treatment to the specific needs of male and female perpetrators of domestic violence.

Although it is likely that victims have experienced multiple forms of child maltreatment, very few studies have examined the co-occurrence of maltreatment subtypes within their sample. Consequently, there is a lack of knowledge on the effects of specific co-occurring maltreatment subtypes. Therefore, the study in **Chapter 6** examined the distinctiveness of two maltreatment dimensions, i.e., abuse versus neglect, and emotional versus physical maltreatment, in identifying developmental problems in a clinical sample of 146 Dutch children from families involved in a Multisystemic Therapy – Child Abuse and Neglect treatment trajectory. The results revealed no differences in child behavior problems within the dimension abuse versus neglect. However, more externalizing behavior problems (e.g., aggressive problems) were found in children who experienced physical maltreatment compared to children who experienced emotional maltreatment. Further, more behavior problems (e.g., social problems, attention problems, and trauma symptoms) were found in victims of multitype maltreatment compared to victims of any single-type maltreatment. The results of this study increase the understanding of the impact of child maltreatment poly-victimization, and highlight the value of classifying child maltreatment into physical and emotional maltreatment. In turn, this understanding may strengthen prevention efforts offered by child protection professionals, given that potential differences in associations between specific dimensions of maltreatment and different developmental outcomes might inform professionals on how interventions addressing those negative outcomes can be further tailored to the needs of individual victims.

General Discussion

In this thesis, we used the core principles of the Risk-Need-Responsivity (RNR) model (Andrews et al., 1990) as a theoretical framework to increase the knowledge on how interventions can be better tailored to specific risk factors, needs, and characteristics of families that are involved in youth and family services. Even though meta-analytic research mostly supports the effectiveness of the RNR principles in forensic care (e.g., Andrews & Dowden, 2006; Dowden & Andrews, 1999; 2000), gaining renewed insights into the effectiveness of adhering to the RNR principles was important, given that the coding of the RNR principles was performed inconsistently across these meta-analytic reviews (Chapter 2; Smith et al., 2009). Notably, we established that none of the included primary studies in the meta-analytic review in Chapter 2 used a validated instrument for risk assessment, and only one of the included studies used a structured instrument in assessing the criminogenic needs of individual clients. These results indicate that treatment programs may be tailored to the general needs of an intervention target group, but not to specific individual risks and needs based on structured assessment procedures. Therefore – in Chapter 2 – we stress the urge for using validated instruments for risk, need, and responsivity assessment to tailor interventions in a systematic, protocolled manner in order to draw a final conclusion about the value of working with RNR principles as described by Bonta and Andrews (2017); i.e., matching intervention intensity and content to the risk level and need factors of individual clients.

The advantages of using validated and reliable assessment instruments compared to clinical, intuitive judgment in decision-making on appropriate care are already well-known in child protection services (Douglas et al., 2002; Van der Put et al., 2016). Structured risk classifications outperform clinical judgment in predicting (the recurrence of) problematic child-rearing situations, and are timesaving in practice as they only comprise variables that are significantly related to problematic outcomes (Van der Put et al., 2016). However, the study in Chapter 3 supported previous assumptions (Douglas et al., 2002; Van der Put et al., 2016) that decision-making processes of practitioners may still be primarily based on unstructured, clinical judgment. Overreliance on such intuitive thinking can be prone to various biases, such as the tendency to overlook important information, or selecting interventions solely based on prior experiences (Helm, 2011; Saltiel, 2016). The study in Chapter 3 showed promising results of using a structured needs assessment instrument (i.e.,

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ARIJ-Needs) in clinical practice to prevent such biases, as practitioners assessed significantly more treatment needs during a needs assessment round with the structured instrument compared to an assessment round without the instrument. In particular, family-, parent,- and parenting-related needs were more often assessed by practitioners using the instrument, which is an important finding given that these factors are the strongest predictors of child maltreatment (see, for instance, Assink et al., 2019; Mulder et al., 2018; Stith et al., 2009). It is expected that by further developing and implementing ARIJ-Needs in child protection services, practitioners can be better supported in identifying relevant treatment targets in families at risk. However, it should be emphasized that ARIJ-Needs is not designed to replace clinical judgment, as case and time specific factors (e.g., severity and urgency) always remain important to consider in choosing the right approach for families involved in child protection services (Van der Put et al., 2018b).

Although the implementation of the risk and need principles in child protection have been addressed in the literature, this was not yet done for the responsivity principle, which states that treatment programs must be tailored to characteristics of clients to optimize treatment effectiveness (Bonta & Andrews, 2017). Applying the responsivity principle allows flexibility in delivering an intervention program based on identified treatment barriers (i.e., responsivity factors), such as a lack of motivation or problem denial that may have a negative impact on the outcome of protocolled interventions in youth and family services if these programs are not specifically designed to target such factors (Van Yperen et al. 2017). The results in Chapter 4 revealed seven distinct treatment barriers related to caregiver characteristics: problem denial, motivation/ willingness to cooperate with treatment, psychological problems, cognitive abilities, cultural background, practical barriers (e.g., financial problems/social support), and barriers to treatment program type (e.g., group therapy). By personalizing treatment circumstances to specific characteristics of caregivers, treatment engagement and completion may be enhanced (Van Yperen et al. 2003). As it is empirically supported that interventions which are better tailored to clients' responsivity characteristics yield better outcomes (Andrews et al., 1990; Hanson et al., 2009), it may in turn be expected that introducing the responsivity principle in youth and family services boosts optimization of treatment circumstances, and hopefully, intervention effectiveness. However, to accomplish this, further research should focus on determining the best approach to treatment optimization after responsivity factors have been assessed. The

study in Chapter 4 provided expert-based knowledge on such treatment tailoring techniques to address responsivity factors (e.g., using visual support or at home video training adapted to the conceptual skills of caregivers, or facilitating transport to care facilities), but this can be substantiated with research-based insights in effective treatment techniques.

Enhancing treatment engagement and completion of specifically domestic violent caregivers is important, considering the high treatment dropout rates of domestic violent perpetrators, and the small treatment effects for reducing domestic violence (Babcock et al., 2002; Buttel & Pike, 2002; Rosenfeld, 1992; Sartin et al., 2006). In Chapter 5, we highlighted the finding that not much is known about which criminogenic risk factors are associated with treatment dropout in domestic violent women, even though recent studies report equal domestic violence victimization prevalence in men and women (de Vogel et al., 2014; de Vogel et al., 2016; Lysova et al., 2019). Despite the availability of such studies that undermine the gendered perspective of domestic violence (i.e., the belief that men are more often perpetrators than women), this approach is often reflected in the aims of many organizations to date (Dixon & Graham-Kevan, 2011; Dutton, 2007). That is, women convicted of domestic violence offenses are still often mandated into batterer intervention programs designed to intervene with male perpetrators (Carney et al., 2007).

By providing gender sensitive interventions tailored to the identified criminogenic needs as described in Chapter 5, the risk of dropping out may be reduced for domestic violent perpetrators. For example, the results in Chapter 5 revealed that socioeconomic risk factors (e.g., unemployment and housing instability) were more prevalent among violent women than men. Along with having a lack of personal support and unstable relationships with family members, these socioeconomic factors were identified as risk factors for treatment dropout in violent women. These results underline the importance of providing socioeconomic support and resources to female perpetrators of domestic violence, which may increase treatment completion and thereby treatment effectiveness in reducing domestic violence perpetrated by women (Buttell et al., 2012). Further, the study in Chapter 5 emphasized the importance of treating substance abuse in male domestic violent perpetrators, as abusing substances is an important risk factor for treatment dropout in male perpetrators. An important consideration regarding the study in Chapter 5 is that factors that predict general recidivism may not be the same for men and women, and there is an ongoing debate

on whether risk assessment tools – such as the one that was used in this study – are sufficiently gender responsive (de Vogel et al., 2019; Henning et al., 2009). Therefore, broadening risk assessment by measuring unique need factors of female perpetrators, such as those related to abuse and trauma, self-esteem and assertiveness, and parenting and childcare, in risk assessment instruments for perpetrators of domestic violence may contribute to further insights into gender differences in risk factors for criminal recidivism and, consequently, better tailored treatments (Hollin & Palmer, 2006).

Besides stressing the urge for assessing (gender) specific needs of domestic violence perpetrators, we highlighted the importance of differentiating between victims of different dimensions of child maltreatment in Chapter 6. Child maltreatment may often be approached as a global public health problem, but limiting the focus to studying the dichotomy of being maltreated or not maltreated falls short of reality as certain combinations of maltreatment are associated with different developmental outcomes (Chapter 6, Manly et al., 2001; Turner et al., 2010; Witt, 2016). The results in this study supported previous findings of poorer health outcomes, such as social problems and attention problems, for victims of multitype maltreatment compared to victims of single type maltreatment (Arata et al., 2007; Clemmons et al., 2003; Edwards et al., 2003; Gross & Keller, 1992; Huguenel et al., 2021; Ney et al., 1994; Spinazzola et al., 2014). Further the results in Chapter 6 were in line with recent findings of Huguenel et al., (2021), who suggested that despite inconsistencies in study results (English et al., 2005; Manly et al., 2001; Pears et al., 2008), the co-occurrence of one or more types of maltreatment with specifically physical maltreatment increases the risk of severe internalizing and externalizing symptoms. These results can be explained by the strong effects of cumulative trauma exposure (i.e., simultaneous or sequential co-occurrence of maltreatment) on developing adverse health outcomes, such as severe PTSD symptoms (Messman-Moore & Bhuptani, 2017). Although the results in Chapter 6 increase the understanding of the impact of child maltreatment poly-victimization, it is also clear that examining the interplay among dimensions of child maltreatment other than maltreatment subtypes (e.g., developmental timing and severity) may provide further insights in adverse health outcomes in victims of child maltreatment (Manly et al., 2001). In turn, these insights may guide practitioners in effectively tailoring interventions to the needs of maltreated children (Pears et al., 2008).

Strengths and Limitations

An important strength of this dissertation is that it is focused on translating the theoretical Risk-Need-Responsivity model that was originally designed to provide appropriate care to individual criminal offenders, into the practice of youth and family services aimed at preventing the risk of (recurring) violence in family systems. In Chapter 2, we critically re-evaluated the empirical evidence supporting the effectiveness of the RNR principles in family interventions. Our coding of the RNR principles was more in line with the original definitions of the RNR principles of Bonta and Andrews (2017) compared to previous meta-analytic reviews (e.g., Dowden and Andrews 2003). Further, recent studies were also included in the current meta-analysis, and we applied a three-level approach to meta-analysis meaning that all information reported in primary studies could be retained, and maximum statistical power could be achieved in the analyses. From the results of Chapter 2, we draw the lesson that the theoretical RNR framework may be promising in providing appropriate treatment, but that the principles need to be applied appropriately first, after which their true effectiveness can be assessed.

The studies in Chapter 3 and Chapter 4 were the first to assess the clinical value of adhering to the need and responsivity principles in child protection services based on practice-oriented qualitative data. By involving practitioners in evaluating theoretical assumptions for improving treatment delivery, we were able to provide practical suggestions to further develop an overall implementation of the RNR model in youth and family services. We aimed to further build a bridge between research and practice in Chapter 5 and 6, by optimizing the use of data that were collected as part of routine outcome monitoring at health care facilities. To our knowledge, no studies used comprehensive measures of criminogenic risk factors for criminal behavior and recidivism in examining gender differences and similarities in domestic violence perpetrators. The study in Chapter 5 was the first to address this gap by identifying risk factors for treatment dropout and risk factor interrelatedness specifically in samples of male and female domestic violent perpetrators, including using an innovative statistical technique for network modeling. The study in Chapter 6 was the first to examine developmental problems in victims of two child maltreatment dimensions: abuse versus neglect, and physical versus emotional maltreatment. The results of this chapter increase the understanding of developmental outcomes in victims of different maltreatment subtypes.

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The research presented in this dissertation also has several limitations that need to be mentioned. First, information on treatment fidelity (i.e., accuracy and consistency of intervention delivery) was not reported in most of the included primary studies in Chapter 1, meaning that it was uncertain whether the risk, need, and responsivity principles were properly applied in intervention delivery. In addition, we were unable to thoroughly examine the effectiveness of the risk and need principles according to the original definitions as described by Bonta and Andrews (2017), as most of the included primary studies failed to use validated risk and need assessment instruments. This limitation is probably an important explanation for not finding significant moderating effects of the RNR principles, and in turn, highlights an important shortcoming in the delivery of treatment in clinical practice and intervention research.

Second, Chapter 3, 4, 5, and 6 included data derived from welfare services located in an urban agglomeration in the Netherlands, which may limit the study's generalizability to youth and family services across other (rural) populations and foreign countries. Therefore, we suggest that future studies may consider including populations that are representative of the socio-demographic backgrounds of the population across countries (Fakunmoju et al., 2013). In addition, varying individual differences (e.g., age and ethnicity) between the sampled participants in Chapter 5 and 6 may have affected the found results. Further research should be undertaken to examine possible interactions between such demographic variables.

Third, the data used in Chapter 5 and 6 concerned retrospective file data that were collected as part of a ROM procedure at health care facilities, meaning that the used instruments were not preselected by the researchers. However, in Chapter 5, the used validated instrument has been based on well-known risk factors for recidivism, and fits the circumstances of clients referred to Dutch forensic outpatient treatment specifically (Wilpert et al., 2018). In chapter 6, the internal consistency of the used Child Behavior Checklist (Achenbach & Rescorla, 2001) was excellent. Therefore, these measurements were considered appropriate measures to meet the aims of the studies.

Suggestions for Future Research and Practice

Using extended randomized controlled study designs in examining 'what works for whom' in youth and family services is highly desirable. However, using available routine

outcome monitoring data gathered in health care facilities (as in Chapter 5 and 6) may also be very valuable for gaining knowledge on common needs and characteristics of specific treatment groups. Such information supports practitioners in providing appropriate interventions through an increased awareness of factors that are associated with the risk of treatment dropout or problematic developmental outcomes, such as child maltreatment.

Hereby, increasing the awareness of the impact of parental- and family-related risk factors should be prioritized, given that such factors are stronger associated with child maltreatment than child related factors (see, for instance, Assink et al., 2019; Mulder et al., 2018; Stith et al., 2009). Child maltreatment with tragic consequences due to clinically overvaluing child-related risk factors and undervaluing parent-related risks may be prevented in the future by implementing validated RNR assessment instruments in practice (e.g., ARIJ-Needs, Chapter 4; Mulder et al., 2018).

In Chapter 2, we further urged future researchers to use validated RNR assessment so that the effects of adhering to the RNR principles on program effectiveness can better be assessed. However, a prerequisite for such studies is the availability of reliable and valid assessment instruments. Although practitioners acknowledged the clinical value of the implementation of the need and responsivity principles from the RNR model (Chapter 3 and 4), the question whether or not adhering to these principles truly strengthens child maltreatment prevention efforts needs to be further examined. Then – in addition to adhering to the risk principle (Van der Put et al. 2018; Vial et al., 2021) – tailoring treatment in youth and family services following the RNR principles can actually be realized.

Final Conclusion

To draw solid conclusions on the effectiveness of the Risk Need Responsivity principles in preventing adverse outcomes in youth and their families, further research is needed in which implementation of the RNR principles in interventions is tested and explicitly described. Therefore, valid and reliable RNR assessment instruments should be used so that treatment can effectively be tailored to the risks, needs and circumstances of individual clients in youth and family services. The results of this dissertation showed that a structured needs assessment supports practitioners in identifying relevant needs of families at risk, and in selecting appropriate interventions

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that target those needs. In addition, seven core responsivity factors related to caregiver characteristics were identified as treatment barriers that may be useful to assess and addressed to enhance treatment engagement and completion of families involved in child protection services. Further, the results of this dissertation highlight the need for developing gender-sensitive risk assessment instruments, and for providing gender-specific intervention components to enhance treatment engagement in domestic violence perpetrators. Last, the results in this dissertation contributed to a better understanding of the impact of child maltreatment poly-victimization. In turn, these insights may guide practitioners in tailoring interventions to the needs of maltreated children.