Hogeschool van Amsterdam

IMPLEMENTING IS REFLECTING

Evidence-based work and the implementation of interventions in youth care

Inaugural lecture, given in a summarised version on Wednesdag 18 May 2011 by Leonieke Boendermaker (PhD), Professor Implementation an Effectiveness in Youth Care Services

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1. Introduction

> “Last year I was trained as a WSART trainer. WSART is intensive group training, intended to teach young people from 12 to 18 years old to control their aggression and prevent them from becoming criminals. We started last year and offer training at the school for special secondary education which is part of our organisation and at our extracurricular treatment groups. What is difficult as a trainer is that you have to ensure that people at the various locations of the school are aware of the training, so that they can send people to participate. We recently had a meeting with all the trainers and we observed that the procedure was different for each trainer. Some carried out the training at school, had whole school classes in the training sessions and therefore don’t make a selection. Others run a group for a couple of specially selected pupils from a class or carry out the training with young people from an extracurricular treatment group. Trainers then adapt the schedule of three sessions per week for doing this. It is very frustrating to experience that the procedure is different everywhere and organising the participants is very time-consuming”.

This was said by a member of staff at the organization for childrens services and education Altra who was participating in the AUAS Masters’ in Social Work. In consultation with her employer, for her Masters’ thesis she decided to conduct research into the preconditions which were necessary for the successful implementation of this Washington State Aggression Replacement Training (WSART). In this she focussed on the imple-mentation of the training.(*)

Her situation is not unique. Recent research into training for parents from the package Ouders van Tegendraadse Jeugd (Parents of Recalcitrant Youth) demonstrates a similar situation. It was also apparent here that members of staff in youth rehabilitation, who were trained to provide parents training in parental skills, spent much of their valuable training time in the acquisition of participants (Boendermaker, Lekkerkerker, Deković, Foolen, & Vermeij, 2010). In the implementation of behavioural interventions in the prison system – training in cognitive skills (COVA), which to a great extent corresponds with WSART from the example mentioned above – it also appeared that a great deal of effort had to be made to acquire participants in the interventions: the number of participants in the initial period could be counted on one hand (Burik & Persoon, 2008a; Burik & Persoon, 2008b). Examples such as this create the impression that in the implementation of interventions organisations limit themselves to training professionals, without subsequent attention being paid to whether an intervention has been well-embedded or not. More than ten years ago, researchers in the area of the treatment of prisoners had already indicated the fact that implementation was a forgotten issue and required considerable more attention (Gendreau, Goggin, & Smith, 1999).

Academic publications about the effects of interventions pay little attention to the level of implementation of interventions (Perepletchikova, 2007). In daily practice it is primarily in well-researched interventions (many of them from abroad) that attention is paid to their implementation and realisation. The intensive family intervention MST (Multi System Therapy) for instance, has a site assessment, an evaluation for an organisation to assess whether the pre-conditions for a good implementation are present. Moreover, MST has five-day training sessions for therapists and supervisors, group and individual supervision for the therapists who work in families, weekly consultations about cases, obligatory follow-up training and feedback on the basis of questionnaires completed by parents and therapists about the action taken by the therapists and supervisors (Cunningham, Randall, Henggeler, & Schoenwald, 2006). In MST this routine was developed some ten years ago, when it became clear that the ‘transplant’ of the intervention

to another location than that of the developer did not progress without problems. Scott Henggeler and his team at the Family Services Research Centre at the University of Charleston (South Carolina, USA) could not supervise therapists at other locations with the same intensity as at their own institute. At the two locations where people were working with MST the good outcomes from previous research were not replicated (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998). For this reason serious work was subsequently undertaken on a system for training, monitoring and evaluating. In the meanwhile a separate commercial organisation, MST services, supervises the implementation of MST everywhere in the world and we also have MST in the Netherlands (Berger & Boendermaker, 2003) (**1**).

The implementation of interventions usually receives far less attention than is the case for MST. In Canada researchers from the Division of Criminal Justice at the University of Cincinnati have now evaluated more than four hundred programmes within the prison or rehabilitation system on the basis of the Correctional Programs Assessment Inventory (CPAI) which they developed. They came to the conclusion that 70% of the implementations of the programmes were not satisfactory (Lowenkamp, Flores, Holsinger, Makarios, & Latessa, 2010). In England it was also apparent that the implementation of behavioural interventions for prisoners and ex-prisoners were not a matter of course. Hard work was carried out there to implement three interventions within the prison system and rehabilitation. Research into the outcomes of these interventions revealed disappointing results so that the question was asked whether this was due to the interventions (which had led to a reduction in re-offending abroad) or their implementation. The British Correctional Services Accreditation Panel therefore switched over to evaluating the implementation on the basis of an Implementation Quality Rating (IQR) which was completed during an audit visit. It soon became clear that there were few programmes where good implementation could be said to exist (Goggin & Gendreau, 2006).

Guidelines are frequently worked with in health care. It is also evident here that guidelines do not automatically apply in the daily working activities of professionals and that attention needs to be paid to implementation (Hutschemaekers, 2010; Smolders, Laurant, Duin, Wensing, & Grol, 2006). The organisation for health research and care intervention ZonMw recently published a booklet containing the experiences of implementation coaches in health care. The coaches are occupied with the implementation of guidelines (for example about the treatment for certain skin disorders or the side effects of chemotherapy) and many of them said that the complexity of the implementation process surprised them and that it required specific knowledge (Linden, Cox, Holleman, & Tol, 2010).
In brief: implementation would appear to be difficult and little attention is paid to it. This has direct consequences for actual practice. If an intervention is not or only partially carried out, then clients will not profit optimally from it. And this is ultimately what it’s about: that clients benefit from the care and supervision which is offered in youth care.

In this lecture I will consider the question which factors play a role in implementation. I will consider five subjects. The working area of this professorship concerns the implementation of interventions in youth care. I will therefore first consider the developments in youth care. I will then deal with the question of what enables an intervention to work and subsequently what the nature of the implementation should therefore be. The fourth step in my argument is what this means for actual practice. I will then discuss the projects in which we have set to work with Amsterdam’s youth organisations to flesh out the implementation. I shall argue that knowledge of the working factors of interventions is important for their implementation. A clear plan is also necessary for an implementation to proceed well with sufficient attention to embedding the intervention and all of this means for professionals is that they have to be able to work with an evidence-based orientation.

2. Developments in youth care services

Youth care is a complicated and turbulent area of work. There are very many different organisations which are occupied with youth care services, each with its own source of financial means (**2**). A number of tragic incidents in which children died made it clear that cooperation problems between organisations existed. This ensured that there was renewed attention for the quality, effectiveness and efficiency of the current youth care system. Three developments are therefore under discussion in youth care:

1. Attention to effectiveness of the care. To stimulate the use of effective interventions a system of accreditation has been introduced in recent years. Two independent accreditation panels (**3**) evaluate interventions and accredited interventions are entered into a national data base. In addition the government finances the availability and dissemination of knowledge about and research into effective or evidence-based interventions in the Knowledge Programme Youth that the Netherlands Youth Institute (NJI), the Netherlands Centre for Youth Health Care (NCJ) and the Netherlands Care Organisation for Health Research and Development (ZonMw) carry out together. Finally institutions are obliged to provide greater insight into information about outcomes of care on the basis of performance indicators.
2. Attention to the professionalization of members of staff in youth care. In the context of the National Action Plan Professionalization in Youth Care, youth care institutions, universities of applied sciences and professional associations have joined forces. Competency profiles have been drawn up for youth care workers and behavioural scientists/psychologists in youth care. In this way, universities of applied sciences can train future members of staff with a more specific orientation. In the near future a professional register will be started up for professionals working in youth care. Disciplinary rules will be linked to it and the obligation for continuing education. In addition the professional associations have given the assignment to develop guidelines for the referral process, crisis intervention, residential care, foster care, children with ADD, children with attachment problems, behavioural disorders, autism or depression. The guidelines intent to be a practical resource for professionals in the appraisals that they make in their work and are based on research evidence, professional expertise as well as client preferences.
3. The reorganisation of the youth care system. After the recent evaluation of the Youth Care Act (Baecke et al., 2009), proposals have been made both in Parliament (Working Group Future Investigation Youth Care, 2010) as well as by the government (Ministry for Youth and Family, 2010) for solving the observed problems. On the basis of this in the coalition agreement for the Rutte Cabinet in 2010 three measures were announced which should make youth care more accessible. One financing system will be introduced for all forms of youth care (youth health care, youth care, youth mental health care and care for young people with a minor mental disability). The responsibility for youth care will be transferred from the provincial governmental bodies to the local authorities. And in every local authority a Centre for Youth and Family will function as the means to access care (**4**).

For all these developments questions about implementation are under discussion. Without good implementation effective interventions are absolutely out of the question. Without well-trained professionals implementation is not possible and without knowledge about effective interventions and evidence-based work a reorganised youth care system would also not be able to function effectively. This professorship at AUAS is focused on a specific subject: the implementation of interventions. This focus was introduced at the request of Amsterdam's youth care organisations who, together with AUAS,

have taken the initiative for this professorship. The most direct partners of the professorship are the six institutions who participate in the Network Effective Youth Care Amsterdam (NEJA). They are: Child Protection Amsterdam Area, Spirit youth and parental help, Altra youth and parental help and special education, MOC ’t Kabouterhuis (centre for medical and special education), a part of HVO Querido (offering care and support for vulnerable people with a mental or social disabilities) and the department of therapeutic family interventions at the youth mental health institution De Bascule. Due to the impending changes in youth care, the professional field for the implementation of inventions will expand beyond just these six institutions. In addition, the demand for implementations will not be limited to interventions. A large number of guidelines will have to find a place in the dealings of professionals in actual practice. Although many of the matters that I will discuss are also applicable to guidelines, in this inaugural lecture I will limit myself to the implementation of interventions in youth care.

3. Interventions in Youth care

The term intervention is a collective name for projects, training methods, forms of treatment and supervision, sanctions and programmes. According to the definition of the Netherlands Youth Institute, it concerns approaches:

- for reducing, compensating or making tolerable a risk or a problem in the development of a young person (up until 23 years old);
- which are aimed at a target group with one or more of these risks or problems;
- which are aimed at the young person, his/her parents and/or the parental environment;
- which is guided by a well-thought through, goal-orientated and systematic working method;
- with a precisely defined duration of time and frequency.

Examples of interventions are training sessions for parents, aimed at improving their parental skills for reducing behavioural problems in their children (**5**), training for children or young people in self-regulation and problem-solving skills (**6**), or more or less intensive family interventions (**7**).

In this way, an intervention is different from the basic methodologies often used in youth care services. The latter concerns working methods which are geared towards clients, regardless of their specific problem. Usually they are approaches in which a certain 'basic attitude' or manner of 'treatment' is evident. Examples of basic methodologies are the solution-focused approach or the skills-focused orientation. An essential characteristic of an intervention is its orientation towards a specific target group. In actual practice this is often disregarded (as in the example of WSART, which I used at the beginning of this lecture). In recent research into the implementation of behavioural interventions in Rehabilitation, carried out by the associate professorship in Rehabilitation and Safety Policy at Avans University of Applied Sciences, members of staff expressed their mixed feelings about the selection of participants for interventions. Through selection fewer rehabilitation clients could participate in an intervention, while all of them do after all "need something" (Vosters & Vogelvang, 2010). This point of departure is a concern for many professionals and is, although understandable because people want to help clients, definitely incorrect. Interventions are developed to approach a specific problem and cannot be arbitrarily applicable to everyone. From research amongst perpetrators of criminal offences it is known that interventions can also have a counterproductive effect. In particular employing intensive residential or group interventions for people with a low risk of reoffending are unsuccessful. It is precisely this group which appears to be sensitive to the negative influence of more experienced perpetrators of criminal offences and after participation they commit more rather than fewer criminal offences (see for example Deković, 2010). The choice of an intervention always has to be geared to the nature and seriousness of the problems of the person in question.

4. Effectiveness in youth care

Why has the attention paid to the effectiveness and effective interventions increased so much in recent years? This concerns the desire to provide qualitatively good care and at the same time to use the limited financial means effectively and efficiently. Knowledge about interventions which lead to a reduction of problems, help to account for the chosen manner of working, to continue to develop and position the profession and keep it affordable (Kuiper, Verhoef, Cox, & Louw, 2008; Van Yperen, 2010). In youth care services people work in two ways in increasing effectiveness. On the one hand carefully developed and researched interventions are implemented (evidence-based practice). On the other hand, increasingly more organisations screen what they have on offer with the use of knowledge about effective interventions and they collect data to be able to evaluate the outcomes (practice-based evidence).

4.1 Evidence-based practice

Nationally and internationally most research has been conducted into interventions for behavioural disorders and/or delinquent behaviour: behaviour which causes considerable social 'trouble'. Following this is research into depressive complaints and fears. We know a lot less about other problems (Boendermaker et al., 2007). A relatively small number of interventions have been researched with an experimental setup. This is research in which participants in an intervention are compared with a comparable group which is formed on the basis of coincidence, a so-called Randomized Controlled Trial (RCT). When positive results are booked for a number of studies conducted in this manner, an effective or evidence-based (based on scientific proof) intervention can be said to exist. Van Yperen & Veerman (2008) demonstrate that estimates about the number of different interventions which are available worldwide lie between the 500 and 1,500. Of these approximately one to five percent has been researched with an experimental design. This means that worldwide there are a limited number of interventions which have been carefully developed and researched. The MST intervention, for example, is based on about some twenty years of development and research. There are also interventions which have been developed on our native soil and have been well-researched from the beginning, but it is a fact that the research tradition in these matters is considerably less significant in the Netherlands than in America.
From a traditional scientific perspective, five phases can be distinguished in the development of evidence-based interventions (Kellam & Langevin, 2003):

1. *Efficacy*: development of the intervention and experimental research, such as that by Henggeler at the University of Charleston with special therapists trained by him.
2. *Effectiveness*: research in a more 'regular' environment (**8**).
3. Sustainability: research into the implementation of the intervention in other locations (into the training and monitoring of the implementation).
4. *Going-to-scale*: research into the implementation in a region or country, in which it concerns questions such as: how do we best support the implementation on such a large scale?
5. *Sustaining systemwide*: in which it concerns questions such as how intensive does the support have to be on the long term and how can it be financed?

Many of the evidence-based interventions have in the meanwhile reached phases 4 and 5 (going-to-scale and sustaining systemwide). So the positive parenting programme (Triple P) has been

implemented in many countries, including the Netherlands and in the Amsterdam region. Our country also has a programme financed by the Ministry of Public Health, Welfare and Sport (VWS; via ZonMw) for the implementation and research into two intensive family interventions as an alternative to secure institutional youth care: Functional Family Therapy (FFT) and Multi System Therapy (MST). It would be beyond the scope of this lecture to name and discuss the available interventions here. Information as far as contents are concerned about the interventions available in the Netherlands can be found in the database effective youth interventions from the Netherlands Youth Institute (**9**).

4.2 Practice-based evidence

In American studies it is estimated that 90% of organisations do not offer any treatment which is evidence-based (Beidas & Kendall, 2010; Schoenwald, Chapman, Sheidow, & Carter, 2009). My estimate of the situation in the Netherlands and in any case in Amsterdam would be the other way round: in the meantime nearly all organisations have one or more evidence-based intervention in their package. In recent years organisations have been stimulated to introduce such interventions. So in 2006 the VWS secretary of state wrote to the Lower House that only evidence-based programmes and instruments would be used in supporting children and adolescents (Pijnenburg, 2010). The Ministry for Justice also propagates this vision, in which for that matter explicit attention is paid to the necessity for these interventions to be well-implemented (Ministry of Justice, 2005). Increasingly more frequently the financing of the care provision is linked to this guiding principle. Although this is certainly a way of stimulating the introduction of evidence-based interventions, it would be a misunderstanding to think that this is synonymous with increasing the effectiveness of youth care. The limited number of well-researched interventions is simply insufficient for serving all the problems and target groups in youth care services. In other words: youth care services does a lot for groups for whom there is not yet an evidence-based intervention or who need more than just participating in an intervention. Altra and MOC ’t Kabouterhuis, for example, provide extracurricular treatment groups or outpatient treatment for children, in combination with Triple P for parents (**10**). Little is known about the effectiveness of the components beyond Triple P. Christine Davies (from the British variant of the NJI), one of the plenary speakers at the congress Youth in Research in March this year, expressed this succinctly when she said that actual practice is often much ahead of scientific research. In actual practice there are approaches (or combinations of approaches) for all sorts of target groups which have not yet received attention in academia. In contrast to the interventions which in the meanwhile are considered to be evidence-based, from the beginning they were not the subject of experimental research. Davies appealed for having this practical knowledge brought under consideration.

The attention being paid to making exactly this sort of knowledge explicit has increased enormously in recent years. The Cooperative Alliance Effective Youth Care in the Netherlands (SEJN) has carried out considerable work in this area and developed support for doing this. In this, two guiding principles are central. The first is that – in a number of areas – there is considerable knowledge available about ‘what works’. By evaluating the growing care provision in actual practice against the background of this knowledge, much insight has already been gained into its possible effectiveness. Secondly, much clarity can be ascertained about its effectiveness by gathering systematic data with clients and by interweaving this data in the help-provision process. The SEJN has developed ways of directly using the information from questionnaires in solution-focused interviews with parents and young people. By discussing the outcomes with them they feel recognition of their problems and it also becomes apparent that not everything is a problem. In this way, the data help in naming the strengths and difficulties, and by setting goals (working with questionnaires). By discussing outcome information with clients, professionals can

compare the data at the beginning and the end, and discuss how the problems were successfully reduced and what is needed to maintain this (Leijsen, 2008). By taking the data for a group of clients together, the outcomes can be discussed with teams. In this manner direct insight will be gained into what are successful and less successful practices. Many different organisations are occupied with this, whether or not it is at the insistence of the provinces as the financier of youth care (Konijn, 2007; De Lange & Chênevert, 2011). The institutions within the NEJA are also working hard to take steps in this and to describe, substantiate and research the provision. The objective is that at least sixty percent of clients receive help with programmes which are well-described and theoretically substantiated, and for which follow-up information on the situation of young people and families is available (**11**). By researching approaches developed in actual practice, practice-based evidence can develop further and become evidence-based practice. By researching evidence-based practice it will become clear whether interventions actually achieve the intended results (figure 1).

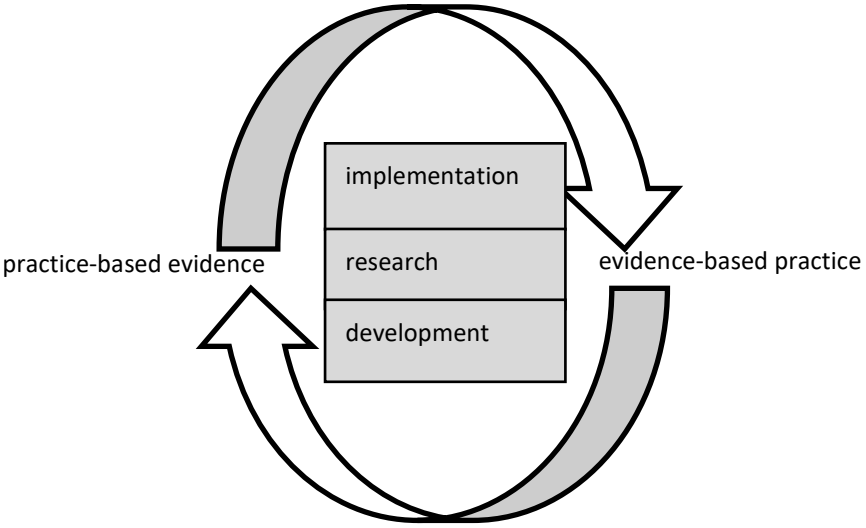

Figure 1: The interaction between evidence-based practice and practice-based evidence.
Source: van Yperen et al., 2010.

5. When does an intervention work?

What enables an intervention to 'work'? The answer to this is simple: an intervention works if it deals with the problem. And to deal with the problem, it has to be clear why it has occurred and how it continues to exist. Based on longitudinal research (research in which a large group of children are studied for a long period of time) much is known about the development of behavioural problems. Through this we know which protective and risk factors in the lives of children and young people play a role in the causes and continued existence of behavioural problems. So, for example, it has become clear that the interactions and relationships within families have an especially strong influence on the development and worsening of behavioural problems. And that the parents' own problems or, for example, the temperaments of children are also influential. In the course of time, factors appear to influence and strengthen each other. The greater number of risk factors there are for a child and his or her environment, the greater the chance of problems. Where risks are present, protective factors can play a role in preventing problems (Loeber, Stouthamer-Loeber, & Farrington, 2008; Murray, Irving, Farrington, Colman, & Bloxsom, 2010). The targeted influencing of protective and risk factors can prevent problems from happening or limit them. On the basis of international overviews of outcomes of effectiveness research into interventions much is known about the way this can best occur.

An example: on the basis of extensive observational research in families with young people with behavioural problems, Patterson, Reid and Dishion (1992) developed the theory of the coercive family process. In such families a manner of dealing with each other has come to exist, in which the mutual exacting of negative behaviour can be said to exist. In these families, children learn to get their own way through negative behaviour, such as complaining, hitting out and being angry and for this reason they demonstrate this behaviour increasingly more often. This is within the family and also outside it. Because of their behaviour they are not particularly liked by their peers and problems come to exist at school and in their neighbourhoods. By teaching parents to change their parenting skills the behavioural problems of their children can be dealt with. From research into parent training it was evident that training parents in parenting skills was effective in reducing this problem behaviour (see amongst others Boendermaker et al., 2010; Lundahl, Risser & Lovejoy, 2006). Central elements in this training are: paying attention to positive behaviour, stimulating positive behaviour by doing or undertaking things together, setting rules in an effective manner and maintaining them and the application of mild punishment (such as time out or the loss of privileges).

Another example concerns research into the approach to serious behavioural problems whether in combination with delinquent behaviour or not. In the meanwhile considerable research is available in which it appears that cognitive behavioural therapeutic training can lead to good results. Young people with serious behavioural problems appear to frequently draw other conclusions from social interaction. In cognitive behavioural therapeutic training these are referred to as 'thinking errors' which can be 'challenged' and transformed into less fixed opinions (Boendermaker & Ince, 2010). In a meta-analysis Landenberger and Lipsey (2005) researched the ingredients in cognitive behavioural therapeutic training which led to the best results. By challenging mistakes in thinking (cognitive restructuring), anger control and intervention in which in addition to the group approach an individual treatment element was also included, it appears that the best outcomes were achieved. Learning to look at the consequences for the victim as the 'only' approach (i.e. 'insight-oriented' without being combined with challenging mistakes in thinking) or interventions in which only behavioural modification took place (which is 'only' behavioural therapy and not cognitive behavioural therapy) appeared to lead to negative outcomes: in

fact the participants re-offended more. So in the meanwhile on the basis of the formation of theory and research the factors which are effective for many problems can be named (**12**). These are referred to as effective factors.
On the basis of meta-analyses it also became clear that there are common working factors in interventions: factors which contribute to their effectiveness, regardless of the sort of treatment or the target group (Andrews & Bonta, 2010; van Yperen, van der Steege, Addink, & Boendermaker, 2010). Examples of such factors are:

- A clear theoretical foundation based on knowledge from scientific research which has been carried out well. A good theoretical foundation includes which risk and protective factors the intervention is targeting and which factors are influenced by the intervention and which are not.
- A good connection between the severity and complexity of the problems and the sort of treatment (risk principle).
- Good harmonization between characteristics, risk factors and needs which directly concern the problem behaviour (need principle).
- Harmonization of the approach to the specific characteristics of the client, such as the way the client learns and is motivated (responsiveness principle).
- A good quality of the relationship between the client and the practitioner (alliance).
- Implementing the intervention according to how it is developed and established in central principles, a handbook or a protocol (programme integrity).
- A good structuring of the intervention (clear objectives, good planning and phasing of the process).
- Good working circumstances of the practitioner (good preparation, a tolerable caseload, support, safe working environment).

The common factors concern characteristics of the intervention (well-substantiated, well-structured, aimed at specific protective and risk factors and problems of a specific seriousness), characteristics of the implementation (such as applied by trained personnel) and skills of the implementers (for building up an alliance with clients and taking into account their motivation and manner of learning).

5.1 Common versus specific working factors

Recently the importance of common and specific working factors has been the subject of discussion. In various publications (Carr, 2009; Wampold, 2001) and at many conferences about youth care services the message has been that the outcomes of the help are only determined to a small extent by specific working factors. It is primarily the common working factors such as being able to establish good contact, demonstrating interest, good communicative skills and being able to motivate and stimulate people, which would be of influence on the behavioural change in clients. It would be much better to invest in ensuring that these general professional skills of members of staff are being well-practised, than to invest in the introduction of specific or other interventions.

Shortly before leaving my previous employer, the NJI, we published a document in which we unravelled this discussion and concluded that the critical studies upon which this discussion is based are obsolete and inaccurate. An empirically-established relationship between the influences of both types of factors has not yet been made (van Yperen et al., 2010). My proposition is that for being able to carry out good interventions both types of factors are necessary and that for a good implementation of interventions both are of great importance. The general professional skills mentioned (part of the common working effective factors) are the basis for the work. Without having a good relation between the client and the

care provider, without the application of motivational techniques, without the needs of clients being brought above board with good communicative techniques, an intervention can naturally not be carried out. It is not by coincidence that the basic methods such as working with a skills orientated approach or the solution focused orientation consist of attitudinal elements which are important in this. However, it is the combination of these general skills (establishing contact, building up a relationship, motivating) with specific professional skills which are required for carrying out an intervention. Which will ensure that an intervention will 'work'. I would like to explain this on the basis of an example from an article by Carolyn Webster-Stratton, the developer of Incredible Years (Webster-Stratton, 2006). This group training is known in the Netherlands as 'Pittige jaren' and is intended for parents of young children. Webster-Stratton demonstrates what trainers need for being able to supervise the training groups well:

- Skills concerning the group process ('rewarding' the contribution of parents, creating a safe environment, building up a good understanding, creating cooperation in the group).
- Leadership (setting rules, determining the agenda, identifying key points, encouraging skills to be applied in other situations, dealing with homework).
- Building up relationships (identifying and supporting feelings, nurturing optimism, normalising problems, using a cooperation model).
- Knowledge (the rationale behind the principles which are learned, knowledge about the development of children and knowledge about the behavioural change in parents and children).
- Use of training resources (homework, the use of a video as an example, role play, brainstorming, identifying resistance).
- Stimulating a response from the group of parents (stimulating questions, the exchange of solutions to problems and the sharing of ideas).

It concerns conveying the key elements of the parental training as far as contents are concerned, of creating the right 'climate' in the group and the use of techniques from the strategy. In other words: it concerns applying common and specific working factors, and for doing this a combination of general and specific professional skills are needed.

In discussions about the use of evidence-based interventions an often-heard remark by professionals and lecturers is that the introduction of such interventions limits the level of professionalism. Professionals have to work according to a strategy and keep to a protocol and that is 'all' (see amongst others Hutschemaekers, 2010). This is a far-reaching misunderstanding of what is needed in general and specific professional skills for being able to carry out interventions well. Webster-Stratton (2006) indicates that the task of the trainers is "to appropriately adapt the program to the needs of a particular population. A critical distinction must be made between implementing the core or the foundational elements of the program and stifling clinical flexibility" (169). In other words, trainers need all their skills and creativity to enable the specific working factors to live up their promise and be successful. And in this they really need their own evaluation capacity and experience. Examples of this were also provided by members of staff from the positive parenting programme (Triple P) in Amsterdam. This year six groups of fourth year students from the minor Youth Care participated in the preparatory research. They interviewed more than 80 youth care workers in Amsterdam's youth care services about the implementation of basic methodologies and evidence-based interventions. The positive parenting programme was one of these and work was carried out with it for a relatively long time. It was striking that indeed the members of staff for this programme in all three institutes where interviews took place, consider the point of professional performance within the frameworks of the programme in the interview. A Triple P trainer says for example: "It's a little bit of Triple P and a little bit of me, you're the one that's

doing it and how the contact progresses is just up to you." Another member of staff said: "You respond to the needs of parents, you pay more attention to one subject for someone than you would for another." And a third: "People often do not do the homework, so you have to decide whether you're going to do it with them now, is that necessary? And for example the subject of the meeting. That's giving complements. I'll practise this in all sorts of ways and the exercises I carry out depend on the parents that I'm with, I'll adjust them accordingly."

5.2 Treatment integrity

In my opinion, in the implementation of interventions, it concerns the good conveyance and implementation of the specific effective factors, the key elements of an intervention. And this is not only for evidence-based interventions, but also for practice-based interventions. For the evidence-based interventions it is clear what these elements are from the handbooks which have been drawn up. For practice-based interventions making the practical knowledge (tacit knowledge or clinical expertise) explicit about the approach to specific target groups is the first step en route to a good implementation. This is followed by evaluating the practice against the background of knowledge about effective factors.

A good implementation is referred to in scientific literature with the terms treatment fidelity or treatment integrity. This concerns carrying out the intervention with the contents, duration, frequency and the scope (the target group) as developed and (for evidence-based interventions) researched for effectiveness (Carroll et al., 2007). Specific attention paid to treatment integrity in research is relatively new. Naturally researchers have always been conscious of the fact that insight is necessary into the implementation if effect research is carried out. A process evaluation will be carried out to acquire a view of the target group reached, the dropouts and the intervention components which have been carried out to subsequently be able to see the outcomes found in perspective and to be able to draw up a good evaluation (Rossi & Freeman, 1993; Rossi, Lipsey, & Freeman, 2004). But it is only in the meanwhile famous meta-analysis of Lipsey & Wilson (1998) that it was clearly demonstrated that a good implementation of the intervention is linked to better outcomes. In this study, information from two hundred research studies about divergent forms of treatment for young people with serious behavioural disorders and delinquent behaviour was coded and put into one file and analysed. From the meta-analysis it appeared that it made a difference for the results whether a developer or researcher was involved in the intervention or not. If that was the case, then there was more involvement with the implementation and that was linked to better outcomes. Furthermore it appeared that interventions which were carried out by specialised personnel (mental health instead of criminal justice) resulted in better outcomes and the 'age' of a programme was also important. Programmes which had existed for longer produced better results. In other words: monitoring the implementation, specifically trained personnel and experience are important for acquiring good results. In the meta-analysis into other interventions, such as drug prevention programmes, anti-bullying programmes in education and interventions at schools geared at reducing the aggression of pupils, it also appeared that the level of implementation was of great importance for the outcomes of the programmes (Durlak & DuPre, 2008).

That the implementation of an intervention with sufficient 'integrity' is important is clearly evident from research into the implementation of the two interventions which we came across earlier in this lecture: the Aggression Replacement Training (ART) and Functional Family Therapy (FFT, an intensive family intervention) in the American state of Washington (Barnoski, 2004). Both interventions appeared to be successful. For the FFT group there was 10% less re-offending than the control group, for the ART group this was 16%. For both interventions a global measurement was kept of the treatment integrity:

the professionals were evaluated by a supervisor about the level of ‘competent implementation’. When the outcomes were divided up into young people with and without a competent therapist, it appeared that the outcomes were very different. The percentage of young people who re-offended after the intervention, was higher amongst the young people who did not have a competent therapist. The percentage of re-offenders was also higher in this group than in the control group who had not received treatment. Amongst the clients of the professionals who had implemented competently the number of perpetrators of criminal offences decreased considerably. In comparison with the control group it appeared that for a competently implemented FFT a 38% reduction in re-offending could be said to exist with regard to the untreated control group. For ART this was 25% (see figure 2). The way in which interventions are implements does thus have direct consequences for clients and an incorrect implementation can have far-reaching consequences for clients and society.

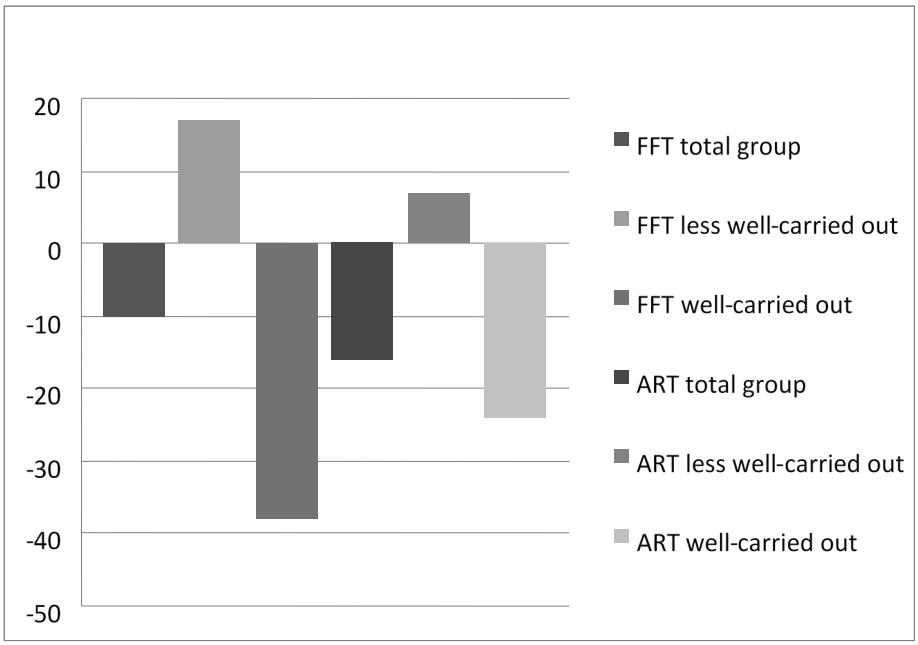

Figure 2: Percentage in reduction of re-offending in contrast with the control group for FFT and ART for total group and divided up into less well-carried out (more re-offending) and well-carried out (less re-offending) implementation. Source: Barnoski, 2004

5.3 Adherence and competence

Treatment integrity in research is frequently unravelled into two components: therapist adherence and therapist competence. Therapist adherence refers to the carrying out of specific effective factors: the key elements of the intervention. These are included in the manuals and handbooks (such as for Incredible Years, Triple P or ART) or are processed in the central principles of an intervention (as is the case for intensive family interventions such as FFT, MST and Multidimensional Family Treatment, MDFT). The degree to which a trainer or therapist applies the key elements determines the degree of the therapist adherence. Competency refers to the technical skills, the treatment which is necessary for ‘conveying’ the key elements and to responsitivity, a good evaluation of the situation and clinical

acumen (Barber et al., 2006; Barber, Sharpless, Klostermann, & McCarthy, 2007; Barber, Triffleman, & Marmar, 2007; Nezu & Nezu, 2008).

Various researchers focus on the question of whether higher adherence results in better outcomes. That has been researched and is the case for MST (Schoenwald et al., 2009), for cognitive behavioural therapy and for MDFT (Hogue et al., 2008). A meta-analysis of the contribution of both adherence and competence to the outcomes of individual psychotherapy provides another picture: neither makes a difference for the outcomes. However, measuring adherence and competency is rather a tricky business, so that the authors of this meta-analysis conclude that there is still too little which can be said about it (Webb, DeRubeis, & Barber, 2010). Other researchers focus on the question of how much adherence and competency is necessary for good outcomes (in other words: what is the minimum treatment adherence and competency necessary for good outcomes). About this point research does not provide definite answers. Nor are there any about the relationship with the alliance between client and care provider. The assumption is that therapy adherence and the alliance between client and care provider are both predictions for the outcomes should sufficient competency be said to exist. A number of research studies demonstrate that it can be more complicated and that probably curvilinear links can be said to exist (Hogue et al., 2008). Research in this area is in its infancy and as Barber et al. (2007) formulate it: it is not yet ready to be used in actual practice. More research is needed for developing good measuring instruments and determining the influence of therapy adherence and competency on outcomes.

6. Implementation

Until now the discussion has focused on an evidence-based intervention being geared towards influencing the protective and risk factors which affect a specific target group. And that it all concerns carrying out and applying the key elements of an intervention, for which therapy adherence and specific competencies are necessary. What does this mean for the implementation of an intervention?

In recent years various overview studies have appeared about implementation processes in youth care (Bijl, Eenshuistra, & Campbell, 2011; Mikolajczak, Stals, Fleuren, De Wilde, & Paulussen, 2009; Stals, Yperen, Reith & Stams, 2008; Vosters & Vogelvang, 2010). In them, amongst other things, use was made of models in health care (Fleuren, Wiefferink, & Paulussen, 2004; Greenhalgh et al., 2005; Grol & Wensing, 2010). Although different terms were used, the factors distinguished in all the models are the same. A surveyable and useable model for the implementation of the interventions is the model by Fleuren et al. (2004). This model (figure 3) is based on literature research and research amongst professionals and has appeared to be helpful in divergent implementation processes (primarily in youth health care).

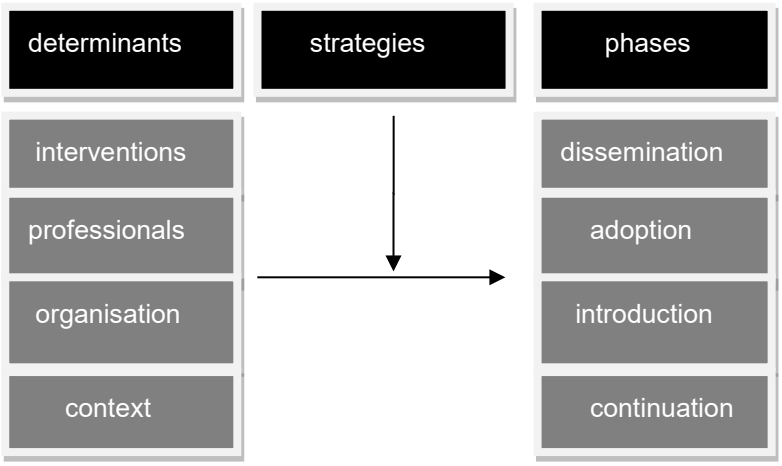

Figure 3: Model for the implementation of interventions. Source: Fleuren et al. 2004.

In an implementation process it appears that four phases can be distinguished: dissemination, adoption, introduction and continuation. Professionals who are going to work with an intervention have to be knowledgeable about the intervention (dissemination), prepared to go to work on it (adoption) and actually start to work on it (introduction). In addition the implementation and the maintenance of the intervention have to be anchored in the organisation (continuation). For that matter, research into implementation processes demonstrates that these processes do not always progress in succession (Fleuren et al., 2004; Fleuren & Jong, 2006; Fleuren, Wiefferink, & Paulussen, 2010; Stals et al., 2008). All sorts of factors influence the progress of these phases. A thorough planning of the process for progressing through these phases is also important, just as conceiving strategies for achieving this in advance (Bartholomew et al., 2006; Fleuren et al., 2004; Grol & Wensing, 2010). There are various types of factors which influence the process, namely characteristics of the intervention (**13**), characteristics of the professionals who carry out the intervention, the organisation where the

intervention is carried out and the context in which an organisation functions. In studies concerning implementation, these are referred to as determinants. If someone wants to implement something in an organisation, then an analysis of the determinants in advance is urgently necessary. Not carrying out such an analysis is the most important pitfall in many implementation processes (Durlak & DuPre, 2008; Fleuren et al., 2004; Fleuren et al., 2010).

For a practical overview of the many determinants which can be of influence on an intended implementation, I refer to Fleuren et al. (2004, 2010). On the basis of the available studies and Delphi research amongst implementation experts they have arrived at a checklist of fifty different determinants which organisations can use for preparing an implementation process well. The degree to which these determinants do play a role or not means that the implementation will progress with greater difficulty or ease. Examples of determinants are:

- Characteristics of the intervention, such as the degree to which the intervention consists of clear procedures and steps, the degree to which the intervention is in keeping with the existing working method, the degree to which it is possible for the intervention – without losing its effectiveness – to be adapted to the individual situation, the degree to which the intervention has a relative advantage for the users (for example, ease, gains in time or more pleasure in work) and the degree to which the intervention can actually be applied. If all these matters are relevant to a high degree then the implementation will progress more easily. This was evident from our preparatory research, that members of staff from De Bascule who were allowed to travel to the Oregon Social Learning Centre (USA) to be trained for the Multidimensional Treatment Foster Care (MTFC), became very enthusiastic about the intervention.
- Characteristics of the professionals who carry out the intervention, such as the degree to which members of staff have the knowledge and skills which are necessary for carrying out the intervention, the individual effectiveness expectation (the degree to which a member of staff feels capable of carrying out the intervention), the degree to which members of staff are over-worked and the degree to which the intervention is suited to the member of staff's conception of his or her tasks. So as was evident from the implementation of behavioural interventions for rehabilitation, members of staff who had been trainers in social skills for many years did not meet the educational requirements for the new interventions. When they were not allowed to set to work on the new intervention this resulted in a loss of face and unrest. Recognition of this in advance could have prevented it (Vosters & Vogelvang, 2010).
- Characteristics of the organisation, such as the size of the organisation, its decision structure, the cooperation between departments who are involved in the intervention, the number of personnel, the logistics procedures and, for example, the amount of time and money which is available for the intervention. From research by Bijl et al. (2011) it appeared, for example, that the secure setting worked as a hindrance for the implementation of behavioural interventions in judicial youth institutions. For all logistics processes the aspect of security is an issue, which has consequences for undertaking a new intervention in the daily state of affairs. If this is taken into consideration in advance then it would make the intervention easier.
- Characteristics of the social political environment (the context), such as the financial means for the sector, the degree to which the intervention fits within the existing legal frameworks, and doubts by the clients about the expertise of the members of staff (the image of youth care).

On the basis of the analysis of these components a choice of various implementation strategies can be made. These strategies are geared to the dissemination of information about the intervention, the

‘winning over’ of people for implementing the intervention, the approach of the training and education, and the setting up of the support system for the implementation. There are no clear indications for the existence of a single ‘best’ approach or strategy. Each situation is different and there are many examples of strategies described, but few have been well-researched (Bartholomew et al., 2006; Fleuren et al., 2004; Grol & Wensing, 2010). Recently the NJI launched an implementation guide, with which institutions can trace the various steps in the determinant analysis and can find information about the known strategies.

7. Introduction and continuation of interventions

Introduction and continuation of interventions
For a good implementation of the key elements of interventions the phases of introduction and continuation are highly important. Various evidence-based interventions have developed a system for supporting the implementation and this is accompanied by research. In addition, information is available on a limited scale about forms of feedback and support in the Netherlands. Without wanting to provide an exhaustive overview, I will consider the available knowledge in the area of implementing interventions.

7.1 Introduction

The preparation for the introduction of an intervention usually starts with more or less intensive training. At the end of a training, the therapist adherence and competence appears to be the highest if the key elements of an intervention are conveyed through active learning. Providing explanations, working through the handbooks and a limited number of supervisions do not result in professional competence. Considerable practice in role play, a great amount of imitation of the trainer and/or film recordings are needed. Combined with support in the form of peer coaching and supervision results in a higher level of treatment integrity (Beidas & Kendall, 2010). The necessity of these forms of active learning also emerged from research into parenting skills training in youth rehabilitation. From the logbooks which the trainers kept, it appears that they dealt with all the subjects and materials (DVD), but experienced difficulties in dealing with the homework and the role plays. In interviews the trainers also said that this was difficult, they felt that doing role play with parents was hard and they did not know how they could encourage parents to participate (Boendermaker et al., 2010). The audits which were carried out in the above-mentioned CPAI also demonstrated that members of staff often miss skills for carrying out the key elements in the interventions for anti-social and delinquent behaviour (cognitive behavioural therapeutic skills) well (Lowenkamp et al., 2010).

7.2 Continuation

Five different ways or instruments can be distinguished for embedding interventions: peer-coaching (‘intervision’ in Dutch), group supervision (discussion of case), individual supervision (focused on the application of the method), feedback on the basis of the evaluation by third parties and feedback on the basis of information about outcomes.

7.2.1 Peer-coaching

Webster-Stratton indicates the direct link between training and supervision. Incredible Years makes use of peer-coaching. Each trainer participates in the peer-coaching every week and people give each other feedback on the recordings or parts of them of the sessions with parents. In this a group process checklist is used for giving feedback on the six skills which were mentioned earlier:

1. The group process (awarding parent’s ideas, creating a safe environment, building up a good understanding).
2. Leadership (drawing up rules, setting the agenda, indicating key points, encouraging generalisation, dealing with homework).

3. Building up relationships (naming and supporting feelings, nurturing optimism, normalising problems, using cooperation model).
4. Knowledge (rationale behind the principles which are being learned, knowledge about the development of children and knowledge about behavioural change).
5. Use of the training resources (homework, video recordings, role play, brainstorming, identifying resistance).
6. Response from the group of parents (stimulating questions, solving problems and sharing ideas).

In addition each trainer can approach a main trainer for consultation who can provide feedback about video recordings, answer questions and think along with him or her. The problems which frequently occur for starter trainers are: becoming discouraged if the participants make little progress, experiencing difficulty in carrying out the role play, difficulties in conveying the key elements and making choices about the implementation being well-suited to the participants. Without peer-coaching and consultation, little progress can be made (Webster-Stratton, 2006).

7.2.2. Group supervision

After five days of training, MST has group supervision, individual supervision, consultation and regular refreshment training sessions. In working with families with young people with serious behavioural disorders and delinquent behaviour MST has nine central principles: the key elements of MST. For example: ‘in the therapeutic contact we emphasise the positive and we use the strengths in the family as the bearers of change’ (principle 2) and ‘the interventions to be implemented are geared towards behaviour chains within and between the systems which maintain the identified problems’ (principle 4). In the weekly group supervision for each case the therapists along with the supervisor examine what is standing in the way of working with the principles and what the barriers for change are in the family. A summary of each case is drawn up according to a fixed format and submitted to the supervisor in advance. In the discussion the therapists sketch their hypotheses about the how and why about the behaviour of the family members and the barriers for change. How this can be approached is subsequently central. Experience demonstrates that twelve to fifteen cases can be dealt with in this manner in approximately two hours (Cunningham et al., 2006). From the preparatory project mentioned earlier it appeared that such an approach was employed by the intervention MTFC which is implemented in Amsterdam by De Bascule.

7.2.3. Individual supervision

For MST individual supervision is used if too much support for competencies is needed in the group supervision. Use is made of oral recordings of the agreements which therapists make in the families. Many frequently occurring problems for the therapists are the avoidance of practising with family members and the avoidance of demonstrating skills in the family, powerlessness in carrying out the activities advised in the group supervision, having a negative and defensive attitude in relation to suggestions which were made in the group supervision and feelings of hopelessness due to the complexity of the problems in the families. Primarily practising via role play appears to increase the level of the competencies (Cunningham et al., 2006).

In the preliminary research mentioned earlier into the implementation of interventions in youth care in Amsterdam, a member of staff working in youth rehabilitation talked about the individual supervision that she is given within the Functional Family Parole Service (FFPS). FFPS is one of the approaches

inspired by Functional Family Therapy (FFT) in which dysfunctional family relations are central (Kopp, 2011). The member of staff provided an example of a family she worked for where the father was angry and aggressive. She could not succeed in carrying out a conversation with him. After consultation with her supervisor she applied a central technique from FFPS of 'reframing'. Literally this is the reframing of the behaviour of clients. Anger, for example, can also be understood to be an expression of commitment and concern. First she discussed and practised it with the supervisor and afterwards observed that she immediately had a result: "So I did it and I directly had a very different father, I was able to cooperate with him" (Boendermaker & Boering, 2011).

7.2.4. Feedback on the basis of an evaluation of the implementation by third parties

For MST people make use of the Therapist Adherence Measure (TAM) and the Supervisor Adherence Measure (SAM). Each month each family where a therapist is working is rung up by an administrative member of staff at MST and the TAM is completed. The clients evaluate the extent to which the therapist had adhered to the nine central MST principles. Each principle is operationalized in expressions such as 'the therapist tries to understand how the problems in our family are linked' (principle 2) and 'our family knows exactly which goals we are working on' (principle 4). The TAM scores of each family are used in the group supervision and if necessary are discussed in the individual supervision. The development of both instruments is researched thoroughly. In the dissemination of MST an efficient but sensitive instrument was looked for so that the treatment integrity could still be evaluated. The result is a list of 26 items, for which a five point scale could be scored for the extent to which the principles were relevant. In the same manner the therapists evaluate their supervisor (Henggeler, Schoenwald, Liao, Letourneau, & Edwards, 2002; Schoenwald, Henggeler, Brondino, & Rowland, 2000).

Another manner of evaluation is that in which independent evaluators (educators from other locations) study the implementation. At the Parent Management Training Oregon (PMTO: an individual training in parenting skills for parents with children with behavioural problems) the Fidelity of Implementation Rating System is used. PMTO trainers film all their sessions with parents and an educator evaluates them as a form of accreditation. In addition the recordings are used in peer-coaching just as for the Incredible Years. The same manner of working is used in Amsterdam at Spirit in the team of the Multidimensional Family Treatment (MDFT) intervention.

A completely different manner, which also provides insight into the implementation but is less geared to the individual, is the building brick method. In case consultation professionals consider the implemented intervention by investigating which parts of the approach have worked well or which parts have not (hits and misses), and which matters have not been included in the intervention description, but do work well (finding) or where there is nothing said about it in the intervention description (obstacle). So the implementation is followed and adjusted where necessary (Vogelvang & Vermeiden, 2008).

7.2.5 Feedback on the basis of outcomes

Research demonstrates that giving feedback to practitioners about the results for clients provides a positive contribution to the outcomes. This is true for individual practitioners and for teams. Lambert (2010) provides an overview of various systems which enable the use of feedback in individual psychotherapy. So amongst other things, systems where people can collect information in between the sessions about the level of progress for clients and compare this with the average progress for clients

with similar problems. The therapist examines this before the session and can adapt the contents of the session accordingly. Information about the contact between the therapist and client or the motivation can also be given as feedback in this way. The diverse variants of interim feedback appear to contribute to positive outcomes for clients and result in less dropping out. A meta-analysis by Knaup, Koesters, Schoefer, Becker en Puschner (2009) points in the same direction – at least for studies of practices in which weekly or fortnightly feedback is given to both the therapist as well as the client. If feedback was only given once, then it had no effect on the outcomes (this meta-analysis concerns small effects).

A somewhat different manner of giving feedback about information about outcomes is the quality interview, which was developed by the Drents organisation Yorneo. In teams of staff carrying out the work and middle management, the data about outcomes is discussed with clients according to a fixed line of questions: Are the figures recognizable? Can we explain them? Do we find the results good enough? Is action for improvement necessary? This leads to discussions about the degree to which the programme has been 'faithfully' implemented and points for improvement can be initiated. At Yorneo between 1999 and 2005 this led to a considerable improvement in the outcomes. The effect sizes which were calculated on the basis of scores on the Child Behaviour Checklist (CBCL) at the start and end of intensive remedial educative family supervision (IOG) increased from a small to a large effect (Veerman, Roosma, & Ooms, 2008). A similar manner of working is used in Amsterdam at Spirit. Here use is made of information about outcomes in what people refer to as the 'methods evaluation'. In addition to the four questions in the quality interview the question: For whom does this work well and for whom does it work less well?' is considered (Konijn, 2010).

8. What does implementation mean for actual practice?

The implementation of interventions in youth care has consequences for the actions of professions, for organisations and because of this also for study programmes. First of all the professionals. For being able to implement evidence-based and practice-based interventions well they need knowledge about the effective factors of interventions. More specifically: about the common and specific working factors for important problem groups in youth care. The implementation of interventions is not merely a matter of working according to a strategy or applying some techniques, but it requires insight into the how and why of treatment. Training can stimulate enthusiasm and provide members of staff with the theoretical background knowledge and beginner skills. Actual professionalism is created by actively learning in professional practice. By combining forms of feedback as far as contents are concerned with feedback on the basis of outcomes, insight can be gained into the level of change in clients. For evidence-based interventions this is important for being able to ascertain whether the intervention worked just as well and was implemented in the same way as by the developer. For practice-based interventions insight can be gained into the effectiveness of the applied key elements. All these matters together mean that it is expected of professionals that they are able to work on an evidence-based basis. In accordance with Kuiper et al. (2008) I am of the understanding that professionals act on the basis of the best available proof of what works, taking into account the wishes and needs of the client and on the basis of their own experience with clients (clinical experience or tacit knowledge). What has remained neglected in critical studies is that evidence-based working primarily means that the professional reflects on his or her practice as far as contents are concerned. Has he or she succeeded to a sufficient extent in conveying the effective elements of an intervention? Does the practice contribute to the desired result? Implementing is therefore reflecting!

At the level of the organisation the implementation of intervention also means reflection. It means reflecting on the intervention to be implemented, the youth care workers who have to set to work on the intervention, and the preconditions in the organisation and the context which are relevant: time, money, manpower and materials. It means, in brief, carrying out a determinants analysis. In addition it means reflecting on the strategies for attracting attention to the intervention (dissemination), for motivating members of staff (adoption), for training (introduction) and for monitoring the implementation (continuation).

Should no evidence-based intervention be implemented, but people set to work on practice-based interventions, that means implementing reflection on the intervention as it is carried out. This will be followed by a phase of description, evaluating against the background of available knowledge about general and specific effective factors, making the key elements explicit and developing reflection instruments. In the implementation of evidence-based interventions these steps will already have been initiated by the developer and it primarily concerns organising the moments and manners in which professionals reflect on the implementation of the intervention. Whether it concerns evidence-based or practice-based interventions: the implementation of the intervention requires reflection on the therapist adherence and the competence of the members of staff, as well as on the outcomes which are achieved.

What does this mean for the study programme? The graduate ‘program on youth care work’ which will commence as of the beginning of the academic year 2011-2012 will provide starter youth care workers. In my opinion this concerns youth care workers who are knowledgeable about effective factors and are able to work in an evidence-based manner. In the near future this will also mean having knowledge about guidelines in youth care. Obligatory professional registration will soon be linked to follow-up and extra training. What the regulations will precisely look like regarding this point is not year clear. In my opinion this would seem to be an excellent opportunity for the profession to integrate the participation in various forms of feedback with the obligatory follow-up and extra training. It is not only courses and training which are necessary, but also and primarily forms of active learning. In this way the professionalism of the members of staff can be strengthened and the treatment integrity increased which will contribute to better results for clients in youth care. I very much hope that in the years to come we will succeed in strongly rooting the implementation of interventions in this way in actual practice. The knowledge about implementation, its phases and the determinants which play a role, should also find their way in educational practice. The Master’s in Social Work would seem to me to be an excellent place for passing on knowledge in this area.

9. The chair on implementation

In the years to come I hope to contribute to the development of knowledge in the area of implementation in youth care. For me, this concerns knowledge about the implementation process as well as knowledge about instruments which contribute to the sound implementation of interventions (with the duration, intensity and scope as intended). We will achieve this by:

- Acquiring knowledge about carrying out determinant analyses, about the implementation strategies which are derived from them and the evaluation of those strategies in their application in the institutions.
- Surveying, developing and researching instruments for the purpose of a sustainable and sound application of interventions, basic methodologies and in the near future, also guidelines.
- Contributing to education and its development in the area of the implementation of interventions, guidelines and evidence-based work in youth care.
- Contributing to the professionalization of members of staff in youth care and lecturers in the study programmes.
- Disseminating the knowledge about the implementation of interventions and guidelines in youth care in workshops, publications, lectures, lessons and other appropriate means.

For this purpose, we will concentrate on four themes: implementation processes, reflection instruments, implementation of specific interventions or problem groups and attention to these subjects in the study programme.

9.1 Implementation processes

At the end of 2010 we started carrying out a process evaluation into the implementation of a new intensive family intervention within the child and youth care organisation Spirit: Multidimensional Family Treatment (MDFT). This intervention is intended for young people with serious behavioural problems (including problematic drug abuse) and their parents. Spirit started in 2010 with a MDFT team of four therapists and a supervisor. In the process evaluation it was ascertained which determinants influence the implementation of MDFT and which implementation strategies were followed, whether the target group was reached, how the intervention was applied, what the contents of the group supervision were which was offered within MDFT and what the experiences of clients and members of staff were.

In addition a project is in preparation in cooperation with Child Protection Amsterdam. A number of years ago the Family Group Conference (FGC; in Dutch Eigen Kracht Conferentie EKC) was introduced as an instrument to enable clients and their families to exercise more influence on the choices that are made in the social care that they receive. For that matter the Dutch government's Lower House has recently adopted an amendment to a change in the Youth Care Act, that as a first step in carrying out a supervision placement, Youth Care Agencies are obliged to give the family the opportunity of drawing up a plan of approach (**14**). This could be, for example, on the basis of an FGC. BJAA is a large organisation and differences appear to exist within the organisation about the degree in which this instrument is employed. In this project we want to ascertain which determinants influence the application of a FGC, which implementation strategies are used within the organisation and what the experiences are with it.

Finally the first ideas are emerging about following the implementation with working with questionnaires in the social work process. The NEJA institutions are all occupied with this in their own way. In this case too the question can be asked about which determinants influence the implementation and which strategies can be employed in response to this.

9.2 Reflection instruments

In the autumn of 2010 preliminary research was started into the ways in which six youth care institutions in Amsterdam approached the implementation of interventions and basic methodologies. A selection of members of staff were interviewed about four basic methodologies and three interventions. It concerned: working with a solution-focused orientation, working with a skill orientated approach, YouTurn, Functional Family Parole Service (FFPS), Positive Parenting Programme (Triple P), Signs of Safety and Multidimensional Treatment Foster Care (MTFC). We will complete this research shortly with the publication of a report and a meeting to discuss the work with the organisations.

In addition to the preparatory research, a literature review was initiated into support systems, the means of measuring treatment integrity in research and actual practice and instruments for auditing the implementation (such as the CPAI as mentioned in the introduction, in which both aspects of the determinant analysis as well as the introduction and continuation have been included).

In 2011 in cooperation with Altra the project 'intervention workshops as an implementation instrument' will start. Altra designs the support for the implementation of interventions and basic methods in these workshops. Following up on the preliminary research we will examine how the key elements of working with a solution-focused orientation can be made more explicit and observable. In this we will work together with the research group on Effective Factors in the Care of Juveniles at Arnhem and Nijmegen Universities of Applied Sciences (HAN), where under the supervision of Marion van Hattem (Associate Professor) a comparable project has taken place. We will also survey the working methods of workplaces under construction about two other interventions. One of the proposed activities is an expert meeting about working with a solution focus for the institutions associated with both research groups.

9.3 Implementation of specific interventions or problem groups

Since the end of 2008 the Amsterdam Region has worked with a special approach for multi-problem families (MPG). Institutions for youth care and institutions for social work provide family managers who set to work with these families. Their work has two important components: working in and together with the families and working with divergent parties and bodies who have something to do with them. We are preparing the project with various partners aimed at developing and researching instruments to embed both elements of the MPG approach.

9.4 Implementation, reflection and the study programme

As already mentioned, the graduation profile youth care worker will start at the beginning of the academic year 2011-2012. As far as contents are concerned, we will contribute to the development of the curriculum of this new study programme by:

- Providing a contribution as far as contents are concerned to the development of the curriculum framework in a working group of lecturers.

- Participating in the steering group from the graduation profile youth care worker.
- Developing educational materials on research skills. Here subjects will be developed in consultation with the SEJN and the institutions: working with assessment instruments, working with outcomes and evidence-based working.

Furthermore, in the context of the so-called ‘external assignment’ which they carry out within the minors, students can participate in our research projects. At the start of the graduation profile youth care worker the same applies for these students (it then concerns the graduation assignment). In consultation with the programme board of the Network Effective Youth Care Amsterdam, a pilot will be started in which organisations, the professorship and the lecturers who supervise the research within the minor Youth Care will reach agreements about the projects to be carried out. In this way, in addition to our projects, a step will be set in the development of a joint research agenda by institutions and the study programme.

Finally there are all sorts of other imminent activities. I would like to mention two here. Inspired by the enthusiastic stories told by colleague Huub Pijnenburg, Professor in Effective Factors in the Care for Juveniles at the HAN, we are occupied with organising a youth care debate in the week for Youth Care – in 2011 from 13 to 20 November – for lecturers and students. And together with the NEJA we regularly organise an expert meeting. For example, there will shortly be one about single subject experimental design. I hope that in the coming years with these projects and activities, the professorship can contribute to reflecting upon the initiation and implementation of interventions. Because it is only in this manner that the available scientific and practical knowledge can actually be rooted in daily practice.

Word of thanks

Coming to end of this lecture I would like to express a few words of thanks. Firstly, I would like to thank Willem Baumfalk, chairman of the School of Social Work and Law and Wilfred Diekmann, head of the Research Centre Social Work and Law, for their confidence in me and from the very beginning their enthusiastic approach to the professorship. My thanks also go to Elke van der Heijden for her efforts regarding the people and means concerning the professorship, and to Laura Koeter and Hans Malschaert, respectively study programme manager MWD and SPH, for their support and commitment.

I would also like to thank the lecturers who are involved in the minor Youth Care, the graduation profile Youth Care Worker and the education about research for their pleasant cooperation. You have taught me much in the past year about teaching within a university of applied science and about 'learning' in general. It promises well for the years to come.

Without the students who are participating in the minor Youth Care and partially in the minor Working I would not have been able to give any examples about Amsterdam situation: thank you for your hard work during the first term of this academic year in the preliminary research for this professorship!

My thanks also go to the members of the Programme Board and Steering Group from the Network Effective Youth Care Amsterdam (NEJA). In particular Germie van de Berg and Carolien Konijn prepared a warm welcome for me: it is fantastic to be able to work with you once again! Together with Theo Schut, both of you took on a lot of work to enable the professorship to be possible on behalf of the youth care institutions. Via you I would also like to thank these six institutions and their members of the board for their confidence in me.

In addition to the institutions I would like to thank Christine Pollman, Michèle Hering and Ruurd Firet (City Region Amsterdam) and Rutger Hageraats and Jeanet Zonneveld (Amsterdam Council) for the cooperation after my somewhat sudden entrance into the world of the MPG approach. I hope that we can continue with the cooperation for many years to come.

A separate word of thanks to Tamara Boering and Cynthia Boomkens, with whom I have made up 'the three Bs' since September 2010. You are working with considerable effort and enthusiasm on the projects which are in progress within the professorship. It's great to work in such a way! I would like to thank my colleague Professor and roommate Rick Kwekkeboom for the hearty welcome, inauguration in the professorship and the sharing of joys and sorrows. In addition to the colleagues in Amsterdam I would also like to thank my colleagues in Groningen and in particular Erik Knorth. For the interest in my experiences here in Amsterdam and for the flexible setup which makes working in two locations possible.

That I was able to set to work here as professor is partially thanks to the knowledge and experience I gained in previous jobs. Without wishing to undermine the work of other colleagues, I would especially like to mention two people. In my WODC time, Josine Junger-Tas offered me the opportunity to develop into being a thorough researcher. Happily I have been able to thank her for this. Tom van Yperen, you persuaded me to make the step from the Justice Department to the Expertise Centre Youth Care at the NIZW (now Netherlands Youth Institute-NJI) and enabled me to become acquainted with youth care. At

least within the Advisory Committee on Guidelines in Youth Care we still come across each other and I hope that we will also be able to do outside of it.

Naturally I would never be standing here if my family and the home front had not been behind me throwing myself into a new adventure. Philippe, Dorien and Sascha: at home we do not concern ourselves with implementation, but there is enough to reflect upon. You all ensure that I can carry out my work happily and with dedication and I promise: we will all now finally go and do some sightseeing in Amsterdam.

Notes

* I woud like to thank Germie van de Berg, Wilfred Diekmann, Margot Fleuren, Carolien Konijn and Tom van Yperen for their comments on an earlier version of this text.

1. See www.mstservices.com and www.mst-nederland.nl.
2. So, under the responsibility of the local councils preventative care (parenting support, youth health care) is offered in Centres for Youth and Family (in Amsterdam: Parent-Child Centres). Specialist help is offered in institutions for youth and parenting help, and financed by the provinces (here: City Region Amsterdam). In addition to this primary and secondary youth care there are other institutions which offer juveniles and their parents help and supervision. There is mental health care for the young (the Jeugd GGZ), care for young people with a mental limitation (care of the disabled), judicial youth care (youth protection, youth rehabilitation and judicial youth institutions) and there are all sorts of supervisory forms for young people with problems in the education system. The care provided by these institutions is not freely accessible: a referral on medical grounds has to be obtained. For the Youth Care and Youth Mental Health Care this is provided by the Youth Care Agency. The other forms of help have their own means of access.
3. These are the Recognition Committee Behavioural Interventions Justice and the Recognition Committee Interventions.See www.rijksoverheid.nl/onderwerpen/recidive/erkenningscommissie-gedragsinterventies and www.jeugdinterventies.nl.
4. In most of the local councils Centres for Youth and Family (CJG's) are already in operation. In Amsterdam they have existed for a longer number of years under the name Parent-Child Centres (OKCs). For the current state of affairs concerning the CJGs: www.cjg.nl.
5. For example: the Parent Management Training developed by Patterson in Oregon (PMTO); Triple P, the 'Positive Parenting Programme' by Sanders from Australia; the programme 'Incredible Years', developed by Webster-Stratton (US); the packet developed in the Netherlands 'parents of Recalcitrant Youth' aimed at parents of young people with police contacts.
6. For example the training Self-control, STOP 4-7, Less angry and rebellious (for children) and all sorts of variants of the aggression regulation training (ART; Goldstein, Glick, & Gibbs, 1998) for young people. The training for children usually also has a component aimed at parents.
7. Such as Intensive Remedial Family Treatment (IOG), Multi System therapy (MST), Functional Family Therapy (FFT), Multidimensional Family Treatment (MDFT) or Multidimensional Treatment Foster Care (MTFC).
8. The difference in the size of the effect found (the effect size) between efficacy and effectiveness research is often referred to (for the start of this discussion, see: Weisz, Weiss, Han, Granger and Morton 1995). When an intervention is carried out for 'normal' clients instead of specially selected groups for an experimental study in a Randomized Controlled Trial (RCT) it would concern clients with less or more complex problems, which makes the acquisition of the same outcomes difficult. Research by Stirman, DeRubeis, Crits-Christoph and Rothman (2005) demonstrates that the difference between clients in a RCT and 'normal' clients are not as great as is frequently thought. They looked at information about people who had not drawn a place for participating in the experimental group of various RCTs (for the treatment of depression, bulimia or an anxiety disorder). These clients were referred by their GPs or psychologists to the possibilities of participating in the RCTs or they had responded to an advertisement and had attended because of the opportunity of receiving cheap treatment. For this reason according to the authors they are really 'normal' clients. 95% of them appeared to match the criteria for at least one of the RCTs which was carried out, 74% matched the admission criteria for two of the RCTs. The conclusion of

the authors was thus that the RCT participants were absolutely not so special and the question is whether the other outcomes of effectiveness studies can be ascribed to the fact that 'normal people with normal problems' participate in the intervention.

9. www.jeugdinterventies.nl.
10. See www.jeugdhulpwijzer.nl for an overview of all programmes which are offered by the Amsterdam institutions for youth care.
11. www.neja.nl.
12. Overviews of them can be found at www.nji.nl/watwerkt.
13. In critical studies characteristics of the innovation are referred to. It may concern the implementation of interventions, guidelines, instruments, protocols, assistance and suchlike. In this Inaugural Lecture I will use the term interventions.
14. Lower House, 2010-2011, 32015

RELEVANTE WEBSITES

- www.kmr.hva.nl/jeugd (link to the page from, amongst others the Professorship in Implementation in youth care on the website of the Knowledge Centre Society and Law HvA)
- www.jeugdhulpwijzer.nl (care provision Amsterdam youth care)
- www.neja.nl (Network Effective Youth Care Amsterdam)
- www.nji/nl/watwerkt (information about what works for certain target groups and sorts of work)

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Curriculum Vitae

Dr L. (Leonieke) Boendermaker has worked since 1 February 2010 as Professor in Implementation and Effectiveness of Youth Care Services at Amsterdam University of Applied Sciences. She combined this position with that of senior researcher at the Department for Special Education, unit Youth Care at the University of Groningen until 2015. She studied social pedagogy in Leiden and Amsterdam (UvA) and gained her PhD in 1999 on a study about the population and interventions in judicial treatment institutions for young people. As of 1986 she worked successively for the Scientific Research and Documentation Centre (WODC) at the Ministry of Justice, the State Institute for girls De Lindenhorst and the Netherlands Youth Institute (formerly the Department for Youth at the Netherlands Institute for Care and welfare, NIZW Youth). She conducts research into the initiation, implementation and the outcomes of interventions within youth care. In addition, she devotes special attention to interventions for young people with behavioural problems and the implementation of interventions within secure and/or judicial youth care.