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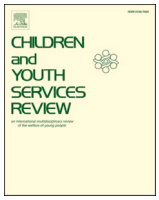

Effective elements of the diagnostic assessment process in youth care. A scoping review

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ABSTRACT

Background: In youth care, diagnostic assessment of high quality is crucial for intervention planning, may increase the likelihood that interventions will be effective and can have therapeutic effects in itself. Therefore, it is important to understand which elements relate to the quality of the diagnostic assessment.
Objective: The objective of this study is to provide an overview of elements that are studied in the context of the diagnostic assessment process in youth care and to identify elements that influence the effectivity of this process.
Methods: A scoping review was conducted to explore the current literature, using the databases ERIC, PsycINFO, Web of Science, Google Scholar, Google Search and ProQuest.
Results: Approximately 50 elements, that affect the diagnostic assessment process in youth care in a positive or negative sense, were identified in 25 studies, of which only 5 were of moderate to high quality. Elements were studied in the general assessment process or in specific phases of this process. No studies have focused on elements affecting the explanatory analysis (the phase in which factors that influence the behavior are analyzed). Elements are clustered in the themes 'parents', 'preconditions', 'care process', 'information exchange and collaboration', and 'professional'.
Conclusions: Given the limited number of high quality studies, it is desirable to do more research on effective elements of the diagnostic assessment process. Based on the findings we suggest to study the role of alliance and shared decision-making in depth, to research effective elements during the explanatory analysis and to include children as participants.

1. Introduction

Diagnostic assessment is a first step in youth care trajectories (Finch et al., 2012). During a diagnostic assessment, information about the symptoms and behavior of the client, as well as explanations for the symptoms and behavior, is gathered and integrated in an explanatory model (also known as case formulation). Based on this information, an intervention plan can be formulated (Witteman et al., 2018). Hence, the purpose of diagnostic assessment is to collect information that guides decision making (Finn & Tonsager, 1997). This means that the diagnostic assessment process contributes to the intervention plan and strongly influences the effectiveness of interventions (Persons et al., 2013). When the diagnostic assessment does not lead to an appropriate intervention plan, interventions may be ineffective in the long run. This may result in children and their families losing confidence and becoming less motivated for (further) treatment (Tempel et al., 2022; Visscher et al., 2022; Vissenberg et al., 2017). In addition to the aim of diagnostic assessment to guide decision-making, the diagnostic assessment process itself can already have therapeutic effects for children and parents (e.g., Gorske, 2008; Hamilton et al., 2009). For example, providing feedback about strengths and weaknesses regarding family interactions during the assessment process, can lead to better family relationships and improved family functioning (Hamilton et al., 2009; Teixeira De Melo and Alarcao, 2013). Another aim of assessment is, therefore, to produce positive

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change in clients (Finn & Tonsager, 1997; Finn & Martin, 2013). From the above, we can conclude that the diagnostic assessment process is a crucial part of the youth care trajectory. However, multiple studies have shown that there is room for improvement in the diagnostic assessment process (e.g., Quinlan-Davidson et al., 2021; Spijk-de Jonge et al., 2022; Uhlhaas et al., 2023; Van Yperen, 2023).

1.1. Guidelines for diagnostic assessment

Since the diagnostic assessment may increase the likelihood that interventions will be effective and can have therapeutic effects in itself, it is important to understand how this diagnostic assessment can be conducted. To improve and maintain the quality of the assessment process, researchers and clinicians have formulated guidelines. Many of these guidelines are formulated for specific disorders, such as autism spectrum disorder (ASD) (e.g., Robertson et al., 2013), depressive disorders (e.g., Walter et al., 2023) or personality disorders (e.g., Shiner & Allen, 2013). In the Netherlands, the general diagnostic assessment guidelines of De Bruyn and colleagues (2003) are used by many clinicians (Bartelink et al., 2013). They described the diagnostic assessment as an iterative process that consists of four phases, namely, the analysis of complaints, the problem analysis, the explanatory analysis, and the indicatory analysis (De Bruyn et al., 2003). During the analysis of complaints, requests for help and experienced symptoms are clarified. The analysis of problems involves describing positive behavior, behavioral difficulties, and the frequency and severity of symptoms. This includes categorizing behavior, among others, by using the Diagnostic and Statistical Manual of Mental Disorders (5e ed.; DSM–5; American Psychiatric Association, 2013). The analysis of problems is followed by the explanatory analysis. In this analysis, hypotheses about the origin, maintenance, reinforcement and reduction of the problems are formulated and explored. After the complaints, problems and explanations are analyzed, an explanatory model is made. In such a model, relations between behaviors and the various influencing factors are displayed (Witteman et al., 2018). Next is the indicatory analysis, in which possible interventions are mapped and an appropriate approach to the problems is formulated, based on the explanatory model (De Kwaadsteniet et al., 2010). The results of the diagnostic assessment can be discussed in a disclosure session, which may lead to offering intervention on basis of an intervention plan (Witteman et al., 2018). This guideline of De Bruyn and colleagues (De Bruyn et al., 2003) has similarities with other guidelines, such as the guideline of Fernández-Ballesteros et al. (2001).

Although these guidelines support professionals during the diagnostic assessment process, they mainly focus on the structure of the diagnostic decision making process and do not provide details about how professionals can conduct this assessment while working with children and their families (Bartelink et al., 2013; Gatej et al., 2019). In addition, the application of these guidelines has not been studied in detail, leaving us with limited insight in the effectiveness of these guiding principles for the diagnostic assessment process (Cooper, 2003; Finch et al., 2012). It is important to obtain more insight in the concrete actions that professionals can take, by identifying the elements that influence the diagnostic assessment process, to optimize this process in youth care practice (Knorth et al., 2007; Van Yperen et al., 2010).

1.2. Effective elements in youth care

Although effective elements in youth care have been increasingly studied in recent decades, the focus has been on (specific interventions in) the treatment phase and not on the pre-treatment phase, in which the diagnostic assessment process takes place. However, a recent study from Nooteboom and colleagues (2021) included the diagnostic assessment process, while identifying elements that influence the youth care trajectory. We will discuss this study, because of its broad scope and since the conceptual framework may be applicable when researching effective elements of the diagnostic assessment process.

Nooteboom and colleagues (2021) studied facilitators and barriers that youth care professionals may encounter when providing integrated youth care and focused on the entire continuum of care. They identified these elements (facilitators and barriers) and clustered them in seven themes, namely 'Child's environment' (including a holistic approach on a family's welfare and collaboration between education and health care systems), 'Preconditions' (including time to address a broad spectrum of problems and for interprofessional collaboration, financial support and funding streams, and availability of professionals and services), 'Care process' (including a broad assessment of problems and the use of screening tools, formulating a shared care plan, and transition between care professionals), 'Expertise' (including extending knowledge by means of training, using evidence based guidelines and self-efficacy of professionals), 'Interprofessional collaboration' (including the importance of interprofessional relationships, familiarity with other professionals, co-location, multidisciplinary meetings, consultation of other professionals and care coordination), 'Information exchange' (including a shared language and motivation to communicate, and the content and frequency of information sharing), and 'Professional identity' (including clear professional roles, shared responsibility, attitudes of professionals toward integrated care, shared thinking, and mutual trust, respect for other professionals and perceived equality). In the discussion of their research, they indicated that *"broad assessment of problems and timely identification of the intensity and type of care a family needs are important aspects of integrated care''* (p. 100). However, they also reported that professionals experience difficulties in prioritizing problems and determining the focus of support (Nooteboom et al., 2021), once again, stressing the importance of studying the effective elements of the diagnostic assessment process in youth care.

1.3. The current study

Diagnostic assessment is a crucial aspect of youth care trajectories. Therefore, it is important to gain more insight in the elements that influence the effectiveness of the diagnostic assessment process. In line with standards for effectivity research in (youth) mental health care (e.g., Harinck et al., 1997), elements are considered effective when there is empirical evidence that they directly influence the outcome of the diagnostic assessment or the subsequent intervention. Spanjaard and colleagues (Spanjaard et al., 2015) add to this definition that elements can be effective independently or in correlation with other elements. Effective elements can be identified by evaluating the process and outcome (Harinck et al., 1997), for example, by questioning the experiences of families and youth care professionals and/or a randomized control trial. In many qualitative studies, the words 'facilitator' and 'barrier' are used instead of 'effective element'. Facilitators are elements of (youth) care that improve or enable the perceived quality of care and client satisfaction and barriers are elements that limit or obstruct the perceived quality of care and client satisfaction (Nooteboom et al., 2021).

The current study aims to provide an overview of the elements reported in the scientific literature, that are expected to influence the effectivity of the diagnostic assessment process in youth care, specifically by answering the following research questions: (1) Which elements are studied in the context of the diagnostic assessment process in youth care? and (2) Which elements are found to affect the diagnostic assessment process in youth care? Summarizing this knowledge may lead to insights for professionals, regarding the possible effects of their choices during the diagnostic assessment process in daily practice. By identifying knowledge gaps, suggestions for further research can be made.

2. Method

Given the explorative nature of the research question, the broad topic of the study and the aim of gaining an overview of the existing

literature on elements that influence the effectiveness of the diagnostic assessment process, a scoping review was conducted. The protocol for this scoping review was preregistered[1] in October 2023 at the Centre for Open Science (OSF) and can be accessed via [link pre-registration, masked for reviewers]. We used the PRISMA standards for scoping reviews (as described in Tricco et al., 2018) to guide our reviewing process.

2.1. Search strategy

Three databases were used to search for relevant studies, namely, ERIC, PsycINFO and Web of Science. The database ERIC focuses on educational and pedagogical literature. The PsycINFO database focuses on psychological literature. Web of Science is a general literature database. The following combination of search terms was used for searching through titles, abstracts, and keywords: ''diagnostics'' AND (''youth'' AND ''care'') AND ''effect''. For every search term, several alternative terms were used, as shown in Table 1. The choice for a broad scope of alternative terms was made, to increase the chance that all relevant studies were found. In addition, the databases of Google Scholar, Google Search and ProQuest were used for free searches. Examples of free search results included, are dissertations and research reports from research institutes and youth care organizations. The aforementioned searches were conducted in September 2023. After the full-text assessment, additional literature was searched via cited references (May 2024) and by contacting researchers of the included studies to identify additional, unpublished studies (June 2024). By including a free search and contacting researchers with the call for unpublished studies, we tried to avoid publication bias. A more detailed overview of the searches in each database can be found in Appendix A.

2.2. Eligibility criteria

Different filters in the databases were used, to obtain a sample of relevant studies. Table 2 presents the filters that were used for the period of publication, language, type of document, and category. Prior to the start of the screening and selection of articles, the inclusion criteria were discussed with the research team. This resulted in five inclusion criteria, namely population, concept, context, availability, and methodology (see Table 3). The criteria population, concept, and context were used to screen the titles and abstracts and assess the full-texts. The availability and methodology criteria were only applied in the full-text assessment.

2.3. Study selection

The selection process was independently conducted by two researchers (the first author of this article and a trained research assistant). First, duplicates were removed, using Endnote. The records were then uploaded to Rayyan, a program in which decisions regarding inclusion and exclusion are tracked and can be compared after independent selection. The researchers screened the titles and abstracts in a first round and assessed the full-texts in a second round. These rounds were followed by a third round for the studies that were selected via cited references and a fourth round for the studies which were shared by contacted researchers. The researchers selected the studies independently, using the inclusion criteria. For most of the excluded articles, there were multiple reasons for exclusion related to more than one of the inclusion criteria. For practical reasons, it was decided that the researchers would only provide one of those reasons in Rayyan, which meant that the researchers stopped reading in detail when one of the inclusion criteria was not met. After screening all studies, the researchers discussed the conflicts in the selection (screened studies that were excluded by one of the researchers and included by the other researchers) and studies that raised questions in light of the selection process, until consensus was reached on which studies to include based on titles and abstracts. In cases of doubt, a third researcher (the last author of this article) was asked to join the discussion to reach a consensus. This was the case in less than 1% of the studies (n = 8). The same process was applied for the full-text assessment. The third researcher was again involved in the selection of less than 1% (n = 1) of the studies in the second round. The selection process is visualized in Fig. 1.

2.4. Data charting

For each study in the review, 'author', 'year of publication', 'country of study', 'study design', 'study sample, 'setting' and 'investigated elements' were extracted. This data extraction process was performed by the same two researchers as the screening and full-text assessment. First, the researchers extracted the data independently. The relevant information in the articles/research reports were marked and summarized in a table. Thereafter, the researchers bundled and discussed the data extraction until agreement regarding the description was reached. To report the findings of each study, the identified elements (1) were linked to the phase of the diagnostic assessment process, namely 'complaint analysis', 'problem analysis', 'explanatory analysis', 'indication analysis', and 'disclosure session'. When it was not clear which parts of the diagnostic assessment were addressed in the study, elements were related to 'general diagnostic assessment process / not specified'. The findings of each phase were subsequently (2) divided in 'positive effect' and 'negative effect' and (3) divided in themes. Thematic analysis was applied, using both deductive and inductive strategies. We used the conceptual model of facilitators and barriers from the study of Nooteboom and colleagues (2021) as a starting point for thematic analysis (deductive). Some of the identified elements did not match the themes of this conceptual model, which led to adaptation of the themes (inductive). The theme 'Child's Environment' was specified to 'Parents'. 'Expertise' and 'Professional Identity' were combined and named 'Professional'. In addition, 'Interprofessional collaboration' and 'Information Exchange' were combined into 'Information Exchange and Collaboration'. Finally, to describe the effective elements in more detail, one researcher (the first author) read the results and discussion sections again and selected quotes that were relevant to the research question.

Since a scoping review is a way to explore the existing literature regarding a specific theme, our research team made the choice to analyze and describe the quality of the included studies, instead of using strict quality criteria for inclusion of the articles in the review. In line with this decision, the choice was made for the Mixed Methods Appraisal Tool (MMAT), version 2018, to analyze quantitative, qualitative and mixed methods studies. Additionally, the Assessing the Methodological Quality of Systematic Reviews, version 2 (AMSTAR-2) was used for the critical appraisal of reviews and *meta*-analyses. Again, this appraisal was independently conducted by two researchers (the first author of this article and the research assistant) and discussed until consensus was reached. After completing the quality appraisal, a conclusion concerning the quality of the studies was made. The developers of the MMAT suggest calculating the percentage of quality criteria that are met (mixedmethodsappraisaltoolpublic.pbworks.com). For the Mixed Methods, they state that the overall quality of the combination of applied criteria cannot exceed the quality of its weakest component. The lowest quality score is 0 (no criteria are met) and the highest quality score is 5 (100% of

[1] During our research we made the choice to map both elements with a positive and a negative effect on the diagnostic assessment process, since most included studies did focus on both kinds of effective elements and it gives a more complete insight in what professionals can do or should avoid during this process. However, in the pre-registration we focused only on the elements with a positive effect. Therefore, the second research question has changed from 'Which elements are found to be effective during the diagnostic phase in youth care?' to 'Which elements are found to affect the diagnostic assessment process in youth care?'.

Table 1
List of terms.

(“diagnostics” or “diagnostic process*” or “diagnostic phase*” or “diagnostic cycl*” or ((“diagnostic” or “psychological”) and (“assess*”)) or ((“diagnostic”) and (“decision making” or “decisionmaking”)) or “case formulation*” or “case conceptuali*” or “holistic theor*” or “ideographic theor*” or “complaint analys*” or “problem analys*” or “explanatory analys*” or “indicatory analys*” or “explanatory model*”)
((“youth” or “child*” or “adolescen*” or “juvenile” or “famil*”) and (“care” or “therap*” or “intervention*” or “counsel*” or “welfare” or “mental health” or “psychotherapy” or “psychiatry” or “probation” or “protection”))
(“effect*” or “efficac*” or “element*” or “factor*” or “facilitat*”)

Table 2
Filters.

Filter	Description
Period of publication	2010 – 2023 *The choice for including literature from 2010 was made since effectivity studies are relatively new and therefore, it is desirable to focus on the most current knowledge.*
Language	English and Dutch *International scientific literature was searched by including English literature. In addition, Dutch literature was included since the diagnostic assessment process have increasingly become focus of attention in youth care in Dutch clinical practice and given the Dutch background of the research team members.*
Document types	Articles, research reports and dissertations *To avoid publication bias, research reports and dissertations were included in addition to scientific, peer reviewed, articles.*
Category	In Web of Science the search was refined by selecting psychology, pedagogy and education related categories to avoid irrelevant studies. Since ERIC and PsycINFO are already focused on psychology, pedagogy and education, no filters related to category were used in those databases.

the quality criteria are met). We interpreted a score of 4 or 5 as high, a score of 3 as moderate and a score of 2 or lower as low. The AMSTAR-2 is not intended to generate an overall score. Reviews are considered to be of high quality when there is no or only one non-critical weakness. A moderate score means that there are multiple non-critical weaknesses. A low score is given when there is one critical flaw (with or without non-critical weaknesses) and a critically low score is given when there are two or more critical flaws. Seven out of 16 items are considered critical according to Shea and colleagues (Shea et al., 2017).

3. Results

In total, 19.041 unique studies were identified in the search, of which 25 studies were included in the review (as shown in Fig. 1). The included studies consist of 23 peer reviewed articles, including a manuscript; 1 Dutch dissertation in fulfillment of the requirements of the degree of Doctor of Philosophy (PhD); and 1 Dutch non-peer reviewed research report.

3.1. Study characteristics

The characteristics of the included studies are summarized in Table 4. Two articles were from the same authors describing two different studies (studies 7 and 8). Most of the data were collected entirely in Global North countries[2] (n = 22). Three studies included data collected in Global North and Global South countries (studies 4, 5, and 14). Nine studies used quantitative study designs (studies 2, 6, 7, 12, 19, 22, 23, 24, and 25), six studies used qualitative study designs (studies 8, 9, 13, 16, 17, and 20), four studies used a mixed methods design (studies 3, 10, 11, and 21) and six studies were reviews, of which 5 were systematic reviews (studies 4, 5, 14, 15, and 18) and one was a scoping review (study 1). The study populations were diverse and included children, adults (see description of ‘population’ in Table 3), parents, other caregivers and family members, teachers, and clinicians. Eleven out of 25 studies included participants in a broad age range. Five studies focused on children until the age of 12 years (studies 13, 17, 21, 24, and 25), of which two studies focused on young children until the age of 6 years (studies 17 and 21). Four studies focused on adolescents (studies 7, 8, 16, and 22) and five studies did not describe age ranges (studies 4, 6, 11, 18 and 20). Ten of the included studies focused on ASD as a classification (studies 1, 3, 5, 9, 10, 12, 15, 18, 19, 21), of which one focused on the combination of ASD and being deaf (study 9). Other studies focused on transgender youth (study 2), children with an anxiety disorder (study 13), children who were abused (study 22) and children with a refugee background (study 16). Eleven studies focused on a child population in general. Sample sizes of the studies ranged from n = 2 (study 5) to n = 2.153 (study 14). Studies were conducted in various settings, such as specialty clinics, youth mental health care services, community mental health outpatient settings, schools, hospitals, and the child welfare system. Seven studies did not describe the setting.

3.2. Quality appraisal

The overall quality of the included studies is relatively low, with 5 studies having a critically low quality score, 15 studies having a low quality score, one study having a moderate score (study 5) and only four studies (8, 13, 17 and 23) having a high score (see Table 4). Low scores result largely from incomplete information in the reports of the study. Examples of other reasons for low scores in the quality appraisal are unknown reliability and validity of used measurements, and limitations of the studies, such as not assessing the risk of bias in reviews and non-representative samples. In Appendix B, a more elaborated quality analyses can be found.

3.3. Findings

In Table 5, the findings of the included studies relevant to our research question are shown schematically. Ordered by phase of the diagnostic assessment process, positive or negative effect and theme. Since the aim of this study was to provide an overview of the elements of the diagnostic assessment process that are investigated, all elements are shown, independent of the quality of the study.

3.3.1. Phase of diagnostic assessment

One study (21) focused solely on the complaint analysis. Eight studies specifically focused on the problem analysis, in which a (DSM) classification was (or was not) given to a child (studies 1, 6, 7, 8, 11, 14, 23 and 25). Some articles included the disclosure session (studies 13) and/or described additional elements that had effects on the diagnostic assessment in general (studies 2, 9, 15) in addition to their focus on the classification. One study (22) focused on the indication analysis and another study (4) identified effective elements in the indication analysis and general assessment. The disclosure session was the point of focus in five studies (3, 10, 17, 20 and 24), although most of these studies also described some elements that are effective in other phases or the general

[2] In the Global Mental Health movement, the North is associated with high-income countries with well-funded and specialized mental health institutions and the South is associated with low- to middle-income countries with less-funded and specialized institutions (e.g. Mills & Fernando, 2014; Rajabzadeh et al., 2021).

Table 3
Eligibility criteria.

Criterium	Description	Examples of excluded studies
Population	Studies were included when they focused on the relevant population within the realm of youth care: professionals which work in youth (mental health) care, children (regardless of diagnosis) and/or their families. In case of longitudinal studies, the study was included when the data collection started during the childhood of the participant who received youth care services, although participants now being adults. With children we refer to youth in the age of 0 to 18 years old, in accordance with the Dutch youth care system and law. We also did include studies that focused on adolescents (children aged 12 to 25 years).	Studies regarding diagnosing children with medical instead of mental health care problems were excluded. In case of studies with multiple population groups, including the population of our interest, studies were included when it was clear which findings applied to this population, and excluded when the population did not explicitly included our population of interest or when it was not clear if study findings were applicable.
Concept	The concepts 'diagnostic process' and 'effective elements' should be integrated in the study. Studies that focused on a specific phase of the diagnostic process were included. In addition, more exploratory studies that focused on elements which were experienced as effective (instead of proven to be effective), were included.	We excluded studies that investigated the reliability or validity of a specific instrument; or described the symptoms or an explanatory model of a specific classification, since these studies do not focus on the diagnostic assessment process. In addition, studies that did not investigate possible elements that *directly* influence the (effectivity of the) diagnostic assessment process, but did describe preconditions, such as finances, or (risk)factors, such as salary or educational level of parents, were excluded. In the same line, studies that only described some implications for the diagnostic process in youth care in the discussion chapter were excluded. Last, studies that investigated the pre-assessment phase (focusing on early screening and/or waiting list support), and intervention phase were excluded, as well as studies that focused on decision making of parents after the diagnostic assessment and before the start of intervention.
Setting	Studies related to youth care were included, also when the study found place in a specific setting such as schools, specialized mental health care clinics or refugee work. When the study focused on the youth care setting(s) but also used references of broader (mental) health care context, the study was included.	Most studies that were excluded based on setting were of purely medical nature.
Availability	Only when the full-text of the study was available, it was included.	Full-texts that were not accessible, even after requesting the articles, were excluded.
Methodology	Research questions or aims of the study and the used methodology needed to be described. Both studies with quantitative designs and qualitative designs were included, as well as reviews.	Study protocols and grant proposals were excluded.

diagnostic assessment. Two studies (12 and 16) only identified elements of the diagnostic assessment in general but not in specific phases, whereas one study (5) focused mostly on the general diagnostic assessment but did identify some elements related specifically to the disclosure session. Last, two studies (18 and 19) identified elements in the complaint analysis, problem analysis and disclosure session, of which one study (19) also described elements related to the indication analysis and diagnostic assessment in general. Surprisingly, no studies have focused on the explanatory analysis. In Table 5, the elements are listed for each phase of the diagnostic assessment.

3.3.2. *Positive and negative effect*

All studies, except those of Connor and colleagues (2015) and Crane and colleagues (2016), identify elements that have a positive influence on the diagnostic assessment process and nine studies identify elements that have a negative influence on the diagnostic assessment process (5, 9, 10, 11, 12, 13, 15, 17 and 20).

3.3.3. *Investigated elements*

The elements investigated in the studies, were categorized in several themes: a) parents, b) preconditions, c) care process, d) information exchange and collaboration, and e) professional. Two studies (5 and 15) described elements related to the theme 'parents'. This theme consists of elements that are related to the experiences and knowledge of parents, influencing the diagnostic assessment process. Elements of three studies (9, 11 and 15) were categorized in the theme 'preconditions', which refers to available resources, informants, professionals and time. The theme 'care process' includes elements related to the preparation of the diagnostic assessment process, the assessment process in general, the use of measurements and tools, the classification/diagnosis, and the advice professionals provide. In total, 21 studies (1, 2, 3, 4, 5, 6, 7, 8, 12, 13, 14, 15, 16, 17, 18, 19, 20, 22, 23, 24, and 25) described elements related to the care process. Elements of 14 studies (2, 3, 4, 5, 9, 10, 13, 15, 17, 18, 19, 20, 21, and 24) were categorized as 'information exchange and collaboration'. This theme consists of elements that are related to collaboration between professionals, alliance and shared decision-making, and the way professionals share information during the diagnostic assessment process. The theme 'professional' was reflected in six studies (3, 4, 10, 11, 15, and 20) and describes elements related to the knowledge (acquisition) and attitude of the professional.

3.3.4. *Effective elements*

All the elements that were investigated in the included studies of this review are listed in Table 5. The elements that are investigated in moderate to high quality studies (5, 8, 13, 17 and 23) are described below in depth, since we assume that the statements regarding the positive or negative influence of the investigated elements in these studies are more valid and reliable and therefore, more useful for clinical practice. To describe the findings of these studies in the most concise way, we choose to describe the identified elements per theme, starting with the elements with a positive effect. Elements related to the themes 'parents', 'care process' and 'information exchange and collaboration' will be discussed. In these high quality studies, there were no elements found to be effective related to the themes 'preconditions' and 'professional'. Within the themes we relate to the phase of the diagnostic assessment process in which the element is found to be effective.

- **Parents.**

Two elements related to the experiences and knowledge of parents have a positive influence during the general diagnostic assessment process, namely parents having positive experiences with first line health professionals and parents gaining knowledge about the behavior and possible classification of their child (Boshoff et al., 2019). Positive experiences with first line health professionals contribute to the general diagnostic assessment process, since these experiences influence future

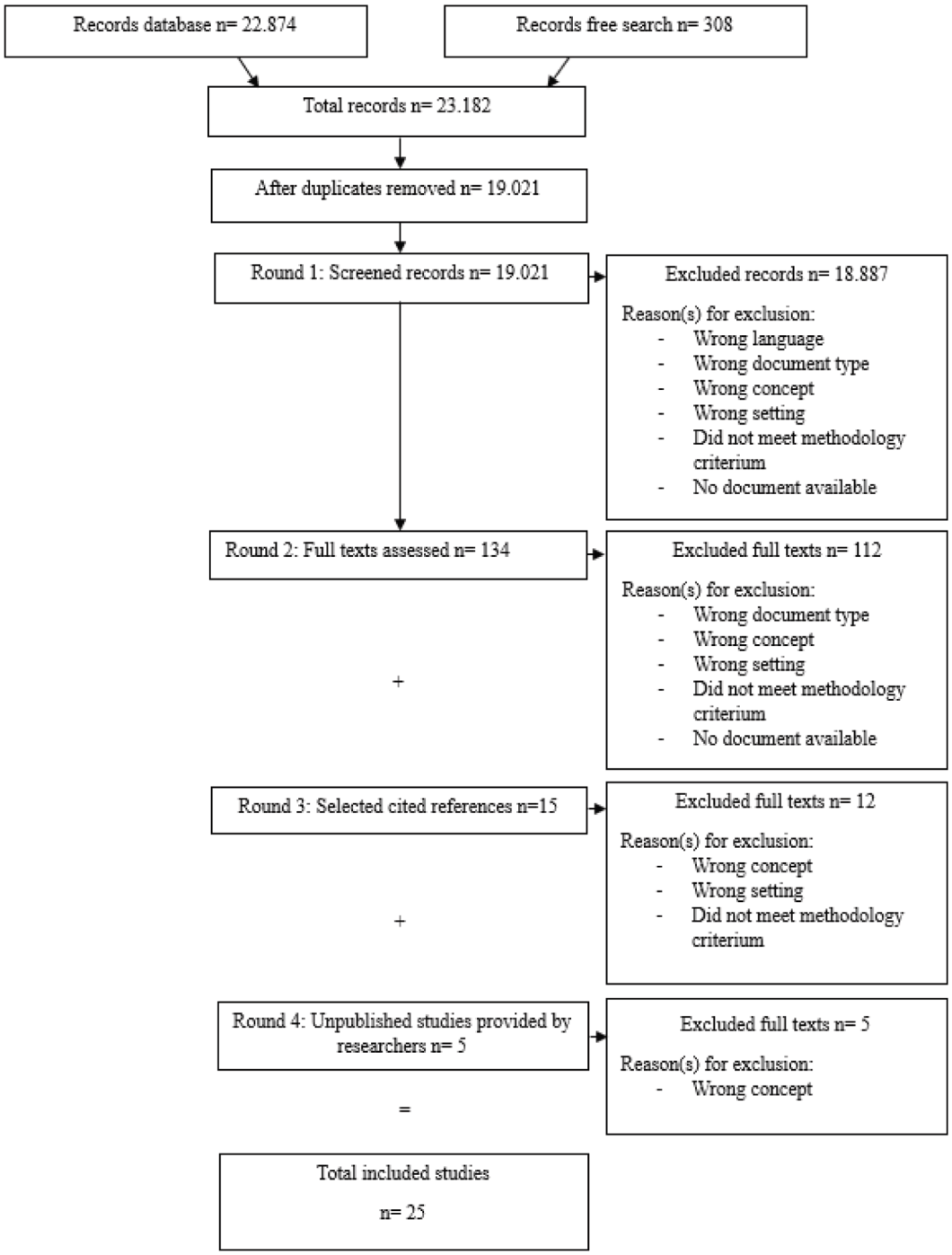

Figure 1: Study selection process

Fig. 1. Study selection process.

alliances between parents and health professionals when it comes to trust and confidence (Boshoff et al., 2019). Furthermore, when parents feel that professionals have expertise that contributes to their prior and current knowledge with respect to the behavior of their child, this may lead to trusting professionals. However, the process of gaining knowledge by comparing prior and current knowledge to the expertise of professionals, could also lead to challenging professionals, when parents advocate for their child (Boshoff et al., 2019).

- **Care Process.**

Preassessment preparation of parents (Klein et al., 2011) and focusing on the child's strengths and directions for growth as well as challenges (Davey et al., 2022; Klein et al., 2011) are found to have a positive effect during the general diagnostic assessment process. Klein and colleagues (2011) reported that preassessment preparation is crucial for effective information provision. In this preparation, professionals can ensure that parents *''have the readiness and emotional resources to process information''* (p.130, Klein et al., 2011). Parents also described that they want to be better prepared for the assessment, for example by receiving a list of frequently asked questions during the assessment and a list of things to be observant of prior to the assessment.

Table 4
Study characteristics.

	Author, year	Country	Study design	Study sample	Setting	Quality appraisal
1	Alfuraydan, et al., 2020	USA	Scoping review	10 studies were included in this review. Sample consist of people (families, parents/caregivers, children, sibblings, adults and/or clinicians) experiencing an ASD diagnosis process. Sample sizes range from n = 4 to n = 370. The ages of the represented children range from 18 months to 22 years.	The settings of the studies are not described	Critically low
2	Allen et al., 2021	USA	Quantitative descriptive[a] survey study	Parents (n = 16) of youth (5–16 years) who completed a psychological assessment with their child at an outpatient psychology clinic within a large pediatric transgender health specialty clinic in a US Midwestern metropolitan city.	Pediatric transgender health specialty clinic	Low
3	Anderberg & South, 2021	USA	Mixed methods study	Interviews: mental health care providers (n = 6) Focus Group: mothers (n = 8) and fathers (n = 2) of children (3–15 years) diagnosed with autism Survey: Parents (n = 189) of children diagnosed with autism in last 3 years.	Varied settings; autism-related diagnostic clinics and community groups	Low
4	Bartelink et al., 2013	Included studies from the Netherlands and International (countries unknown)	Systematic review	81 international studies and 54 Dutch publications were included in this review. Samples of the included studies are not described.	Youth care, mental health care and health care	Critically low
5	Boshoff et al., 2019	Included studies from USA (12), Canada (2), UK (2), Wales (1) Sweden (1), Cyprus (1), Israel (1), China (1), India (1)	Systematic review	22 studies included in this review The samples of all studies consist of caregivers of children with ASD. The included caregivers vary between samples: only fathers (1 study); only mothers (3); parents (17); parents, aunts, and a grandfather (1). Sample sizes vary from n = 2 to n = 738. The age of the represented children ranges from 2 to 14 years.	The settings of the studies are not described	Moderate
6	Boyle et al., 2023	Canada	Quantitative descriptive study	737 parents (n = 737) from general population, schools and community-based child/youth mental health outpatient clinics (age range of represented children not described).	General population, schools and community-based child/youth mental health outpatient clinics	Low
7	Bradford & Rickwood, 2015a	Australia	Quantitative quasi-experimental study	Youth 12–25 year (n = 339) that receive mental health care via 'Headspace Canberra' and 13 clinicians.	Youth mental healthcare services	Low
8	Bradford & Rickwood, 2015b	Australia	Qualitative study	Youth 12—25 years (n = 129) from two major cities in Australia.	General community, mental health service and Alcohol and other Drug service	High
9	Brenman et al., 2017	UK	Qualitative ethnographic study	Multidisciplinary mental health professionals (n = 16) who have conducted autism assessments for deaf children aged 0 – 18 years.	Specialized center for Deaf service and generic youth mental health care	Low
10	Chamak et al., 2011	France	Mixed methods, retrospective, survey study	Questionnaires: French parents (n = 248) of children diagnosed with ASD (children aged 4 to 45 years at time of data collection) Interviews: subsample (n = 43)	The settings of the studies are not described	Low
11	Connors et al., 2015	USA	Mixed methods study	Questionnaire: School mental health clinicians from 10 community programs in different US States (n = 144). Interviews: Program managers (n = 6) and subsample of clinicians (n = 8) No information is given with regard to the age range of the children with whom the clinicians are working.	School mental health service	Low
12	Crane et al., 2016	UK	Quantitative descriptive survey study	Parents (n = 1047) of children with an autism spectrum disorder (mean age 11.8, SD = 6.1 years).	Services providing information, support or assistance to parents of children with ASD	Low

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Table 4 (*continued*)

	Author, year	Country	Study design	Study sample	Setting	Quality appraisal
13	Davey et al., 2022	UK	Qualitative study	Mothers (n = 11) of children (7 – 12 years) diagnosed with an anxiety disorder.	Anxiety and Depression in Young People Research Clinic	High
14	Hemmingsson et al., 2017	Included studies from USA (20), UK (3), Sweden (3), Netherlands (3), France (1), Switzerland (1), Serbia (1), Australia (3), Canada (2), Taiwan (1), Korea (1)	Systematic review	39 studies included in this review Samples of these studies vary, with a total number of 10.520 child-parent dyads (smallest sample size is n = 22 and largest is n = 2153). The age of the included children ranges from 5 to 20 years.	The settings of the studies are not described	Critically low
15	Howes et al., 2021	Included studies from UK (3), USA (1) Canada (1), Belgium (2)	Systematic review	7 studies were included in this review The samples of all studies consist of health professionals who diagnose ASD. Sample sizes vary from n = 5 to n = 116. Five studies only included professionals who diagnose children. Two studies included professionals who diagnose children and adults.	The studies are not conducted in a specific setting. Described settings are: National Health Service, education sector, local authorities, hospitals, centers for developmental disorders, private clinics, special boarding schools, ambulatory centers, university, community and a charitable organization.	Critically low
16	Khawaja & Howard, 2020	Australia	Qualitative case study	Students 13–14 years (n = 3) from refugee backgrounds (originally from Iraq), who were not progressing academically despite intensive intervention, and their class teachers and parents.	School	Low
17	Klein et al., 2011	Canada	Descriptive qualitative study	Professionals of an interdisciplinary assessment team (n = 12). Parent-couples (n = 9) of children (1 – 6 years) who participated in assessment with at least 4 disciplines.	Tertiary care interdisciplinary neurodevelopmental diagnostic assessment clinic	High
18	Legg & Tickle, 2019	UK	Systematic review	11 studies were included in this review All samples consist of UK parents (2 studies with only mothers, 1 study with only fathers) with a child diagnosed with ASD. Sample sizes vary from n = 4 to n = 184. Age ranges of the represented children are not described.	The settings of the studies are not described	Critically low
19	Moh & Magiati, 2012	Singapore	Quantitative descriptive survey study	Parents (n = 102) of children with a diagnosis of autism (2 – 17 years). Professionals (n = 17) from public and private organizations providing ASD diagnostic services.	ASD special schools, intervention centers and hospitals	Low
20	Pearson et al., 2020	Canada	Descriptive qualitative study	Parents (n = 17) of children (age range not described) who received a developmental diagnosis from one of the clinical multidisciplinary teams in Northern Columbia	The setting of the study is not described	Low
21	Sheldrick et al., 2019	USA	Mixed methods study	Quantitative: Parents of children (0–3 years) eligible for ASD screening and their early Intervention providers (n = 1.654 children). Interviews: Subsample of parents (n = 22) and providers (n = 20).	Early intervention agencies	Low
22	Toche-Manley et al., 2014	USA	Quantitative descriptive multi-year study	Abused youth 11–18 years (n = 162) and their clinicians (counselors, case managers, therapists).	Child welfare system	Low
23	Van der Ende et al., 2012	The Netherlands	Quantitative longitudinal survey study	Children 4–40 year (n = 1.875) leading to n = 12.059 informant pairs (including children, parents, teachers and partners).	No specific setting	High
24	Westermann, 2010	The Netherlands	Quantitative randomized control study	Sample: Parents (n = 78) of children (age below 12) in two Dutch youth mental health care clinics.	Youth mental health care	Low
25	Woolford et al., 2015	New Zealand	Quantitative randomized study	Children 5–12 years (n = 33) and female child mental health practitioners (n = 5) from 4 child mental health clinics.	Child mental health clinics	Low

[a] Since the qualitative part of this study is very small in relation to the quantitative part and qualitative data are only described in the discussion, the decision is made to analyze the quality of this article with the criteria for a quantitative descriptive study instead of a mixed methods study.

Table 5
Reported findings.

	Positive effect/facilitator	Negative effect/barrier
General diagnostic assessment process / not specified	Parents • *Parents having positive experiences with first line health professionals (*Boshoff et al., 2019*)* • *Parents gaining knowledge about the behavior and possible classification of their child (*Boshoff et al., 2019; Howes et al., 2021) Preconditions • Having the opportunity to work with an interpreter or translator in case of cultural and language differences (Brenman et al., 2017; Howes et al., 2021) Care Process • *Preassessment preparation of parents (*Klein et al., 2011*)* • Using a personalized approach (Howes et al., 2021), by consulting colleagues and working hypothesis-driven (Khawaja & Howard, 2020) • *Focusing on the child's strengths and directions for growth as well as challenges (*Anderberg & South, 2021; Davey et al., 2022; Klein et al., 2011*).* • Working goal oriented, structured and systematic (Bartelink et al., 2013), e.g. by structuring the diagnostic assessment process with an explanatory model, like the ''dialogue model'' (Westermann, 2010) Information Exchange and Collaboration • Working in multidisciplinary teams (Howes et al., 2021; Brenman et al., 2017) • Positive and constructive collaboration between parents and professionals (Moh & Magiati, 2012) • Taking time for relationship building (Legg & Tickle, 2019) • Respecting parents' perspectives (Allen et al., 2021; Chamak et al., 2011) • Communicating in an adequate way (Legg & Tickle, 2019) Professional • Positive attitude of the professional: open minded, direct and sympathetic (Chamak et al., 2011)	Preconditions • Having a lack of time to complete a diagnostic assessment (Howes et al., 2021) Care Process • *A lengthy and complex diagnostics process (*Boshoff et al., 2019; Crane et al., 2016) Information Exchange and Collaboration • Multi-agency working, depending on the relation with the agencies (Howes et al., 2021) • *Not being heard / Concerns not being acknowledged (*Boshoff et al., 2019*)* • *Inadequate communication styles from the professional (*Boshoff et al., 2019*)*; e.g. *Using medical jargon* (Klein et al., 2011; Pearson et al., 2020)
Complaint analysis	Information Exchange and Collaboration • Taking concerns of parents seriously (Legg & Tickle, 2019; Moh & Magiati, 2012; Pearson et al., 2020) as well as professional concerns (Sheldrick et al., 2019)	No elements are mentioned in the studies.

Table 5 (*continued*)

	Positive effect/facilitator	Negative effect/barrier
Problem analysis	Care Process • In case of gender dysphoria, parents hearing their child telling the clinicians the story of the unfolding of the gender identity (Allen et al., 2021) • Using reported checklist or interviews (Boyle et al., 2023) • *Using multi-informant reports (*Van der Ende et al., 2012; Hemmingsson et al., 2017*)* • *Conducting separate parent and child interviews (*Davey et al., 2022*)* • Using telehealth approaches (Alfuraydan et al., 2020), *like the electronic psychosocial application for assessment* (Bradford & Rickwood, 2015a; Bradford & Rickwood, 2015b) • Inviting children to draw when talking about presenting problems (Woolford et al., 2015) Information Exchange and Collaboration • Listening to parents talking about the behavior of their child (Howes et al., 2021) • Providing information and emotional support, so parents can decide about whether to pursue a diagnosis or not (Legg & Tickle, 2019); Explaining the process and reasons for diagnosing (Moh & Magiati, 2012)	Preconditions • Measures not being available to professionals (Connors et al., 2015) • Weaknesses in diagnostic tools and guides, like tools that are not sensitive enough to support diagnosing someone with an atypical presentation (Howes et al., 2021), tools not being adapted to the client population (Brenman et al., 2017) and items of tools not being understandable for respondents (Connors et al., 2015) • Difficulty reaching parents (Connors et al., 2015) Professional • Lack of knowledge of the professional about the classification (Howes et al., 2021) • No attention for evidence based assessment in supervision (Connors et al., 2015)
Explanatory analysis	No elements are mentioned in the studies.	No elements are mentioned in the studies.
Indication analysis	Care Process • Using self-reports in order to evaluate youth's needs and strengths to support intervention planning (Toche-Manley et al., 2014) Information Exchange and Collaboration • Planning interventions in dialogue with parents and children (Bartelink et al., 2013; Moh & Magiati, 2012) Professional • Using up-to-date knowledge about psychological and pedagogical theories and effectivity of interventions (Bartelink et al., 2013)	No elements are mentioned in the studies.
Disclosure session	Care Process • Consideration of location and attendees (Anderberg & South, 2021; Pearson et al., 2020) • *Receiving a diagnosis (*Boshoff et al., 2019; Davey et al., 2022*)* • Sharing specific information on the classification of the child to	Parents • Parents having too little knowledge regarding a classification (Howes et al., 2021). • Parents having too much knowledge of challenges related to a classification (Howes et al., 2021).

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Table 5 (*continued*)

	Positive effect/facilitator	Negative effect/barrier
	make parents understand the child's core presenting difficulties (Anderberg & South, 2021; Legg & Tickle, 2019; Moh & Magiati, 2012) • Clarifying parents' questions regarding the classification (Allen et al., 2021) • *Reinforcing parents in their ability to parent competently (*Klein et al., 2011*)*	
	Information Exchange and Collaboration • Sharing perspectives of multiple disciplines with parents (Pearson et al., 2020) • Informing parents about appropriate interventions for their child (Moh & Magiati, 2012), including parentings advice (Anderberg & South, 2021; Legg & tickle, 2019) and how to prioritize interventions (Anderberg & South, 2021) • *Providing information about the diagnosis face to face as well as written (*Davey et al., 2022*)* • *Using visualization, for children (*Davey et al., 2022*)*, as well as for parents, by visualizing an explanatory model (Westermann, 2010)	Care Process • *Receiving a diagnosis (*Boshoff et al., 2019; Davey et al., 2022*)* • *Providing an incorrect diagnosis (*Boshoff et al., 2019*)* • *Providing an incorrect alternative diagnosis (*Boshoff et al., 2019*)* • *Providing an incorrect advice (*Boshoff et al., 2019*)*
	Professional • Being thoughtful and sensitive/empathic when sharing the diagnosis (Anderberg & South, 2021; Pearson et al., 2020)	Information Exchange and Collaboration • Receiving a big amount of information (Pearson et al., 2020) or not enough information about the diagnosis (Chamak et al., 2011); Not checking ''*whether parents had understood their initial explanation and whether more time and repetition would have been helpful*'' (Chamak et al., 2011, p.92)

Elements found in studies of moderate to high quality are shown in italics.

In addition, parents expressed that they feel the need to hear about their child's strengths (strength-based approach) and directions related to development as well as challenges (child-specific information) (Klein et al., 2011). In line with this finding, parents in the study of Davey and colleagues (2022) found it supportive when professionals communicated optimism about the child's future, for example because they felt that they could move forward, although their child received a classification.

Three elements positively influence the problem analysis. First, Davey and colleagues (2022) reported that *"separate parent and child interviews enabled families to be open and honest in their responses …. [While] some parents felt it was necessary to have a thorough appraisal and appreciated the opportunity to share their experiences in detail, others felt there was an expectation to overshare, … [experiencing that] questions were extremely inappropriate and didn't seem to be relevant.''* (p.663). Second is the use of multi-informant reports (Van der Ende et al., 2012), since each informant contributes unique information, and therefore, ratings of informants are not interchangeable. Children typically reported higher scores than their parents and teachers did and *"correlations among informant pairs that involve a teacher as a rater are the lowest''* (p.295), which may reflect the different perspectives of the informants as well as differences due to influences of the environment. Last, the use of an electronic psychosocial application for assessment (Bradford & Rickwood, 2015b) is seen as an effective element during the problem analysis. Bradford and Rickwood (Bradford & Rickwood, 2015b) asked adolescents to talk hypothetically about the use of an e-tool and reported that the use of an e-tool could increase the degree of disclosure among adolescents, since adolescents would experience no fear of judgments by the professional while using the application. In addition, the use of an e-tool could help with structuring thoughts, which, for example, helps adolescents to decide what to focus on during follow-up face to face sessions. Other advantages of the use of an e-tool mentioned are the belief that using the e-tool would: allow disclosure to occur in a stepped process; save time; allow young people to disclose in a modality they are comfortable with; allow some young people the opportunity to better articulate their concerns; and provide health professionals with the necessary background information without young people becoming overwhelmed by emotions (Bradford & Rickwood, 2015b). Adolescents in the study of Bradford and Rickwood (2015b) that preferred a face-to-face session over the use of an electronic psychosocial application were mostly concerned about the loss of non-verbal communication. Other concerns of the use of an e-tool were concerns for privacy and confidentiality if their information was 'hacked'; the belief that talking provides more in-depth responses; the concern that questions may be misinterpreted and therefore answered incorrectly; and a sense of permanence when issues are put into writing that is not felt when you talk to a health professional.

During the disclosure session, reinforcing parents in their ability to parent competently (Klein et al., 2011) is an element with a positive effect, since such reinforcement helps parents to believe that they can handle the situation competently. It offers parents perspective, which they see as a desired outcome of the diagnostic assessment process.

Receiving a diagnosis in itself can have both positive and negative effects (Boshoff et al., 2019; Davey et al., 2022). For example, the emotions that parents experience when their child receives a diagnosis, can be positive or negative: *"[Parents experienced] shock, despair, depression, distrait, devastation, being extremely upset, frustration, and experiencing a loss comparable to the loss of a family member [when receiving the diagnosis]…… [Other parents reported] feeling relief and validated by the diagnosis …''* (p.154, Boshoff et al., 2019). In addition, Davey and colleagues (2022) reported that parents experienced positive emotions when receiving a diagnosis helped them to better understand their child's thoughts, feelings and behavior and that parents experienced negative emotions, such as frustration, when they *"felt that they already had a good understanding of their child's difficulties''* (p.662). Some parents expressed concerns about the consequences of the diagnosis for their child, for example, being stigmatized or over-identifying with the diagnosis. They also mentioned that they worried that other, co-existing problems would not be noticed because of the diagnosis. While some *"parents felt that the sole benefit of a diagnosis is that it facilitates access to intervention''* (p. 664), *"[other] parents described feeling more in control of their situation and better able to support their child''* (p.665).

A lengthy and complex diagnostic assessment process (Boshoff et al., 2019) has a negative effect on the general diagnostic assessment process, and providing an incorrect diagnosis, providing an incorrect alternative diagnosis and providing incorrect advice (Boshoff et al., 2019) negatively influences during the disclosure session. All these elements contribute to the emotional experiences of parents, which are related to a delayed acceptance of the diagnosis by parents and a delay in taking

action regarding organizing support for their child.

- **Information Exchange and Collaboration.**

Providing information about the diagnosis face to face as well as written and using visualization for children (Davey et al., 2022) have a positive effect during the disclosure session. Parents appreciated receiving a detailed description of their child's diagnosis face-to-face, since it provided the opportunity to ask questions. However, they also experienced difficulty absorbing the verbal information. Therefore, they prefer to receive written information as well. Most of the parents were content with the received information, but some parents were concerned about the age-appropriateness of the information for their children, suggesting that the use of visual aids may be helpful to explain it to their child (Davey et al., 2022).

During the general diagnostic assessment process, not being heard, concerns not being acknowledged and inadequate communication styles from professionals (Boshoff et al., 2019), such as using medical jargon (Klein et al., 2011), are seen as elements that have a negative effect. The experience of not being heard and concerns not being acknowledged can result in negative emotions of parents, such as distress, anger and frustration, and in losing valuable time for early intervention, when it takes a long time before concerns are taken seriously (Boshoff et al., 2019). In line with this experience, parents report that assessments *"were typically conducted in environments unfamiliar to the child, which impacted on the opportunity to observe the child's full potential''* (p.153, Boshoff et al., 2019) and consequently *"professionals often need to take parents' word for reported observations which may not be displayed during consultations''* (p.151, Boshoff et al., 2019). Since the diagnostic assessment process can be experienced as emotional and overwhelming by parents, the way information is communicated by professionals is very important (Klein et al., 2011). Multiple aspects of inadequate communication are mentioned by Boshoff and colleagues (2019), such as not effectively communicating the need for diagnosis and services and the use of overtly medical language, overemphasizing negative outcomes and sharing information through a standard brochure rather than providing individual support. These aspects of communication reduce the degree of trust that parents have in professionals. In addition, the communication style used with children during the diagnostic assessment was questioned by parents, which lead them to question the validity of the assessment (Boshoff et al., 2019). In addition, Klein and colleagues (2011) reported that parents complained about the jargon used by professionals. The parents suggested the use of parent-friendly language instead.

4. Discussion

4.1. Summary of evidence

The aim of this study was to gain insight in effective elements in the diagnostic assessment process in youth care, specifically by answering the following research questions: (1) Which elements are studied in the context of the diagnostic assessment in youth care? and (2) Which elements are found to affect the diagnostic assessment process in youth care? Irrespective of the quality of the studies, approximately 50 investigated elements related to the diagnostic assessment in youth care were identified, reflecting the following themes: parents (i.e., parents' experiences and knowledge), preconditions (i.e., available resources, informants, professionals and time), care process (i.e., preparation, general assessment process, measurements/tools, classification/diagnosis and advice), information exchange and collaboration (i.e., collaboration with colleagues, alliance and shared decision-making, and way of information sharing of professional), and professional (i.e., professional knowledge and attitude).

To answer the question 'Which elements are found to affect the diagnostic assessment process in youth care?', only the high quality studies are taken into account. The elements reported in these studies are related to the themes 'parents', 'care process' and 'information exchange and collaboration'. We can conclude that the use of multi-informant reports, e-tools for assessment, and separate parent and child interviews can have a positive effect during the phase of the problem analysis. In addition, providing information about the diagnosis face to face as well as written, using visualizations, talking about the child's strengths and directions for growth as well as challenges, and reinforcing parents in their ability to parent competently have a positive effect during the disclosure session. Receiving a diagnosis can have a positive or a negative effect. Last we identified several elements that influence the diagnostic assessment in general. Preassessment preparation of parents, positive experiences with first line health professionals and parents gaining knowledge about the behavior and possible classification of their child have positive effects on the assessment. The experience of not being heard, receiving an incorrect (alternative) diagnosis or incorrect advice, length and complex diagnostic assessment processes and inadequate communication styles have a negative effect. Elements related to the complaint analysis and the indication analysis were found only in low quality studies. No elements related to the explanatory analysis could be determined at all.

4.2. Limitations

A systematic method was used to select studies regarding effective elements of the diagnostic assessment process, critically appraise the included studies and analyze the results of those studies. This led to an overview of elements that influence the diagnostic assessment process and insight in what further research is needed. Despite this thorough approach resulting in the findings of this study, some critical comments should be made and conclusions should be drawn with caution. The generalizability of the findings is questionable, since some countries, mostly global North countries, are overrepresented in youth care research. Youth care systems and diagnostic assessment protocols differ across countries (e.g., related to funding streams and culture) which may influence both the elements that have been studied in the first place and the elements that were identified effective in the included studies. Additionally, the study populations differ between studies. Therefore, it is not clear whether the identified effective elements of the diagnostic assessment process are related to specific populations or might also be (as) effective in more diverse or heterogeneous youth care practices. For example, Allen and colleagues (2021) reported that parents of children with gender dysphoria, appreciated hearing their child telling the clinicians the story of the unfolding of their gender identity, which might not be transferrable to other youth care populations. However, including the child's perspective and ideas in the diagnostic assessment process related to other classifications (e.g., ADHD or ASD) might also have a positive impact. Given the lack of a current overview of elements that play a role in the diagnostic assessment in youth care, we see it as a strength of this scoping review that we have included studies of a broad range of settings within the youth care field.

Another reason to take caution in interpreting the results of this scoping review, is the quality of the included studies, which was appraised as (critically) low in 20 of the 25 studies. Thus, only five studies provided convincing evidence for the contribution of certain elements to the effectiveness of the diagnostic assessment process in youth care. Additionally, although the total number of included studies ($n = 25$) seems rather large, most elements were only studied in a limited number of these studies. In other words, to date, only little empirical evidence on the effectivity of the diagnostic assessment process in youth care is available. This scoping review, therefore, adds to the knowledge base on diagnostic assessment in youth care and shows a gap in the literature.

4.3. Conclusion

We started this scoping review with the question which elements that possibly contribute to the effectivity of the diagnostic assessment process were investigated in previous studies and what the scope of that existing literature would be. We found 25 studies that met our inclusion criteria, describing more than 50 elements related to the experiences and knowledge of parents, preconditions of the diagnostic assessment process, the procedure of this process, information exchange and collaboration and the knowledge and attitudes of the professional. However, in the limited number of studies with moderate to high quality, only elements related to the themes 'parents', 'care process', and 'information exchange and collaboration' were found. To make statements about the effects of the elements reported in low quality studies, further research of good quality is needed.

Many of the elements that were identified in the low, moderate and high quality studies, were related to the interaction between the professional and the parents of the child, with a focus on the content and manner of information sharing and collaboration. This finding stresses the importance of alliance and shared decision-making. Alliance is seen as an important factor of the effectivity of (youth) mental health treatment (e.g. Hawley & Garland, 2008; Friedlander et al., 2011; Wampold, 2001; Welmers-van de Poll et al., 2018). The importance of alliance between parents and professionals is explicitly mentioned in the included studies. Moh and Magiati (2012), for example, identified positive and constructive collaboration between parents and professionals as an effective elements. Positive parent-professional alliance leads to increased family participation and fewer cancellations and no-shows (Hawley & Weisz, 2005). Although the included studies in our study do not explicitly describe the importance of alliance between child and professional, some of the identified elements are related to creating circumstances in which children can share true feelings (e.g. conducting separate child interviews (Davey et al., 2022), using e-tools for assessment (Bradford & Rickwood, 2015a, b) and drawing when talking about problems (Woolford et al., 2015)).

Alliance is also an important facilitator of shared decision-making (Barnhoorn et al., 2023; Bjønness et al., 2020; Van Bijleveld et al., 2013), since a good relationship, in which the child/parent and youth care professional mutually trust each other, is essential for the child/parent to speak freely and to experience that the professional takes their opinion seriously. In addition, a good alliance helps youth care professionals to assess the value of the opinions and to estimate whether true feelings are genuinely expressed (Van Bijleveld et al., 2013). Our finding that shared decision-making is related to the effectivity of the diagnostic assessment process is in line with the findings of Langer and Jensen-Doss (2016), who reported that engaging families in decision making increases the chances of effective treatment, since it leads to more personalized intervention planning.

The focus on the relationship between professionals and parents in our findings can be explained by the study designs of the included studies, since almost half of these studies and 3 out of 5 moderate to high quality studies (5, 13 and 17) asked parents for their experiences during the diagnostic assessment process. In contrast, the experiences of children are not studied that often, while including the perspective of children is important, since they are key stakeholders in youth care. Additionally, the inclusion of children as participants results in additional knowledge, since adults may not always be aware of what children know, comprehend, or experience, and they might have different perceptions of children's needs and perspectives (e.g., Hunleth et al., 2022; Olsen, 2024).

By categorizing the elements in the phases of the diagnostic assessment process, it became clear that some elements were found to affect the diagnostic assessment process in general, while other elements were found to be relevant for a specific phase of the diagnostic assessment process. However, since these elements were not investigated in all phases of the diagnostic assessment process, the question arises whether these elements are indeed phase-specific or that they do have a broader impact on the process. Furthermore, it is noteworthy that the phase of explanatory analysis has not been studied at all. Several studies point out that this phase is also not given enough attention in daily youth care practice (e.g., Spijk-de Jonge et al., 2022; Tempel and Vissenberg, 2018). This may offer an explanation for the lack of research concerning effective elements of this phase.

4.4. Implications

This scoping review results in valuable implications for clinical practice. Most of the scientific literature on diagnostic assessments focuses on aspects of clinical reasoning, the steps of a diagnostic assessment and the content of psychological assessment for specific groups or mental disorders (e.g., what questions to ask or what instruments to use). Less literature focuses on the process of the diagnostic assessment, the importance of the relationship (alliance) and how to collaborate with families during this process. The results of this scoping review underscore the importance of the alliance in diagnostic assessment and the need for shared decision-making to improve the quality of the diagnostic assessment process. Therefore, the identified effective elements in this review should guide youth care practice.

In addition, this scoping review leads to implications for research. This review provides an overview of investigated elements that may influence the effectivity of the diagnostic assessment process, after which knowledge gaps have been identified. Further research of high quality in clinical youth care practice is needed to identify effective elements of all phases of the diagnostic assessment process and provide clear implications for clinical practice. Since we noticed that the explanatory analysis was not explicitly researched, a focus on the phase of the explanatory analysis in the diagnostic assessment in future studies can add new insights to the existing body of literature. In addition, we were surprised that the participation of children in the studies was very limited and we suggest studying the experiences and perspectives of children in the diagnostic assessment process. Last, we suggest researching the influence of alliance and shared decision-making in depth, to provide youth care professionals with meaningful insights in how to collaborate with families during the diagnostic assessment process, since this collaboration seems to be a very important aspect.

Ethical statement

Ethical approval is not applicable

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.childyouth.2026.108816.

Data availability

Pre-registration is available via https://osf.io/m93js. Appendixes are available via [sent with manuscript, will be deposited in data repository of OSF when article is accepted].

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