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Self-reported care activities in a home-based intervention programme for families with multiple problems

Tim Tausendfreund, Janneke Metselaar, Jelte Conradie, Maria Helena de Groot, Nicolien Schipaanboord, Jana Knot-Dickscheit, Hans Grietens and Erik J. Knorth

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Abstract

Purpose – The purpose of this paper is to describe the development and application of the KIPP-list of care activities. The acronym KIPP stands for Knowledge and Insight into Primary Processes. The instrument is intended as a tool for family coaches to systematically report care activities conducted in the Dutch family support programme *Ten for the Future* (in Dutch: *Tien voor Toekomst*).

Design/methodology/approach – The design of the instrument was based on the components of the programme and a literature search for similar instruments used in the Netherlands, complemented by a staff survey. A series of three studies was carried out to test the instrument's validity and user-friendliness, and to assess its potential for programme evaluation.

Findings – The majority of care activities were performed in cooperation with one or both parents alone, and less frequently with children or external professionals. Although the main focus of the work of the family coaches fell into the categories of "collecting information" and "working towards (behavioural) change" with families, the relatively high frequency of all the types of care contacts emphasises the intensity of this family support programme with a complex target group.

Originality/value – Data gathered with the instrument provided meaningful information by descriptive analysis. KIPP thereby proved its general feasibility in increasing insight into service provision. The instrument can be useful in several stages and on several levels of quality assurance and service optimisation, including reflective practice, supervision, team management and research.

Keywords Care activities, Family coaching, Family support, Primary care processes, Self-reports, Service use, Systems orientation, Vulnerable families

Paper type Research paper

Introduction

There is considerable demand for interventions proven as effective in child welfare (Axford and Morpeth, 2013; Carr, 2009). Evaluation studies are meant to provide knowledge about and insight into the effects and effectiveness of interventions, and they can do so via various research methods and with differing degrees of certainty (Veerman and Van Yperen, 2007). The focus of evaluation studies often lies on pre-post-test designs that compare the client's situation before the intervention to relevant outcomes after. While this method can provide valuable information at either time, the conclusions that can be drawn about possible connections between the intervention and the observed changes are limited if no comparison group is available or detailed data about the inner workings of the intervention is non-existent.

Group comparisons certainly have scientific value, such as that attributed to randomised control trials, but these are not always feasible in child and youth care (Otto *et al.*, 2009) and may have undesirable consequences when used for research into less controllable interventions like

family-oriented services (Boddy *et al.*, 2011) or those with complex target groups such as families with multiple problems (Devaney and Spratt, 2009).

Both the target group of families with multiple problems, as well as the provision of intensive long-term family support programmes for them, are issues of international interest. The need to specifically and adequately address this target group in child welfare has been articulated repeatedly in publications from various countries (e.g. Morris, 2013; Sousa and Eusébio, 2007; Spratt and Devaney, 2009) and descriptions of long-term family interventions that are geared to specifically address the problem have been widely reported (De Melo and Alarcão, 2011; Krasiejko, 2011; Marsh *et al.*, 2006; McCartt Hess *et al.*, 2000; Sousa and Rodrigues, 2012; Thoburn *et al.*, 2013).

For intensive home-based programmes that are accredited in the Dutch database of effective interventions (Netherlands Youth Institute, 2014), the following characteristics have been identified as common to best practice:

- parenting-related support in the family's home, with a contact frequency of at least once a week, aimed at multiple areas of life;
- establishment of a needs-led care plan, with participation and empowerment of the family members as guiding principles;
- a systemic focus on the family as a whole, and interventions driven by social learning theory to improve parenting skills, child behaviour and the involvement of social networks; and
- professional training and regularly performed supervision of care workers to enhance programme integrity and advance collaborative work (Van der Steege, 2007, p. 34).

The conclusions of a recent Dutch meta-analysis on programmes for families with multiple problems, conducted by Holwerda *et al.*'s (2014), support these findings. Additionally they mention two other important characteristics, namely, a relatively low caseload of five to ten families per full-time professional and the provision of material and financial support. The above components can be identified by compiling the features that are common in effective or promising programmes. However, despite this progress, a lack of structural, substantive information about direct activities in the primary care processes has been observed, a surprising omission given that most evaluation studies focus on the outcomes of services (Sinclair, 2010). For this reason, the primary care process has also been referred to before as a "black box" (Staff and Fein, 1994), and a need for more detailed scientific insight into it has been articulated, especially for home-based interventions such as family preservation services (Craig-van Grack, 1997).

Intensive family support is a somewhat unstructured form of social services, given that it is geared towards a relatively wide target group presenting a variety of problems (Morris, 2011). One example of such a service is the Salvation Army's home-based long-term care programme entitled Ten for the Future (TF) (in Dutch: *Tien voor Toekomst*), which is targeted towards families with multiple problems with children under the age of 18. This is a wide target group, not only because of variations in the ages of the children and parents, but also because of the high levels of diversity in family composition, differences in levels of child development, diverse cultural backgrounds and the number of areas in which the clients experience difficulties.

In the period 2006-2014 a research project was carried out at the University of Groningen in order to develop more knowledge about the characteristics of the target group and results of the services provided in TF, as well as to gain more detailed insight into the primary care processes intrinsic to the intervention. The research project was based on theoretical foundations about care arrangements for families with multiple problems (Tausendfreund *et al.*, 2012a, b), the characteristics of the target group, related client based outcomes (Tausendfreund, Knot-Dickscheit *et al.*, 2014) and the content of the intervention programme (the subject of this article). In TF, the primary process – the black box – is shaped by the contact between the family coaches (in Dutch: *gezinscoaches*) and the client's family. Gaining insight and knowledge about these processes through self-reported care activities would not only allow us to draw more rigorous inferences in

subsequent outcome studies but could also contribute to general knowledge about the provision of family support. To obtain structural information about the content of the TF intervention, an instrument was developed that enables the documentation of the primary process of services from self-reports by the family coaches. This produces the KIPP-list of care activities (KIPP stands for Knowledge and Insight into Primary Processes).

In this paper, we first explain what a list of care activities is and how the KIPP-list was developed. Second, we present results of the preliminary data we obtained using the list. The central research question of the study was as follows:

RQ1. What care activities do family coaches regularly report in delivering TF?

Method

Family coaches have unique and valuable information about the primary care they provide. This can be analysed by asking the family coaches to document the care activities they have performed in each of their client visits. An activity can be defined as follows: “a nameable set of coherent care activities worked out in concrete steps to form a time-limited intervention” (Ten Brink *et al.*, 1997, p. 5). In order to simplify the self-reported documentation of the care activities, a list (KIPP) was developed which was designed to be completed quickly – taking less than five minutes to fill up. Categorisation of care activities further provided a systematic way of data collection and minimised the need for lengthy journal documentation, as well as providing data for analysis. Thus, a comprehensive list of possible care activities was compiled for care professionals to use which, in addition, incorporated the specific tasks of family coaches.

Intervention

The intervention TF was developed by the Salvation Army of the Netherlands (in Dutch: Leger des Heils) in 1997 (Leger des Heils Noord, 2006), with the first team starting in 1999. The overarching goal of the programme is: “preserving the independence of the family system within generally accepted social limits” (Leger des Heils Noord, 2006, p. 11); an intervention goal which broadly resembles that associated with family preservation: namely the prevention of out-of-home placement while also entailing proximal and intermediate instrumental goals (Hurley *et al.*, 2012; Rosen and Proctor, 1981), such as the improvement of parenting skills and family functioning. Individual care goals are further specified for clients in relation to ten areas of life (see Table I).

The intensity of the intervention is expressed in terms of the number of hours of face-to-face contact per week, a level that is negotiated for each client individually between the Salvation Army (as care provider) and the respective financing agency. The underlying programme theory is eclectic and includes systems theory, learning theory, directive and contextual therapy

Table I Ten areas of life and corresponding goals of TF

<i>Areas of life</i>	<i>Intervention goals</i>
Housekeeping	Acquiring practical skills in housekeeping to self-sufficiently maintain a household
Administration and finances	Managing finances according to income
Care responsibility	Enhancing safety and wellbeing of the parent(s) as well as the children
Parenting	Enhancing parenting skills
Education	Creating learning environments for the parent(s) and the children
Daily activities	Parent(s) acquiring sufficient income
Mental health	Maintaining good health, including the management of possible addictions
Care management	Organising formal care arrangements if necessary
Social network	Maintaining a supportive social network
Behaviour management	Learning to live within socially acceptable boundaries

Source: Adapted and translated from Leger des Heils Noord (2006)

(Leger des Heils Noord, 2006, pp. 17-21). Family coaches working for TF are professionally trained child and youth care workers qualified at higher vocational levels, with additional training in Intensive Family Home Care (in Dutch: Intensieve Ambulante Gezinsbehandeling) – a systems-theory guided 12 day course spread over eight months focusing specifically on work with families presenting multiple problems.

Decision making on the eligibility of potential clients is the responsibility of one specific care worker in each province, referred to as intake manager. The criteria applied for programme admission were: the family must have a permanent address; at least one child under 18 years must be living in the family's home at admission; the client referred to the programme must display a need for support on at least four of the ten areas of life (see Table I.); there must be no direct threat to the safety of the family coach; and if severe mental health problems are present, a mental health care professional must be allocated to deal with these specialist needs. The specific care goals as well as care intensity in terms of the amount of face-to-face contact were negotiated between the intake manager and the funding agency, in agreement with the client, every six to 12 months for each family. The median duration of the intervention was found to be 15 months ($SD = 10.4$; range 3-47 months) for clients for whom care ended ($n = 67$) within the period of our outcome study (Tausendfreund *et al.*, 2014).

Instrument

The aim of this study was to develop and apply an empirically and theoretically sound list of care activities for the intervention TF. Before further research into the validity and reliability of the KIPP could be undertaken, it was important to ensure that the items on the list corresponded to services in practice and that the care activities were linked to theoretical concepts that inform intensive family support, specifically TF. In order to satisfy these demands, a literature study and a staff survey were conducted.

Reliability and validity of the KIPP. As the KIPP is an experimental self-report instrument, the main focus of the early stage of development was on enhancing its face and content validity. This meant we had to ensure that the items covered all the basic principles of the programme theory and that family coaches felt capable of communicating all core elements of their daily practice via the instrument.

We therefore studied TF's programme description (Leger des Heils Noord, 2006) and compiled literature on comparable instruments that had already been implemented in the Netherlands for either a similar target group or a similar type of intervention. Based on this literature study, a preliminary version of the KIPP was constructed and later refined through a staff survey (Conradie *et al.*, 2011). The staff survey involved attending team meetings and client visits as well as conducting semi-structured interviews with family coaches and team managers. In addition, selected digital and physical case files from TF were analysed and family coaches provided written feedback on the user friendliness of the instruments, so producing the version used in this study.

Detailed information on psychometric qualities is not yet available, which is a limitation common in other studies that utilise self-report instruments on activities performed in home-interventions (cf. Evenboer *et al.*, 2012; Ten Brink *et al.*, 2004).

Activities. A large portion of the activities that were included in this preliminary version came from existing lists of care activities designed for similar programmes (Berger, 2006; Bolt and Metselaar, 2005; Damen, 2007; Metselaar and Doornbos, 2006; Schaeffer-Van Leeuwen *et al.*, 2005; Ten Brink *et al.*, 1997). From this, 227 potentially useful care activities were compiled from which those likely to be best suited for TF were selected. In making this initial selection, care activities were eliminated if one of the following criteria applied (Damen, 2007):

- the activity does not fit within the range of services offered by TF (e.g. "medical assistance");
- the procedure is too general (e.g. "listening");
- the procedure is too specific (e.g. "asking the miracle question");

- the activity is a basic activity (e.g. “being kind and tolerant”); and
- the activity is a means (e.g. “address, compel to consider” is a part of the activity “provide feedback”).

After the first selection, 129 care activities remained, several of which were duplicates or largely comparable activities. A second selection round was therefore held using two additional criteria for exclusion:

1. the activity is identical to another more well-defined and operationalised activity on the list; and
2. the procedure is part of one of the other selected activities.

After the two initial selection rounds, 46 care activities remained that were judged as suitable candidates for describing the primary care processes in TF. Additionally four other care activities were added or substantially reformulated in order to provide a better fit between the activities on the KIPP and the services offered through TF, namely:

1. paying attention to mental and/or addiction problems;
2. stimulating or providing education;
3. activating housekeeping skills; and
4. assistance with record-keeping and financial management.

Categorisation. The 50 selected care activities were then divided thematically into five categories. The rationale behind this division was: first, those that enhance orientation and thereby the clarity of the items in the list. Second, those that aid the differentiation of care activities in that they target the same area of life but in different ways. Third, were categories that provide theoretical grounds for general statements about different types of activities. Furthermore, an option to add additional activities to each category was provided. As a result of all these considerations, the number of activities on the final KIPP-list of activities was thereby increased to 55 (cf. Appendix 1).

The five-fold categorical division eventually used was adapted from the *Verrichtingenlijst Intensieve Gezinsbegeleiding* (List of Activities for Intensive Family Counselling) (Bolt and Metselaar, 2005) and included:

Establishing and maintaining a working relationship. This category involves care activities that contribute to a positive working relationship between the family coach and the family. The development of a good relationship and trust has been shown to enhance the effectiveness of the services (Mason, 2012). Of all 55 care activities, 13 per cent ($n = 7$) were grouped in this category.

Collecting information. This category involves activities that gather information about the family, the problems they experience and the goals they wish to achieve. Because the work of family coaches is needs-led (Metselaar *et al.*, 2007), it is important to involve the family directly in formulating care goals (Van Yperen *et al.*, 2006). This is necessary to match the problem, the need for care and the establishment of the intervention goals. Of all 55 care activities, 35 per cent ($n = 19$) were grouped in this category.

Working towards change (including change in behaviour). The care activities in this category have the objective of realising change. In TF this can be achieved by various means linked to theories on systems theory, learning theory, directive and contextual therapy (Leger des Heils Noord, 2006, pp. 17-21). Of all 55 care activities, 33 per cent ($n = 18$) were grouped in this category.

Finding solutions and support in the environment. An important characteristic of TF is that services are integrated, combining elements of home care, youth services and other forms of organising support, to address both socioeconomic and psychosocial problems (Ghesquière, 1993). This necessitates maintaining contact with the various institutions involved with the family, as well as with the family's own social network (Sousa and Rodrigues, 2009). Of all 55 care activities, 9 per cent ($n = 5$) were grouped in this category.

Easing the burden of tasks. Given that the target group for TF is characterised by a chronic and complex set of problems, it is often difficult for the families to address the large number of problems that they are experiencing. As part of the service, therefore, the family coach can play a practical role, partially taking over tasks or care activities until the family is able to manage them on their own (Dallos and Hamilton-Brown, 2000). Of all 55 care activities, 11 per cent ($n = 6$) were grouped in this category.

Additional information. In addition to coding care activities, we included the following information as relevant to the care activity: the type of contact (face-to-face, phone or e-mail), the clients involved (children, parents, other relatives, professionals) and the date and duration of the intervention. A maximum of six unique care activities could be coded via KIPP in each case.

Finally a manual was compiled that provided codes for the care activities that could be incorporated into the report form completed by the family coaches (cf. Appendix 1) and for those care activities that required clearer definition (cf. example given in Appendix 2).

Our first draft was presented to family coaches, team leaders and managers and further adjusted on the basis of their feedback. An additional questionnaire was used after the first wave of data collection (T1) to assess the manual's user friendliness and to identify if changes were needed. For the second wave of data collection (T2), an additional specification was added: the phase in the care process the client is in (start, main phase, end, aftercare). At a later stage a digitalised version in form of a MS Excel sheet was used to better streamline data collection with the workflow of the family coaches (cf. Appendix 3).

Design

Three waves of data collection (T1, T2, T3) using KIPP were conducted over a time period of 22 months (T1 in April 2010, T2 in February 2011, T3 in February 2012) in the three Northern Provinces of the Netherlands (Friesland, Groningen, Drenthe). Each collection took ten weeks. After each exercise, results were presented to the team management, but maintaining the anonymity of the family coaches and clients.

Sample

Over the course of ten weeks, a total of 2,562 care activities were reported for 665 contacts with 188 clients from 50 family coaches. We excluded contacts for which more than six activities were scored on the Excel version of the KIPP-list used in the third wave of data collection (T3), because this deviated from instructions and would have had the effect of skewing comparisons because of difference in data range compared with the paper version used in the earlier exercises (T1 and T2). The number of contacts that were excluded for this reason was relatively small ($n = 16$).

The clients and coaches included in each of the three data sets were not exclusive because they could participate in more than one sample wave depending on the length of their involvement and staffing arrangements. The characteristics of the samples for each wave are presented in Table II.

Table II Sample composition in the three waves of data collection within TF

Characteristic	T1	T2	T3	Total
Duration, in weeks	2	4	4	10
Family coaches	19	9	22	50
Clients	76	30	82	188
Contacts	196	145	324	665
Care activities	855	613	1,094	2,562

Notes: T1 and T3 were implemented in three teams of approximately 50 family coaches. Data collection at the second wave (T2) was limited to one of the three provinces with 12 coaches working in the province at that time

Analysis

Descriptive statistics were used to explore characteristics of contacts and care activities in terms of proportions, means, range and standard deviations. In our results we distinguish: type of contact, persons involved in the care activity, care phases, categories of care activities and the most frequently used interventions.

Results

Type of contact

Clients in our sample had on average weekly face-to-face contact with their family coaches (see Table III). The duration of home visits was found in all the surveys to be longer than two-hours. The shortest visit lasted ten minutes, and the longest lasted eight hours. Telephone contacts were reported in the first (T1) and third wave (T3), with a total of 12 and 50 telephone contacts that lasted on average 47 minutes ($SD = 42.7$; 2-120) and 36 minutes ($SD = 28.3$; 5-135), respectively.

Client involvement

For 423 face-to-face contacts, the person or people to whom the activity was directed was recorded for T1 and T3 (see Table IV). In the majority of cases (65 per cent, $n = 1,048$) this was with one of the parents alone, with a similar ratio found for telephone contacts ($n = 62$). Of the 139 care activities scored in T1 and T3 as telephone contacts, 63 per cent ($n = 87$) were conducted with one or both parents alone, and 29 per cent ($n = 41$) with an external professional alone.

Table III Caseload and face-to-face contact characteristics in TF

Workload	T1 ^a			T2 ^b			T3 ^d		
	M	SD	Range	M	SD	Range	M	SD	Range
Clients reported per coach	4	1.5	2-6	3.3	1.6	1-6	3.7	1.8	1-7
Average contacts per client, per week	1.2	0.6	0.5-2.5	1.2	0.6	0.3-2.5	0.8	0.4	0.3-1.8
Contact duration, in minutes	156	73.5	10-480	— ^c	—	—	127	48.6	15-328
Care activities per contact	4.5	1.5	1-6	4.6	1.5	1-6	3.8	1.4	1-6

Notes: Only for face-to-face contacts reported in this table. *M*, mean; *SD*, standard deviation; range, minimum-maximum. ^aFace-to-face contacts T1: $n = 179$; ^bface-to-face contacts T2: $n = 145$; ^cface-to-face contacts T3: $n = 244$; ^ddata on contact duration were missing for T2

Table IV Person or people with whom the care activities were performed in face-to-face contacts in TF

Activity performed with	T1		T2 ^a		T3		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
One or both parents	479	67	—	—	569	63	1,048	65
One or both parents and one or more children	100	14	—	—	170	19	270	17
Family member and external party	62	9	—	—	103	11	165	10
One or more children	43	6	—	—	33	4	76	5
External party without family member	33	5	—	—	29	3	62	4
Total ^b	717	100	—	—	904	100	1,621	100

Notes: ^aData on client involvement were not reported for the second wave; ^bsum of the percentages in the column add up to 101, 99 and 101 per cent, respectively, due to rounding of final numbers

Care phases

Information about the phase of care was added to the KIPP from the second wave onwards (T2-T3). The data indicated that most of the families (80 per cent, $n = 24$) were in the core phase of care. In the third wave (T3), the majority of contacts (83 per cent, $n = 269$) also fell within this phase, with 11 per cent ($n = 35$) of the contacts in the start phase and 3 per cent ($n = 11$) in the end phase of care.

Theoretical categories

The division of the care activities into categories allows for more general statements regarding the content of the intervention. Table V provides an overview of the absolute and relative proportions for each category in which care activities were performed. The name of each category indicates the goal of the care activities therein.

Care activities belonging to the first three categories, "collecting information", "working towards change (including change in behaviour)" and "establishing and maintaining a working relationship", are the ones most frequently used. "Easing the burden of tasks", which accounts for 13 per cent of the total care activities performed, plays a smaller but still recognisable role. The least utilised category is "finding solutions and support in the environment". Nevertheless, 10 per cent of the care activities that were performed belonged to this category.

Individual activities

The most detailed insight into the primary service process is obtained by analysing the care activities performed at the level of the individual activity. It can be assumed that if certain care activities are carried out frequently, they are likely to play a more central role in the primary care process. Table VI provides an overview of the most frequently performed care activities. These 11 care activities were selected because they amount to more than half of the total number of care activities recorded in each wave and add up to more than 50 per cent of all care activities reported in the three periods of data collection.

In addition to the frequently performed care activities listed above, several care activities were seldom performed. With the exception of the activities "network analysis" ($n = 4$), "competence analysis" ($n = 3$), "debriefing questionnaires" ($n = 3$) and "aftercare" ($n = 3$), all of the care activities were performed overall more than five times. Thereby all of the codes proved potential usability for a list of care activities in TF.

Discussion and conclusions

According to self-reports by family coaches, the majority of care activities were performed in cooperation with one or both parents alone (more than 60 per cent in both waves that recorded client involvement). Although it was expected that the parents would play a central role in the services, the share of care activities reported as performed in direct contact with children (5 per cent) or other external agencies (4 per cent) seems comparatively small. This collaboration,

Table V Frequency and distribution of activities performed in TF, by category

Category	T1		T2		T3		Total	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Collecting information	222	26	191	31	339	31	752	30
Working towards change (including behaviour change)	215	25	151	24	356	33	722	28
Establishing and maintaining a working relationship	189	22	129	21	195	18	513	20
Finding solutions and support in the environment	96	11	71	12	82	7	249	10
Easing the burden of tasks	133	15	71	12	122	11	326	13
Total	855	100 ^a	613	100	1,094	100	2,562	100 ^a

Notes: Including telephone contacts. ^aSum of the percentages in the column add up to 99 and 101 per cent, respectively, due to rounding of final numbers

Table VI The 11 most frequently performed care activities in TF

Code: Activity	T1 ^a		T2 ^b		T3 ^c		Total ^d	
	n	%	n	%	n	%	n	%
C1: Discussing a specific situation or problem in the family	58	6.8	35	5.7	100	9.1	193	7.5
A3: Providing emotional support	53	6.2	37	6.0	65	5.9	155	6.0
A2: Blending in	57	6.7	36	5.9	41	3.7	134	5.2
E4: Coordinating with external professionals	50	5.8	23	3.8	57	5.2	130	5.1
B9: Information through conversations	8	0.9	29	4.7	75	6.9	112	4.4
E2: Assistance with record-keeping and financial management	36	4.2	35	5.7	41	3.7	112	4.4
D2: Support in contacting authorities	43	5.0	33	5.4	29	2.7	105	4.1
B1: Discussing the needs of the family	31	3.6	29	4.7	37	3.4	97	3.8
B11: Discussing problems ... between family members	35	4.1	13	2.1	43	3.9	91	3.6
B3: Discussing strengths in and around the family	32	3.7	23	3.8	32	2.9	87	3.4
D3: Accompanying client to agencies	29	3.4	24	3.9	33	3.0	86	3.4
Total	432	50.5	317	51.7	553	50.5	1,302	50.8

Notes: Cut off point for inclusion of care activities in the table was reaching a frequency of ≥ 50 per cent of all care activities performed in total ($n = 2,562$). ^a $n = 855$; ^b $n = 613$; ^c $n = 1,094$; ^d $n = 2,562$

however, does not solely depend upon choices made by the family coach but is also determined by the characteristics of the clients (e.g. very young children, objectives of the referral agency (e.g. a focus on changing parent behaviour) and the preferences of individual family members. Nevertheless, the systems orientation of the services seems to be jeopardised by the large share of care activities that are carried out in cooperation with one or both parents alone (Tausendfreund *et al.*, 2014).

The study also provided information about the categories to which the care activities belong. While it can be concluded that care activities from each of the categories were used, family coaches were largely concerned with “collecting information” and “working towards change (including behavioural change)”. Fewer activities were reported for the category “establishing and maintaining working relationships”. But the fact that only a small proportion of clients’ care was found to be in the starting phase of the programme puts this into context, given the relatively long programme duration (Tausendfreund *et al.*, 2014). As the majority of data stemmed from the main phase, it is not surprising that there is a lower direct emphasis on relational aspects. Nevertheless, the prominent share of the category “collecting information” is striking and illustrates the extent to which continual needs and goal assessment is part of a monthly routine in a family-oriented, home-based intervention for families with multiple problems.

Care activities aiming at “easing the burden of tasks” and “finding solutions and support in the environment” played only a limited role in the overall range of interventions. However, individual care activities, such as “coordination with external professionals” or “support in contacting authorities”, were still found among the most frequently performed actions which less significance for this category, yet also indicates the important contribution of some of these activities to the overall package of service provision. That activities were reported as seldom performed, such as “network analysis” ($n = 4$), “competence analysis” ($n = 3$), “debriefing questionnaires” ($n = 3$), and “aftercare” ($n = 3$), might suggest a marginal role, but equally may reflect limits of our study design. Care activities that have a frequency of occurrence of lower than once per month have a smaller chance of being reported in questionnaires completed annually. In the case of network analysis, earlier findings of this study (such as the strong emphasis on direct contact with the parents) further underline the need for re-assessing the relevancy of a systems orientation in practice.

Strengths and limitations

This study has several strengths. First of all, there is a dearth of research into the details of primary care processes in home-based interventions for families with multiple problems

(Evenboer *et al.*, 2012). In that way, our approach of measuring intervention activities might be deemed unique.

The interpretation of data gathered with the instrument also provided meaningful information, albeit at a descriptive level, and thereby proved its feasibility as a method of increasing insight into the “black box” of service provision. Ultimately, this opens up new opportunities for evaluation research by systematically adding information about the “throughput” into input-output-oriented designs.

Furthermore, the data gathered with the instrument can be useful at all stages for determining quality assurance and service optimisation. It offers family coaches guidance by routinely adding a moment of systematic reflection on the activities they perform, it can potentially aid communication in supervision and review and can provide information that is potentially valuable for decision-making at a team level.

This study also has several limitations. The first methodological constraint arises from the scope of the study. Although a wealth of data were gathered, the study was limited in terms of time, participating family coaches and their clients. Nevertheless, the work of 50 family coaches was monitored, referring to more than 650 client contacts and including over 2,500 care activities.

A second limitation is related to reliability, validity and acceptability of the instrument. Family coaches spent a significant amount of their time with routine administration. Asking for additional reports on routine task performance adds to this. We designed the instrument with this in mind, yet it is of primary importance to ensure acceptability by giving coaches incentives which they perceive as valuable for their work. Possibilities of streamlining the instrument with existing routine administration should be explored as well as the provision of easy to access case summaries for family coaches. Up until now the KIPP has been used in TF in addition to routine administration. In the future, it could be merged into day-to-day record keeping, providing data for routine outcome measurement and the monitoring programme integrity. Indeed, integrity can be maintained by virtue of the fact that KIPP gives the family coaches a concise toolkit for reaching care goals. The KIPP-list can therefore not only serve as an instrument through which care activities are registered retrospectively, but also as a guide for day-to-day practice, as well as a refined description of the programme for inclusion in the Dutch databank for effective interventions (Netherlands Youth Institute, 2014).

Furthermore, it would have been desirable to train the family coaches more extensively in working with the list of care activities, to further enhance reliability. Despite the fact that the manual accompanying the list of care activities attempts to operationalise the care activities as objectively as possible through nomenclature, description, explanation and possible methods, some degree of subjectivity and interpretation in scoring is inevitable. However, a lack of psychometric data are common among studies that utilise self-reports instruments to record care activities (see 2.2.1). Two considerations are important in this regard. First, the yet unresolved issue about the psychometric qualities of these self-report instruments should be weighed against alternative research methods that provide insight into the primary care process, such as observational methods. The main advantage of the self-report instruments is that they can be implemented on a broad scale and be conducted repeatedly, providing a more general overview of all the care activities that are carried out. Studies of the family preservation programme Families First have demonstrated that the information gathered from self-report instruments can be used for meaningful interpretations of outcomes measured with standardised instruments, provide the methodological restraints are carefully considered (Veerman *et al.*, 2003). Further research on psychometric properties of the instrument is warranted, especially the inter-rater consistency through, for example, complementary observations.

In conclusion

Data gathered with the instrument provided meaningful information. KIPP thereby proved its general feasibility in increasing insight into service provision. The instrument can be useful at several stages and on several levels of quality assurance and service optimisation, including reflective practice, supervision and team management.

Implications for policy and practice

- The interpretation of data gathered with the KIPP instrument provided meaningful information about the “black box” processes intrinsic to service provision. This opens up new opportunities for evaluation research by systematically adding information about the “throughput” into input-output study designs.
- Data gathered with the instrument can be useful at all stages of service delivery and on several levels of quality assurance and service optimisation. It offers care workers guidance by routinely providing an opportunity for systematic reflection on the care activities they perform. It can also aid communication and help in supervision by providing case-based data and can produce information that is valuable for decision-making, especially at team level.
- In this study, results produced by applying the instrument underlined the need for re-assessing the relevance of a systems orientation in home-based family support. Furthermore, they suggest that in some services for families with multiple problems, children are directly involved in care activities less often than adults, and this deficiency needs to be met if services are to improve.

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(The Appendix follows overteaf.)

Appendix 1

Table A1 Overview of activities in 10 for the future

A:	<i>Establishing and maintaining a working relationship</i>
A1	Introductions
A2	Blending in
A3	Providing emotional support
A4	Communication or feedback about the cooperation in care
A5	Conflict management
A6	Increasing motivation
A7	Other (please specify)
B:	<i>Collecting information</i>
B1	Discussing the needs of the family
B2	Discussing the family's perception of possible solutions
B3	Discussing strengths in and around the family
B4	Setting goals with the family
B5	Evaluating/adjusting goals and goal attainment process
B6	Setting points to be addressed with the family
B7	Evaluating/adjusting working points to be addressed
B8	Gathering information through observation (including participation)
B9	Information through conversations
B10	Working with observation and (homework) assignments
B11	Discussing problems in the communication and interaction between family members
B12	Competence analysis
B13	Network analysis
B14	Analysis of safety
B15	Analysis of leisure activities
B16	Analysis of functioning at school
B17	Introducing and administering questionnaires
B18	Debriefing questionnaires
B19	Other (please specify)
C:	<i>Working towards change (including change in behaviour)</i>
C1	Discussing a specific situation or problem in the family
C2	Describing a problem in terms of observable behaviour
C3	Instructions and suggestions for changing behaviour
C4	Behaviour exercises
C5	Providing feedback on behaviour
C6	Discussing and practising a daily routine and the day-to-day functioning of the family
C7	Activating housekeeping skills
C8	Practising communication and interaction in the family
C9	Working on skills for coping with cognition and emotions
C10	Working on authority relationships in the family
C11	Working on the cooperation between parents/guardians
C12	Providing information about and practising parenting skills
C13	Interventions concerning leisure activities
C14	Paying attention to mental and/or addiction problems
C15	Providing therapeutic materials
C16	Stimulating or providing education
C17	Aftercare
C18	Other (please specify)
D:	<i>Finding solutions and support in the environment</i>
D1	Mobilising social support and building a social network
D2	Support in contacting authorities
D3	Accompanying client to agencies
D4	Referring to services or service agencies
D5	Other (please specify)
E:	<i>Easing the burden of tasks</i>
E1	Support in housekeeping
E2	Assistance with record-keeping and financial management
E3	Finding alternative housing for family member in crisis
E4	Coordinating with external professionals
E5	Organising care
E6	Other (please specify)

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