Fidelity and flexibility of care activities in child-centered youth care for children growing up in families experiencing complex and multiple problems

van Assen, Arjen; Knot-Dickscheit, Jana; Grietens, Hans; Post, Wendy

Published in:
Children and Youth Services Review

DOI:
10.1016/j.childyouth.2021.105923

Publication date:
2021

Children and Youth Services Review 123 (2021) 105923

Contents lists available at ScienceDirect

Children and Youth Services Review

journal homepage: www.elsevier.com/locate/childyouth

Fidelity and flexibility of care activities in child-centered youth care for children growing up in families experiencing complex and multiple problems

Arjen van Assen [a,*], Jana Knot-Dickscheit [a], Hans Grietens [b], Wendy Post [a]

[a] University of Groningen, the Netherlands
[b] KU Leuven, Belgium

ARTICLE INFO

Keywords:
Child-centered care
Home-based care
Integrated services
Multi-problem families
Flexible care
Treatment fidelity

ABSTRACT

Researchers, practitioners, and policymakers in the field of child and family welfare have emphasized the need for child-centered services for children growing up in families experiencing complex and multiple problems (FECMP). However, the provision of evidence-based services for these children requires knowledge of the care activities of these services. The aim of this study was to investigate care activities and considerations related to the care provision of child-centered care for children growing up in FECMP. To study these care activities and considerations we investigated the care process of a program called Child and Youth Coaching. Hybrid coding was used to identify and compare care activities from multiple sources. In the first phase of analysis a coding scheme of care activities was derived from the program manual. Secondly, these care activities were identified from practice using daily care reports, intake forms, and interviews with coaches and the developers of the intervention. During this stage additional care activities were identified from practice. All care activities were compared across sources to assess whether care provision in practice adhered to the program manual (fidelity), and to investigate whether care provision varied across cases (flexibility). Furthermore, considerations that played a role in care provision were identified (considerations). The results showed treatment fidelity for most care activities. However, some treatment standards were only broadly defined in the program manual. Flexibility in treatment was mainly observed in the adaptation of problem assessment to the capabilities and interests of the child. Overall, Child and Youth Coaching promoted child participation by focusing on children's perspectives in problem assessment, setting care goals, and determining care activities. However, several barriers to child participation were identified such as non-disclosure about the family situation, young age, and a lack of motivation. Although children experiencing these barriers to participation need additional attention in future intervention development and research, we conclude Child and Youth Coaching is a promising program in promoting the participation and wellbeing of children growing up in FECMP.

1. Introduction

1.1. Innovative services for children growing up in families experiencing complex and multiple problems

Families experiencing complex and multiple problems (FECMP) are characterized by an accumulation of interrelated problems in multiple areas of life (Ghesquière, 1993; Knot-Dickscheit & Knorth, 2019; Tausendfreund, Knot-Dickscheit, Schulze, Knorth, & Grietens, 2016). Due to the complexity of the problems these families experience, traditional social services are often ineffective in improving their wellbeing (Baartman, 2019; Van Assen, Knot-Dickscheit, Post, & Grietens, 2020). Although family-focused home-based programs have been developed to meet the complex needs of FECMP, children growing up in these families often still show considerable problems after care has ended (Van Assen et al., 2020). Several studies have found that care professionals often fail to engage and motivate families (Schout, De Jong, & Zeelen, 2011), effectively coordinate care across services (Joosse, Teisman, Verschoor, & Van Buuren, 2019), and involve children with services (Alberth & Bühler-Niederberger, 2015; Dutch Inspectorate of Youth Care, 2016). As traditional social services are often unable to arrange suitable care for children growing up in FECMP, innovative approaches are needed to

* Corresponding author.
E-mail address: a.g.van.assen@rug.nl (A. van Assen).

https://doi.org/10.1016/j.childyouth.2021.105923
Received 30 August 2020; Received in revised form 21 December 2020; Accepted 31 December 2020
Available online 5 January 2021

meet the needs of these children. Huang and Han (2019) state that "*Social innovation refers to a specific type of idea or practice that addresses a defined need such as income inequality, education disparities, and access to healthcare in a creative, resourceful, and sustainable manner. It represents a departure from traditional social services by transcending antiquated and often rigid systems of care*" (p. 173). In this study, the care process of Child and Youth Coaching - an innovative child-centered approach for children growing up in FECMP - is investigated.

1.2. Home-visiting programs for families experiencing complex and multiple problems

Family-focused home-visiting programs are often used to provide support in multiple areas of life for FECMP. Evaluation studies of these programs have shown mixed results. Most notably home-visiting programs for FECMP have been criticized for their inability to prevent out-of-home placement (Al et al., 2012; Department of Health and Human Services, 2001; Van Assen et al., 2020). Although several studies show a decrease in children's emotional and behavioral problems, children still experience considerable problems at case closure (Al et al., 2012; Van Assen, Knot-Dickscheit, Post, & Grietens, 2019a; Van Assen et al., 2020; Veerman, Janssens, & Delicat, 2005).

Several studies have suggested that the limited improvement of children participating in home-visiting programs may be due to a lack of participation of children in the care process. One of the main characteristics of home-visiting programs is the use of a system-focused approach. However, Busschers and Boendermaker (2015) state that care workers experience considerable challenges in involving all family members in the care process. In line with these findings, Tausendfreund et al. (2015) found that in a Dutch home-visiting program care workers only rarely worked directly with children and focused mostly on the parents. In the context of child protection and family support services several authors have suggested that a more child-centered approach is needed (Alberth & Bühler-Niederberger, 2015; Dutch Inspectorate of Youth Care, 2016; Munro, 2011; Tausendfreund, 2015; Van Assen, Knot-Dickscheit, Post, & Grietens, 2019b). A study by Thoburn, Cooper, Brandon, and Connolly (2013) showed that the use of a dual care worker approach (i.e. simultaneous services by a child-focused and family-focused care worker) was related to positive change in families. In the Netherlands, the Salvation Army has started with a dual care worker approach combining Child and Youth Coaching with family-focused care (Salvation Army, 2019).[1]

1.3. Child and Youth Coaching

Child and Youth Coaching is a child-centered program for children growing up in FECMP. Coaches support children by discussing their perspective on their life situation and working towards care goals using behavioral techniques, social skills training, and skills practice in real life situations. Care is provided using a dual care worker approach. This approach implies that children receive child-centered services from the Child and Youth Coaching program whilst simultaneously parents receive family-focused services from the Ten for the Future program (for a description of the family-focused services see Tausendfreund, 2015; Tausendfreund & Van Driel, 2019). Care goals of Child and Youth Coaching are centered around seven themes 1) self-image and self-confidence, 2) emotions, 3) social skills, 4) anxiety, 5) bullying, 6) mourning and loss, and 7) physical development and wellbeing. Coaches combine supporting activities (e.g. sports, crafts) with care activities focused on the care goals of the child. An elaborate description of Child and Youth Coaching is provided by Van Assen et al. (2019b).

1.4. Identifying care activities

Within the field of child and family support there is a growing consensus that services for families and children should be evidence-based. Several studies have emphasized that in order to have evidence-based services, researchers should not only investigate "*what works*", but also "*why something works, for whom and under what circumstances*" (Flay et al., 2005; Veerman & van Yperen, 2007). This requires that "*the essential elements of the intervention (*e.g.*, goals, target group, methods and activities, requirements) have been made explicit*" (Veerman & van Yperen, 2007, p. 216). By describing essential program elements in detail, mechanisms of effective programs can be identified, replicated, and disseminated (Flay et al., 2005). However, the majority of program evaluations in youth care - especially those investigating home-based programs - focus on program outcomes (Craig-Van Grack, 1997; Van Assen et al., 2020). In many cases there is a lack of substantive information about the essential elements of programs such as the care activities that make up the primary care process. Therefore, some authors have characterized the primary care process as a "black box" (Fein & Staff, 1994).

Describing care activities of programs is especially challenging in the case of FECMP (Boddy, Smith, & Statham, 2011; Ghesquière, 1993; Holwerda, Reijneveld, & Jansen, 2014; Tausendfreund et al., 2015). As the problems these families experience are complex and dynamic, care services are often characterized by a personalized and flexible approach (Dutch Ministry for Justice and Security, 2019; Tausendfreund et al., 2016; Thoburn et al., 2013). This complicates the identification of standardized care activities and the development of guidelines that apply to all families and children taking part in a program. However, a personalized and flexible approach to care has been identified by parents as one of the most valued characteristics of family-focused home-based care (Dutch Ministry for Justice and Security, 2019). This implies that programs for FECMP do not only require a detailed description of standardized care activities, but also flexibility in care provision. The need for a flexible and personalized approach implies there is a risk involved in solely emphasizing the use standardized care activities and outcomes within the evidence-based framework. Boddy et al. (2011) have suggested that such an emphasis may lead to the prioritization of standardized programs over more individualized approaches. In the context of FECMP, several studies have suggested that by emphasizing on standardization the complexity of these cases could be ignored (Joosse et al., 2019; Tausendfreund, 2015; Van Den Berg, Van Der Goot, & Jansen, 2008).

It should be noted that evidence-based practice usually is not regarded as the straightforward application of standardized care elements derived from research. Evidence-based practice is usually viewed as a joined process where scientific evidence is used to shape practice taking into account client perspectives and clinical expertise of care workers (Gilgun, 2005; McNeece & Thyer, 2004; Thyer & Pignotti, 2011). This implies that the identification of standardized program elements is still valuable, but should be placed within a dynamic context where care professionals make decisions to tailor services to the needs of clients. In this study we aimed to do this by using a flexibility within fidelity framework (Kendall & Beidas, 2007; Kendall, Gosch, Furr, & Sood, 2008).

1.5. Flexibility within fidelity

In an attempt to bridge the gap between research and practice, several authors have proposed the use of a flexibility within fidelity framework (Kendall & Beidas, 2007; Kendall et al., 2008). Kendall and Beidas (2007) state that "*There can and should be an overarching structure, but the service provider is also permitted flexibility in the fulfilling of the main*

[1] The Salvation Army of the Netherlands provides a wide range of services including family-focused ambulatory support services (Ten for the Future), Child and Youth-Coaching, foster care, residential care, reunification programs and custody and rehabilitation services. See Van Assen et al. (2019) for an elaborate description of the program.

Table 1
Case Characteristics and Questionnaire Scores of Cases.

Alias	Age	Gender	SDQ	QPS	BIC-Q	Case closure
David	9	Boy	25 (clinical)	103 (poor)	46 (sufficient)	Goals partly achieved, transfer to specialized services
Ruth	15	Girl	18 (clinical)	123 (average)	43 (sufficient)	Successful, goals achieved
Thomas	12	Boy	9 (no problems)	125 (average)	38 (sufficient)	Successful, goals achieved
Kees	10	Boy	22 (clinical)	100 (poor)	26 (insufficient)	Out-of-home placement
Nathalie	6	Girl	15 (subclinical)	120 (Average)	30 (insufficient)	Successful, goals achieved
Sharona	7	Girl	10 (no problems)	114 (poor)	39 (sufficient)	Successful, goals achieved

goals of the treatment program" (p. 17). Within this framework, the concept of treatment fidelity refers to whether a program is implemented as intended (Goense, Boendermaker, van Yperen, Stams, & van Laar, 2015). Flexibility refers to the tailoring of a program to the personal needs of a client within the boundaries of fidelity (Kendall & Beidas, 2007). The principle of the flexibility within fidelity refers to the idea that the basic elements of a program are specified to promote fidelity and the use of scientifically validated intervention approaches. However, care activities are not used in a rigid and standardized way, but care workers are flexible in their application of program elements in practice. This allows care workers to use their clinical expertise and tailor services to the needs of their clients (Kendall & Beidas, 2007; Kendall et al., 2008).

1.6. Taxonomy of care activities

In their framework for evidence-based youth care, Veerman and van Yperen (2007) use the term *essential intervention elements* to denote aspects of the program that should be specified for the program to be considered as potentially effective. Examples of these elements are *care goals, target group characteristics, techniques, activities* and *requirements*. As this study is focused on flexibility and fidelity in care provision in the Child and Youth Coaching program, the analysis is focused on care activities of child and youth coaches. Care activities are the actions of care professional that make up the content of the program. These activities are distinct techniques (e.g. modeling, social skills training) used by practitioners to achieve the desired outcomes (Visscher et al., 2018). To guide the identification of care activities we used the Taxonomy of Interventions for Families with Multiple Problems (TIFMP) (Visscher et al., 2020, 2018, 2020). This taxonomy contains care activities of eight programs for FECMP and severe parenting problems that showed positive results in evaluation studies.

1.7. Aim and research question

The aim of this study is to assess the fidelity and flexibility of care activities of the Child and Youth Coaching program, and identify considerations that played a role in shaping practice. The central research questions of this study are:

1. How are care activities described in the program manual of Child and Youth Coaching reported in practice? (*Fidelity)*
2. How do reported care activities of Child and Youth Coaching vary across cases? (*Flexibility)*
3. Which considerations play a role in shaping the care process of Child and Youth Coaching? (*Considerations*)

2. Method

2.1. Design

A qualitative research design with multiple sources was used to identify the care activities of the Child and Youth Coaching program. An initial coding scheme was devised based on the TIFMP (Visscher et al., 2018). Care activities were first identified from the program manual and subsequently from multiple sources describing the intervention practice (interviews, intake forms and care reports). Activities identified from the program manual and practice were compared to assess fidelity and flexibility. Furthermore, considerations in care provision were identified.

2.2. Participants

We analyzed the intake forms of 39 children that were included in a comprehensive evaluation of the Child and Youth Coaching program. These children were included through regular admission procedures between June 2016 and December 2019.[2] From this group, 379 daily care reports of six cases were analyzed to identify care activities from practice. These cases were selected to be heterogeneous based on their scores on questionnaires regarding emotional and behavioral problems (Strengths and Difficulties Questionnaire; Van Widenfelt, Goedhart, Treffers, & Goodman, 2003), Psychosocial Skills (Questionnaire Psychosocial Skills; Van der Ploeg & Scholte, 2013), and quality of the pedagogical environment (Best Interest of the Child Questionnaire; Zijlstra, Kalverboer, Post, Knorth, & Ten Brummelaar, 2012). To assess the representativeness of the cases included in our study we have compared their demographics with the larger sample of children participating in the comprehensive evaluation study. With regards to age at the start of the program (m = 9.8, range 6–15) the cases were comparable to the sample of our comprehensive evaluation (m = 10.9 range 4–17). Furthermore, the cases in this study were comparable with regard to gender (50% boys vs. 52% boys). Demographic characteristics of the cases included in our study are shown in Table 1. Furthermore, scores and classifications on all three questionnaires and reasons for case closure are included in the table for each case.

Finally, we conducted six interviews to identify activities and considerations with regard to care provision from the perspective of the professionals. Two developers of the program and four coaches were interviewed. The first program developer worked as a coordinator and trainer for the Child and Youth Coaching program. The second program developer was the supervising behavioral specialist. These respondents were selected due to their central role in the development of the program. The four coaches were selected to be heterogeneous in terms of their experience as a coach. Two coaches had less than two years of experience and two had more than five years of experience.

2.3. Instruments

To identify care activities from the program manual the original draft of the manual (Salvation Army, 2015) and a revised version (Salvation Army, 2019) were used. Multiple sources were used to identify care activities in practice from multiple perspectives and avoid reporting bias

[2] The comprehensive evaluation consisted of three groups: a group admitted through regular procedures (indicated Child and Youth Coaching), a group not admitted through regular procedures receiving additional Child and Youth Coaching services (non-indicated Child and Youth Coaching) and a group receiving only family-focused care (control). As our aim is to investigate care activities for the indicated target group, only children in the first group are included in this study.

related to the use of a specific source (e.g. activities not reported in care reports). These data were collected as part of a comprehensive evaluation study on the effects of Child and Youth Coaching (Van Assen, Post, Knot-Dickscheit, & Grietens, 2021). An overview of the sources used in this study is provided in Table 2.

Table 2
Sources used to identify Care Activities.

Source	Description
Manual	The program manual of Child and Youth Coaching (Salvation Army, 2015/2019) includes a description of the aim of the program, a theoretical framework, inclusion criteria, main themes, the care process, care materials (e.g. worksheets), organization, and required care worker attitudes and competences.
Intake form	The intake form (Salvation Army, 2016) is used during the first session and contains information on the child's care history, needs, goals, and strengths. Furthermore, the intake includes a first assessment of problem areas of the child and family.
Care reports	In care reports coaches reported basic information (date, duration of session, name of the child) on every session. Furthermore, they indicated which care goals were addressed and provided a summary of the session.
Interviews	The interview protocol was designed by the authors of this paper based on the principles of episodic interviewing (Flick, 1997, 2014). First, the respondents were asked to reflect on their experience with the Child and Youth Coaching program. Secondly, the main topic of the interview was introduced and coaches were asked about the care activities that comprised the Child and Youth Coaching program. Thirdly, all respondents were questioned about care provision for FECMP in general. Finally, respondents were encouraged to reflect considerations that played a role in their care provision.

2.4. Procedure

Ethical approval was obtained from the Ethical Committee of the Department of Child and Family Welfare of the University of Groningen. Children and parents participating in this study were contacted for participation in the study during the intake procedure of the program. An informed consent form was signed, allowing researchers to use the digital case files for research purposes. These digital case files contained the intake forms and daily care reports used in this study. Data from the case files were gathered between June 2016 and December 2019. The interviews with the program developers and coaches were conducted between December 2017 and April 2019. Five interviews were conducted at the offices of the care organization, one interview was conducted at the University of Groningen. Interviews on average lasted about an hour (m = 63 min, sd = 15, range = 51–91). The interviews were recorded and verbatim transcripts were used for analysis.

2.5. Analysis

The analysis consisted of five phases (see Fig. 1). In *phase 1* a coding scheme was developed from the program manual (Salvation Army, 2015/2019). The TIFMP (Visscher et al., 2018) was used as an initial codebook to identify care activities in the program manual. Care activities described in the program manual that were not covered by the taxonomies were added to the codebook. In addition, we coded other program elements such as target group characteristics, care goals and program structure as well. This was done because these elements may play a role in considerations regarding care provision (see phase 5). The identification of care activities was done by the first author and discussed with the other authors to check for agreement.

In *phase 2* we coded verbatim transcripts of the interviews, intake forms and daily care reports to identify care activities from practice. Care activities in practice were identified using hybrid coding. The

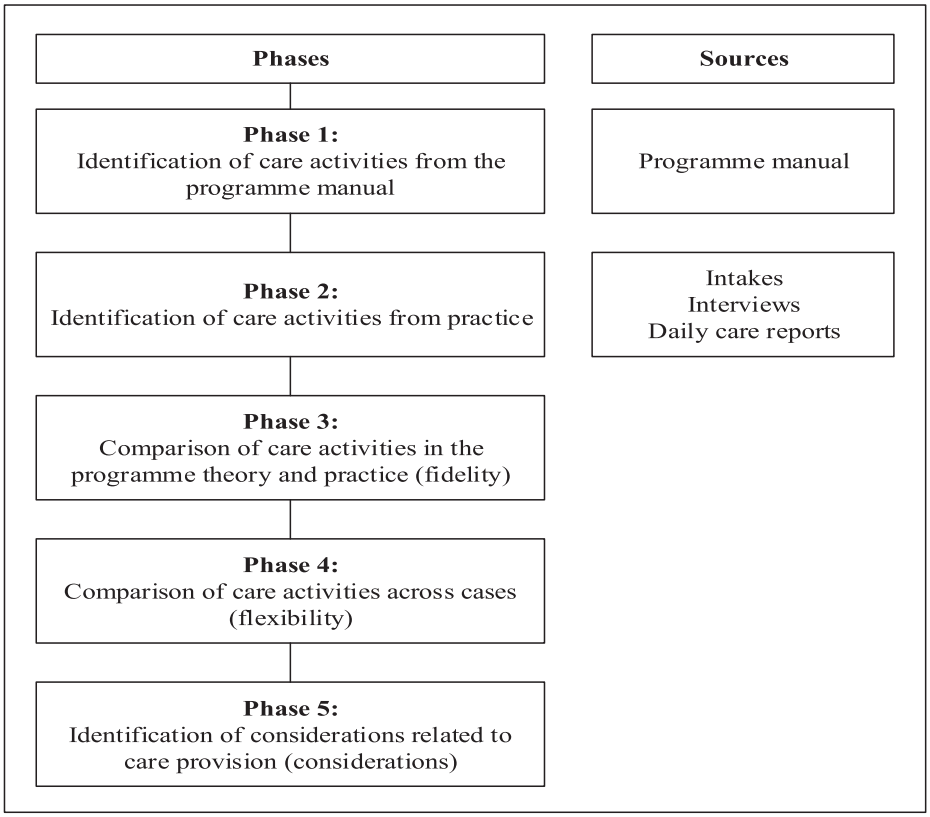

Fig. 1. Graphical Representation of the Study Design and Sources.

coding scheme devised in phase 1 was used to identify care activities from the program manual in practice; care activities not included in the program manual were coded inductively and added to the codebook.

In *phase 3* we compared to what extent care activities described in the program manual (*phase 1)* were similar to care activities identified from practice (*phase 2)*. First, we reviewed the coding of care activities by assessing whether fragments coded as the same care activity represented similar concepts. Secondly, we compared to what extent codes from the program manual occurred in practice to assess treatment fidelity.

In *phase 4* we compared care activities identified in the first three phases of the analysis across cases. This was done by comparing care activities in the daily care reports of the six cases included in this study. Furthermore, we analyzed fragments of the interviews where differences in care provision across cases were addressed.

In *phase 5* we identified considerations in care provision for all care activities. In the treatment manual several considerations with regard to care provision were mentioned. Furthermore, considerations that played a role in shaping the care process were reported in care reports and interviews. Codes related to other program elements were used to aid the identification of considerations (e.g. when case characteristics played a role in choosing care activities a cross-analysis of care activities and target group characteristics was performed). After identifying considerations for all care activities separately, we compared considerations across care activities. By categorizing considerations that played a role in care provision several important themes that played a role in care provision were identified.

3. Results

3.1. Assessment of problems

Fidelity and Flexibility. The program manual (Salvation Army, 2019) does not provide specific guidelines for problem assessment and case conceptualization. However, it emphasizes problem assessment is mainly performed by discussing life events from the perspective of the child. Furthermore, materials (e.g. worksheets, games) are available to assess problems for the main themes of the program. For each theme suggestions for care goals and topics are provided in the manual. Analysis of intake forms showed emotion and behavior (82% of cases in intake forms), social skills (74%), and self-image and self-confidence (46%) to be the most prevalent themes. Other themes such as mourning and loss and physical wellbeing were observed in a smaller part of the cases. Analysis of care reports showed that assessment of problems was most prominent at the start of cases, but continued throughout the program for all cases. In accordance with the program manual, problem assessment mostly occurred through discussing life events. The most prominent activities were *discussing family interactions* (m = 72% of sessions, range 40–89%), *discussing emotions and behavior* (m = 49% of sessions, range 21–76%) and *discussing the social network* (m = 50% of sessions, range 20–64%). Furthermore, coaches frequently reported information gathered from *observations* during coaching sessions (m = 63% of sessions, range 30–85%). Flexibility in problem assessment could be observed in how problem assessment was combined with other activities. For several cases, coaches *(1,2,3,B)*[3] reported they alternated between "fun" activities and problem assessment whereas others *(3,4,C)* combined these activities. For example, in the case of Nathalie (6 years) the session started with a worksheet after which there was time for other activities. Coach 3 provided an example of addressing the theme 'winning and losing' during a game of table football.

Considerations. In line with the manual several coaches mentioned activities to assess problems should be adapted to the characteristics of the child. Especially for children with needs with regard to self-image and self-confidence the manual emphasizes assessment activities should be *easy at the start* so children can have success experiences. In the interviews, coaches reported they adapted their activities to the *level of comprehension* and *interests* of the child. Multiple respondents *(1,2,4)* also reported that problem assessment was also influenced by the *motivation* and *disclosure* of children. They stated a lack of motivation or disclosure can impede the assessment of problems and the proper identification of suitable care goals and activities (see par 3.2).

3.2. Planning and evaluation

Fidelity and Flexibility. The program manual divides the basic structure of the program into a starting phase, intervention phase, a closing phase, and in some cases aftercare. It emphasizes the coach is responsible for monitoring the basic structure of the program and assuring activities are focused towards achieving the care goals. The first *care plan* should be written within the first six weeks and followed-up with an *oral evaluation* every three months, and a *written evaluation* and an *update of the care plan* every six months. At case closure a *final evaluation* is conducted. In all care reports and interviews care plans were used and evaluated in line with the program manual.

As indicated in paragraph 3.1 the care plan contains goals centered around the needs of the child. The manual emphasizes that care goals and care activities should be based on the input and needs of the child. Although all care goals in intake forms and care reports were focused at the needs of the child, the way children were involved in *setting care goals* varied across cases. For example, Ruth (15 years) formulated her own care goals based on needs she identified herself. In her fourth session the care report stated "*She finds it troublesome that when she speaks her mind she does so in an angry way. She's often told she does things the wrong way. This makes her angry. She wants to learn to express her feelings better and define her boundaries before getting angry"*. In other cases goals were formulated by coaches based on their assessment of the child's needs or were more strongly influenced by the perspective and needs of parents and care workers. For example, David (8 years) stated he did not know which goals he wanted to achieve. In response his coach suggested they could work on managing his anger.

All respondents indicated they frequently involved children in *determining care activities*; which was confirmed by the care reports (m = 65% of sessions; range 41–91%). However, children were most involved in determining the location of coaching and choosing supporting activities (e.g. playing sports, shopping). The extent in which children were involved in determining activities more directly related to the care goals (e.g. behavioral exercises, worksheets) varied across cases. In some cases, goal-oriented activities were initiated mostly by coaches. In some cases children were offered a restricted range of choice. For example, coaches sometimes offered a limited number of worksheets to children to choose from. In other cases children have had a more active role in shaping the care process.

Considerations. The analysis showed that the most notable differences in structuring the program were observed in how children were involved in shaping the care process. All interview respondents indicated that they try to center the program around the child's perspective. Coach 2 stated: "*I always try to make clear from the start that we will focus on goals that the child wants to work on. They can impose all kinds of things from the outside, but I think the goals of the child should be central"*. However, several considerations that played a role in involving children in structuring the program were identified. Several respondents *(1,2,3,4)* stated that not all children have the *capacity to identify their desired care goals and activities*. In multiple care reports it was indicated that children were unable to formulate care goals. Furthermore, multiple coaches stated that a barrier to child-centered program was children's *motivation for goal-oriented activities*. Coach 1 provided an example of two boys: "*They just don't want a care plan or goals. […] So I*

[3] Interviews with coaches are referred to with numbers, C for the coordinator, and B for the behavioral specialist. For care reports fictitious names are used to assure the privacy of children.

think, 'I do want to be open with you, discuss things, and connect. But it's a bit difficult if they don't want to cooperate". Another barrier in involving children in setting goals and determining activities was *non-disclosure*. For example, Ruth (15 years) disclosed about traumatic experiences and family problems early in the trajectory (session 3). However, in other cases children indicated they didn't want to discuss their life situation with their coach and preferred to restrict coaching to 'fun activities' The lack of substantive information about how children experience their life was identified as a barrier in adopting child-centered care goals and involving children in determining care activities. However, coach 3 noted that coaches should be cautious about adopting a too goal-oriented approach and stated: "*When you work with adult clients you have a very goal-oriented approach. […] In coaching children that's actually not the case at all. You go there and sometimes feel like 'I just spent an hour playing football'. But later on you hear it made a great difference for the child"*.

3.3. Working on change

Fidelity and Flexibility. For each of the main themes, the program manual contains guidelines for activities to affect change. The most prominent activities focused on realizing change are psychoeducation and structuring events and behavior. Analysis of case reports showed that *structuring events and behavior* (m = 38% of sessions, range 31–51%) was a frequently reported activity. Following problem assessment through discussing life events, coaches frequently used reflective questions to structure events. For example, structuring of events can be observed in the case file of Ruth (15 years): "*When she is moody she wants to be left alone, but the teachers keep giving her attention. The coach asks what happens when she is moody. She says she stares out of the window… It looks like she doesn't hear anything, but she hears everything. That's why teachers come to her and have remarks. This makes her angry, she doesn't like it"*. In some cases supporting materials or worksheets were used to structure events. For example, ABC-schemes (derived from Cognitive Behavioral Therapy) were used to structure events. Another activity that occurred prominently in the manual was *psychoeducation*. Examples of topics covered with regard to psychoeducation in the manual are psychiatric diagnoses, physical and sexual development, divorce, and bullying. Psychoeducational activities were frequently reported in care reports for multiple cases; for example, education on the influence of a disease on behavior (Thomas, 12 years) or the impact of high conflict divorce on children (Sharon, 7 years).

The most notable flexibility in working on change was observed in the extent to which *behavioral exercises* were used to practice behaviors (m = 32% of sessions, range 23–53%). In most cases coaches focused activities to achieve behavioral change on the individual behavior of the child. However, in the case of Ruth (15 years) coaching frequently involved *working on communication* by addressing communication patterns of Ruth with family members and peers. Furthermore, coaches frequently reported activities intended to *reinforce behavior* (m = 33% of sessions, range 25–43%). Positive reinforcement was provided mostly by giving complements and in some cases with rewards (e.g. fun activities or a small present). Activities that were reported in a limited number of sessions were providing *direct feedback on behavior*, *modeling behavior*, *working on self-care*, *working on daily structure*, and *working on transfer*.

Considerations. All respondents reported they aimed to adapt services to the *interests of the child*. The coordinator of the program provided an example of how personal interests of the child were incorporated in the services: *"We connect services to what the child likes. In one case I went to a horse riding school with a girl. She had no friends; was quite closed-off […], but she did love horses. So at the start of the care trajectory I gave her the lead. I asked what she wanted to do at the riding school. She wanted to walk past the horses and pet them; she said "this one doesn't want to be petted, but this one does". So I asked "how do you see?". She said "you see it in the eyes." She observed a lot. She could describe the horses' emotions exactly. Then we made the link to classmates and her home situation*." (C). Coaches indicated the extent to which activities focused on working on change was based on several considerations. Firstly, the extent to which different activities took place depended on the *age* and *capabilities* of children. With younger children the amount of time spend on working on change and the range of activities were limited compared to older children. Furthermore coaches mentioned that a lack of *motivation* and *non-disclosure* sometimes limited the possibilities for working on change (see par 3.2).

3.4. Helping with concrete needs

Fidelity and Flexibility. The program manual indicates coaches can provide help with concrete needs when needed. For example, coaches can provide transport to services when parents are unable to do so. Furthermore, several themes contain care goals that also involve activities focused on helping with concrete needs. For example, to improve the daily routine of children coaches provided support by *arranging funding* and *transport*. Activities focused on helping with concrete needs were only reported to a limited extent in the daily care reports and interviews. Some examples of activities were helping with moving (David, 8 years), providing transport to health care services (Ruth, 15 years), and buying school supplies together (Thomas, 12 years).

Considerations. Analysis of the care reports showed that activities focused on helping with concrete needs were intended to *remove practical barriers* to achieving the care goals within the themes of Child and Youth-Coaching. For example, providing transport to sports activities are intended to promote a healthy daily routine. This implies activities that aim to provide support with concrete needs are not central to the program but always subsidiary to the central care goals of the program.

3.5. Activating the professional and social network

Fidelity and flexibility. The program manual provides a number of guidelines for involving the professional and social network in services. Firstly, the program manual indicates activities that focus on the *coordination of care across services*. For example, "*joint intakes and evaluations are planned regularly to coordinate care provision"* (Salvation Army, 2019, p. 21). Secondly, child and youth coaches can play a role in *motivating* children and parents for participation in services. Furthermore, coaches can provide *practical and emotional support*. For example, by joining a child during in therapy sessions barriers to participation may be removed. Furthermore, coaches can act as a *neutral and independent* professional, for example when child protection services are involved or in case of high conflict divorce. Finally, coaches can provide *continuity in care provision after out-of-home placement*. When children are placed in foster care or residential settings they are often confronted with changes in their life situation such as broken ties with their biological family, traumatic experiences, and a loyalty conflict between their foster family and biological family. As child and youth coaches have no parental task they can play a neutral role and represent the child's interests, for example in discussing visitation arrangements.

Most activities focused on activating the professional and social network were focused at coordinating care with the children's school, mental health professionals, or child protection services. The program manual emphasizes that Child and Youth Coaching can be combined with other types of (specialized) care when needed. For example, coaching was combined with therapy (David, 8 years) or health care services (Thomas, 12 years). As indicated in paragraph 3.2 parents and other professionals were in some cases also *involved in setting care goals*. Finally, in a limited number of sessions other family members or peers were involved in group activities or coaching sessions.

Considerations. The manual emphasizes that Child and Youth Coaching is not indicated for children with psychiatric problems in need of specialized treatment. However, Child and Youth Coaching can be combined with specialized services to *remove barriers to care*. The

supervising behavioral specialist stated "*Sometimes therapy is indicated […], but then it doesn't happen. Then Child and Youth Coaching can be a good option because we are very accessible and can provide access to specialized services. We don't provide therapy – it's coaching. However, we can support a child [in the therapeutic process] and help to practice exercises.*". Multiple coaches (*1,3,4*) stated that good collaboration with parents and other professionals can help in providing suitable care. However, all respondents expressed the concern that involving parents and other professionals may harm the child-centered focus of the program and influence the relationship with the child (see paragraph 3.6).

3.6. Maintaining the practitioner-client collaboration

Fidelity and Flexibility. The program manual provides several guidelines for maintaining the practitioner-client collaboration. Most notably the need of transparent communication and coordination of information sharing is emphasized in the manual. The manual states *"what the child discusses with the child and youth coach is confidential. When the child and youth coach thinks it should be discussed with parents this is discussed with the child first. Furthermore, it is discussed with the child how and by whom the information will be shared"* (Salvation Army, 2019, p. 12). In all interviews the respondents indicated they consistently *discussed the sharing of information* with parents or professionals with children. In the care reports of multiple cases children are consulted when information is shared, for example in sending e-mails to schools (Ruth, 15 years), discussing the care plan (Sharon, 7 years), or addressing parent–child interactions and/or safety concerns discussed during coaching (Nathalie, 6 years). One of the coaches also indicated she was transparent in discussing information she obtained from parents or professionals with the child (Coach 1). Although all coaches discussed the sharing of information consistently with children, the extent to which information was shared varied across cases. Furthermore, coaches frequently *discussed the experiences with services* with children (see also par 3.2). Finally, coaches frequently provided *emotional support*, for example with the death of a relative (Ruth, 15 years) or being placed out-of-home (David, 8 years).

Considerations. Both in the manual and interviews several considerations were stated for emphasizing transparency, especially with regard to the sharing of information. Coaches predominantly emphasized the need to *promote trust*. Coach 2 specifically mentioned that the involvement of multiple services may lead to distrust from children. The coach emphasized that family workers are often very involved with parents. This may cause children to think that these care workers are aligned with parents, which may be a barrier to the disclosure of negative events in the family by children. Therefore, providing children with their own coach *promotes disclosure*. Therefore, all respondents emphasized they were reticent in sharing information with other care workers or child protection services. Coach 3 stated: "*I am afraid that they [other professionals] have the notion that they can use to gather information […]. I think the program should be focused on the needs of the child*". Although all coaches aimed to promote a good client-practitioner collaboration by maintaining a transparent, safe, and child-centered environment there were differences between cases in the relation. Coaches reported they differed the extent in which they involved children with information from other services (such as child protection) varied according to *age* and *capabilities of the child*. Finally, coaches stated that in the case of *safety concerns* they are obliged to share information. However, all respondents emphasized that in these cases they always discussed how they shared information with the child. This is in line with the guideline concerning safety in the program manual.

4. Discussion

4.1. Conclusion, implications, and recommendations

Multiple studies have suggested that children growing up in FECMP could benefit from more participation in care (e.g. Tausendfreund, 2015; Thoburn et al., 2013). Research on child participation has emphasized that participation does not solely consist of informing children and hearing children's opinion, but also involves of taking into account these opinions and actively involving children in care provision and decision making (Bouma, 2019; Križ & Skivenes, 2017). Our analysis showed children in the Child and Youth Coaching program were actively involved in setting care goals, determining care activities, and decision making. Based on our analysis we conclude children experiencing significant barriers to their participation in care require additional attention. Nonetheless, Child and Youth Coaching can be regarded as a promising child-centered program with the aim to promote the participation and wellbeing of children growing up in FECMP.

The aim of this study was to assess treatment fidelity and flexibility of the Child and Youth Coaching program. The use of source triangulation allowed for the comparison of care activities from multiple perspectives. As indicated in the introduction, programs for FECMP are often characterized by considerable flexibility in service provision (Dutch Ministry for Justice and Security, 2019). In the case of Child and Youth Coaching this was reflected in the program manual which provided an outline of the basic structure of the program, but allowed for flexibility in care goals and activities (Salvation Army, 2019). The triangulation of sources allowed for a comparison of activities identified from theory and practice and provided a first indication of treatment fidelity. The barriers observed in achieving treatment fidelity (e.g. motivational problems, inability to determine care goals, non-disclosure about the family situation) were most prominent in the cases that did not have successful case outcomes. Furthermore, coaches mentioned these barriers limited the possibility to realize positive change. This provides the first evidence that treatment fidelity may positively influence case outcomes. However, more research is needed to establish the effect of treatment fidelity on program outcomes. Research on treatment fidelity in family-focused programs such as Families First (Damen & Veerman, 2013) and Multi-Systemic Therapy (Henggeler & Schaeffer, 2016) has shown treatment fidelity to be related to positive outcomes. The effectiveness of the Child and Youth Coaching program will be addressed in another study (Van Assen, Post, et al., 2021).

As the program manual only contained a basic structure of the program there were considerable differences in care activities across cases. In all cases children were involved in setting care goals and determining care activities to promote child participation. However, the extent and way in which children were involved in shaping services varied considerably across services. The analysis showed that most flexibility of care activities was observed in determining care goals and activities and the use of behavioral exercises. Different approaches to care provision were mostly used to adapt services to the needs of children. In most cases care provision occurred in line with the guidelines outlined in the program manual (Salvation Army, 2019). However, in some cases several barriers to child-centered care led to the adaptation of goals based on the input of parents, coaches, or other professionals. The program manual (Salvation Army, 2019) clearly states that care goals should be in line with the perspective of the child. Flexibility in setting care goals could be observed in whether these goals were discussed at the start of the program or the result of a collaborative process of identifying suitable care goals. However, in some cases (e.g. David, 8 years) parent or professional-initiated goals were adopted when children were unable or unwilling to formulate care goals. Similar barriers played a role in the limited extent to which children were involved in activities focused on working on change in some cases. These findings are in line with earlier findings suggesting child participation is often limited for young children and children experiencing developmental or behavioral problems (Bijleveld, Dedding, & Bunders-Aelen, 2015).

Studies on care provision for FECMP have emphasized the need for a flexible and personalized approach to care (Dutch Ministry for Justice and Security, 2019). Although care services for FECMP require a great deal of flexibility, there is a risk in overemphasizing flexibility. Kendall

and Beidas (2007, p.16) state: "*When it is necessary to deviate from a manual a good deal, it is valuable to monitor and assess effectiveness at multiple points. Research is needed to examine the notion of flexibility within fidelity in an empirical manner to determine the boundaries of an evidence supported treatment (*i.e.*, when flexibility turns into nonadherence).*". Our findings suggest care activities are mostly in line with treatment standards outlined in the program manual. However, there is a need to further examine and develop the program with regard to the participation of children that experience significant barriers in their participation (e.g. young age, non-disclosure, lack of motivation).

4.2. Strengths and limitations

As indicated in the introduction, the flexible and personalized approach to care provision complicates the identification of standardized care activities and guidelines that apply to all families and children taking part in the program. In this study we used a qualitative approach using the flexibility within fidelity framework. This allowed us to both identify standardized care activities and explore flexibility in care activities. Source triangulation and a heterogeneous sample were used to allow for the identification of activities from multiple perspectives. However, by using a qualitative design with a small number of cases and respondents our findings do not provide information about the extent in which care activities occur in practice. This implies the statistics provided in this study are merely descriptive and not suitable to make inferences about the prevalence of care activities across cases. In future research a quantitative study using systematic reporting of care activities identified in this study can be used to assess the extent to which care activities occur in practice and vary across cases (see for example Tausendfreund et al., 2015; Visscher et al., 2020; Visscher et al., 2020). Furthermore, this study used several sources providing information from an adult perspective. In line with the emphasis on child participation, it may be beneficial to also include the perspective of children on service provision. The perspective of children on their participation in the Child and Youth-Coaching program will be discussed in another study (Van Assen, Knot-Dickscheit, Post, & Grietens, 2021).

Daily care reports by care workers were used to obtain a description of the care process. This source was chosen because it is less biased than the use of formats with predefined activities. However, the use of unstructured reporting may result in reporting bias as not all care activities performed during sessions are equally likely to be reported in the daily care reports. To assure activities that were less likely to be reported in care reports would also be included in the study we identified activities from interviews and intake files as well.

4.3. Final remarks

Huang and Han (2019) emphasized that today's children and youth face an increasing convoluted set of issues and stressors. This is especially the case for children growing up in FECMP as they are confronted with considerable challenges in multiple areas of life (Tausendfreund et al., 2016). The problems providing suitable care using traditional services for these families have been well-established (Alberth & Bühler-Niederberger, 2015; Boddy et al., 2011; Busschers & Boendermaker, 2015; Ghesquière, 1993; Joosse et al., 2019). Therefore, innovative care programs such as Child and Youth Coaching may provide a valuable addition to existing services. Michelini (2012) emphasized that social innovations should be scalable and sustainable. This study examined the treatment fidelity and flexibility of the Child and Youth Coaching program. Based on our analysis we find that child and youth coaches provide care in line with the guidelines outlined in the program manual. These treatment guidelines can be used to disseminate the program to a wider audience. Currently, the Child and Youth Coaching program is being expanded throughout the Netherlands. Although more research is needed on the outcomes of the program (Van Assen, Post, et al., 2021; Van Assen, Knot-Dickscheit, et al., 2021), we conclude from our analysis that Child and Youth-Coaching is a promising innovative approach for children growing up in FECMP.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

CRediT authorship contribution statement

Arjen van Assen: Conceptualization, Data curation, Methodology, Formal analysis, Investigation, Writing - original draft. **Jana Knot-Dickscheit:** Conceptualization, Methodology, Validation, Formal analysis, Writing - review & editing. **Hans Grietens:** Conceptualization, Methodology, Writing - review & editing. **Wendy Post:** Conceptualization, Methodology, Writing - review & editing.

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.

Appendix A. Definitions of care activ ities (based on Visscher et al., 2018)

Category	Activity	Definition
Gathering information	Observation	Gathering information through observing behavior during sessions.
	Discussing competences	Discussing and/or analyzing strengths, points of attention, protective factors, and stressors.
	Discussing daily routine	Discussing and/or analyzing (part of) the child's daily routine from waking up until going to bed
	Discussing emotions and behavior	Discussing and/or analyzing the emotions and behavior children experience in their life.
	Discussing safety	Discussing and/or analyzing the safety of the child to prevent child abuse and neglect, or other unsafe situations.
	Discussing the family system	Discussing and/or analyzing how the family system (or subsystems within the family) interact with each other and their surroundings.
	Discussing care needs	Discussing and/or analyzing care needs and determining which problems are the cause of these needs.
	Discussing living environment and interests	Discussing and/or analyzing interests of the child and/or events that occurred in the daily life of the child.
	Discussing negative and/or traumatic experiences	Discussing and/or analyzing negative (incl. traumatic) events that children experienced in their life (e.g. out-of-home placement, parent's divorce).
	Discussing social network	Discussing and/or analyzing the social network with the intention to identify persons who can provide support.
	Discussing school	Discussing and/or analyzing the experiences and functioning of children at school.
	Discussing physical wellbeing (incl. sexuality)	Discussing and/or analyzing the physical wellbeing (e.g. life style, health, sexuality) of children.

(*continued on next page*)

(*continued*)

Category	Activity	Definition
	Discussing general wellbeing	Discussing and/or analyzing the general wellbeing of the child.
	Discussing self-image and self-confidence	Discussing and/or analyzing how children perceive and value themselves.
	Filling out and discussing questionnaires	Using questionnaires to gather information at the start of the program, to monitor progress throughout the program, and/or evaluate at the end of the program.
Structuring the program	Intake	Providing information on the services and gathering the first information during the first session.
	Determining activities, subjects and/or coaching location	Determining (with or without the child) which activities will take place during the session, which subjects are discussed, and/or where coaching will take place.
	Determining care goals	Determining the care goals that are the central focus of the program.
	Determining session structure	Determining how different activities are structured during the session (e.g. how much time is focused on care activities and 'fun' activities).
	Writing the care plan	Writing a care plan that contains the case characteristics, care goals, and planned activities.
	Determining and evaluating working points and behavioral agreements	Determining concrete working points and (behavioral) agreements that can be achieved in a short period of time and are focused on achieving the care goals.
	Evaluation (incl. case closure)	Determining case progress based on the care goals in the care plan. If necessary goals can be adapted.
	Aftercare and relapse prevention	Providing care after case closure in order to signal and/or prevent the recurrence of problems.
Building andmaintaining the working relationship	Becoming acquainted	Getting to know the child in order to build a working relationship.
	Discuss sharing of information	Discussing with the child which information can be shared with parents and/or professionals.
	Discuss the care relationship and care needs	Discussing the care relationship and care needs of the child (e.g. discussing expectations, resistance, and quality of the relationship)
	Provide emotional support	Providing warmth, empathy, and positive attention (both verbal and non-verbal).
	Improve motivation for care	Improving motivation of the child for participation in the care services.
Working with the environment	Coordinate with and support towards other services	Coordinating care goals, services, and agreements with other care providers and/or organizations to optimize the care for the child/family.
	Coordinate with and support towards parents	Coordinating care goals, services, and agreements with the parents of the child to optimize the care for the child/family.
	Mobilizing and expand social support	Mobilizing people in the environment of the child who can provide care and support.
	Respite care or out-of-home placement	Realizing (temporary) respite care or out-of-home placement.
	Guide towards other care	Motivating children for participation in other services and providing support towards these services in order to realize suitable care provision for the child.
Working on change	General education and expand experiences	Providing information and learning experiences to expand children's environment.
	Psychoeducation	Providing information on a problem and how to handle the problem.
	Direct feedback on behavior	Providing direct feedback on the child's behavior to realize change.
	Behavioral exercises	Explaining, modelling, and practicing exercises to change behavior.
	Group activities	Participating group activities (e.g. group-based social skills training)
	Solution-focused care	Using solution-focused communication techniques to identify possible solutions to problems.
	Practicing practical skills	Practicing practical skills to achieve care goals (e.g. sports, school subjects).
	Reinforcing behavior	Using positive reinforcement (e.g. compliments, gifts, fun activities) to promote desired behavior.
	Structuring events, emotions, and behavior	Structuring events, cognitions, emotions, and behaviors to identify underlying patterns, decrease undesired behavior and increase desired behavior.
	Modelling	Providing exemplary behavior with the intention to promote the desired behavior in the child.
	Working on communication and interaction	Identifying problematic interaction patterns and working on improved communication.
	Working on daily activities	Working on improving the daily structure of children. This includes activities focused on improving structure throughout the day (e.g. by making a planning) and activities intended to find suitable activities (e.g. trying out sports or cultural activities).
	Working on self-care	Working on improving self-care (e.g. brushing teeth).
	Working on generalization	Working on the application of learned skills in comparable situations.
Other	Administration	Administrative activities and writing daily care reports.
	Practical support	Providing practical support (e.g. transportation, cleaning)
	Supporting activities	Fun activities, usually chosen by children themselves (e.g. playing football, crafts).

References

Al, C. M. W., Stams, G. J. J. M., Bek, M. S., Damen, E. M., Asscher, J. J., & Van Der Laan, P. H. (2012). A meta-analysis of intensive family preservation programs: Placement prevention and improvement of family functioning. *Children and Youth Services Review, 34*, 1472–1479. https://doi.org/10.1016/j.childyouth.2012.04.002

Alberth, L., & Bühler-Niederberger, D. (2015). Invisible children? Professional bricolage in child protection. *Children and Youth Services Review, 57*, 149–158. https://doi.org/10.1016/j.childyouth.2015.08.008

Baartman, H. E. M. (2019). Zorgwekkende Gezinnen; Veranderingen in Visie en Zorg [Troubled Families; Changes in Perspective and Care Provision]. In J. Knot-Dickscheit, & E. J. Knorth (Eds.), *Gezinnen met Meervoudige en Complexe Problemen* (pp. 28–51). Rotterdam: Lemniscaat.

Bijleveld, G. G., Dedding, C. W., & Bunders-Aelen, J. F. (2015). Children's and young people's participation within child welfare and child protection services: A state-of-the-art review. *Child & Family Social Work, 20*(2), 129–138. https://doi.org/10.1111/cfs.12082

Boddy, J., Smith, M., & Statham, J. (2011). Understandings of efficacy: Cross-national perspectives on 'what works' in supporting parents and families. *Ethics and Education, 6*(2), 181–196. https://doi.org/10.1080/17449642.2011.622992

Bouma, H. (2019). Taking the Child's Perspective: exploring children's needs and participation in the Dutch child protection system (Doctoral dissertation, University of Groningen). doi: 10.33612/diss.97960770.

Busschers, I., & Boendermaker, L. (2015). Safety for children first: Focus on children in Intensive Family Case Management. *International Journal of Child and Family Welfare, 16*(1/2), 40–56.

Craig-Van Grack, A. (1997). A taxonomy and recording instrument for process measurement of family preservation services. *Child Welfare, 76*(2), 349.

Damen, H. R., & Veerman, J. W. (2013). The more the better: Adherence to programme elements of Families First in the Netherlands reduces risk of out-of-home placement. Retrieved from: *International Journal for Child and Family Welfare, 16*(1/2), 113–131 https://hdl.handle.net/2066/199133.

Department of Health and Human Services. (2001). *Evaluation of family preservation and reunification programs*. Washington, DC: Department of Health and Human Services.

Dutch Inspectorate of Youth Care. (2016). Casusonderzoek Drenthe: Onderzoek naar aanleiding van het overlijden van een kind [Case Study Drenthe: Investigation Following The Death of a Child]. Retrieved from: https://www.inspectievenj.nl/toezichtgebieden/j/jeugd/documenten/rapporten/2016/05/27/casusonderzoek-drenthe—onderzoek-naar-aanleiding-van-het-overlijden-van-een-kind.

Dutch Ministry for Justice and Security. (2019). *We voelen ons niet serieus genomen [We don't feel like we're taken seriously]*. Den Haag: Ministerie van Justitie en Veiligheid.

Fein, E., & Staff, I. (1994). Inside the black box: An exploration of service delivery in a family reunification program. *Child Welfare, 73*(3), 195.

Flay, B. R., Biglan, A., Boruch, R. F., Castro, F. G., Gottfredson, D., Kellam, S., … Ji, P. (2005). Standards of evidence: Criteria for efficacy, effectiveness and dissemination. *Prevention Science, 6*(3), 151–175. https://doi.org/10.1007/s11121-005-5553-y

Flick, U. (1997). *The episodic interview*. London: London School of Economics, Methodology Institute.

Flick, U. (2014). *An introduction to qualitative research* (5th ed.). London: Sage.

Ghesquière, P. (1993). *Multi-problem gezinnen: Problematische hulpverleningssituaties in perspectief [Multiproblem families: Problematic care situations in perspective]*. Leuven: Garant.

Gilgun, J. F. (2005). The four cornerstones of evidence-based practice in social work. *Research on Social Work Practice, 15*(1), 52–61. https://doi.org/10.1177/1049731504269581

Goense, P., Boendermaker, L., van Yperen, T., Stams, G. J., & van Laar, J. (2015). Implementation of treatment integrity procedures. *Zeitschrift für Psychologie*. https://doi.org/10.1027/2151-2604/a000161

Henggeler, S. W., & Schaeffer, C. M. (2016). Multisystemic Therapy: Clinical overview, outcomes, and implementation research. *Family Process, 55*(3), 514–528.

Holwerda, A., Reijneveld, S. A., & Jansen, D. E. M. C. (2014). *De effectiviteit van hulpverlening aan multiprobleemgezinnen: Een overzicht [The effectiveness of care for multiproblem families: An overview]*. Groningen: UMCG.

Huang, C.-C., & Han, K. (2019). Social innovation in child and youth services. *Children and Youth Services Review, 103*, 173–177. https://doi.org/10.1016/j.childyouth.2019.06.008

Joosse, H., Teisman, G., Verschoor, S., & Van Buuren, A. (2019). *Wanneer vele handen het werk niet lichter maken: Een complexiteitsbenadering voor gezinnen en instanties met multiproblematiek [When Many Hands don't make Light Work: A Complexity Approach for Families and Organizations with Multiple Problems]*. Rotterdam: Erasmus Universiteit.

Kendall, P. C., & Beidas, R. S. (2007). Smoothing the trail for dissemination of evidence-based practices for youth: Flexibility within fidelity. *Professional Psychology: Research and Practice, 38*(1), 13. https://doi.org/10.1037/0735-7028.38.1.13

Kendall, P. C., Gosch, E., Furr, J. M., & Sood, E. (2008). Flexibility within fidelity. *Journal of the American Academy of Child & Adolescent Psychiatry, 47*(9), 987–993. https://doi.org/10.1097/CHI.0b013e31817eed2f

Knot-Dickscheit, J., & Knorth, E. J. (2019). Gezinnen met meervoudige en complexe problematiek: Inleiding [Families with multiple and complex problems: Introduction]. In J. Knot-Dickscheit, & E. J. Knorth (Eds.), *Gezinnen met Meervoudige en Complexe Problemen* (pp. 22–27). Rotterdam: Lemniscaat.

Križ, K., & Skivenes, M. (2017). Child welfare workers' perceptions of children's participation: A comparative study of England, Norway and the USA (California). *Child & Family Social Work, 22*, 11–22. https://doi.org/10.1111/cfs.12224

McNeece, C. A., & Thyer, B. A. (2004). Evidence-based practice and social work. *Journal of Evidence-Based Social Work, 1*(1), 7–25. https://doi.org/10.1300/J394v01n01_02

Michelini, L. (2012). *Social innovation and new business models: Creating shared value in low-income markets*. London: Springer Science & Business Media.

Munro, E. (2011). The Munro review of child protection: Final report. A child-centred system. Retrieved from http://www.education.gov.uk/munroreview/downloads/8875DfEMunroReportTAGGED.pdf.

Salvation Army (2015). Handleiding Kinder- en Jeugdcoaching (concept) [Manual Child and Youth Coaching (concept)]. Salvation Army of the Northern Netherlands: Groningen.

Salvation Army (2016). Intakeformulier Kinder- en Jeugdcoaching [Intake Form Child and Youth Coaching]. Salvation Army of the Northern Netherlands: Groningen.

Salvation Army (2019). Handleiding Kinder- en Jeugdcoaching (herzien) [Manual Child and Youth Coaching (revised)]. Salvation Army of the Northern Netherlands: Groningen.

Schout, G., De Jong, G., & Zeelen, J. (2011). Beyond care avoidance and care paralysis: Theorizing public mental health care. *Sociology, 45*(4), 665–681. https://doi.org/10.1177/0038038511406591

Tausendfreund, T. (2015). *Coaching families with multiple problems: Care activities and outcomes of the flexible family support program Ten for the Future. (doctoral dissertation)*. Groningen: University of Groningen.

Tausendfreund, T., Knot-Dickscheit, J., Schulze, G. C., Knorth, E. J., & Grietens, H. (2016). Families in multi-problem situations: Backgrounds, characteristics, and care services. *Child and Youth Services, 37*(1), 4–22. https://doi.org/10.1080/0145935X.2015.1052133

Tausendfreund, T., Metselaar, J., Conradie, J., De Groot, M. H., Schipaanboord, N., Knot-Dickscheit, J., Grietens, H., & Knorth, E. J. (2015). Self-reported care activities in a home-based intervention programme for families with multiple problems. *Journal of Children's Services, 10*(1), 29–44. https://doi.org/10.1108/JCS-07-2014-0034

Tausendfreund, T., & Van Driel, I. M. (2019). '10' voor Toekomst bij gezinnen met meervoudige en complexe problemen [Ten for the Future for families experiencing complex and multiple problems]. In J. Knot-Dickscheit, & E. J. Knorth (Eds.), *Gezinnen met Meervoudige en Complexe Problemen* (pp. 274–295). Rotterdam: Lemniscaat.

Thoburn, J., Cooper, N., Brandon, M., & Connolly, S. (2013). The place of "think family" approaches in child and family social work: Messages from a process evaluation of an English pathfinder service. *Children and Youth Services Review, 35*(2), 228–236. https://doi.org/10.1016/j.childyouth.2012.11.009

Thyer, B. A., & Pignotti, M. (2011). Evidence-based practices do not exist. *Clinical Social Work Journal, 39*(4), 328. https://doi.org/10.1007/s10615-011-0358-x

Van Assen, A. G., Post, W. J., Knot-Dickscheit, J., & Grietens, H. (2021a). Outcomes of a Child and Youth Coaching program for children and teenagers growing up in families experiencing complex and multiple problems. Manuscript in preparation.

Van Assen, A. G., Knot-Dickscheit, J., Post, W. J., & Grietens, H. (2021b). Children's and teenagers' experiences with their participation in a Child and Youth Coaching program. Manuscript in preparation.

Van Assen, A. G., Knot-Dickscheit, J., Post, W. J., & Grietens, H. (2019a). Het effect van intensieve pedagogische thuishulp op kinduitkomsten en uithuisplaatsing: Internationaal onderzoek [The effect of intensive home-visiting programs on child outcomes and out-of-home placement: International studies]. In J. Knot-Dickscheit, & E. J. Knorth (Eds.), *Gezinnen met Meervoudige en Complexe Problemen* (pp. 332–356). Rotterdam: Lemniscaat.

Van Assen, A. G., Knot-Dickscheit, J., Post, W. J., & Grietens, H. (2019b). Kinder- en Jeugdcoaching: Het belang van kindgerichte hulpverlening bij gezinnen met meervoudige en complexe problemen [Child and Youth Coaching: The need for child-centered care in families experiencing complex and multiple problems]. In J. Knot-Dickscheit, & E. J. Knorth (Eds.), *Gezinnen met Meervoudige en Complexe Problemen* (pp. 332–356). Rotterdam: Lemniscaat.

Van Assen, A. G., Knot-Dickscheit, J., Post, W. J., & Grietens, H. (2020). Home-visiting interventions for families with complex and multiple problems: A systematic review and meta-analysis of out-of-home placement and child outcomes. *Children and Youth Services Review, 114*, Article 104994. https://doi.org/10.1016/j.childyouth.2020.104994

Van Den Berg, D., Van Der Goot, S., & Jansen, M. B. (2008). Cirkel van onmacht, mechanismen in hulpverlening: Hulpverlening aan multiprobleemgezinnen vanuit de praktijk geanalyseerd. Een experiment in het kader van het Amsterdamse project Systeem in beeld. [Circle of inability, mechanisms in care. Support for multi-problem families analyzed from practice; an experiment in the context of the Amsterdam project System in Focus]. Retrieved from http://simenvandergoot.nl/media/Cirkel_van_onmacht.pdf.

Van der Ploeg, J. D., & Scholte, E. M. (2013). *Vragenlijst Psychosociale Vaardigheden [Questionnaire Psychosocial Skills]*. Houten: Bohn Stafleu van Loghum.

Van Widenfelt, B. M., Goedhart, A. W., Treffers, P. D., & Goodman, R. (2003). Dutch version of the Strengths and Difficulties Questionnaire (SDQ). *European Child & Adolescent Psychiatry, 12*(6), 281–289. https://doi.org/10.1007/s00787-003-0341-3

Veerman, J. W., Janssens, J. M. A. M., & Delicat, J. W. (2005). Effectiviteit van Intensieve Pedagogische Thuishulp: Een meta-analyse [Effects of Intensive Pedagogical Home-Visiting: A meta-analysis]. *Pedagogiek, 25*(3), 176–196.

Veerman, J. W., & van Yperen, T. A. (2007). Degrees of freedom and degrees of certainty: A developmental model for the establishment of evidence-based youth care. *Evaluation and program planning, 30*(2), 212–221. https://doi.org/10.1016/j.evalprogplan.2007.01.011

Visscher, L., Evenboer, K. E., Jansen, D. E. M. C., Scholte, R. H. J., Knot-Dickscheit, J., Veerman, J. W., Reijneveld, S. A., & Van Yperen, T. A. (2018). Identifying practice and program elements of interventions for families with multiple problems: The development of a taxonomy. *Children and Youth Services Review, 95*, 64–70. https://doi.org/10.1016/j.childyouth.2018.10.030

Visscher, L., Evenboer, K. E., Scholte, R. H. J., Van Yperen, T. A., Knot-Dickscheit, J., Jansen, D. E. M. C., & Reijneveld, S. A. (2020). Elucidating care for families with multiple problems in routine practice: Self-registered practice and program elements of practitioners. *Children and Youth Services Review, 111*, Article 104856. https://doi.org/10.1016/j.childyouth.2020.104856

Visscher, L., Jansen, D. E. M. C., Evenboer, K. E., Van Yperen, T. A., Reijneveld, S. A., & Scholte, R. H. J. (2020). Interventions for families with multiple problems: Similar contents but divergent formats. *Child and Family Social Work, 25*(1), 8–17. https://doi.org/10.1111/cfs.12646

Zijlstra, A. E., Kalverboer, M. E., Post, W. J., Knorth, E. J., & Ten Brummelaar, M. D. C. (2012). The quality of the childrearing environment of refugee or asylum-seeking children and the best interests of the child: Reliability and validity of the BIC-Q. *Behavioral Sciences and the Law, 30*, 841–855. https://doi.org/10.1002/bsl.1998