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Taking care together

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4

CHAPTER

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

This chapter is based on:

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Abstract

Researchers, practitioners and policymakers in the field of child and family welfare have emphasised the need for more child-centred services for children growing up in families experiencing complex and multiple problems. 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-centred care for children growing up in families experiencing complex and multiple problems. To study these care activities and considerations we investigated the care process of a programme 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 based on a taxonomy of care activities was used to identify care activities described in the programme manual. Secondly, these care activities were identified in practice using daily care reports, intake forms and interviews with coaches and the developers of the programme. During this stage additional care activities were identified from practice. Care activities identified from the programme manual and care activities identified from practice were compared to assess whether care provision in practice adhered to the programme 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, treatment standards were only broadly defined in the programme manual. Flexibility in treatment was mainly observed in the adaptation of care activities 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 may be a promising programme in promoting the participation and wellbeing of children growing up in families experiencing complex and multiple problems.

4.1 Introduction

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

Families experiencing complex and multiple problems are characterised by an accumulation of interrelated problems in multiple areas of life (Ghesquière, 1993; Knot-Dickscheit & Knorth, 2019; Tausendfreund et al., 2016). Due to the complexity of the problems these families experience, services are often ineffective in improving their wellbeing (Baartman, 2019; Van Assen et al., 2020). Although family-focused home-visiting programmes have been developed to meet the needs of families experiencing complex and multiple problems, children growing up in these families often still experience 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 et al., 2011), effectively coordinate care across services (Joosse et al, 2019), and involve children directly in services (Alberth & Bühler-Niederberger, 2015; Inspectie Jeugdzorg, 2016). As social services are often unable to arrange suitable care for children growing up in families experiencing complex and multiple problems, innovative approaches are needed to meet the needs of these children. Huang and Han (2019) state:

> 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 (Huang & Han, 2019, p. 173).

In this study, the care process of Child and Youth Coaching - an innovative child-centred approach for children growing up in families experiencing complex and multiple problems - is investigated.

4.1.2 Home-visiting programmes

Family-focused home-visiting programmes are often used to provide support in multiple areas of life for families experiencing complex and

multiple problems. Evaluation studies of these programmes have shown mixed results. Most notably home-visiting programmes for these families have been criticised for their inability to prevent out-of-home placement (Al et al., 2012; Department of Health and Human Services, 2002; Van Assen et al., 2020). Although several studies show a decrease in children's emotional and behavioural problems, children still experience considerable problems at case closure (Al et al., 2012; Van Assen et al., 2019a, 2020; Veerman et al., 2005). Several studies have suggested that the limited improvement of children participating in home-visiting programmes may be due to a lack of direct participation of children in the care process. One of the main characteristics of home-visiting programmes is the use of a system-focused approach. However, Busschers and Boendermaker (2015) state that care workers experience considerable challenges in actively involving all family members in the care process. In line with these findings, Tausendfreund et al. (2015) found that in a Dutch home-visiting programme 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-centred approach is needed (Alberth & Bühler-Niederberger, 2015; Inspectie Jeugdzorg, 2016; Munro, 2011; Tausendfreund, 2015; Van Assen et al., 2019b). A study by Thoburn and colleagues (2013) showed that the use of a dual key 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 key worker approach combining Child and Youth Coaching with family-focused care (Leger des Heils, 2019).

4.1.3 Child and Youth Coaching

Child and Youth Coaching is a child-centred programme for children growing up in families experiencing complex and multiple problems. Coaches support children by discussing their perspective on their life situation and working towards care goals using behavioural techniques, social skills training, and skills practice in real life situations. Care is provided using a dual key worker approach. This approach implies that children receive child-centred services from the Child and Youth Coaching programme whilst simultaneously the whole family receives family-focused services

from the Ten for the Future programme (for a description of the family-focused services see Tausendfreund, 2015; Tausendfreund & Van Driel, 2019). Care goals of Child and Youth Coaching are centred 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 (for a more elaborate programme description see Chapter 3).

4.1.4 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 emphasised 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 programme (e.g., goals, target group, methods and activities, requirements) have been made explicit" (Veerman & van Yperen, 2007, p. 216). By describing essential elements in detail, mechanisms of effective programmes can be identified, replicated, and disseminated (Flay et al., 2005). However, the majority of programme evaluations in youth care - especially those investigating home-based programmes - focus on 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 programmes such as the care activities that make up the primary care process. Therefore, some authors have characterised the primary care process as a "black box" (Fein & Staff, 1994). Describing care activities of programmes is especially challenging in the case of families experiencing complex and multiple problems (Boddy et al., 2011; Ghesquière, 1993; Holwerda et al., 2014; Tausendfreund et al., 2015). As the problems these families experience are complex and dynamic, care services are often characterised by a personalised and flexible approach (Ministerie van Justitie en Veiligheid, 2019; Tausendfreund et al., 2016; Thoburn et al., 2013). This complicates the identification of protocolled care activities and the development of guidelines that apply to all families and children taking part in a programme. However, a personalised and flexible

approach to care has been identified by parents as one of the most valued characteristics of family-focused home-based care (Ministerie van Justitie en Veiligheid, 2019). This implies that programmes for families experiencing complex and multiple problems do not only require a detailed description of care activities, but also flexibility in care provision. The need for a flexible and personalised approach implies there is a risk involved in solely emphasising the use of protocolled care activities and outcomes within the evidence-based framework. Boddy et al. (2011) have suggested that such an emphasis may lead to the prioritisation of protocolled programmes over more individualised approaches. In the context of families experiencing complex and multiple problems, several studies have suggested that by emphasising protocolled care the complexity of these cases could be ignored (Joosse et al., 2019; Tausendfreund, 2015; Van Den Berg et al, 2008). It should be noted that evidence-based practice usually is not regarded as the straightforward application of protocolled 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 protocolled programme 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 flexibility within a fidelity framework (Kendall & Beidas, 2007; Kendall et al., 2008).

4.1.5 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: "There can and should be an overarching structure, but the service provider is also permitted flexibility in the fulfilling of the main goals of the treatment programme" (p. 17). Within this framework, the concept of treatment fidelity refers to whether a programme is implemented as intended (Goense et al., 2015). Flexibility refers to the tailoring of a programme 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 programme are specified to promote fidelity and the use of scientifically validated approaches. However, care activities are not used in a rigid way, but care workers are flexible in their application of programme 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).

4.1.6 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 programme that should be specified for the programme 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 programme, the analysis in this study 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 programme. These activities are distinct techniques (e.g. modelling, 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., 2018, 2020). This taxonomy contains care activities of eight programmes for families experiencing complex and multiple problems and severe parenting problems that showed positive results in evaluation studies.

4.1.7 Aim and research questions

The aim of this study is to assess the fidelity and flexibility of care activities of the Child and Youth Coaching programme, 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 programme 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)

4.2 Method

4.2.1 Design

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

4.2.2 Participants

We analysed the intake forms of 39 children that were included in a comprehensive evaluation of the Child and Youth Coaching programme. These children were included through regular admission procedures between June 2016 and December 2019. From this group, 379 daily care reports of six cases were analysed to identify care activities from practice. These cases were selected to be heterogeneous based on their scores on questionnaires regarding emotional and behavioural problems (Strengths and Difficulties Questionnaire; Van Widenfelt et al., 2003), Psychosocial Skills (Questionnaire Psychosocial Skills; Van der Ploeg & Scholte, 2013), and quality of the pedagogical environment (Best Interests of the Child Questionnaire; Zijlstra et al., 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 (Chapter 6). With regards to age at the start of the programme (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 4.1. 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 programme and four coaches were interviewed. The first programme developer worked as a coordinator and trainer for the Child and Youth Coaching programme. The second programme developer was the supervising behavioural specialist. These respondents were selected due to their central role in the development of the programme. 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.

Table 4.1
Characteristics of cases for case file study

Alias	Age	Gender	SDQ	QPS	BIC-Q	Case closure
David	9	Boy	25 (clinical)	103 (poor)	46 (sufficient)	Goals partly achieved, referral to specialised 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

4.2.3 Instruments

To identify care activities from the programme manual the original draft of the manual (Leger des Heils, 2015) and a revised version (Leger des Heils, 2019) were used. Multiple sources were used to identify care activities in

practice from multiple perspectives and avoid reporting bias 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 the Child and Youth Coaching programme (Chapter 6). An overview of the sources used in this study is provided in Table 4.2.

Table 4.2
Sources used to identify care activities

Source	Description
Manual	The programme manual of Child and Youth Coaching (Leger des Heils, 2015, 2019) includes a description of the aim of the programme, 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 (Van Assen & Leger des Heils, 2016) is filled out 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 based on the principles of episodic interviewing (Flick, 1997; Flick, 2014). First, the respondents were asked to reflect on their experience with the Child and Youth Coaching programme. Secondly, the main topic of the interview was introduced and coaches were asked about the care activities that comprised the Child and Youth Coaching programme. Thirdly, all respondents were questioned about care provision for families experiencing complex and multiple problems in general. Finally, respondents were encouraged to reflect considerations that played a role in their care provision.

4.2.4 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 programme. 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 programme

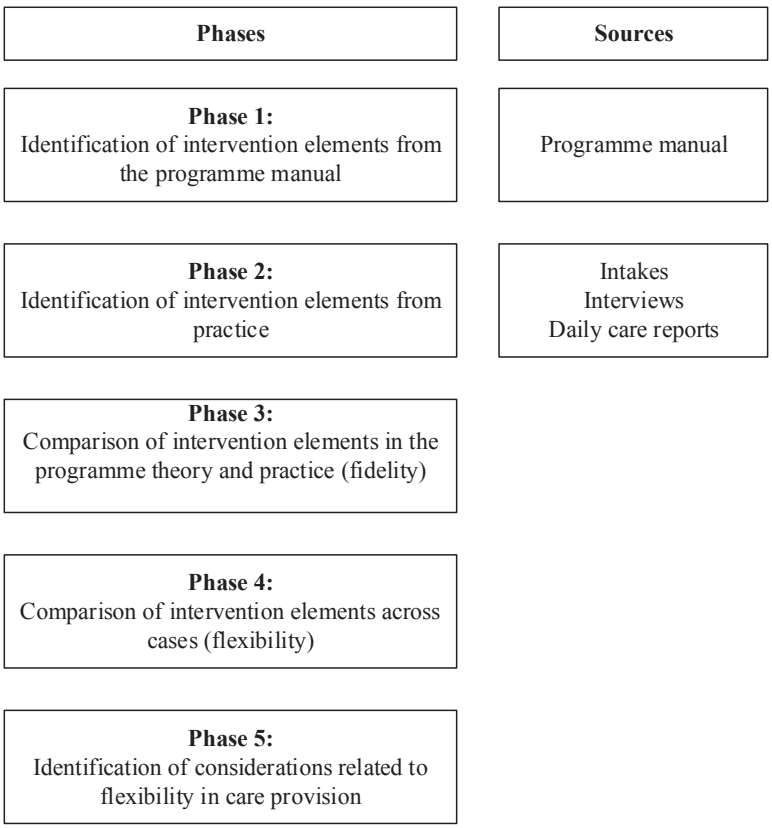
developers and coaches were conducted between December 2017 and April 2019. Five interviews were conducted at the offices of the care organisation, and one interview was conducted at the University of Groningen. Interviews on average lasted about an hour (M = 63 min, SD = 15, range 51–91). The interviews were recorded and verbatim transcripts were used for analysis.

4.2.5 Analysis

The analysis consisted of five phases (see Fig. 4.1). In phase 1 a coding scheme was developed from the programme manual (Leger des Heils, 2015, 2019). The TIFMP (Visscher et al., 2018) was used as an initial codebook to identify care activities in the programme manual. Care activities described in the programme manual that were not covered by the taxonomies were added to the codebook. In addition, we coded other programme elements such as target group characteristics, care goals and programme 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 coding scheme devised in phase 1 was used to identify care activities from the programme manual in practice; care activities not included in the programme manual were coded inductively and added to the codebook. In phase 3 we compared to what extent care activities described in the programme 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 programme 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 analysed 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 programme 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.

Figure 4.1
Graphical representation of the study design and sources



4.3 Results

4.3.1 Assessment of problems

Fidelity and Flexibility. The programme manual (Leger des Heils, 2019) does not provide specific guidelines for problem assessment and case conceptualization. However, it emphasises 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 programme. For each theme suggestions for care goals and topics are provided in the manual. Analysis of intake forms showed emotion and behaviour (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 programme for all cases. In accordance with the programme 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 behaviour (*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) 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 emphasises 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 4.3.2).

4.3.2. Planning and evaluation

Fidelity and Flexibility. The programme manual divides the basic structure of the programme into a starting phase, intervention phase, a closing phase and in some cases aftercare. It emphasises the coach is responsible for monitoring the basic structure of the programme 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 programme manual. As indicated in paragraph 3.1 the care plan contains goals centred around the needs of the child. The manual emphasises 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 chosen 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. behavioural exercises, worksheets) varied across cases. In some cases, goal-oriented activities were predominantly initiated 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 programme were observed in how children were involved in shaping the care process. All interview respondents indicated that they try to centre the programme 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 programme 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-centred programme 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 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-centred 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".

4.3.3 Working on change

Fidelity and Flexibility. For each of the main themes, the programme manual contains guidelines for activities to affect change. The most prominent activities focused on realizing change are psycho-education and structuring events and behaviour. Analysis of case reports showed that structuring events and behaviour (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 Behavioural Therapy) were used to structure events. Another activity that occurred prominently in the manual was psycho-education. Examples of topics covered with regard to psycho-education in the manual are psychiatric diagnoses, physical and sexual development, divorce, and bullying. Psycho-

educational activities were frequently reported in care reports for multiple cases; for example, education on the influence of a disease on behaviour (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 behavioural exercises were used to practice behaviours (*M* = 32% of sessions, range 23–53%). In most cases coaches focused activities to achieve behavioural change on the individual behaviour 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 behaviour (*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 behaviour, modelling behaviour, 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 programme 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. (Coordinator).

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).

4.3.4 Helping with concrete needs

Fidelity and Flexibility. The programme 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 programme but always subsidiary to the central care goals of the programme.

4.3.5 Activating the professional and social network

Fidelity and flexibility. The programme manual provides a number of guidelines for involving the professional and social network in services. Firstly, the programme 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” (Leger des Heils, 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 programme manual emphasises that Child and Youth Coaching can be combined with other types of (specialised) 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 emphasises that Child and Youth Coaching is not indicated for children with psychiatric problems in need of specialised treatment. However, Child and Youth Coaching can be combined with specialised services to remove barriers to care. The supervising behavioural 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 specialised 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-centred focus of the programme and influence the relationship with the child (see paragraph 3.6).

4.3.6 Maintaining the practitioner-client collaboration

Fidelity and Flexibility. The programme manual provides several guidelines for maintaining the practitioner-client collaboration. Most notably the need of transparent communication and coordination of information sharing is emphasised 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. (Leger des Heils, 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 emphasising transparency, especially with regard to the

sharing of information. Coaches predominantly emphasised the need to promote trust. Coach 2 specifically mentioned that the involvement of multiple services can lead to distrust from children. The coach emphasised 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 emphasised 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 programme should be focused on the needs of the child"

Although all coaches aimed to promote good client-practitioner collaboration by maintaining a transparent, safe, and child-centred 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 emphasised 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 programme manual.

4.4 Discussion

4.4.1. Conclusion, implications and recommendations

Multiple studies have suggested that children growing up in families experiencing complex and multiple problems could benefit from more participation in care (e.g. Tausendfreund, 2015; Thoburn et al., 2013). Research on child participation has emphasised 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 programme 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-centred programme with the aim to promote the participation and wellbeing of children growing up in families experiencing complex and multiple problems.

The aim of this study was to assess treatment fidelity and flexibility of the Child and Youth Coaching programme. The use of source triangulation allowed for the comparison of care activities from multiple perspectives. As indicated in the introduction, programmes for families experiencing complex and multiple problems are often characterised by considerable flexibility in service provision (Ministerie van Justitie en Veiligheid, 2019). In the case of Child and Youth Coaching this was reflected in the programme manual which provided an outline of the basic structure, but allowed for flexibility in care goals and activities (Leger des Heils, 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 realise 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 programme outcomes. Research on treatment fidelity in family-focused programmes 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 programme will be addressed in another study (Van Assen et al., 2021).

As the programme manual only contained a basic structure, 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 behavioural 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 programme manual (Leger des Heils, 2019). However, in some cases several barriers to child-centred care led to the adaptation of goals based on the input of parents, coaches, or other professionals. The programme manual (Leger des Heils, 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 programme 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 behavioural problems (Bijleveld, Dedding, & Bunders-Aelen, 2015).

Studies on care provision for families experiencing complex and multiple problems have emphasised the need for a flexible and personalised approach to care (Ministerie van Justitie en Veiligheid, 2019). Although care services for families experiencing complex and multiple problems require a great deal of flexibility, there is a risk in overemphasising 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 programme manual. However, there is a need to further examine and develop the programme with regard to the participation of children that experience significant barriers in their participation (e.g. young age, non-disclosure, lack of motivation).

4.4.2 Strengths and limitations

As indicated in the introduction, the flexible and personalised approach to care provision complicates the identification of protocolised care activities and guidelines that apply to all families and children taking part in the programme. In this study we used a qualitative approach using the flexibility within fidelity framework. This allowed us to both identify protocolled 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 to 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). 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 programme will be discussed in another study (Van Assen et al., 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.

4.4.3 Final remarks

Huang and Han (2019) emphasised 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 families experiencing complex and multiple problems 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 programmes such as Child and Youth Coaching may provide a valuable addition to existing services. Michelini (2012) emphasised that social innovations should be scalable and sustainable. This study examined the treatment fidelity and flexibility of the Child and Youth Coaching programme. Based on our analysis we find that child and youth coaches provide care in line with the guidelines outlined in the programme manual. These treatment guidelines can be used to disseminate the programme to a wider audience. Currently, the Child and Youth Coaching programme is being expanded throughout the Netherlands. Although more research is needed on the outcomes of the programme (Van Assen, et al., 2021), we conclude from our analysis that Child and Youth Coaching is a promising innovative approach for children growing up in families experiencing complex and multiple problems.