CHAPTER 1

GENERAL INTRODUCTION
CHAPTER 1

The general aim of this dissertation is to provide insight into the system of psychosocial care for children and adolescents by investigating long-term outcomes, in particular their functioning, and the training and collaboration of youth professionals. The research within this dissertation contributes to evidenced-based working in the care for children and adolescents with psychosocial problems. Until now, there is a gap in the scientific knowledge about the content of the psychosocial care as offered and the short and long-term outcomes. Furthermore, it is unclear whether the care offered is adequate to address these problems. The results of this dissertation aim to contribute to narrowing this gap.

This general introduction will first give a description of psychosocial problems in children and adolescents, and of the various settings of psychosocial care in The Netherlands and in Aruba. Second, previous research on outcomes of psychosocial care and the knowledge gaps will be addressed. Third, we introduce the Collaborative Center on Care for Children and Youth with behavioural and emotional problems (C4Youth), the context in which the study took place, and the database used in this study (TakeCare). Finally, the research questions are presented.

Psychosocial problems in children and adolescents

Psychosocial problems that is, behavioural, emotional and social problems, can have severe and lasting consequences for children, their families and society [1,2,3]. It is estimated that up to one in five children worldwide experience psychosocial problems [4, 5] and this number seems to be increasing in recent years during the Covid-19 pandemic [see e.g. 6, 7, 8, 9].

Children with psychosocial problems experience poorer daily and social functioning [10, 11, 12] and have poorer physical health [13] and educational outcomes then children without these problems [14, 15]. Psychosocial problems in childhood also affect society because these problems are related to health and developmental concerns in later life [16, 14], such as increased mental and physical health problems [17] and social problems [18].

Psychosocial problems can be roughly divided into behavioural, emotional and social problems. Behavioural- or externalizing problems are outwardly visible in, for example in aggressive, delinquent- or hyperactive behaviour. Emotional- or internalizing problems are not always visible but do affect the child’s or adolescent’s emotional state, for example in anxiety, depressive feelings or psychosomatic complaints [19]. Social problems involve difficulties in creating and maintaining relationships with others [20].

On top of actually having psychosocial problems, psychosocial care for children and adolescents, as described in the next section, also focusses on children in endangered situations that may lead to such problems, such as settings of abuse and neglect. These regard a considerable number of children and adolescents too, e.g. it is estimated that 3% of the children and adolescents in The Netherlands experience a form of child abuse or neglect [21]. In most cases of child abuse or neglect, the parent was the perpetrator. Known risk factors for child abuse and neglect are: low educational level, unemployment, non-Dutch descent, one-parent family, step-family, large families (i.e. with 4 or more children), and young age of the child [22].
Psychosocial care for children and adolescents
In The Netherlands children, adolescents and their families can receive psychosocial care from professionals in various types of services. Three main types of care providers can be distinguished: Preventive Child Healthcare (PCH), Child and Adolescent Social Care (CASC), and Child and Adolescent Mental Healthcare (CAMH). PCH aims to promote, protect and secure children’s and adolescents’ well-being. The focus is on early identification of psychosocial problems [23]. In case of more severe problems, PCH professionals refer children and families to specialised care (i.e. CASC or CAMH); other health-care professionals such as general practitioners may refer too. In CASC, child (social) workers and child development specialists provide specialised care (i.e. trauma support, supportive independent living, foster care) to children and families in endangered situations. CASC focuses strongly on the social and economic context of children and adolescents with psychosocial problems [24]. In CAMH, psychologists and psychiatrists provide children and families with specialised care for psychosocial problems and psychiatric disorders [25]. The offered care in CAMH is mainly aimed at the behaviour or emotion of the child or adolescent and is less social and context focused than in CASC [24]. Finally, residential care is provided, as a last resort, to children and youth when other types of care and treatment do not seem to be sufficient [26]. Children and adolescents up to the age of 18 may voluntarily or involuntarily, be removed from their own home environment for a certain period of time.

In Aruba the organizations involved in the psychosocial care for children and adolescents can be divided into six categories: 1) education and development (e.g. schools and baby health centres), 2) the provision of information, advice and minor support (e.g. youth health care, school social work), 3) (intensive) care and treatment (e.g. primary and secondary psychological care), 4) reporting, identification and coordination (e.g. child welfare investigators, child abuse report line), 5) judicial interventions and measures (e.g. juvenile and vice police) and 6) crisis and residential care [27, 28].

Youth professionals and their education
In both Aruba and The Netherlands, various professionals with different educational backgrounds are involved in the psychosocial care for children and adolescents. Preventive child health physicians and nurses provide care to children and families with mild child and family problems, in PCH. Psychologists and psychiatrists provide specialised care to children and adolescents with more severe psychosocial or psychiatric problems, mostly in CAMH. And child and youth (social) workers and pedagogues provide care for children with psychosocial problems, as well as for children with social and economic problems within the family that could impede or threaten the child, mostly in CASC. In practice, children and adolescents often receive care from more than one organization [29, 30] and there is overlap in the care offered by different providers [29]. In this dissertation we use the term ‘youth professionals’ to refer to all these professionals working in the care settings described above. The psychosocial care for children and adolescents will further be denoted as ‘youth care’.

The youth care setting has proven to be a challenging workplace. Professionals need a variety of skills to meet the educational, social, physical, emotional and cultural needs of the children and their families they provide care to. This is shown for instance by the high turnover rates among
professionals, especially in residential care [31, 32, 33]. This has a negative impact on the well-being of children and adolescents receiving care from those organization [34] and decreases the likelihood of achieving positive outcomes in psychosocial care for youths. This raises the question whether the training of youth professionals and the way education prepares them adequately for working in this challenging workplace.

In Aruba it has been found that the various organizations involved in care for children and adolescents and their families do not always collaborate in identifying psychosocial problems and in decision-making and/or program implementation [35]. To promptly identify and address any obstacles to the development of children, it is needed that education, healthcare, social-service and justice-system professionals collaborate properly. Moreover, Aruba is a relatively small island (180km²; 106,766 inhabitants [36]) and can be described as a multi-ethnic and multi-lingual society [37]. This may also require a specific form of collaboration between youth professionals. Therefore more insight is needed into the collaboration between various professionals who work with children and their families in Aruba.

**Long-term) outcomes of psychosocial care**

Research on the effectiveness of psychosocial care has shown that treatment in controlled settings for specific problems can lead to positive effects [e.g. 36, 37, 38]. However, research in a more naturalistic settings, where comorbidities are common and treatments are typically less intensive [39, 40] is still limited.

Research in naturalistic settings makes it possible to include all different kinds of psychosocial problems (e.g. behavioural, emotional and social problems) and all types of psychosocial care (e.g. PCH, CAMH and CASC) whereas RCTs typically assess one specific intervention in a small, homogeneous sample without complex problems or with as few as possible co-morbid problems, thereby limiting external validity [41]. Moreover, research on long-term outcomes in a naturalistic setting enables to investigate whether the positive effects of often relatively short-term RCT’s also persist in the longer term.

The limited number of studies on outcomes of psychosocial care in a naturalistic setting show heterogeneous results varying from positive results [e.g. 42, 43] to a very limited association between treatment and outcomes [44] or even worse mental health outcomes [45]. Reasons for these heterogeneous findings may be a rather crude assessment of treatment, that is, only dichotomised as yes/no treatment and a short follow-up period. Therefore, there is an urgent need for information on the characteristics of care provision in a naturalistic setting, which enables to determine associations between psychosocial problems, the care delivered, and outcomes [46].

On top of this lack of studies in naturalistic settings, evidence is very limited on the effect of psychosocial care on the daily functioning of adolescents with psychosocial problems. Research shows that adolescents with psychosocial problems experience worse functioning in various life domains compared to their healthy peers [47, 48] but evidence on the effects of care on this functioning is still limited and completely lacking regarding self-reported functioning on the longer term. Receiving preventive or specialised care for psychosocial problems may improve the functioning of adolescents
in various life domains. Moreover, because some psychosocial problems can be chronic and long-lasting effects on functioning is in particular relevant. For instance, care may help children and adolescents to better cope with their psychosocial problems, and thus function better even if their problems remain.

**Context in which the study was conducted: C4Youth and TakeCare**

This study was done in the setting of the Collaborative Center on Care for Children and Youth with behavioural and emotional problems C4Youth, one of several academic collaborative centres, established in the northern Netherlands and aimed at care for children and adolescents in the North of The Netherlands with emotional and behavioural problems (www.c4youth.nl). The first goal of C4Youth is to promote an exchange of knowledge between research, practice, education and policy [49]. The second goal is to collect evidence on the functioning of the entire chain of care for children and adolescents, and on its long-term outcomes. C4Youth has been initiated by the University Medical Center Groningen (UMCG), Department of Health Sciences, over ten years ago, with the University of Groningen, Department of Orthopedagogy, as co-initiator, and with a large number of regional partners from practice, research, training and policy.

C4Youth initiated a longitudinal prospective cohort study named TakeCare (Tracing Achievements, Key processes and Efforts in professional care for Children and Adolescents Research) to augment evidence on children’s and adolescents enrolment in psychosocial care, on the various types of care offered to them, and on the outcomes of this care. In addition, TakeCare has been designed to cover three specific themes, in addition to measuring the outcomes of care. These concern entry into care [50], classification of the provision of care [51] and communication in care between practitioners and clients [52]. This dissertation builds further on these results and is the first study that assesses the long-term outcomes of care after three years. In Figure 1 the research questions addressed in this dissertation are shown schematically.

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Process (organization of care)</th>
<th>Outcomes</th>
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<td>T1 (entry)</td>
<td>T2, T3, T4</td>
<td>T5 (36 months after T1)</td>
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**Figure 1** Conceptual model of this dissertation with its research questions
CHAPTER 1

Research questions
1) To what extent do children and adolescents who receive care via PCH, CASC and CAMH (care cohort), differ from other children and adolescents (community cohort)?
2) Which care trajectories for children and adolescents with psychosocial problems can be distinguished in terms of intensity and duration of care, and are these care trajectories associated with problem reduction after three years?
3) Does care improve self-reported daily functioning of adolescents with emotional and behavioural problems?
4) What are the experiences of youth workers regarding how the bachelor of social work prepares for working in a residential youth care setting?
5) How do professionals in Aruba experience the collaboration in psychosocial care for children and adolescents and what areas of improvement do they see?

Outline of the dissertation
The further outline of this dissertation is as follows. Chapter 2 provides a description of the TakeCare cohort, which was set up to obtain evidence on the care chain for children and adolescents with psychosocial problems, and its long-term outcomes. The cohort profile describes the characteristics of the children, adolescents and their families in a care and community cohort. In Chapter 3 we examined the association between care trajectories based on duration and intensity of care, and the reduction in psychosocial problems after three years. In Chapter 4 we report on a study about self-reported functioning in different life domains of adolescents with various EBP, and the role of care during a three-year period. Self-reported functioning was measured in four life domains: home life, friendships, classroom learning and leisure activities. In Chapter 5 the results of a qualitative study on the experiences of youth workers regarding how the bachelor of social work prepares for working in a residential youth care setting, are presented. Chapter 6 gives a description of the qualitative study about the collaboration between youth professionals on Aruba. Finally, in Chapter 7 we will draw conclusions concerning our main findings and discuss these findings in a broader context. Furthermore we will address the strengths and limitations of the study and, at last, the implications for research, practice, policy and education will be discussed.
References


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