CHAPTER EIGHT

General discussion

The aim of this study was to partly open the black box of care and treatment provided to children and adolescents with behavioural and emotional problems by developing, testing and applying a taxonomy to classify the most salient aspects of the care and treatment provided. Within the Collaborative Centre on Care for Children and Youth (C4Youth), which is particularly focused on children and adolescents with behavioural and emotional problems, a Taxonomy of Care for Youth (TOCFY) was developed. By using TOCFY we were able to gather information on the care provided in a catchment area in the northern Netherlands. The systematically recorded information on characteristics of care and treatment will be of interest in the realms of practice, policy, education and research.

In this general discussion we will first summarize the main findings for each of the research questions formulated. Thereafter, the research findings will be discussed in a broader context. In addition, the strengths and limitations of the study will be taken into account and implications for practice, policy, education and research will be addressed.

Main research findings

We opened the black box of child, youth and family care in part by answering several research questions. The main research findings based on these questions are summarized here.

The first research question was:

Are there taxonomic instruments in the field of child, youth and family care which are capable of classifying the most important aspects of the care process? What kind of domains do these taxonomic instruments contain?

A literature review showed that there were only a few taxonomic instruments available in the field of child, youth and family care. Information was reported on 13 taxonomic instruments with respect to their clinical or conceptual use, the units of analysis, the domains, categories and sub-categories, the levels of classification and their psychometric qualities. None of these taxonomies was fully capable of classifying the most salient aspects of the care and treatment provided to children and adolescents with behavioural and emotional problems. Based on the literature, we identified several domains that were relevant to any Taxonomy of Care for Youth (TOCFY): the intervention content, the judicial context, the duration, the intensity, the recipients of care, the expertise of the main professional concerned, and the environment in which the intervention takes place.

Concluding that we had to develop a taxonomic instrument ourselves, the second research question was:

Which steps are required in the development of a taxonomy of care? What are the results concerning the conceptually relevant domains, the standardization of levels of classification and terminology used, and a final classification system at the meso-level?

The empirical development procedure consisted of seven stages: a literature review, expert interviews, an analysis of intervention descriptions, an analysis of care records, expert meetings, a standardization phase, and a pilot test of TOCFY. Using the information gained from these various stages, our TOCFY comprised six domains: content, judicial context, duration, intensity, recipients, and
Introduction

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expertise of the professional. Within the ‘content’ domain, the level of classification was standardized at the meso-level, the most detailed level still feasible in a cohort study, according to professionals. The terminology used in the ‘content’ domain was based on organization-specific labels of interventions. Using these labels enhanced the manageability and feasibility of the instrument for use by professionals. The terminology used to classify treatment characteristics in the other five domains was similar across care organizations, facilitating a comparison of these domains both within and across these organizations.

The third research question was: *What are the psychometric qualities of the taxonomy of care? Is the taxonomy a reliable and feasible instrument?*

TOCFY was found to be a reliable and feasible instrument for gathering information on the care and treatment offered to children and their families within various types of care organizations. The inter-rater reliability of TOCFY, with an overall inter-rater agreement of 89.8% (including missing values) and 82.2% (excluding missing values), was fairly good. Reliability was somewhat lower for the domains of ‘duration’ and ‘expertise’. For the ‘duration’ domain, this related to the fact that some care trajectories had not yet been completed. For the ‘expertise’ domain one explanation might be the fact that frequently more than one professional was involved in the treatment trajectory. This led to some minor differences in the categories scored by the raters. The categories of the six domains of TOCFY were applicable for over 90% of the assessments by professionals, representing good feasibility in daily practice. We concluded that TOCFY was a reliable and feasible instrument with face validity for assessing the most salient characteristics of care and treatment within different types of care organizations. Preferably, these findings should be replicated in other populations and areas.

In the next step we developed a specific assessment procedure to compare the ‘content’ of interventions between and within care organizations, to this point described by organization-specific labels. Before doing so we ascertained whether the interventions were conceptually and empirically grounded. In this respect, we used four criteria: (1) whether a protocol description was available, (2) whether the intervention was theoretically founded, (3) whether research had been done on the intervention, and (4) whether scientific literature had been published on the intervention. The interventions that met all four criteria were labelled ‘well defined’, while the interventions that did not meet all the criteria were labelled ‘poorly defined’. The assessment procedure was first applied to the latter group, considering this to be the most difficult to characterize. It was subsequently applied to the group of ‘well-defined’ interventions, and then to all interventions combined.

The fourth research question focused on these ‘poorly defined’ interventions and was formulated as: *To what degree can similarities and differences in the content of ‘poorly defined’ interventions within and across care organizations in a catchment area be determined?*

The ‘poorly defined’ interventions (N = 56) offered in the primary health care organization (N = 1), the child and youth care organization (N = 29), and the mental health care organizations (MHC-A, N = 20; MHC-B, N = 6) were compared by using a set of 20 standardized descriptors. A specific set of descriptors was formulated for each of the seven main types of support: ‘family support’,
‘parenting support’, ‘individual child support’, ‘trauma support’, ‘experiential learning support’, ‘independent living support’ and ‘foster care support’. Professionals scored the degree of applicability of these descriptors on a seven-point Likert scale and interventions with sufficiently similar descriptors were merged. We found similarities concerning the content of a substantial number of interventions, both for interventions from the same organization and for interventions from different organizations. The method led to a reduction of the number of distinct interventions from 56 to 27, equivalent to a decrease of 52%. These reductions were greater in the main types of care: ‘family support’ and ‘parenting support’.

The fifth research question was: *To what extent can the number of ‘well-defined’ interventions in a catchment area be reduced based on their content? Is there a difference between ‘well-defined’ and ‘poorly defined’ interventions in terms of reduction?*

In total, 34 ‘well-defined’ interventions were analysed, derived from the primary health care organization (N = 6), the child and youth care organization (N = 13), and the mental health care organizations (MHC-A, N = 10; MHC-B, N = 5). One intervention used in MHC-A was not included in the comparison because it was no longer provided. The results showed that the number of distinct interventions could be reduced, especially within the main types of care: ‘individual child support’ and ‘family support’. In fact, the total number of interventions was reduced from 34 to 19 distinct interventions (a reduction of 44%), which is a somewhat smaller decrease than within the group of ‘poorly defined’ interventions. As a result, a more transparent and systematic overview of distinct interventions used by these organizations was established. This information could support all those concerned when deciding upon the appropriate type of care for children with behavioural and emotional problems.

Finally, the sixth research question was: *Which types of care are provided to children and adolescents with behavioural and emotional problems within and across care organizations in the catchment area? Does this differ depending on the gender and age of the target group?*

‘Individual child support’ and ‘family support’ were most often provided to children and adolescents with behavioural and emotional problems. In addition, care was mostly offered without judicial interference and was often found to extend beyond three months. Most interventions were aimed at the child or at the child and the parents/careers. The greater part of the interventions were ‘poorly defined’. Care was mostly provided in an ambulatory/outpatient or home-based care setting. By using TOCFY we found differences between the types of care provided to boys and girls and between two age groups (4-11 and 12-23 years of age). Boys and girls both received equal levels of ‘individual child support’, but boys received ‘parenting support’ much more often. ‘Experiential learning support’ and ‘independent living support’ were only provided to the group of 12-23 year olds. For the group of 4-11 year olds, interventions mainly concerned ‘family support’ and ‘parenting support’.

TOCFY helped to provide insight into the care obtained within various types of care settings in the region, taking into account child characteristics, care characteristics, the evidence base of the interventions, and the settings in which the interventions were offered.
DISCUSSION OF MAIN FINDINGS

The Taxonomy of Care for Youth (TOCFY) helped to partly open the black box of care for children and adolescents with behavioural and emotional problems and to gain insight into the care offered by various types of care organizations. Our study provided information on the care offered at a rather detailed level, unlike previous overviews of care, which only provided information on a more general macro-level (Bot et al., 2012; Cabiya et al., 2006; Garland et al., 2010; Maschi et al., 2009; Van Eijk, Verhage, Noordik, Reijneveld, & Knorth, 2013). In this regard, the present study yielded interesting findings which will be discussed below.

TOCFY consists of six domains: ‘content’, ‘judicial context’, ‘duration’, ‘intensity’, ‘recipients’ and ‘professional expertise’. As categories in the ‘content’ domain, TOCFY used organization-specific labels for interventions, such as ‘parent training’, ‘coaching conversations’ or ‘ambulatory immediate care’, enabling better usability for professionals who apply TOCFY and promoting face-validity. The terminologies used in the other five domains were equal for all care organizations. For the aim of comparatively reporting on contents we clustered interventions into seven main types of support. This enabled the comparison of the intervention content within and across care organizations. Because the more detailed information of the ‘content’ domain remained available, the information could still be used to list the types of care offered in each of the four care organizations separately.

Our study showed that despite the variation in terms that were used to label interventions, the content of quite a few of these interventions were fairly similar. These similarities in content were not only found concerning interventions within a care organization but also regarding interventions across care organizations. By using sets of descriptors for each main type of support, a reduction of 52% in the number of distinct interventions was achieved within the group of ‘poorly defined’ interventions, with the greatest reductions occurring in the main type of care, ‘family support’. This is in line with the findings of Loeffen, Ooms and Wijgergangs (2004) and Veerman, Janssens and Delicat (2005), who showed that more than 90 differently labelled ‘family preservation programmes’ in the Netherlands had considerable overlap in their methods and target groups. TOCFY may thus provide a means to structure this rather large number of interventions.

Within the group of ‘well-defined’ interventions, the reduction was 44%, primarily occurring in the main type of care offered, ‘individual child support’. Although this proportional reduction was somewhat smaller than for the ‘poorly defined’ group, it was still substantial. The relatively large reduction within this group of ‘well-defined’ interventions does not accord with claims by Van der Linden and De Graaf (2010), and Hibbs (2001), who argued that due to the relatively strong impact of the ‘evidence-based practice revolution’ in the mental health care field or to the demands of insurance companies, interventions were more likely to be clearly distinct. Our research indicates that these interventions were not as distinct as they might have appeared to be with respect to methodological aspects that configure the intervention.

As shown in Chapters 5 and 6, care organizations use a wide variety of labels to describe interventions. They might do so to emphasize the unique character of their care package and to
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The outcomes of such rankings could be discussed within focus groups and might be one way to
support and enhance research on the effective components of interventions (Abraham & Michie, 2008;
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2010).

There are several ways in which interventions might be classified. While we classified them
into main and subtypes of support based on their content, interventions might also be classified based
on their target group or the specific type of problem behaviour addressed, as was done in studies
by the Netherlands Youth Institute on 'what works' for specific target groups (Netherlands Youth
Institute, 2014a). The 'Distillation and Matching Model' (DMM) developed by Chorpita and Daleiden
(2009) attempted to combine these two ways of classifying interventions so that certain profiles with
evidence-based practice elements could be established. This provides the opportunity to classify
interventions based on their content, target group and specific type of problem behaviour. TOCFY may
also add to this approach, but this deserves additional study.

In this study we were able to conduct research within the Collaborative Centre on Care for
Children and Adolescents (C4Youth). This provided the opportunity to develop, test and apply a
Taxonomy of Care for Youth in close cooperation with practitioners working in primary health care,
child and youth care, and mental health care. A context such as this was and is crucial in ensuring
the validity and usefulness of the data we were able to collect. One advantage of an academic
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This clustering of common components of interventions as proposed by Barth and Liggett-Creel
(2014) also relates to the assessment procedure used within our own study. We consulted experts
to discern those methodological aspects that were typical of the interventions used by their own
organization. Starting here, a next step could be to engage professionals in the identification of those
methodological aspects which they consider (1) most prominently used in practice, and which are (2) the
most important for explaining, that is, realizing, positive effects in the target group respectively.

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the validity and usefulness of the data we were able to collect. One advantage of an academic
collaboration centre such as C4Youth is that further assessment of intervention content using expert
panels or focus groups can be arranged relatively easily. The same holds true for the implementation of
results with a potential impact on policy and practice (see also below).
STRENGTHS AND LIMITATIONS

STRENGTHS
A first strength of this study is that we developed and used TOCFY within various fields of care: primary health care, child and youth care, and mental health care. In this way, we were able to obtain a relatively detailed and comprehensive overview of the most salient aspects of the care offered to children and adolescents within our catchment area, and regarding a wide range of care.

A second strength is that professionals from the field were greatly involved during the empirical development procedure, which without doubt increased the face validity and manageability of TOCFY. In addition, the content validity was reinforced by consulting experts, who acknowledged that the domains, categories and sub-categories sufficiently covered the range of care that needed to be classified by TOCFY within their daily routines.

A third strength of this study is the relatively large size of our sample, which increases the external validity of the results concerning care offered to children and adolescents with behavioural and emotional problems.

A fourth strength is that in relation to gathering information on the care offered, we were able to obtain information from the professional who was most involved during the treatment. In this way, we received information that was directly linked to the care and treatment that was offered to these children, adolescents and their families.

LIMITATIONS
A first limitation of this study is that we did not include all of the providers of care and treatment in the catchment area, excluding some smaller groups. Nevertheless, previous research showed that their share in the care in this catchment area was rather small (Van Eijk et al., 2013). Furthermore, regarding the four care organisations that actually participated, some small units did not take part, in particular in CYC and MHC-A fields. Nevertheless, a large majority of the target group of organizations concerned children with psychosocial problems was included in the study.

A second limitation is that the response rate of the sample used (Chapter 7) concerned 56.6%, providing a risk of selection bias. However, a non-response analysis regarding the effect of gender, age, urban-rural origins and reported behavioural and emotional problems showed only trivial to small differences between respondents and non-respondents (Verhage et al., submitted).

A third limitation is that we primarily included experts from the fields of research, policy, education and practice in the specific catchment area. Nevertheless, we expect that our findings on the manageability of the instrument are generalizable to other regions or cultural contexts. However, additional research is desirable.

A fourth limitation might lie in the fact that we did not ask professionals to rank the descriptors used to characterize the content of the ‘poorly defined’ and ‘well-defined’ interventions (Chapters 5 and 6). Additional information on the ranks of these descriptors might have been useful for further
characterizing similarities and differences between the distinct types of interventions.

**IMPLICATIONS FOR PRACTICE, POLICY, RESEARCH AND EDUCATION**

**PRACTICE**
The domains, categories and sub-categories of TOCFY enable professionals to gather information on the care provided to children and adolescents with behavioural and emotional problems in an argued valid and reliable way. Practitioners in other regions or countries could likewise use the structure, including the domains, categories and sub-categories of TOCFY to obtain an overview of the care and treatment offered within their own catchment areas. This provides care organizations with more detailed information on the care and treatment offered, which could be used for several purposes, such as optimizing the care trajectories of children and adolescents.

The present study used TOCFY in the form of a digital questionnaire for professionals working within PHC, CYC and MHC services. The answer categories in the questionnaire were linked to the domains, categories and sub-categories as classified in TOCFY. Both the manageability and feasibility of this digital questionnaire version were good. Therefore, it would be of interest to further elaborate a digital assessment tool which could easily be used by professionals in the near future without being linked to a questionnaire. A digital version of an assessment tool might allow organization-specific adaptations – if necessary – to be made more easily within the domains, categories and sub-categories of TOCFY.

**POLICY**
Using TOCFY within one catchment area provides relatively detailed information on the types of care offered to children and adolescents within that area. In addition, this type of information could be used for regionally based planning of care (NYI, 2014b). While this not only holds for policymakers in the Netherlands, in relation to international policy, more knowledge about care and treatment characteristics is needed (McAuley, Pecora, & Rose, 2006; Vostanis, 2007). This means that the framework of TOCFY might also be useful internationally.

**EDUCATION**
The knowledge gathered by using TOCFY provides major input for university curricula and other educational services. Information on the various fields of care and the types of interventions offered could be used to enhance our knowledge of youth care. Furthermore, TOCFY could be used as an instrument to measure the most important characteristics of the care process; for example, it could be used during internships and to accumulate actual knowledge that could be used when entering the labour market.
RESEARCH
By using TOCFY we are able to provide more detailed and meaningful information on the care offered to children and adolescents with behavioural and emotional problems. This type of information could be used in future research to determine whether there is a connection between the problem behaviour initially presented by these young clients, the care they receive and the outcomes that become apparent after the termination of care (Miller & Row, 2009; Ten Brink, Veerman, De Kemp, & Berger, 2004).

In this study we assessed the inter-rater reliability, face validity and feasibility of TOCFY, but information on test-retest reliability is still lacking. Thus, further research should assess the test-retest reliability and provide more information on the stability of the scores over time. Furthermore, it would be of interest to assess the validity, feasibility and inter-rater reliability of TOCFY in other catchment areas in the Netherlands and internationally.

Although we provided a comprehensive overview of the types of care offered within this study, the diagnostic parts of the care trajectory were lacking. Therefore, another possibility for future research would be to include the diagnostic part of the care trajectory, which is also important when providing an overview of the entire chain of care and treatment for children and adolescents. A somewhat similar method as that employed in the current study might be used in such research.

Reporting on the care offered was based on the seven main types of support. These distinct types could be further characterized in future research. Studies by Pijnenburg (2010), Van Yperen, Van der Steege, Addink and Boendermaker (2010) and Barth and Ligget-Creel (2014) found similarities concerning the activities and techniques used across various types of interventions. Therefore, it would not only be of interest to ask professionals to rank the applicability of the methodological aspects in reality, but also to rank these aspects based on their potential effectiveness.

CONCLUSION
This study partly succeeded in opening the black box of care for children and adolescents with behavioural and emotional problems by developing, testing and applying a taxonomy to classify salient aspects of the care and treatment provided. We developed a Taxonomy of Care for Youth which was shown to be reliable and feasible for professionals in daily practice, and which could be used to obtain an overview of the care offered to children within primary health care, child and youth care, and mental health care. This more detailed information on what kinds of interventions are offered in different areas provides ample opportunity to improve the care offered to children and youth with behavioural and emotional problems. We must still ask ourselves: Why does one form of care and treatment have the intended effects, while other forms do not?
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References


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