Summary

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. Chapter 1 provides a brief introduction to behavioural and emotional problems and the various fields and settings for the provision of care in the Netherlands. The labelling of interventions offered to children with behavioural and emotional problems is also discussed. In this regard, the systematic recording of care and treatment elements plays an important role, enabling a comparison of the care offered, both within and across care organizations. Furthermore, the Academic Collaborative Centre on Care for Children and Youth (C4Youth), focused on behavioural and emotional problems, is introduced.

Overview of care taxonomic instruments

Chapter 2 provides an overview of the taxonomic instruments available in the field of health care, family care, and child and youth care. A systematic analysis of the literature yielded thirteen taxonomies which varied widely in terms of important characteristics such as content and level of classification. Eight of the taxonomies were applied in clinical practice, with patients or clients as the unit of analysis. The other five taxonomies concerned the conceptual level and were applied to intervention manuals. Information on their psychometric qualities was scarce: only two studies reported on the reliability of the instruments. In addition, little information was available on the feasibility of these taxonomic systems in daily practice. None of the thirteen 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.

The literature review provided a good overview of the potentially relevant elements of a Taxonomy of Care for Youth (TOCFY) that might help us to better understand the kind of care and treatment offered to children and adolescents with behavioural and emotional problems. An ideal Taxonomy of Care for Youth (TOCFY) should at least cover the intervention content, the intervention recipients, the professional skills needed for the intervention, the duration of an intervention, its intensity and the setting needed.

Empirical development procedure

Chapter 3 presents an empirically developed taxonomy of care, feasible for use in daily practice, as well as a description of the development procedure. The procedure consisted of a literature review, followed by expert interviews, an analysis of intervention descriptions, an analysis of care records, expert meetings, a standardization phase, and a pilot test of the beta version. The findings of our study
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showed that using an empirical procedure is feasible and leads to the identification of, and consensus on, the characteristics that a care taxonomy should include.

The resulting Taxonomy of Care for Youth (TOCFY) consisted of six domains: content, judicial context, duration, intensity, recipients and the expertise of the professional. The terminology used in the 'content' domain concerned organization-specific labels of interventions, facilitating better manageability and feasibility. The terminology used in the other five domains was similar across organizations, facilitating a comparison of these domains within and across care organizations. Using TOCFY in daily practice provides the opportunity to gather information on care and treatment characteristics within care organizations.

Psychometric qualities

Chapter 4 reports on the assessment of the psychometric qualities of TOCFY. The care provided to children and adolescents was classified by two raters using the TOCFY domains. The inter-rater reliability was measured by using percentages of agreement. In cases where information on a domain was lacking, raters scored the category, 'Unknown or not otherwise specified.' As these missing values might affect the agreement measures, the percentages were assessed with and without missing values. Inter-rater reliability was good, especially given the complex nature of TOCFY, with agreement percentages of 89.8% (with missing values) and 82.2% (without missing values). Reliability was somewhat lower for the domains of 'duration' and 'expertise' of care. For the 'duration' domain, this had to do with the fact that some care trajectories were ongoing. For the 'expertise' domain, one explanation might be the fact that more than one professional was frequently involved during the treatment trajectory. This caused some minor differences in the categories scored by the raters. The feasibility of TOCFY was assessed by measuring how well professionals were able to apply the six domains to the care provided. Domains, categories and sub-categories of TOCFY could be applied to over 90 percent of the assessments, representing good feasibility. We conclude that TOCFY is a reliable and feasible instrument with face validity for assessing the most salient characteristics of care and treatment within different types of care organizations.

Comparing the care offered within and across care organizations (1)

In Chapter 5, the aim was to compare the content of the ‘poorly defined’ interventions within and across care organizations in our catchment area. Four criteria were used: (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. Interventions that met all four criteria were labelled ‘well-defined’, the others, ‘poorly defined’.

First, the group of ‘poorly defined’ interventions was assessed within 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). We started with the group of ‘poorly defined’ interventions as we considered they would be the most difficult to characterize. Thereafter, interventions were divided into seven main types of support: ‘family support’, ‘parenting support’, ‘individual child support’, ‘trauma support’, ‘foster care support’, ‘experiential learning support’, and ‘independent living support’. For each main type of support, a specific set of descriptors was used to assess the content, which led to a reduction from 56 to 27 distinct interventions. The reduction mainly occurred within the groups ‘family support’ and ‘parenting support’. Within child and youth care in particular the number of distinct interventions could be readily reduced. The descriptors used allowed the characterization of the content of care offered to children with behavioural or emotional problems and their families within and across care organizations. Based on this, we were able to discern similarities and differences in the content of the ‘poorly defined’ interventions and to create a systematic overview of distinct interventions.

Comparing the care offered within and across care organizations (2)

In Chapter 6, the same method was applied to the group of ‘well-defined’ interventions (N = 34), 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), resulting in 19 distinct types of interventions. The total reduction within this group of ‘well-defined’ interventions (44%) was somewhat lower than the one within the group of ‘poorly defined’ interventions (52%). Within the group of ‘well-defined’ interventions the largest reduction was obtained within the care characterized as ‘individual child support’, while within the group of ‘poorly defined’ interventions this reduction concerned ‘family support’. Despite the fact that the ‘well-defined’ interventions were theoretically grounded and had been researched, the content was often not that different with respect to methodological aspects that configure the intervention. Although our outcomes indicate that the content of many interventions is rather similar on a meso-level, implementation in daily practice could differ depending on the type of problem behaviour and the target group. Assessing the similarities and differences between interventions in a catchment area will help to gain a clearer overview of the care offered.
Care provided to children and adolescents with BEP in one catchment area

Chapter 7 presents an overview of the care provided to children and adolescents with behavioural and emotional problems (BEP) in one catchment area. The most frequently offered types of care were ‘individual child support’ and ‘family support’. Care was mostly offered without judicial interference and usually was longer than three months. In most cases, the interventions were aimed at the child or at the child and the parents/carers. The greater part of the interventions offered were ‘poorly defined’ and offered in an ambulatory/outpatient or home-based care setting. Concerning gender we found that both boys and girls equally received ‘individual child support’, but that boys more often received ‘parenting support’. Regarding age differences, we found that ‘experiential learning support’ and ‘independent living support’ were only provided to the group of 12-23 year olds. For younger children, aged 4-11, care mainly concerned ‘family support’ and ‘parenting support’. TOCFY enabled us to obtain more detailed and meaningful insight into the care provided within various types of care settings, taking into account child characteristics, care characteristics, the evidence base of interventions, and the settings in which care and treatment were offered.

Discussion and implications

Chapter 8 summarizes and discusses the main research findings of this study. Furthermore, strengths and limitations are assessed and implications for practice, policy, education and research formulated. This study showed that TOCFY is a reliable and feasible instrument with high face validity for gathering more detailed information on the care offered to children and adolescents with behavioural and emotional problems in one catchment area. Using this type of information creates opportunities for more research into the pivotal question of how and why care works (or does not).

Practitioners from other regions or countries might also use the TOCFY system to obtain an overview of the care offered within their own catchment area. Policymakers could use the information for the regionally based planning of care. Universities and other educational services could implement this knowledge in their curricula, providing students with a more detailed and up-to-date understanding of the types of care offered within a specific area. Gathering more knowledge concerning the most salient aspects of the care offered allows us to partly open the black box of care offered to children and adolescents with behavioural and emotional problems.
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