It's all about the Family:
Research on Dutch Families with Multiple and Complex Problems

E.H. (Dineke) Smit

Abstract

Despite the scaling up of family-focused interventions, the number of child out-of-home placements continued to rise in the Netherlands. Most of these children came from families with multiple and complex problems. The underlying reasons for the rise of out-of-home placements were unknown. The main goal is to prevent children from being placed in out-of-home care. To achieve this, research was conducted to gain insight into the experiences of youth care professionals using family-focused interventions. A mixed method research study was done based on the questionnaire of Bodden and Decovic (2015). Qualitatively, 16 semi-structured interviews with youth care providers were conducted and a quantitative statistical analysis of 206 cases of families with multiple and complex problems were analyzed. Family-focused interventions are highly regarded and used by all stakeholders. However, help for families with multiple and complex problems is fragmented and so are the multiple (and possibly contradictory) family interventions. All 206 cases showed problems in all domains. Factors that interfere with family functioning are the most common, child factors the least. There is no significant relationship between child out-of-home placement and child factors. With each additional family problem, the chance of out-of-home placement increases by 10%. This study shows the complexity, not only of the families themselves but also the caregivers involved in these families. It is important to recognize and understand this complexity. Dealing with this complexity requires a different approach. The addition of a client supporter or an expert by experience is recommended.

Keywords: families, multiple problems, complex problems, outpatient treatment, family-focused interventions
E.H. (Dineke) Smit is philosopher of science and PhD candidate Radboud University Nijmegen Netherlands, as a researcher involved in the complexity of good mental healthcare. Furthermore, Smit is involved in the European Forum for Primary Care, the working group Mental and is a director of Steunpunt GGZ (Fulcrum Mental Health), an organization that supports clients with mental health problems in Utrecht, Netherlands. She is a volunteer board member of a foundation that shelters homeless families and a member of several supervisory boards. E-mail: e.h.smit@4sophia.nl; Orcid-ID: https://orcid.org/0000-0002-8322-8793. Recent publications include: Smit, D., & Derksen, J. (2020). The complexity of healthcare fraud-ethical and practical considerations. ethic@-An international Journal for Moral Philosophy, 19 (2), 367-385; Smit, E. D., & Derksen, J. J. (2017). Vignette research on messy and confusing problems in primary mental healthcare. Europe's journal of psychology, 13 (2), 300; and Smit, E. H., & Derksen, J. J. (2015). The complexity of primary care psychology: Theoretical foundations. Nonlinear dynamics, psychology, and life sciences, 19 (3), 269-284.
Introduction

When a child is placed out of home there is a break in their development. The effects of multiple breaks on development negatively impacts development in adult life (Berger, Bruch, Johnson, James, & Rubin, 2009; Fantuzzo & Perlman, 2007; Mennen, Brensilver & Trickett, 2010). The Netherlands Youth Institute concludes in its report Speerpunten voor residentiële jeugdhulp (Spearheads for Residential Youth Care):

Unintentionally, the system of youth care contributes to the negative spiral in which many children in residential youth care end up. Transfers, a lack of perspective, education that does not match their capabilities and under stimulation aggravate the problems they face (Netherlands Youth Institute, 2019, p. 5).

Youth services in the eastern part of the Netherlands experienced problems in reducing the number of out-of-home placements and that out-of-home care often lasted longer than was expected. Family-focused interventions had been used to support families as much as possible, but results lagged behind. Most of the children who had been placed in out-of-home care came from families with multiple and complex problems (FMCP). Families with multiple and complex problems face a higher risk for developing more problems (Deković, 1999). Factors of influence are child factors, parent factors, childrearing factors, family functioning factors and contextual factors (Verhoeven, Junger, van Aken, Deković & van Aken, 2007). Bodden and Dokovic added two other factors: social network factors and mental health factors (Bodden & Deković, 2010). To gain a better understanding of the problems of families with multiple and complex problems and of the implementation of family-focused interventions in daily practice, the regional youth service initiated a study. The purpose of this study was to get tools to prevent or reduce the number of children in out-of-home placement. This required the involvement of mental health professionals and youth care workers working at local access facilities. The participation of parents was desired but unfortunately, due to the Corona Virus measures, could not be carried out sufficiently. The study was conducted by one principal researcher, the interviews were conducted by two researchers. A multidisciplinary sounding board was used to help decide on the research design and interpretation of the research results.

Research Questions

- What experiences do caregivers have with FMCP and with family-focused interventions?
- What problems do FMCP struggle with the most and is there a significant correlation between the different problems? How are these problems related to the (imminent) out-of-home placement of children?
- What potential means of improvements are there as a result of the research findings?
Method

The research was based on a mixed method research process (Braun & Clarke, 2013). We started with a literature study in order to achieve a workable definition of families with multiple and complex problems. Subsequently, through an iterative process with the sounding board and the researchers, three research questions were drafted. A research design was developed, including an interview protocol, a pseudonymization protocol (with respect to the privacy of the families), and a communication plan.

Semi-structured interviews with youth care workers working at the local access centres and mental health providers (psychologists, psychiatrists) were part of the design, conducted by two researchers. These youth care workers are part of the local access teams and are part of the municipal youth service. Eleven local access teams were asked to participate in this study. Also 11 providers of youth mental healthcare and 2 youth protection organizations were asked to participate. In the end, 8 local access teams for youth care, 7 youth mental health providers and 1 youth protection organization participated in this research. This resulted in 16 semi-structured interviews with the following questions.

1. What is your perception of families with multiple and complex problems?

2. How many families are involved in your community, in your health care organization?

3. What does the assistance to FMCP look like from your perspective?

4. What role do family-oriented interventions play in FMCP?

5. What are the advantages and disadvantages of family-oriented interventions in FMCP?

6. Where are opportunities to improve assistance to FMCP?

The interviews were conducted by two researchers (8 interviews each). The interviews were recorded - with permission - to support reporting. The reports of the interviews were summaries of the conversations while retaining concrete answers to the questions asked. Also, any examples that were seen as particularly significant were included verbatim in the report.

The interview consisted of three parts. The first part involved the open-ended question of, “What is your perception of FMCP” (question 1). The second part consisted of questions 2 to 6. This phase was concluded with the interviewees having the opportunity to add anything they felt had not been sufficiently addressed during this interview. After the third part, three FMCP cases were reviewed using the characteristics of FMCP developed by Bodden and Dokovic (2010). The interviewees could indicate whether or not the items mentioned were an issue, for example psychiatric or psychosocial problems including developmental problems in one or more children in this family.

They could also name additional information if they wished. Additional information
was for example "we are not sure, but have a strong suspicion", or “we don’t know this information” or “we can’t say yet because the child is too young to conclude.” It was the interviewee who ultimately decided whether or not to tick the box. At the end of the interviews, interviewees were asked if they would be willing to complete more FMCP questionnaires. Many did, resulting in 206 cases that were screened using Bodden and Deković's questionnaire. This data (206 scored questionnaires) was analyzed by SPSS.

In the original design, it was also planned to link the pseudonymized cases to the data of the Region IJssel’s Monitor (RIJM), a local dataset with information about the families and the giving care. However, the RIJM data proved to be unable to draw reliable conclusions for several reasons and after some consultation, this part of the research was therefore dropped.

This research took place from January, 2020 to September, 2020. All interviews were conducted during the months of May-June-July and were conducted online due to the Corona Virus measures. An attempt was made to interview parents from families with multiple and complex problems as well. However, we did not find any parents willing to participate in this study.

**Results**

With respect to the research question “What experiences with FMCP do youth care workers have with these families and with family-oriented interventions?”, the following results emerged.

**The Interviews**

General Picture of Families with Multiple and Complex Problems

All involved were able to paint a clear picture of families with multiple and complex problems. Often mentioned were: multiple problems in multiple areas of life, low level of parenting, relationship problems, financial problems and high care costs. The psychological problems of parents were mentioned relatively more often than the psychological problems of the children. It was also frequently mentioned that the complexity and plurality can also be in the inability to find appropriate help. None of the interviewees worked with a standard screening list to distinguish when there is a family with multiple and complex problems.

How many families are likely to be involved?

None of the interviewees had a concrete overview of how many FMCP there are in their community. Families with multiple and complex problems are not specifically mentioned in reports as being FMCP. However, they did have some idea of how many families might be involved. The estimated number was related to the size of the municipality and/or the caseload.
with which they were familiar. A number of local access teams reported that there had recently been a study into the top 10 most intensive and most expensive clients and their characteristics. Among this latter group are several FMCP.

What does help look like for families with multiple and complex problems?

The following help is provided (in no particular order): ACT team (intensive service delivery model intended for people with serious mental illness), Parenting support, Family treatment for children or babies with behavioural problems, CINGS (Child IN Healthy System), Basic Trust (treatment for children with problematic attachment), regular mental health care, domestic help, debt counselling, 10 for future (family counselling at home), Intensive Ambulatory Family Treatment, Intensive Psychiatric Family Treatment, Intensive Home Treatment, parent counselling, systemic therapy, trauma treatment, sexual problems treatment, broad-based counselling, 24-hour care, Cognitive Behaviour Treatment, Multidimensional Family Therapy, Non-violent Resistance and outpatient counselling.

The importance of parents taking charge of their own lives was widely recognized and endorsed. Examples of parents not taking charge of their own lives that were given were: complex divorces, psychiatric problems of one or both parents and families in which the parents did not agree with the solutions offered by youth care workers. It was indicated that families with multiple and complex problems in general are families who have difficulty in tapping into their own control. The reason given was that self-direction requires a specific competence that not everyone possesses.

It was indicated that the supply of help is fragmented, multiple parties contribute to the recovery of the individual child and/or family. As a result, families receive advice from multiple professionals and from different perspectives and with respect to different goals. There is collaboration but it is hampered by many changes of caregivers and seems to be mostly about "utility for one's own responsibilities". What do I need to know about the other person to be able to carry out my tasks and responsibilities well? Funding also made collaboration difficult. Access providers (bachelor degree), employed by the municipality, determine in the Netherlands whether specialized youth care professionals (master and PhD degree) may be deployed. Specialized youth care is provided by child psychologists and youth psychiatrists. When these access providers stop funding specialized mental health youth care for the (longer term) interest of the child, this complicates the mutual trust. Interviewees also mentioned that collaboration costs time and money. They indicated that they did not want to spend more time collaborating than actual helping the child and/or parents.

Whereas the specialized mental youth care providers seem to be looking more at what they can still offer, the access providers see the limited results of all the deployed care. All recognized the pattern of stacking of help or continuous scaling up. A new provider offers hope and perspective and starts working adequately, until it no longer works and history repeats itself with the next provider. It was pointed out that this pattern does not stimulate the parents to take charge of their own lives. Choosing a new care provider that brings hope sounds like self-governance, but when disappointment follows, this then demotivates the self-governance.

A number of access providers mentioned the desire to work from broad and intensive deployment at the start and then to consistently scale down (instead of stacking and scaling up). The following image appeared:
A proper screening at the start (when there are indications that this family might belong to the target group of multiple and complex problems).

A concrete approach to the problems in several areas in which temporary taking over the direction is not shunned.

Help that is aimed at normalizing the problems and reducing the complexity (not at solving and then preventing relapse).

By adding an independent client-support person to this family, the encouragement of family self-direction can be sustained.

Relapse prevention is found in sustainable, accessible and low-threshold support.

The question "When is the care good enough" came up regularly. As long as care providers do not have clear frameworks for this and families continue to ask for help, the two reinforce each other. Also, the question whether the help to FMCP should completely fall under the youth law was brought up several times. In the Netherlands the municipalities are responsible for making all forms of youth care available. For example, help at home with problems in the family, but also specialized mental youth care. Municipalities have a legal obligation to provide youth assistance and support. For example, to young people with a disability, disorder, disease or growing up problems. Reimbursing care to FMCP based on the youth care law, implemented by local municipalities, limits the latitude you have to be able to indicate help to parents only.

To what extent do family interventions play a role in families with multiple and complex problems?

Different family interventions are used (a wide variation, from well-defined methods to general interventions from the family perspective). Interviewees indicated that it is difficult to achieve results with parents who are unwilling or unable to do so. Enabling these families to use their own social networks is difficult to achieve. There is unanimous agreement that the focus should be at the family level and therefore everyone considers the family-oriented approach of paramount importance. There is however hardly any harmonization at the family level with regard to the method of family interventions. The question that arises especially at the level of local access is where formal treatment ends and informal support begins and what is the place of support in the whole chain. The respondents indicated that there is no overview of which family-focused interventions are used when and by whom. The effectiveness of the multitude of interventions is especially questioned by the local access providers.

A number of those responsible for enabling local access mentioned that because family-focused interventions were only offered from the provider location; they lacked: “the eyes and ears in the family”. According to them, family-focused interventions does not mean only listening, but also looking and feeling along, trying to get the family’s perspective. When it comes to the effectiveness of family-focused interventions, they wonder what help is more
appropriate: scientifically based family interventions at the location of the mental health providers or practical support tailored to the family. Youth care worker responsible for local access explains:

I went out to a family in a disordered household. I said, ‘Let’s do the dishes together.’ While the dishes were being washed, I would just talk to the mother or father about different issues.

When it comes to the expertise of the mental health providers, there is – even after additional training – a lot of hesitation regarding family-focused interventions. The importance of the working relationship between the psychologist and the parent(s) was often mentioned as a factor influencing the effects of the family-focused interventions. The psychologists sees the effects of the parent(s)’ lack of competence in dealing with the children and at the same time sees the underlying traumas of the parent(s). Knowledge of family-focused interventions, of specific psychiatric behavioural patterns and/or factors of influence following a trauma and/or the practical hands-on help tailored to the individual are rarely held by one individual mental healthcare provider, so therefore, multiple mental health providers are deployed in the practice.

Less explicitly mentioned but frequently discussed was the desire for an integrated team that works on the basis of (a) an unambiguous vision and (b) an unequivocal methodology, (c) expertise in all areas, and (d) ample resources and (e) possibilities rather than problems. A team that focuses on reducing the multiple and complex problems in the family rather than a fragmented offering on sub-problems.

What advantages and disadvantages to family-focused interventions in families with multiple and complex problems are mentioned?

Although everyone is positive about family-focused interventions in general and considers their value indispensable, mainly points for improvement that were brought to attention with fragmentation mentioned most often. In no particular order, the following points were mentioned according family-focused interventions:

- A lot of fragmentation;
- You remain dependent on what the parents share with you;
- Implementation can be better, at the moment there is too much focus on the child;
- One family, one plan, does not work so well with this target group;
- Not every family-focused intervention empowers the parents;
● Social networks should be better involved;
● Family-focused interventions often work on the level of the problems in the family instead of on the level of the functioning of the family;
● We say we work family-focused, we think so, but do we really?
● Too little help is provided, there are too many partitions and not enough customization and flexibility;
● The waiting times for care are too long;
● There are too little intergenerational interventions;
● There is too much work on problems while there is not a solution for every problem;
● I miss a vision on normalization;
● After the family as a whole has been admitted to out-of-home, there is little targeted aftercare; the family then falls back;
● Too little attention to financial problems;
● In family-focused interventions, you have to be careful about your position as a psychologist;
● Starting with light interventions does not work sufficiently with these families;
● The psychiatrist has a lot of influence but does not see the family functioning in the home situation;
● It does not work well when specialist professionals starts saying what the generalist youth care workers should do;
● It is said that there is collaboration, but does this actually happen?

Where are the opportunities for further development of family-focused interventions for families with multiple and complex problems?

Concrete possibilities for development are mentioned, such as the use of a home support team, more room for creative solutions, increasing the expertise of the access team and the creation of a 0-100 team, up to more services with broad expertise in power of youth probation and youth protection. Several interviewees indicated that the deployment of ACT teams would be a positive development, but that the criteria for deployment of this team creates (too) many obstacles making it difficult to access. Also, there is a need for more use of peer-workers, trained experts by experience and/or volunteers.
The wish for a development agenda also includes better practical handling of addiction problems, (structural) financial problems and complex divorces. The local access providers, and/or district teams indicated that they would like to have tools to better deploy their own network. They also wrestle with the question of how to keep out low-complex requests for help in a low-threshold environment.

A number of participants mentioned the need for more integrated care. But how do you get this done? And how do you cooperate more with each other and make the system of funding youth care less bureaucratic?

There is a need for practical guidelines regarding the normalization or de-medicalization of psychological problems and for a manageable standard indicating to what extent family distress is acceptable. In other words: when is the care good enough? According to the interviewees, this desired development takes place at the level of (local) society.

The Questionnaire

A total of 206 questionnaires were completed, of which 26 were done by mental health providers and 180 by local access providers and/or district teams.

The questionnaire multi-problem families of Bodden and Deković (2010) have seven domains, each domain has several factors. The seven domains are: child factors, parent factors, childrearing factors, family functioning factors, contextual factors, factors within the social network and mental health care factors. The question of the involvement of Safe at Home and/or the Child Protection Board was added in this study.

Which areas or factors were most common?

To assess which areas occur most frequently, the scores per area are added up and divided by the number of questions. For example, family functioning (total score 889) contains six questions or factors that can be scored on: 889:6=148.16 rounded off to 148.

Table 1

| Most Mentioned Areas in the Bodden and Deković Questionnaire |
|-------------------------------------------------------------|
| Contextual factors such as multiple negative life events, financial hardship, and low Social Economic Status | 151.6 |
| Family functioning factors such as family conflicts, marital problems, and communication issues | 148 |
| Long history of mental health care, including out-of-home placement | 124.5 |
| Childrearing factors such as pedagogical powerlessness and attachment problems | 120 |
Parent factors such as mental or psychosocial problems and cognitive problems 116

Involvement of Safe at Home and/or the Child Care and Protection Board - added question 114.5

Problems within the social network such as absent of social network 109.5

Child factors, such as psychiatric or psychosocial problems and cognitive problems 106

All cases had at least one positive score in each domain. The five most common factors were: multiple negative life events (93%), communication problems in the family (91%), psychiatric or psychosocial problems including psychosomatic factors in parent(s) (89%), psychiatric or psychosocial problems including developmental problems of (one of) the child(ren) (87%) and pedagogical powerlessness (87%).

If multiple negative life events were involved, 91% also included psychiatric or psychosocial problems of (one of) the parents, as well as communication problems in the family (91%) and psychiatric or psychosocial problems in (one of) the children (87%). If communication problems in the family occur, then in 93% of the cases multiple negative life events also occur, in 91% also psychiatric or psychosocial problems of parents, 87% psychiatric or psychosocial problems of the children, in 87% pedagogical powerlessness and also 87% conflicts in the family occur. If psychiatric or psychosocial problems including psychosomatic factors are present in parent(s), 94% also have multiple negative life events, communication problems (93%), psychiatric or psychosocial problems in child(ren) in 88% and in 88% pedagogical powerlessness. If psychiatric or psychosocial problems including developmental problems of (one of) the child(ren) are involved, then 93% of these cases also involve multiple negative life events, 91% involve communication problems in the family and 90% involve psychiatric or psychosocial problems including psychosomatic factors in the parent(s). If there is a question of pedagogical powerlessness, then in 92% of those cases there are also several negative life events, in 91% communication problems in the family and in 90% there are also psychiatric or psychosocial problems including psychosomatic factors with parent(s).

In 10% of the cases there were 29 to 34 factors involved. In all these cases we see a parent with psychiatric or psychosocial problems, a parent who is or has been a victim/witness/perpetrator of abuse, inadequate parenting strategy, marital problems and multiple negative life events.

Families with Multiple and Complex Problems: Child, Rearing or Context

The focus was on whether and with what other factors the child factors are related. This was due to the fact that all care of families with multiple and complex problems had been reported primarily under the name of the child while they were relatively less common than - as indicated earlier - family factors.
Child Factors

In the domain child factors, 8 factors can be distinguished: 1) psychiatric or psychosocial problems including developmental problems; 2) behavioural problems; 3) psychosomatic problems and addictions; 4) cognitive problems (such as low IQ and learning disabilities) and intellectual disabilities; 5) victim or witness of maltreatment; 6) victim or witness of abuse; 7) neglect; and 8) victim or witness of domestic violence.

The child factors 'behavioural problems' and 'abuse' show no significant correlation with the problems within the other domains. There was a correlation, however, for the child factors 'psychiatric or psychosocial problems' (87%), 'psychosomatic problems' (28%) and 'cognitive problems' (51%) although they show significantly less coherence with other problems. Thus, the coherence they show is in a different direction than expected. This means that in those families where the child factor 'psychiatric or psychosocial problems' is present, there are significantly less often addiction problems of (one of) the parent(s) and low cohesion in the family. This means that in those families where 'psychosomatic problems and addiction child' are present, parents are less likely to be victims/witnesses/perpetrators of abuse and low socio-economic status is significantly less likely. This means that in those families where 'cognitive problems of the child' are present there is significantly less often conflict in the family and significantly less often low cohesion in the family. There is a significant relationship with cognitive problems of the child with cognitive problems of the parent(s), but conflicts in the family play significantly less often.

In 48% of the cases, children witnessed or were victims of maltreatment. If children were victims or witnesses of maltreatment, there was a significant relationship with behaviour problems of the parent(s), addiction of the parent(s), are one or both parents victims, witnesses and/or perpetrators of maltreatment, with marital problems in the family, with conflicts in the family, with a lot of external locus of control, with lack of organization in the family, low economic status and conflicts with friends and/or neighbours.

In 54% of the cases, there was neglect of one or more children in the family. This neglect was significantly associated with behaviour problems of one of the parents, addiction of one of the parents, cognitive problems of one of the parents, with parents who are victims, witnesses and/or perpetrators of abuse, with lack of organization in the family, with financial problems, low social economic status (SES) and a disturbed or deficient social network.

Table 2

How Victim or Witness Abuse is Related to Child Factors and Parenting Factors

| Related variables     | P-value | % with related problem in group with victim/witness of abuse | % with related problem in the group with no victim/witness of abuse | % with related problem in the whole sample |
|-----------------------|---------|-------------------------------------------------------------|-------------------------------------------------------------------|------------------------------------------|
| Parent: behaviour problems | <0.001  | 70%                                                         | 36%                                                               | 53%                                      |
| Parent: addiction     | 0.001   | 37%                                                         | 15%                                                               | 25%                                      |
In 54% of the cases there was neglect of one or more children in the family. This neglect was significantly associated with behavioural problems of one of the parents, addiction of one of the parents, cognitive problems of one of the parents, with parents who are victims, witnesses and/or perpetrators of abuse, with lack of organization in the family, with financial problems, low SES and a disrupted or deficient social network.

### Table 3

**How Neglect is Related to Child Factors and Parenting Factors**

| Related variables | P-value | % with related problem in group with victim/witness of abuse | % with related problem in the group with no victim/witness of abuse | % with related problem in the whole sample |
|-------------------|---------|-------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------------|
| Parent: behaviour problems | 0.015   | 62%                                                         | 44%                                                             | 53%                                      |
| Parent: addiction  | 0.049   | 31%                                                         | 19%                                                             | 25%                                      |
| Parent: cognitive problems | 0.001   | 59%                                                         | 34%                                                             | 46%                                      |
| Parent: victim / witness / perpetrator of abuse | 0.002   | 82%                                                         | 61%                                                             | 68%                                      |
| Family functioning: high external locus of control | 0.025   | 71%                                                         | 55%                                                             | 61%                                      |
Family functioning: no family organization | <0.001 | 70% | 43% | 57%
Contextual: financial problems | 0.005 | 72% | 52% | 62%
Contextual: low SES | 0.002 | 76% | 55% | 67%
Social network: disrupted social network | 0.007 | 79% | 61% | 70%

Domestic violence was present in 54% of the cases, significantly correlated with 14 other factors.

Table 4

How Domestic Violence is Related to Child Factors and Parenting Factors

| Related variables | P-value | % with related problem in group with victim/witness of abuse | % with related problem in the group with no victim/witness of abuse | % with related problem in the whole sample |
|-------------------|---------|-------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------|
| Parent: behaviour problems | <0.001 | 73% | 28% | 53% |
| Parent: addiction | 0.003 | 34% | 15% | 25% |
| Parent: cognitive problems | 0.018 | 55% | 37% | 46% |
| Parent: victim / witness / perpetrator of abuse | <0.001 | 96% | 39% | 68% |
| Family: relationship problems | <0.001 | 91% | 60% | 76% |
| Family: family conflicts | <0.001 | 97% | 63% | 82% |
| Family: communication problems | 0.004 | 96% | 84% | 91% |
| Family: low cohesion | 0.021 | 73% | 57% | 65% |
| Family: high external locus of control | 0.004 | 73% | 52% | 61% |
| Family: no family organization | <0.001 | 69% | 42% | 57% |
| Contextual: financial problems | 0.006 | 75% | 55% | 62% |
| Contextual: low SES | 0.016 | 78% | 60% | 67% |
We zoomed in on the question of whether involving or helping the client’s own network had a chance of succeeding. In the qualitative part (interviews) it became clear that involving the client’s own network is very difficult. In 69% of the families, the social network is either inadequate or disrupted. In absolute terms this concerns 143 families (out of 206), 57 families were not affected and in six families it was not clear whether they had a deficient or disrupted social network. When it comes to the association between certain factors and a disrupted social network, we see a significant difference on several variables. The table below shows where the significant differences are between the group of FMCP with and without a disrupted and/or limited network.

### Table 5

Differences are Between the Group of FMCP with and without a Disrupted and/or Limited Network

| Related variables                                      | P-value | With disrupted network | Without disrupted network |
|--------------------------------------------------------|---------|------------------------|---------------------------|
| Child: neglect                                          | 0.007   | 62%                    | 40%                       |
| Child: domestic violence                                | 0.002   | 64%                    | 39%                       |
| Parent: psychiatric or psychosocial problems            | 0.035   | 93%                    | 83%                       |
| Parent: cognitive problems                              | 0.039   | 53%                    | 36%                       |
| Parent: victim / witness / perpetrator of abuse         | 0.001   | 79%                    | 55%                       |
| Childrearing: insufficient rearing skills               | 0.02    | 90%                    | 77%                       |
| Childrearing: low parental responsiveness              | 0.015   | 60%                    | 46%                       |
| Childrearing: attachment problems                       | <0.001  | 67%                    | 35%                       |
| Family: relationship problems                           | 0.014   | 82%                    | 64%                       |
| Family: family conflicts                                | 0.026   | 86%                    | 72%                       |
| Family: high external locus of control                  | 0.013   | 70%                    | 50%                       |
We zoomed in on the relationship of the different domains and/or factors and out-of-home placement. The study shows that there is a significant relationship between the total number of problems in the family and 'risk of outplacement', 'involvement of Safe at Home' and 'involvement of the Child Care and Protection Board'. The chance of being placed in a home increases by 10% when one more problem is added to the family. The chance of involvement of the Child Care and Protection Board increases by 14% when one more problem occurs in a family. The chance of involvement of Safe at Home increases by 16% when there is one more problem in a family.

The tables below show which problems show significant differences between the groups where the factor ‘long history with mental health care’, 'out-of-home placement', 'involvement of Safe at Home' or 'involvement of the Child Care and Protection Board' is and is not present. We see for all three that there seems to be a connection with different problems in the family. What is particularly striking is that there is very little correlation between the removal of a child and the child factors. In addition, we see that ‘involvement of Safe at Home’ 'psychological problems child' and 'pedagogical powerlessness' show an unexpected opposite relationship (marked in green and with a *).

### Long History with Mental Health Care

#### Table 6

| Variable                                | P-value | With long history of mental health care | Without long history of mental health care |
|-----------------------------------------|---------|----------------------------------------|------------------------------------------|
| Child: cognitive problems               | 0.006   | 59%                                    | 31%                                      |
| Parent: psychiatric of psychosocial problems | 0.003   | 94%                                    | 74%                                      |
| Parent: cognitive problems              | 0.044   | 52%                                    | 31%                                      |
### Out-of-home Placement

**Table 7**

*Differences between the Groups where the Factor 'Out-of-home Placement' is and is not Present*

| Variable                                                   | P-value | Out-of-home placement | No out-of-home placement |
|------------------------------------------------------------|---------|------------------------|---------------------------|
| Child: sexual abuse                                        | 0.008   | 16%                    | 4%                        |
| Childrearing: low responsiveness                            | 0.039   | 68%                    | 53%                       |
| Childrearing: rejection                                     | 0.009   | 62%                    | 42%                       |
| Social network: conflicts with neighbors or friends         | 0.016   | 49%                    | 31%                       |
| Long history mental health care                             | 0.029   | 91%                    | 79%                       |
| Involvement Child Care and Protection Board                 | 0.001   | 62%                    | 38%                       |

### Involvement Safe at Home

**Table 8**

*Differences between the Groups where the Factor Involvement of ‘Safe at Home’ is and is not Present*

| Variable                                                   | P-value  | Safe at Home | No Safe at Home |
|------------------------------------------------------------|----------|--------------|-----------------|
| Child: psychiatric of psychosocial problems*               | 0.022    | 86%          | 97%             |
| Child: victim or witness of abuse                          | <0.001   | 60%          | 25%             |
| Child: domestic violence                                   | <0.001   | 67%          | 36%             |
| Parent: behaviour problems                                 | <0.001   | 68%          | 27%             |
### Child Care and Protection Board Involvement

**Table 9**

**Differences between the Groups where the Factor Involvement of Child Care and Protection Board is and is not Present**

| Variable                                          | P-value | Involvement with Child Protection Council | No involvement with Child Protection Council |
|---------------------------------------------------|---------|-------------------------------------------|---------------------------------------------|
| Child: victim or witness of abuse                 | 0.021   | 58%                                       | 41%                                         |
| Child: domestic violence                          | 0.013   | 67%                                       | 49%                                         |
| Family: relationship problems                     | 0.041   | 84%                                       | 71%                                         |
| Family: high external locus of control             | 0.001   | 76%                                       | 53%                                         |
| Social network: disrupted social network          | 0.016   | 64%                                       | 80%                                         |
| Social network: conflicts with neighbour’s or friends | >0.001  | 56%                                       | 25%                                         |
| Out-of-home placement                             | 0.001   | 53%                                       | 29%                                         |
| Safe at Home                                      | 0.001   | 79%                                       | 56%                                         |
Limitations to the Data Research

There are a number of limitations in this study that may affect the results. This exploratory study focuses on families with multiple and complex problems where multiple significance tests were conducted. Due to the multiplicity of tests, there is also an increased chance of chance capitalization. Dichotomous data (concerning or not concerning) was used in completing the questionnaire. This did not sufficiently reveal the severity and extent of these problems. The percentage of applied cases (completed questionnaires) was 12% from the mental health providers (psychologists and psychiatrists) and 88% from the youth workers at the local access centres. This was mainly due to the willingness and/or ability to devote time to this. The perspective of local providers on FMCP is thereby more strongly represented than the perspective of mental health providers such as psychologists and psychiatrists.

The biggest omission is the lack of information from the families themselves. They are a hard-to-reach group and at the time of Corona Virus they had other priorities on their minds over participation in an abstract study. Also in the literature, only limited information is available on the perspective of family members from families with multiple and complex problems. We advocate other ways of reaching them, for example through experts by experience.

The 206 cases used for this research represent, in the best case, are only 10% of the total number of families with multiple and complex problems in this youth region (NIJ, 2020, VNG, 2020). It is therefore recommendable to repeat this study in other youth regions to test the reliability of the results.

Conclusions

This research started with three research questions. First, what experiences with FMCP do youth care workers have with these families and with family-oriented interventions? Second, what problems do FMCP face the most and is there a significant correlation between the different problems? How are these problems related to the (imminent) out-of-home placement of children? Third, what potential solutions become apparent from the results of the research?

What experiences with FMCP do youth care professionals have with these families and with family-oriented interventions?

The image of families with multiple and complex problems that was presented by the respondents, corresponds to common descriptions in the literature. Multiple problems in multiple life areas, low level of parenting, relationship problems, financial problems, and high cost of care were most frequently mentioned. None of the respondents work with a standard screening list to distinguish whether or not a family has multiple and complex problems. None of the respondents had a concrete overview of how many FMCP there are. No link could be made between the registration system of the youth region and the insights of youth care workers regarding families with multiple and complex problems.
There is a broad support for family-focused interventions. At the family level, unfortunately, there is hardly any harmonization with regard to the method of family interventions. The supply of family-focused interventions is experienced as fragmented and a constant pile-up of help. Whereas the mental healthcare providers focus more on which scientifically substantiated interventions are possible, the local authorities seem to judge the effectiveness mainly on the structural results of the family-focused interventions.

The difficulty experienced by youth care workers in addressing the own social network of a family with multiple and complex problems is supported by the result that almost 70% of these families has a limited or disrupted network. The frequently mentioned hesitation to act and the cooperation problems between the different youth care providers / workers need to be further developed and improved.

All municipalities and also the youth region IJsselland in the east of the Netherlands have a vision on youth care, as a further elaboration of the Youth Act (RSJ, 2019). In practice, this vision falls short when it comes to handling families with multiple and complex problems. A low threshold and starting with small steps, one of the core elements on this vision, often leads to a continuous accumulation of care at FMCP which can have a negative effect on the self-reliance of the parents. Also, the question when the care is sufficient, good enough, could not be answered by professionals (alone).

What problems do FMCP face the most and is there a significant correlation between the different problems? How are these problems related to the (imminent) out-of-home placement of children?

At the domain level, we see that the domains of contextual factors - such as multiple negative life events, financial problems and having a low economic status - and family factors - such as conflicts, relationship problems and communication problems - are relatively more common than the domain of child factors while the child factors are often at the heart of youth care.

At the factor level we see that the top five most common factors are: multiple negative life events (93%), communication problems in the family (91%), psychiatric or psychosocial problems including psychosomatic factors in parent(s) (89%), psychiatric or psychosocial problems including developmental problems of (one of) the child(ren) (87%) and pedagogical powerlessness (87%). There are many different significant relationships between the factors. In 10% of the cases 29 to 34 (out of 37) factors were at play. In this 10% cases we see a parent with psychological problems, a parent who is or has been a victim/witness/perpetrator of abuse, insufficient parenting strategy, relationship problems and multiple negative life events.

A striking conclusion was that there was little correlation between the out-of-home placement of a child and a positive score on child factors. It could also be concluded that in those cases where there was involvement of Safe at Home, compared to the group where there was no involvement of Safe at Home, there were significantly fewer psychological problems of the child and the pedagogical powerlessness of the parents.

That there is a significant relationship between the total number of problems in the family with multiple and complex problems and 'chance of out-of-home placement', 'contact with Safe at Home' and 'contact with the Child Care and Protection Board' was partly to be
expected. What was unexpected was the fact when one more problem in these families occurred, the probability of out-of-home placement increases with 10%. Also, if one or more new problems arose in these families, the probability of Child Care and Protection Board being deployed increases by 14% and the change of deploying Safe at Home increases with 16%. This suggests that stabilizing and/or reducing the number of problems can reduce out-of-home placement and deployment of Child Care and Protection Board and/or Safe at Home.

Eighty percent of families with multiple and complex problems have between 14 and 29 (out of 37) defined problems. To give an idea of what such a family might look like, a case study below with ‘only’ 16 problems:

The Walters family consists of mother Ine, father Henrik and the children Emma, Luuk and Daan. Father and mother have (1) relationship problems which cause daily conflicts in the family; (2) Ine and Henrik both suffer from psychological problems; (3) whereby father, out of powerlessness, at times behaves aggressively; (4) there are financial problems; (5) these financial problems are not the first time; (6) because of all the tensions they no longer seem to understand each other well and the mutual communication almost invariably ends in quarrels; (7) this leads to a negative influence on their ability to use a consistent parenting strategy; (8) and their ability to respond adequately to the children; (9) Luuk and Daan show many behavioural problems; (10) with Luuk experimenting a lot with drugs lately; (11) Fortunately, Emma is very sweet and helps well with organizing everything the family needs to do; (12) Mother Ine loves her children very much but does not know how to manage her own problems and those of the children; (13) Ine and Henrik have hardly any contact with the family; (14) Ine’s family hardly accepts Henrik. Henrik himself comes from a family with a lot of violence; (15) he has broken with them. For years, Ine and Henrik have been receiving help from an 'I don't know how many’ care providers; (16) which requires a lot of organizational skills to keep track of all agreements and goals.

What potential solutions become apparent from the results of the research?

The assumption that in families with multiple and complex problems, dysfunction as a family is the core problem, can be confirmed. The choice for more family-focused interventions thus seems logical and solving. However, these research results show that the solution (everyone offers family-focused interventions) simultaneously creates an additional problem when these family-focused interventions are insufficiently coordinated. To prevent fragmentation and further overburdening of the FMCP, the family-oriented interventions should be offered as an integrated supply. The youth region or municipality can stimulate this integrated care by considering integrated help as a necessary condition to be able to offer help and support to families with multiple and complex problems. It is understandable that the suffering of children is close to the heart of care workers and that respecting the autonomy of the family is highly valued in our society. Nevertheless, help should be primarily aimed at the functioning of the family as a whole, by ensuring a healthy(er) dynamic within the family for the benefit of the child. The registration of families with multiple and complex problems also
needs to be improved. When it comes to a FMCP registration and funding, this should be done at the family level. Reporting only at the child level gives a distorted picture of the costs in youth care. This means that there must be a better possibility of offering integrated care to children (Youth Act, implemented by the municipalities) and their parents (Health Insurance Act, implemented by health insurers). Using the characteristics of FMCP of Bodden and Deković, converted into a questionnaire, can be helpful in this regard. The final recommendation is to support families with multiple and complex problems with an independent client supporter and to make good use of experts by experience.

**Discussion**

What this study shows is the complexity, not only of the families themselves but also the complexity of the caregivers involved in these families. It is important to recognize and understand this complexity.

Something is complex if its made up of usually several closely related connected parts, the more parts and the more connections are entwined within the system, the more complex it will be, and the more difficult it will be to analyze such a system (Sturmberg & Martin, 2013, p. 1).

Dealing with this complexity requires a different approach than usual (Ellis et al., 2017, Edgren & Barnard, 2012). To date, the tendency has been to address, for example, behavioural problems in children and/or limited parenting skills, with scientifically effective methods in order to reduce the number of out-of-home placements. This care was mostly provided by different health care providers from different organizations. In this context of increasingly specialized and cut up care, integrated care does not sufficiently develop (Rosenberg & Hickie, 2013). Flexible interactions between stakeholders is needed (Ellis et al., 2017). Relationship-building and information sharing and space for self-organization is therefore required (Tsasis et al., 2012). So, one of the main challenges is the switch from solving disconnected problems to intervene in the dynamics of the family. Dealing with complexity, it is more effective to intervene with safe-trail-and-error interventions to more stabilize the dynamics of the family as a whole (Van der Merwe et al., 2019; Van Beurden et al., 2011; Snowden & Boone, 2007). We must however realize that this is easier said than done.

When a family has complex and multiple problems and there are several care institutions involved, it is advisable to use an independent client supporter or experience expert to support the family in its self-management (Bakker et al., 2017). Independent client supporters or experience experts are able to translate the wishes of the family into achievable goals and can act as a bridge to the care providers. They can contribute to improving the social network and can offer hope and perspective (Karbouniaris et al., 2020, Weerman, 2018).

By supporting the family as a whole, it may be possible to reduce the number of children placed out of home. And, in doing so, may be able to make a positive contribution to reducing the transformation of intergenerational dysfunction in families (Gomis-Pomares et al., 2021).
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