university of groningen

University Medical Center Groningen

University of Groningen

Interventions for families with multiple problems

Visscher, Loraine; Jansen, D.E.M.C.; Evenboer, K.E.; van Yperen, T.A.; Reijneveld, S.A.; Scholte, R.H.J.

Published in:
Child & family social work

DOI:
10.1111/cfs.12646

IMPORTANT NOTE: You are advised to consult the publisher's version (publisher's PDF) if you wish to cite from it. Please check the document version below.

Document Version
Publisher's PDF, also known as Version of record

Publication date:
2020

Link to publication in University of Groningen/UMCG research database

Citation for published version (APA):
Visscher, L., Jansen, D. E. M. C., Evenboer, K. E., van Yperen, T. A., Reijneveld, S. A., & Scholte, R. H. J. (2020). Interventions for families with multiple problems: Similar contents but divergent formats. *Child & family social work*, *25*(1), 8-17. https://doi.org/10.1111/cfs.12646

Copyright
Other than for strictly personal use, it is not permitted to download or to forward/distribute the text or part of it without the consent of the author(s) and/or copyright holder(s), unless the work is under an open content license (like Creative Commons).

The publication may also be distributed here under the terms of Article 25fa of the Dutch Copyright Act, indicated by the "Taverne" license. More information can be found on the University of Groningen website: https://www.rug.nl/library/open-access/self-archiving-pure/taverne-amendment.

Take-down policy
If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Downloaded from the University of Groningen/UMCG research database (Pure): http://www.rug.nl/research/portal. For technical reasons the number of authors shown on this cover page is limited to 10 maximum.

Download date: 04-06-2022

DOI: 10.1111/cfs.12646

ORIGINAL ARTICLE

WILEY CHILD & FAMILY SOCIAL WORK

Interventions for families with multiple problems: Similar contents but divergent formats

Loraine Visscher[1] | Danielle Jansen[1,2] | Els Evenboer[1] | Tom van Yperen[3] | Sijmen Reijneveld[1] | Ron Scholte[4,5,6]

[1] Department of Health Sciences, University Medical Center Groningen, University of Groningen, Groningen, The Netherlands

[2] Department of Sociology and Interuniversity Center for Social Science Theory and Methodology (ICS), University of Groningen, Groningen, The Netherlands

[3] Department of Pedagogy and Educational Sciences, University of Groningen, Groningen, The Netherlands

[4] Behavioural Science Institute, Radboud University, Nijmegen, The Netherlands

[5] Tranzo, Tilburg University, Tilburg, The Netherlands

[6] Institute for Studies on Personality Disorders (VISPD), De Viersprong, Halsteren, The Netherlands

Correspondence
Loraine Visscher, Department of Health Sciences, University Medical Center Groningen, University of Groningen, Antonius Deusinglaan 1, FA10, Room 6.17, 9713 AV Groningen, The Netherlands.
Email: l.visscher@umcg.nl

Funding information
The Netherlands Organization for Health Research and Development, Grant/Award Number: 729300016

Abstract

For families with multiple problems (FMP), knowledge is lacking on the practice elements of interventions (the distinct techniques practitioners use to promote positive outcomes) and their program elements (intervention design and delivery systems). The aim of this study is to identify both common and specific practice and program elements so as to determine contents and overlap between interventions. For FMP, we selected interventions that had at least moderate (>0.5) effect sizes in the Dutch context (N = 8). A deductive content analysis was used to assess the manuals of these interventions with the taxonomy of interventions for FMP. We defined as common those elements found in at least five of the eight interventions and as specific those found in fewer than five. Of the practice elements, 79% were common across the interventions, and 21% were intervention specific. Interventions with the highest percentages of intervention-specific elements derived from the taxonomy were 10 for the Future (15%), Family Central (14%), Intensive Family Therapy (14%), and Multisystemic therapy (11%). Core program elements: duration, intensity, intervision, supervision, and consultation, varied greatly between interventions. Among interventions for FMP, we found practice elements to have considerable overlap. Among program elements, we found greater variety.

KEYWORDS

child and youth care, common elements, families with multiple problems, interventions, practice elements, program elements

1 | INTRODUCTION

Families with multiple problems (FMP), also defined as multiproblem families or multistressed families, face complex and intertwined problems in different areas of life, such as parenting problems, psychosocial problems, health problems, social network problems, and problems in the domains of justice (Bodden & Deković, 2016; Morris, 2013; Tausendfreund, Knot-Dickscheit, Post, Knorth, & Grietens, 2014). As the problems of FMP are often intergenerational, children raised in these families are at great risk of developing behavioural and emotional problems (Spratt, 2011). Furthermore, most FMP are multi users of care (Pannebakker et al., 2018). To reduce the problems of FMP and the consequences of those problems, various interventions have been developed, aimed mainly at improving parenting skills, reducing problem behaviour and preventing out of home placement of the child (Evenboer, Reijneveld, & Jansen, 2018). Well-known examples of such interventions are Multisystemic Therapy (MST) and Multidimensional Family Therapy (MDFT; Ogden & Hagen, 2006; van der Pol et al., 2017).

However, in spite of increasing evidence of the effectiveness of interventions targeting FMP, detailed information on their contents is lacking (Michie, Fixsen, Grimshaw, & Eccles, 2009). This makes it

 © 2019 John Wiley & Sons Ltd

difficult to interpret and compare outcomes of studies on interventions for FMP. Practitioners have to choose from among interventions the one best suited to the specific needs of an FMP but without having clear guidance as to their content (Kazdin, Bass, Ayers, & Rodgers, 1990; Lee et al., 2014). Questions also arise about the overlap between interventions for FMP, and whether or not, it is necessary to choose between interventions, considering their possible redundancy.

An overview of similarities and differences between interventions for FMP is needed. In the broader field of child and youth care, several studies have already shown that although most of the interventions have different labels, their content is actually the same (Evenboer, Huyghen, Tuinstra, Knorth, & Reijneveld, 2016; Garland, Hawley, Brookman-Frazee, & Hurlburt, 2008; Lee et al., 2014; Veerman, Janssens, & Delicat, 2005). For example, one of these studies concluded that 17 different "Family Preservation Interventions" did not differ in their content or target group (Veerman et al., 2005). Another study on 91 interventions for children and adolescents with behavioural and emotional problems also indicated that these interventions have substantially overlapping content, with the greatest overlap within the main category "family support" (Evenboer et al., 2016).

One way to gain more insight into the content of interventions for FMP is to identify their practice and program elements (Blase & Fixsen, 2013; Chorpita, Daleiden, & Weisz, 2005; Michie, Hyder, Walia, & West, 2011). Practice elements concern the content of an intervention, as they are distinct techniques (e.g., modelling, social skills training) applied by the practitioner to promote positive outcomes. Program elements are aspects of the intervention format or the service delivery system, that might affect the results, for example, 24-hr reachability (Lee et al., 2014). Identification of these practice and program elements may provide insight into similarities (common elements) and differences (intervention-specific elements) between interventions for FMP and improve our understanding of what works for whom (Evenboer et al., 2018), thereby enhancing tailoring of interventions to the specific needs of families (Barth et al., 2012; Chorpita, Becker, & Daleiden, 2007; Garland et al., 2008; Weisz et al., 2012). The aim of this study is therefore to identify practice and program elements of interventions for FMP in order to determine contents of interventions and overlap between them.

2 | METHOD

To identify practice and program elements of interventions, we assessed manuals of interventions targeting FMP.

2.1 | Selection of interventions

We selected interventions based on a systematic review of the literature on 30 interventions targeting FMP (Evenboer et al., 2018). We searched for interventions, which had at least a moderate effect size of 0.5 in the Dutch context on domains such as problem behaviour of the child and/or parenting stress. This resulted in the selection of eight interventions: MST, MDFT, Intensive Family Treatment (IFT), Families First (FF), Family Central (FC), Parent Management Training Oregon (PMTO), 10 for the Future (10Ftf), and Triple P 4–5.

2.2 | Measures and procedures

We assessed all eight intervention manuals to identify practice and program elements by using the taxonomy of interventions for FMP (TIFMP). This taxonomy is a reliable instrument to identify practice and program elements of a wide range of interventions for FMP (Visscher et al., 2018). It consists of 53 practice elements, divided into eight main categories.

a. Assessment of problems (e.g., analysis of competencies)
b. Planning and evaluation (e.g., designing the treatment plan)
c. Working on change (e.g., working on communication and interaction)
d. Learning parenting skills (e.g., learning to set rules)
e. Helping with concrete needs (e.g., helping with financial tasks)
f. Activating the social network (e.g., mobilizing and expanding the social network)
g. Activating the professional network (e.g., coordinating the approach with other professionals and/or organizations working with the family)
h. Maintaining practitioner-client collaboration (e.g., talking about expectations).

Furthermore, the taxonomy consists of six program elements: duration and intensity of the intervention, supervision (discussing the family with a supervisor during an organized meeting), intervision (discussing the family with colleagues during an organized meeting), consultation (discussing the family with an independent expert during an organized meeting), and 24-hr reachability.

Assessment of the intervention manuals by means of the TIFMP involved a deductive content analysis (Elo & Kyngäs, 2008). This required the use of a structured data matrix (the TIFMP) and using this taxonomy to review the manuals for intervention elements and label each element. During this assessment, the first author and a research assistant independently assessed the intervention manuals of the eight selected interventions, using the TIFMP. For each practice element of the taxonomy, we first assessed whether it occurred in the intervention manual. Second, we searched the manual for additional practice elements that had not yet been identified, for example because they did not match the terminology of the taxonomy. Third, we searched the manual for explicit information about each program element. After each assessment, each separate assessor produced a preliminary list of identified practice and program elements. Next, the two assessors compared their lists. In cases of disagreement, the intervention manuals were assessed again to reach consensus on the

practice and program elements. For each intervention, this resulted in one list of included elements.

2.3 | Analysis and reporting

First, we described the characteristics of the included interventions (i.e., duration, the aim, the target group, the focus, and theory of change). Second, we assessed the practice elements (present or not) of the interventions. To identify common and intervention-specific practice elements, we defined practice elements as common if they were found in at least five of the eight interventions and as intervention specific if they were found in fewer than five of the eight interventions. Third, we described the program elements.

3 | RESULTS

3.1 | Characteristics of the included interventions

All interventions target families that at least face severe parenting problems and/or have multiple and complex problems in different life domains. The interventions mainly aim to improve parenting skills, reduce problem behaviour of the child, and prevent an out of home placement of the child. The ages of the group targeted by the interventions vary, for children from 0 to 23 years. Furthermore, the interventions vary in duration from 1 (FF) to 12 months or longer (10Ftf). More detailed background information on the eight interventions is shown in Table 1.

3.2 | Common and intervention-specific practice elements

We found that 79% of the practice elements of the TIFMP were common, in that they were present in the majority of the interventions (at least five of the eight), whereas 21% of the practice elements were intervention-specific. The proportions of common elements per intervention ranged from 85% to 100%. Common practice elements appeared in particular in the categories "assessment of problems," "planning and evaluation," "working on change," "learning parenting skills," and "maintaining the practitioner-client collaboration." Intervention-specific practice elements appeared mainly in the three categories: "helping with concrete needs," "activating the social network," and "activating the professional network."

Interventions containing the highest percentages of specific elements were 10Ftf (15%), FC (14%), IFT (14%), and MST (11%). The remaining four interventions had fewer intervention-specific practice elements, with PMTO (3%) and Triple P 4–5 (0%) having the least. This means that 10Ftf, FC, IFT, and MST, in addition to sharing common practice elements, also focus on specific issues like helping with concrete needs and activation of the social and professional network around FMP. Table 2 provides an overview of the common and intervention-specific practice elements of the eight interventions.

3.3 | Program elements of interventions targeting FMP

Regarding program elements, we found that these elements varied greatly between interventions. For example, the duration of the interventions varied between 1 month (FF) and 1 year or longer (10Ftf). Regarding intensity, the number of contacts between the professional and the client also varied between one contact per day (FF) to a mean of two or three contacts per week (IFT, MDFT, MST). Supervision and intervision were part of almost all interventions, except Triple P 4–5 and MDFT, respectively. The organization and the compulsory nature of supervision (discussing the family with a supervisor during an organized meeting) and intervision (discussing the family with colleagues during an organized meeting) differed between interventions. Furthermore, we found consultation (discussing the family with an independent expert during an organized meeting) to be included in one intervention (MST). Finally, we found that 24-hr reachability (either by the practitioner, a colleague in the team, or an accessibility service within the department) was included in 10Ftf, FF, MST, and MDFT; 24-hr reachability was not included in FC, IFT, Triple P 4–5, and PMTO. A detailed overview of program elements per intervention is shown in Table 3.

4 | DISCUSSION

The aim of this study was to identify practice and program elements of interventions targeting FMP in order to reveal contents and overlap between interventions. We found that the eight interventions for FMP have considerable overlap of 79% in practice elements (common elements). This corresponds with previous studies examining overlap between interventions in child and youth care (Evenboer et al., 2016; Lee et al., 2014; Veerman et al., 2005). However, four interventions (10FtF, FC, IFT, and MST) contained a higher percentage of specific elements and a relatively greater variety of practice elements. Between the different interventions, we also found substantial variation in program elements. For example, duration varied between 1 month and a year or longer, and in some interventions, intervision, supervision, and consultation were not compulsory elements.

The findings of our study contribute to existing knowledge by unravelling not only the common elements of interventions but also their intervention-specific elements. With regard to practice elements, our study showed that four interventions for FMP contained a more unique and varying set of practice elements. These four: 10Ftf, FC, IFT, and MST, unlike the other four interventions, focus on a broader range of problems (including elements regarding helping with concrete needs, as well as the social and professional network). The comprehensive nature of this set of elements may be explained by the broader focus of these interventions, which also address the context of the family: school, social network, and peers. By contrast, other interventions like PMTO and Triple P 4–5 focus more on the family system and less on broader social networks (Evenboer et al., 2018). The comprehensiveness of the elements of 10Ftf, FC, IFT, and MST

TABLE 1 Background information on the eight selected interventions

Intervention	Duration	Aim of the intervention, target group, focus of the intervention, and theory of change
Parent Management Training Oregon (PMTO)	5 months	PMTO aims to provide parents with more systematic and effective parenting strategies to enhance their relationships with their children and reduce the number of conflicts. The target group is parents with children between 4 and 12 years who show severe externalizing problem behaviour in combination with hyperactivity. The focus of the intervention is to reinforce positive behaviour in the parents/child (ren). The intervention uses the social interaction learning theory as theory of change.
Multisystemic therapy (MST)	3 to 5 months	MST aims to provide intensive treatment in a home-based situation to prevent out of home placement. The target group is children from 12 to 18 years with severe antisocial/border-crossing behaviour and their parents. Problems could occur in multiple life domains and could lead to out of home placement of the child. The intervention focuses on the child, family, friends, school, and peers. This intervention uses the social ecological theory of Bronfenbrenner as theory of change.
Multidimensional Family Therapy (MDFT)	3 to 7 months	MDFT aims to reduce criminal and addictive behaviour and related behavioural and emotional problems of the child, to enhance communication within the family, and to increase the social cohesion. The target group is youth from 12 to 19 years with multiple problem behaviour like delinquency and/or addiction, complemented by school truancy. At least one parent should join the therapy. The intervention focuses on the child and his family and peers. It uses the social ecological theory of Bronfenbrenner as theory of change.
Intensive Family Treatment (IFT)	5 to 7 months	IFT aims to reduce children's problem behaviour and parental stress and to increase parenting skills and activate the social network of the family. The target group is families with children between 0 and 23 years with multiple and complex problems in different life domains. These families can be stubborn and difficult for the therapist to reach. The intervention focuses on preventing out of home placement or reunification. The intervention uses goal-driven work as theory of change.
Families First (FF)	1 month	FF aims to reduce the problem behaviour of the child and strengthen the competencies of the family, thereby reducing parenting stress, increasing parenting skills, and activating the social network of the family. The target group is families in an acute crisis, serious enough to risk of out of home placement of the child. The focus is on managing the crisis and assuring the safety of the family members. The intervention uses the competence model as theory of change.
Family Central (FC)	6 to 12 months	FC aims to enhance communication between family members and collaboration between parents, thereby reducing behavioural problems of the child (ren) and activating the social network of the family. The target group is youth between 0 and 18 years and their family, who could have serious parenting problems and developmental problems. These families can be stubborn and difficult for the therapist to reach. The focus is on the accumulation of problems and trying to find balance in the various domains of life. The intervention uses the competence model, goal-driven working, and working according to a system approach as theories of change.
10 for the Future	12 months	10 for the Future aims to provide assistance on 10 different areas of life: household work, education, self-care, development of the child, enhancing the social network, finance, parenting skills, daily routine, psychosocial and addiction problems, and coordination of care. The target group is families with complicated and multiple problems in different life domains, with a risk of out of home placement of the child. The focus is on a safe environment for the child (ren) and parent (s). The intervention uses goal-driven working as theory of change.
Triple P 4–5	2 to 2.5 months	Triple P aims to prevent children from having serious behavioural and emotional problems by enhancing parental competencies. The target group of Triple P 4 is parents who have children with severe behavioural problems and are in need of a targeted training in parenting skills. The target group of Triple P 5 is families with multiple behavioural problems combined with other family related problems. Level 5 is deployed when no or insufficient improvement is seen in the behaviour of the child after level 4 because parenting problems are linked with other problems (e.g., depression, stress, or relational problems). The intervention uses the social learning theory, the theory of behavioural change, and the social information theory as theories of change.

TABLE 2 Practice elements of interventions for families with multiple problems

Practice element	10Ftf	FF	FC	IFT	MDFT	MST	Triple P 4–5	PMTO
(a) Assessment of problems								
Discussing the guiding question[a]	X	X	X	X	X	X	X	X
Analysis of competencies[a]	X	X	X	X	X	X	X	X
Analysis of network[a]	X	X	X	X	X	X	X	X
Analysis of safety[a]	X	X	X	X		X		
Analysis of the family system[a]	X	X	X	X	X	X	X	X
Analysis of leisure time	X				X	X		
Analysis of school functioning[a]	X				X	X	X	X
Analysis of daily routine[a]	X	X	X	X	X			
Analysis of individual problems[a]	X	X	X		X	X	X	X
Using homework assignments to observe and register behaviour[a]		X	X	X	X	X	X	X
Using questionnaires[a]	X	X	X	X	X	X	X	X
Discussing results from questionnaires[a]		X	X	X	X	X	X	X
Problem assessment[a]	X	X	X		X	X	X	X
(b) Planning and evaluation								
Designing the treatment plan[a]	X	X	X	X	X	X	X	X
Designing working points or (behavioural) agreements[a]	X	X	X	X	X	X	X	X
Evaluating working points or (behavioural) agreements[a]	X	X	X	X	X	X	X	X
Evaluating the treatment plan[a]	X	X	X	X		X	X	X
(c) Working on change								
Working on recognizing, avoiding, and coping with situations eliciting problem behaviour and helping to remove these causes[a]	X		X	X	X	X	X	X
Working on thoughts[a]	X		X	X	X	X	X	
Working on emotions[a]	X	X	X	X	X	X	X	X
Working on desired behaviour[a]	X	X	X	X	X	X	X	X
Working on undesired behaviour		X	X	X				
Working on communication and interaction[a]	X	X	X	X	X	X	X	X
Working on authority relationships			X		X	X		
Working on the daily routine	X	X	X	X				
Working on safety[a]	X	X	X	X	X	X		
Working on generalization[a]	X	X	X	X	X	X	X	X
(d) Learning parenting skills								
Learning to apply reinforcements and positive consequences[a]	X	X	X	X	X	X	X	X
Learning to apply mild punishments and negative consequences[a]	X	X	X	X	X	X	X	X
Learning to monitor the child[a]	X			X	X	X		X
Learning to show commitment to the child[a]		X		X	X	X	X	X
Learning to handle conflicts[a]	X		X	X	X		X	X
Learning to set rules[a]	X		X	X	X	X	X	X
Learning to be responsive[a]	X	X		X	X	X	X	X
Learning to perform social skills						X		X
Learning to collaborate[a]	X		X	X	X	X	X	X

(Continues)

TABLE 2 (Continued)

Practice element	10Ftf	FF	FC	IFT	MDFT	MST	Triple P 4–5	PMTO
(e) Helping with concrete needs								
Selfcare	X							
Administration and financial control[a]	X	X	X	X		X		
Having contact with school and/or other authorities[a]	X		X	X	X	X		
Housekeeping[a]	X	X	X	X		X		
(f) Activating the social network								
Mobilizing and expanding social support[a]	X	X	X	X	X	X		
Maintaining the social network[a]	X	X	X	X		X		
Stimulating leisure time	X				X	X		
(g) Activating the professionals network								
Collaborating with other professionals and/or organizations working with the family[a]	X	X		X	X	X		
Coordinating the approach with other professionals and/or organizations working with the family				X				
Referring to other organizations or authorities[a]	X	X	X		X		X	
Organizing respite care	X		X	X				
(h) Maintaining the practitioner-client collaboration								
Talking about expectations[a]	X	X	X	X	X		X	X
Talking about resistance to care[a]	X	X	X	X	X		X	
Working on motivation[a]	X	X	X	X	X	X	X	X
Offering emotional support[a]	X		X	X	X	X	X	X
Working on the quality of the relationship	X		X	X		X		
Evaluating the quality of the relationship	X		X	X				
Total number of practice elements of the TIFMP that are part of the intervention	46	35	43	44	40	42	32	31
Total percentage of common elements[a] within the intervention	(39/46) 85%	(33/35) 94%	(37/43) 86%	(38/44) 86%	(37/40) 93%	(37/42) 89%	(32/32) 100%	(30/31) 97%

Abbreviations: 10Ftf, 10 for the Future; FC, Family Central; FF, Families First; IFT, Intensive Family Treatment; MST, multisystemic therapy; MDFT, Multidimensional Family Therapy; PMTO, Parent Management Training Oregon.

[a]Common element: a practice element present in the majority of the interventions.

could be important in cases requiring attention to the full range of problems of FMP. However, more research is needed to determine this in day to day practice.

Despite the considerable overlap in practice elements across interventions for FMP, we found that their program elements greatly varied. These findings shed new light on the similarities and differences of interventions for FMP. Until now, no (inter) national study, besides focusing on the practice elements, has also taken into account the program elements of these interventions. Differences in, for example, their duration and intensity may be caused by differences in their aims. For example, FF focuses on families in acute crisis and aims to manage the crisis and assure the safety of the family members. Therefore, FF lasts 1 month and has a greater intensity than interventions not specifically focusing on situations of acute crisis. In shorter interventions like FF, practitioners may choose to select a set of practice elements applicable to specific problems present in that family at that specific moment. In longer lasting interventions like IFT or 10Ftf, practitioners may use a more varied set of practice elements but apply them less frequently.

In summary, the practice elements (contents) of most interventions for FMP are similar, but their program elements (formats) greatly differ. These program elements should thus be considered when comparing interventions. Previously, various authors suggested that, based on their overlapping content, the number of interventions in child and youth care could be reduced (Evenboer et al., 2016; Veerman et al., 2005). However, such a reduction does not seem feasible when taking their program elements into account. These program elements: duration, intensity, and sequence, provide a format in which to carry out the practice elements. Therefore, these program elements may clearly affect intervention outcomes. Further research is needed to unravel the application of practice and program elements of these interventions in daily practice.

TABLE 3 Program elements of interventions for families with multiple problems, per intervention

Program element	10Ftf	FF	FC	IFT	MST	MDFT	Triple P 4–5	PMTO
Duration	12 months or more	1 month	6 to 12 months	5 to 7 months	3 to 5 months	3 to 7 months	2 to 2.5 months	5 months
Intensity	• Starting phase: on average three to four contacts per week • Changing phase: on average two contacts per week • Final phase: on average two contacts per week	• Information phase: seven contacts per week • Changing phase: on average three to five contacts per week • Final phase: on average two to four times a week	On average one contact per week	• Starting phase: on average two contacts per week • Changing phase: on average two contacts per week • Final phase: on average one contact per week	On average three contacts per week	On average two to three contacts per week	On average one contact per week	On average one contact per week
Supervision	Structurally individual supervision or supervision in a group (frequency of supervision not defined in the manual).	Individual supervision once every 2 weeks. Also telephone calls with supervisor.	Individual supervision once every 4 to 6 weeks.	Supervision with a minimum of once every 2 weeks (individual or in a group).	Weekly supervision in a small group, based on the progress report.	Live supervision, supervision via recordings, and self-supervision. In the first 2 years every week. Thereafter, once every 2 weeks.	Not part of Triple P 4–5.	At least 20 times supervision of 2 hr per session.
Intervision	Intervision at least once in a quarter.	Weekly intervision.	Intervision (team coaching) once every 2 weeks led by the supervisor.	Supervision at least once every 2 weeks (individual) or intervision (in a group).	Not part of MST.	Not part of MDFT.	At least four supervision meetings in the first year after the training.	Treatment sessions recorded to be reflected on with colleagues (intervision).
Consultation	Not part of 10Ftf.	Not part of FF.	Once every 2 years the practitioner hands in to his supervisor a recording of a treatment session. The supervisor gives feedback based on a	Not part of IFT.	After each group supervision session, the supervisor calls with a consultant of the national knowledge centre about the progress	Not part of MDFT.	Not part of Triple P 4–5.	Not part of PMTO.

(Continues)

TABLE 3 (Continued)

Program element	10Ftf	FF	FC	IFT	MST	MDFT	Triple P 4–5	PMTO
			standardized form. A number of recordings are also assessed by a consultant from the national knowledge center.		reports. Consultant comments on these reports and the comments are discussed.			
24-hr reachability	Within the department of 10Ftf is a reachable accessibility service.	Practitioner or a colleague in the team is 24-hr reachable.	Not part of FC.	Practitioners ensure structural reachability; 24-hr reachability is not part of IFT.	Practitioner or colleague in the team is 24-hr reachable.	Practitioner can be 24-hr reachable if needed.	Not part of Triple P 4–5.	Not part of PMTO.

Abbreviations: 10Ftf, 10 for the Future; FC, Family Central; FF, Families First; IFT, Intensive Family Treatment; MST, multisystemic therapy; MDFT, Multidimensional Family Therapy; PMTO, Parent Management Training Oregon.

4.1 | Strengths and limitations

A major strength of this study is its use of a reliable existing taxonomy specifically targeting FMP. In this way, we were able to identify the practice and program elements of the interventions in a structured and reliable manner. In addition, we used two independent reviewers to assess the intervention manuals, thereby reducing the likelihood of bias.

Another strength is the use of a nationally representative set of interventions. Moreover, several included interventions—MDFT, MST, PMTO, and Triple P 4—are also used internationally. This increases the generalizability of the results for other countries.

A limitation of our approach might be the use of only eight interventions, which could have led to overlooking some important elements. However, the range of interventions that we included can be considered representative for FMP as they are major interventions in the Dutch setting, where they have been shown to be effective (Evenboer et al., 2018).

A second limitation of our method is that there may be some practice or program elements that are not (yet) described in the intervention manuals but that nevertheless have become standard practice This may have led to overlooking some elements that are part of the intervention (for example in daily practice) but are not explicitly listed in the intervention manual. Therefore, further research has to be done on the practice and program elements that are part of the interventions in daily practice and compare these elements with elements found in the intervention manuals.

4.2 | Implications

The outcomes of our study have several implications for care organizations and researchers related to care for FMP. First, the detailed overview of the content of different interventions offers care organizations insight into their similarities and differences. Such an overview enables the organizations to make a founded decision as to the value of the various interventions when added to their existing care provision for FMP (Lee et al., 2014; Veerman et al., 2005).

Second, more detailed knowledge on both common and specific elements of interventions enables better interpretation and comparison of outcomes of studies on their effectiveness. On the basis of the list of elements included in specific interventions, researchers can determine whether differences in outcomes can be explained by differences in content (Veerman et al., 2005). This knowledge also adds to the accumulation of evidence from different effectiveness studies (Chorpita et al., 2005).

An evident next step is to collect evidence on the practice and program elements involved in FMP interventions in daily practice. Questions to be answered include: Are interventions carried out as intended? Do the duration and intensity of an intervention influence the frequency of applied practice elements? In which sequence are these practice elements applied? This subsequent step may further enrich our understanding of the content of these interventions in daily practice, which may indeed be different.

5 | CONCLUSION

Our findings show that most interventions for FMP, in spite of their different labels, have similar contents (practice elements) but greatly differing formats (program elements). This enhances our understanding of the use of these interventions in daily practice and can contribute to improving care.

FUNDING INFORMATION

This study received funding from The Netherlands Organization for Health Research and Development (ZonMw; grant number 729300016).

CONFLICT OF INTEREST

The authors declare no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

ETHICAL APPROVAL

The Medical Ethics Committee of the University Medical Center Groningen in the Netherlands determined that ethical approval was not needed for this study (reference number METc2016.005 dated March 7, 2016).

ORCID

Loraine Visscher https://orcid.org/0000-0002-2235-602X

REFERENCES

Barth, R. P., Lee, B. R., Lindsey, M. A., Collins, K. S., Strieder, F., Chorpita, B. F., … Sparks, J. A. (2012). Evidence-based practice at a crossroads: The timely emergence of common elements and common factors. *Research on Social Work Practice*, *22*(1), 108–119. https://doi.org/10.1177/1049731511408440

Blase, K., & Fixsen, D. L. (2013). Core intervention components: Identifying and operationalizing. ASPE Research Brief, (February), 21. https://doi.org/10.1177/1049731509335549

Bodden, D. H. M., & Deković, M. (2016). Multiproblem families referred to youth mental health: What's in a name? *Family Process*, *55*(1), 31–47. https://doi.org/10.1111/famp.12144

Chorpita, B. F., Becker, K. D., & Daleiden, E. L. (2007). Understanding the common elements of evidence-based practice: Misconceptions and clinical examples. *Journal of the American Academy of Child and Adolescent Psychiatry*, *46*, 647–652. https://doi.org/10.1097/chi.0b013e318033ff71

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Services Research*, *7*(1), 5–20. https://doi.org/10.1007/s11020-005-1962-6

Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, *62*(1), 107–115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

Evenboer, K. E., Huyghen, A. M. N., Tuinstra, J., Knorth, E. J., & Reijneveld, S. A. (2016). What's thedifference? Using descriptors to classify the care provided to children andadolescents with behavioral and emotional problems. *Children and YouthServices Review*, *61*, 353–358. https://doi.org/10.1016/j.childyouth.2016.01.010

Evenboer, K. E., Reijneveld, S. A., & Jansen, D. E. M. C. (2018). Improving care for multiproblem families: Context-specific effectiveness ofinterventions? *Children and Youth Services Review*, *88*, 274–285. https://doi.org/10.1016/j.childyouth.2018.03.024

Garland, A. N. N. F., Hawley, K. M., Brookman-Frazee, L., & Hurlburt, M. S. (2008). Identifying common elements of evidence-based psychosocial treatments for children' s disruptive behavior problems. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*(5), 505–514. https://doi.org/10.1097/CHI.0b013e31816765c2

Kazdin, A. E., Bass, D., Ayers, W. A., & Rodgers, A. (1990). Empirical and clinical focus of child and adolescent psychotherapy research. *Journal of Consulting and Clinical Psychology*, *58*(6), 729–740. https://doi.org/10.1037//0022-006X.58.6.729

Lee, B. R., Ebesutani, C., Kolivoski, K. M., Becker, K. D., Lindsey, M. A., Brandt, N. E., … Barth, R. P. (2014). Program and practice elements for placement prevention: A review of interventions and their effectiveness in promoting home-based care. *American Journal of Orthopsychiatry*, *84*(3), 244–256. https://doi.org/10.1037/h0099811

Michie, S., Fixsen, D., Grimshaw, J. M., & Eccles, M. P. (2009). Specifying and reporting complex behaviour change interventions: The need for a scientific method. *Implementation Science*, *4*(1), 40. https://doi.org/10.1186/1748-5908-4-40

Michie, S., Hyder, N., Walia, A., & West, R. (2011). Development of a taxonomy of behaviour change techniques used in individual behavioural support for smoking cessation. *Addictive Behaviors*, *36*(4), 315–319. https://doi.org/10.1016/j.addbeh.2010.11.016

Morris, K. (2013). Troubled families: Vulnerable families' experiences of multiple service use. *Child and Family Social Work*, *18*(2), 198–206. https://doi.org/10.1111/j.1365-2206.2011.00822.x

Ogden, T., & Hagen, K. A. (2006). Multisystemic treatment of serious behaviour problems in youth: Sustainability of effectiveness two years after intake. *Child and Adolescent Mental Health*, *11*(3), 142–149. https://doi.org/10.1111/j.1475-3588.2006.00396.x

Pannebakker, N. M., Kocken, P. L., Theunissen, M. H. C., van Mourik, K., Crone, M. R., Numans, M. E., & Rijneveld, S. A. (2018). Services use by children and parents in multiproblemfamilies. *Children and Youth Services Review*, *84*, 222–228. https://doi.org/10.1016/j.childyouth.2017.12.003

Spratt, T. (2011). Families with multiple problems: Some challenges in identifying and providing services to those experiencing adversities across the life course. *Journal of Social Work*, *11*(4), 343–357. https://doi.org/10.1177/1468017310379256

Tausendfreund, T., Knot-Dickscheit, J., Post, W. J., Knorth, E. J., & Grietens, H. (2014). Outcomes of a coaching program for families with multiple problems in the Netherlands: A prospective study. *Children and Youth Services Review*, *46*, 203–212. https://doi.org/10.1016/j.childyouth.2014.08.024

van der Pol, T. M., Hoeve, M., Noom, M. J., Stams, G. J. J. M., Doreleijers, T. A. H., van Domburgh, L., & Vermeiren, R. R. J. M. (2017). Research review: The effectiveness of multidimensional family therapy in treating adolescents with multiple behavior problems—A meta-analysis. *Journal of Child Psychology and Psychiatry and Allied Disciplines*, *58*(5), 532–545. https://doi.org/10.1111/jcpp.12685

Veerman, J. W., Janssens, J., & Delicat, J.-W. (2005). Effectiviteit van Intensieve Pedagogische Thuishulp: Een meta-analyse. *Pedagogiek*, *25*(3), 176–196. Retrieved from http://www.pedagogiek-online.nl/index.php/pedagogiek/article/view/279

Visscher, L., Evenboer, K. E., Jansen, D. E. M. C., Scholte, R. H. J., Knot-Dickscheit, J., Veerman, J. W., … van Yperen, T. A. (2018). Identifying practice and program elements of interventions for families withmultiple problems: The development of a taxonomy. *Children and*

Youth Services Review, *95*, 64–70. https://doi.org/10.1016/j.childyouth.2018.10.030

Weisz, J. R., Chorpita, B. F., Palinkas, L. A., Schoenwald, S. K., Miranda, J., Bearman, S. K., … Mayberg, S. (2012). Testing standard and modular designs for psychotherapy treating depression, anxiety, and conduct problems in youth: A randomized effectiveness trial. *Archives of General Psychiatry*, *69*(3), 274–282. https://doi.org/10.1001/archgenpsychiatry.2011.147

How to cite this article: Visscher L, Jansen D, Evenboer E, van Yperen T, Reijneveld S, Scholte R. Interventions for families with multiple problems: Similar contents but divergent formats. *Child & Family Social Work*. 2020;25:8–17. https://doi.org/10.1111/cfs.12646