Towards increased understanding of integrated Youth Care: a qualitative evaluation of facilitators and barriers for professionals

Nooteboom, L.A.

5 Practical recommendations for Youth Care professionals to improve evaluation and reflection during multidisciplinary team discussions: an action research project

Laura Nooteboom, Eva Mulder, Robert Vermeiren, Janna Eilander, Sanne van den Driesschen, Chris Kuiper

Submitted

ABSTRACT

Integrated care for children and their families is often organized in multidisciplinary teams. In these teams, evaluation and reflection during Multidisciplinary Team Discussions (MTDs) are fundamental to learning, improving interprofessional collaboration, and increasing the quality of care. Since the effectiveness of MTDs varies widely, this study's objective was to identify facilitators and barriers for evaluation and reflection in MTDs, and concurrently formulate practical recommendations for professionals. This study's action research cycle consisted of a qualitative component to identify facilitators and barriers, by observations in multidisciplinary teams and interviews with professionals, parents, managers, and local policy makers. Concurrently, practical recommendations were iteratively developed in project team meetings, learning sessions, and a focus group. Based on the identified facilitators and barriers, nine practical recommendations were formulated, including: preparatory activities to ensure purpose, timing, and relevant stakeholder involvement; specific points of attention during MTDs to ensure effectiveness; and tracking follow up steps after MTDs to ensure a learning process. We conclude that the nine practical recommendations can support professionals in Youth Care to increase satisfaction and improve effectiveness of evaluation and reflection during MTDs.

INTRODUCTION

All too often, children and their families in Child and Youth Care settings (Youth Care) experience psychosocial-, emotional-, cognitive-, or stress-related impairments impacting several life domains (e.g., at home, school, and in the community). The needs of these families exceed the expertise and possibilities of a single professional discipline or organization, due to a combination of problems including problems with parenting, learning difficulties, mental health issues, financial or housing restraints, violence or criminal activities, and substance abuse (Brooks, Bloomfield, Offredy, & Shaughnessy, 2013). Hence, multiple professionals from a wide range of services in Youth Care are involved in a family's care process, from universal and preventive services like social work and parenting support, to specialized services such as specialized mental health care (Hilverdink, Daamen, & Vink, 2015). To overcome fragmentation in support for these families, organizing integrated care is a necessity. Integrated care can be defined as coordinated, coherent and continuous support, aligned across life domains, and tailored to the needs of families (Tausendfreund, Knot-Dickscheit, Schulze, Knorth, & Grietens, 2016; World Health Organization, 2016).

Integrated care is often organized in multidisciplinary teams to facilitate interprofessional collaboration (Cooper, Evans, & Pybis, 2016; Janssens, Peremans, & Deboutte, 2010). Multidisciplinary team composition is based on families' needs, including professionals representing community work, social work and education, specialized mental health care, parenting support, financial support, and child protection. Also, the intensity of interprofessional collaboration varies per case, from sharing brief information and consultation, to collaboratively identifying problems and developing shared care plans (Saint-Pierre, Herskovic, & Sepúlveda, 2018).

Yet, a major challenge to provide integrated care in multidisciplinary teams is that professionals frequently hold different views, adopt diverse working approaches, or lack collaboration (Cooper et al., 2016; Golding, 2010). Moreover, since the needs of families often differ across

life domains and change over time, professionals in multidisciplinary teams must be flexible in their approaches, roles, and responsibilities (Garcia et al., 2014; Golding, 2010). Hence, evaluating and reflecting on care processes in multidisciplinary teams are crucial to tailor integrated care to families' changing needs (Huxley et al., 2011; Nooteboom, van den Driesschen, Kuiper, Vermeiren, & Mulder, 2020; Raine et al., 2014; World Health Organization, 2016).

Background

Evaluation is conceptualized as systematically monitoring, collecting, discussing, and interpreting information with the intention to appraise the value and effectiveness of a process, plan, or outcome (World Health Organization, 2007). Reflection on the other hand, is a structured approach to gain insight in one's own thoughts, values, experiences, and behaviors, and focusses on professional competency and professional development (Korthagen, 2017). Reflecting on prior experiences and evaluating care processes from a multidisciplinary view are both fundamental to learning and can lead to enhanced quality of care, professional development, and improved working approaches of professionals (Golding, 2010; Korthagen, 2017; Raine et al., 2015).

In multidisciplinary teams, evaluation and reflection generally take place during Multidisciplinary Team Discussions (MTDs; Nooteboom et al., 2020; Raine et al., 2014). MTDs are regularly (often weekly) held team discussions and defined as a moment of collaborative learning in which professionals evaluate and reflect on for example: (1) the care process of families, (2) interprofessional collaboration within and outside their multidisciplinary team, or (3) one's own working approach (Nooteboom et al., 2020). Evaluation and reflection in MTDs can improve shared decision making and increase insight in a care process, leading to better outcomes for people in care (Nancarrow et al., 2013; Rosell, Alexandersson, Hagberg, & Nilbert, 2018). Moreover, evaluation and reflection in MTDs can lead to improved interprofessional collaboration, by taking advantage of the broad expertise of a multidisciplinary team, developing a common vision and language between professionals, redefining roles and responsibilities if needed, and reducing fragmentation of care (Heneghan, Wright, & Watson, 2014).

Although there is an abundance of working methods available for evaluation and reflection in MTDs (Gordijn, Eernstman, Helder, & Brouwer, 2018), the implementation, effectiveness, and efficiency of these working methods vary widely across settings and teams (Raine et al., 2015; Raine et al., 2014). In that, a major barrier is the broad diversity of professional disciplines involved in MTDs, leading to misunderstanding of each other's working approach, a lack of purpose, and less effective decision making (Nooteboom et al., 2020; Raine et al., 2014; Rosell et al., 2018). Also, discussing a broad range of problems in a limited amount of time can lead to a lack of purpose and structure, a lack of in depth discussion, and inconsistent documentation of decisions during MTDs (Raine et al., 2014). Particularly in Youth Care, these barriers might hinder the effectiveness of evaluation and reflection, since there are various professional disciplines involved in the MTDs and professionals often discuss a broad range of problems that families in Youth Care encounter (Nooteboom et al., 2020). Hence, to achieve effective evaluation and reflection in MTDs, it is necessary to meet certain preconditions.

Previous research in adult mental health care led to 21 recommendations to improve the effectiveness of MTDs (Raine et al., 2015). These recommendations include the importance of a goal-oriented working approach, clear documentation of outcomes of the MTDs, and sufficient chairing of the session. Nevertheless, these recommendations were constrained to evaluations of single adult interventions and their treatment plan implementation, whereas in Youth Care, professionals often support multiple family members with a variety of problems across life domains. To our knowledge, there is a lack of practical recommendations to guide Youth Care professionals in multidisciplinary teams in improving evaluation and reflection during their MTDs. Therefore, this study's objective was to identify facilitators and barriers for evaluation and reflection in MTDs, and concurrently to formulate practical recommendations in collaboration with professionals from multidisciplinary teams, their managers, local policy makers, and families in Youth Care.

METHOD

This study was part of a four-year research project in collaboration with local multidisciplinary teams in the Netherlands (Academic Workplace 'Gezin aan Zet' [Family's Turn]). The study approach was derived from action research, a community-based research method enabling broad understanding of complex processes in practice, while engaging all stakeholders in the research process (Abma et al., 2017; Migchelbrink, 2007). Hence, action research enhances the validity and applicability of study outcomes (Nyström, Karltun, Keller, & Andersson Gäre, 2018). The current study's action research cycle consisted of a qualitative component to identify facilitators and barriers to MTDs from multiple perspectives (i.e., by interviews and observations; Malterud, 2001), and concurrently an iterative process of formulating, discussing, implementing, evaluating, and adapting practical recommendations based on the identified facilitators and barriers (i.e., by project team meetings, learning sessions, and a focus group). Completeness and reporting quality of the practical recommendations were improved by complying with the Reporting Items for practice Guideline in HealThcare (RIGHT) statement (Chen et al., 2017).

Setting and participants

In 2015, there has been a decentralization of the Youth Care system in the Netherlands. Ever since, municipalities are responsible for organizing and providing Youth Care on a local level, including preventive health services, youth mental health services, and specialized Youth Care (Hilverdink et al., 2015). This local organization should lead to integrated support at an earlier stage, within the family's own environment and with easy access to a variety of services in Youth Care (Hilverdink et al., 2015). To provide integrated support, almost each municipality formed local multidisciplinary teams, the so-called Youth Teams (Van Arum & Van den Enden, 2018). Youth Teams operate locally in a primary care setting as a linking pin between preventive services and specialized Youth Care (Hilverdink et al., 2015).

The current study was conducted in collaboration with six Youth Teams in the Netherlands. In general, the six teams held similar compositions and tasks: a multidisciplinary team of approximately eight to twelve professionals providing (ambulatory) support to children (aged 0-23) and their families with a broad variety of psychosocial, stress-related, and socio-economic problems. Youth Teams focus on strengthening families' capacities, involving families' social network, and coordinate support in collaboration with other (local) services. The following disciplines were represented in each participating Youth Team: social work and education, specialized mental health care, infant mental health care, support for youth with (mild) mental retardation, parenting support, and child protection. The exact composition of each team slightly changed during the research project, mostly due to turnover of staff.

Youth Team professionals were the intended primary users of the practical recommendations resulting from the current study. Approximately 60 professionals actively participated in the team observations, the semi-structured interviews, and the iterative process to developing practical recommendations. Additionally, to include relevant perspectives on facilitators and barriers, we interviewed parents of children who were supported by one of the Youth Teams, managers of the participating teams, and local policy makers. These stakeholders also participate in evaluation and reflection of Youth Team professionals, for example during clinical case discussions (families). To develop the practical recommendations, four professionals, a parent representative, two managers, and four researchers (EM, LN, CK, and JE/SvdD) closely collaborated in bimonthly project team meetings. Alongside this project team, a steering committee advised the researchers twice a year, by reviewing the recommendations and discussing the research progress. The steering committee consisted of the researchers (LN, EM, SvdD), a professor in child psychiatry (RV), six local policy makers (from The Hague and Holland Rijnland), four representatives from University (Leiden University Medical Center, The Hague University of Applied Sciences, Leiden University of Applied Sciences), a representative of TNO (independent research

organization), and one parent representative. Members of the steering committee also played an important role in the implementation of the recommendations in their own organizations.

Data collection

The action research data collection cycle was divided in two interdependent processes: (1) a qualitative study to identify facilitators and barriers to evaluation and reflection by means of observations of MTDs and semi-structured interviews (Malterud, 2001), and concurrently (2) an iterative process to develop practical recommendations based on the identified facilitators and barriers (Migchelbrink, 2007). An overview of the study design can be found in Figure 1.

Qualitative study: observations and interviews

Observations

Between 2016 and 2018, two researchers (LN and JE) independently conducted bimonthly, non-participant, unstructured observations (Mulhall, 2003) of existing MTDs in the six participating Youth Teams. Each observation had a duration of approximately 2 hours. Field notes were taken, including notes on the preparation, structure, and participants of the MTDs, roles and professional behavior during the MTD, types of cases discussed, and documentation of decision making. After each observation, field notes were discussed (JE and LN) and summarized in an online logbook for further analysis.

Interviews

In 2016, 2017, and 2018, four separate rounds of semi-structured interviews were conducted: two rounds with professionals from the participating Youth Teams (2016 and 2017), one round with parents receiving support from the multidisciplinary teams (2017), and one round with managers of the teams and local policy makers (2017/2018). Participation was voluntary, and all participants were informed on the aim and procedure of the interviews by means of written informed consent. The interviews were guided by topic lists adjusted to the group

Figure 1. *Study design*

of participants (e.g., professionals, parents, managers, or local policy makers). All interviews were conducted by one of the researchers (LN or JE) together with a student of the Leiden University Medical Center. After each interview, participants were asked to fill in a demographic questionnaire. To avoid interpretation bias, all interviews were audio-recorded and transcribed verbatim afterwards (Tufford & Newman, 2010). No participant expressed interest in commenting on the transcripts.

In both interview rounds with professionals we aimed to include at least three professionals per Youth Team. Convenience sampling was applied based on availability and there were no further in- or exclusion criteria. For the 2016 interview round, the topic list included general questions regarding facilitators and barriers in their daily practice, including the MTDs. The topic list of the 2017 interviews specifically focused on facilitators and barriers of evaluation and reflection in their weekly MTDs, integrated care, and working in multidisciplinary teams. Parents were invited to participate in this study by an email from their Youth Team professional. Professionals were encouraged to approach all parents in their caseload to target a representative group of parents and prevent convenience sampling bias.

To ensure parental perspectives were based on actual experiences, we purposively included parents with at least three visits to a Youth Team professional. The topic list was formulated in collaboration with a parent representative and included questions regarding the collaboration between professionals and parents, parental involvement in shared decision making, evaluation of a care process, and interprofessional collaboration. The managers and local policy makers were recruited by the two researchers (LN and JE). There were no further in- or exclusion criteria and convenience sampling was applied based on availability. Topics for the interviews with managers and local policy makers included facilitators and barriers in evaluation, reflection, interprofessional collaboration, and integrated care.

Iterative process to develop practical recommendations

Based on the facilitators and barriers identified in the qualitative study, practical recommendations were concurrently formulated, discussed, applied, evaluated and adapted in project team meetings, learning sessions, and a focus group. These activities not only encouraged discussion to reveal multiple perspectives, but also improved the applicability and implementation of the results in practice (Femdal & Solbjør, 2018).

Project team meetings

Between 2016 and 2019, 23 project team meetings took place in which study progress and preliminary recommendations were discussed. The meetings were guided by an agenda that was formulated in advance. The project team strived to consensus by an iterative course of action and informal decision making, led by an independent and experienced action researcher (CK). After each project team meeting, field notes taken by one of the researchers (LN, JE, or SvdD) were summarized and verified by all project team members. Actions originating from these meetings (e.g., adapt recommendations, implementation activities, inform practice) were applied and evaluated in the following meeting.

Structured learning sessions

In 2018, each Youth Team participated in three structured learning sessions. The function of these learning sessions was twofold: (1) reflect on the preliminary findings and thereby stimulate in depth interpretation and a learning process in practice, and (2) a member check to validate the conceptual formulation of the recommendations by discussing the interpretation, relevance, and applicability (Thomas, 2017). A week before each learning session, professionals received a factsheet with preliminary recommendations. One of the researchers (JE or LN) was the moderator during the learning session, the other took notes for the written summary. During the learning sessions, professionals reflected on the recommendations and formulated action points to improve evaluation and reflection in their MTDs. Subsequently, professionals were encouraged to implement the formulated action points during the following MTDs. This implementation process was monitored

during the MTD observations that followed the learning session and was discussed during project team meetings.

Focus group

In 2019, a focus group took place with 20 professionals from Youth Teams in Holland Rijnland and The Hague, who were unfamiliar with this study. The focus group served as a member check and as an implementation activity to improve feasibility. The focus group was led by a trained moderator (LN) and supported by an observer (SvdD) who took field notes and wrote a summary afterwards. During the focus group, preliminary recommendations were shared by means of a predefined script and a fictional case to practice with the application of the recommendations.

Analysis and interpretation

All interview transcripts and observation summaries were imported into Atlas.ti (v7), a computer program for labelling and organizing text content. Thematic content analysis was applied to all imported data, to identify facilitators and barriers that might influence the effectiveness of evaluation and reflection in MTDs (Leavy, 2014). A facilitator was conceptualized as a component enabling professionals to perform evaluation and reflection in MTDs. A barrier was defined as a component limiting professionals to perform evaluation and reflection in MTDs. Each analysis followed the same structure: familiarization with the data, identifying themes, coding, charting, mapping, and interpretation (Pope, Ziebland, & Mays, 2000). Open coding was applied to transcripts of the observation summaries and the separate interview rounds by at least two of the researchers (LN, JE, SvdD). The source of the coded fragments was also labeled, to identify whether the information was based on an observation and from which team, or on an interview with one of the stakeholders (e.g., professionals, parents, managers, or policy makers). This labeling enabled us to control for potential differences between teams or stakeholders when merging the coded fragments from various sources to identify generic themes (charting). Since our aim was to find generic elements (barriers and facilitators) across participants, themes from each source were

systematically compared and eventual differences were discussed during project team meetings. The researchers looked for a consensus between the different stakeholders' perspectives to formulate generic recommendations. To limit possible adverse effects of prejudices, the data was interpreted back and forth as an iterative process and supplemented by reflective discussions of the researchers (LN, SvdD, and JE; mapping and interpretation). No interrater reliability was calculated since previous research points out that interrater reliability in coding segments seems ineffective for reliability purposes (Smith & McGannon, 2018). In general, there was agreement in coding between the researchers apart from some lingual differences.

The identified themes of facilitators and barriers formed the basis on which we formulated the practical recommendations. The researchers (LN, SvdD, EM, and CK) formulated preliminary recommendations based on the identified barriers and facilitators in the MTD observations and interviews. These preliminary recommendations were continuously discussed and refined during project team meetings, applied in learning sessions, and pilot-tested in a focus group. Written summaries of these activities were compared to the preliminary recommendations and served as an addition to the analysis to verify and refine the recommendations. Apart from some linguistic modifications, no major changes were suggested by professionals from the focus group, indicating transferability of the recommendations to other multidisciplinary teams in Youth Care.

RESULTS

Demographics

In 2016, 32 professionals participated in the first interview round: 5-6 professionals per Youth Team. In the second round of interviews in 2017, 24 professionals participated (e.g., 4 professionals per Youth Team), of which 10 individuals who were also interviewed during the first round. Professionals had experience in different aspects of Youth Care (e.g., social work and education, specialized mental health care, infant mental health, (mild) mental retardation, coaching, parenting

support, and child protection). In addition to the interviews with professionals, 21 parents from different families participated in a semi-structured interview. All parents had received support from a Youth Team professional. Furthermore, 19 managers and local policy makers participated in a semi-structured interview. Table 1 presents a detailed overview of participant characteristics.

Outcomes

To identify facilitators and barriers to evaluation and reflection in MTDs, we systematically compared observational data and interview fragments from different sources. In general, professionals discussed progression of individual care processes as main part of the MTDs, followed by a shorter discussion of interprofessional collaboration, team development, and regular issues in their daily practice. Each individual team had its own working approach, structure, and culture during the MTDs, which varied during the study due to changes in team composition or new working approaches.

Table 2 presents a list of facilitators and barriers reported during the interviews and observed during MTDs. Overall, facilitators and barriers reported in the various interview rounds corresponded with the facilitators and barriers observed during the MTDs. For example, according to professionals and from the observations, it was difficult to distinguish the subject, purpose, and focus of MTDs. Moreover, most facilitators and barriers described by parents, managers, and policy makers were also reported by professionals. For example, they all described that a lack of structure and preparation of MTDs led to dissatisfaction and a lack of effectiveness. Moreover, from both the interviews and the observations, we concluded that too many professionals attending the MTD decreased the effectiveness of the MTD. Especially in case there was a broad variety of professional disciplines involved, this led to prolonged MTDs with too many topics to be discussed in a limited amount of time, an unsafe team climate, and lengthy decision-making processes.

Table 1. *Demographic characteristics of the participants*

Variable	Professionals R1 (n=32)	Professionals R2 (n=24)	Parents (n=21)	Managers and policy makers (n=19)
Interview duration min [m (range)]	49 (35-60)	56 (39-79)	53 (31-90)	48 (41-60)
Gender [n (%)]				
Male	2 (6.3%)	2 (8.3%)	4 (19.1%)	1 (5.3 %)
Female	30 (93.7%)	22 (91.7%)	17 (80.9%)	18 (94.7%)
Age in years				
Mean age in years (SD)	39.00 (9.13)	39.25 (11.04)	43.75 (8.47)	47.37 (9.38)
Age range in years	24-61	24-61	26-57	28-61
Cultural Background [n (%)]				
Western			17 (85.0%)	
Non-Western			3 (15.0%)	
Highest Educational Level [n (%)]				
Primary Education			2 (10.0%)	
Intermediate Vocational Educ.			8 (40.0%)	
Higher Vocational. Educ.	24 (75.0%)	21 (87.5%)	7 (35.0%)	9 (47.4%)
University	8 (25.0%)	3 (12.5%)	3 (15.0%)	10 (52.6%)
Study [n (%)]				
Socio-pedagogical assistance	10 (31.2%)	11 (45.8%)		
Pedagogics	8 (25.0%)	6 (25.0%)		
Psychology	3 (9.4%)	1 (4.2%)		
Social work	7 (21.9%)	5 (20.8%)		
Other	4 (12.5%)	1 (4.2%)		
Profession [n (%)]				
Manager				4 (21.1%)
Coach				4 (21.1%)
Policy maker				7 (36.8%)
Staff advisor				2 (10.5%)
Other				2 (10.5 %)
Years of work experience				
Mean years of experience (SD)	15.98 (8.78)	14.23 (9.67)		
Range years of experience	3-39	1.5-35		
Marital Status [n (%)]				
Two-parent household			10 (50.0%)	
Divorced			9 (45.0%)	
Single-parent household			1 (5.0%)	
Number of children [n (%)]				
One child			5 (25.0%)	
Two or more children			15 (75.0%)	
Missing (n)			1	

NB: R1 = interviews round 1, R2 = interviews round 2

Table 2. *Recommendations based on facilitators and barriers to evaluation and reflection in Multidisciplinary Team Discussions (MTDs)*

	Recommendation	Facilitators	Barriers
1	Decide on the subject and goal of the MTD	Clear subject of the MTD (e.g. team process, content of care) Define goal and purpose beforehand	Unclear subject, purpose and focus of the MTD Interchangeably evaluate different subjects during the MTD
2	Differentiate between those involved and those attending the MTD	Decide on those involved and who should attend the MTD Inform all those involved afterwards Availability of professionals MTDs in smaller groups	Too many professionals attending the MTD Lack of sharing information afterwards A broad variety of professional disciplines involved without a clear purpose
3	Decide on the moment and duration of the MTD	Schedule MTDs in advance Sufficient time in between MTDs Estimate duration of each component of the MTD	Not prioritizing MTDs due to a high workload Too lengthy MTDs Too many topics to be discussed in limited amount of time Planning too many MTDs in a short amount of time
4	Timely prepare the MTD and gather input from stakeholders beforehand	Timely and sufficient preparation Collect relevant input from stakeholders	Lack of preparation by those involved in the MTD Lack of input from relevant stakeholders
5	Follow the general structure of MTDs and decide on the working approach	Flexible, shared working approach Time to acquire a working approach Clear format of the MTD An a priori formulated agenda Visualized structure of the MTD Reprise of a preparatory assignment	Rigid working approach that does not fit purpose of the MTD Lack of structure or agenda Variety of working approaches Lengthy decision-making processes

	Recommendation	Facilitators	Barriers
6	Allocate tasks to ensure structured MTDs	Clear allocation of tasks: process guard, chair, secretary, time guard Discussion of tasks and roles beforehand	No secretary Too many tasks for the chair No time guard
7	Ensure a safe team climate during the MTD	Open and curious attitude, equality, and mutual respect Clear intentions Room for reflection on limitation and doubts Familiarity Positive atmosphere with focus on learning Appreciation of the multidisciplinary character	Changes in team composition Feelings of dissatisfaction (Negative) consequences after the MTD Interprofessional conflicts Unfamiliarity with those involved in the MTD Inequalities between those involved Lack of participation in the MTD
8	Ask reflective questions and provide constructive feedback during the MTD	Objective questions with a focus on learning and improvement Sharing representative information Sufficient time for feedback	Directly provide a solution Focus on negative feedback Focus on incidents outside the context
9	Register and monitor follow-up steps at the end of the MTD	Collaboratively formulate follow up steps (SMART) at the end of the MTD Summary with highlights of the MTD Regularly monitor follow up steps	Lack of time at the end of the MTD Undefined follow-up steps Lack of registration of follow up steps

After listing the identified facilitators and barriers, the iterative process of formulating the recommendations was conducted during project team meetings and learning sessions. This process led to nine practical recommendations to guide professionals in improving evaluation and reflection during MTDs, also listed in Table 2. In the following section, the nine recommendations are described in detail.

1. Decide on the subject and goal of the MTD

Being aware of the goal and subject prior to the MTD can lead to increased feelings of motivation, effort, and focus during MTDs. In that, professionals should be aware of goals focusing on team processes (e.g., improving interprofessional collaboration, reflect on team functioning) and goals concerning the content of care (e.g., enhance insight in care processes, reflect on client satisfaction, increase awareness of one's own working approach).

2. Differentiate between those involved and those attending the MTD

In general, MTDs are reported as more efficient in relative smaller groups. It is not always a necessity that those involved also physically attend the MTD, as long as a summary of the MTD is reported to all those involved afterwards.

3. Decide on the moment and duration of the MTD

MTDs should be scheduled in advance to ensure evaluation and reflection are regularly performed, even during busy periods. To stimulate a learning process, implement change, and ensure improvement in practice, professionals should ensure sufficient time in between MTDs. The duration of the MTD should be estimated beforehand and can vary depending on the goal, subject, and size of the group.

4. Timely prepare the MTD and gather input from stakeholders beforehand

Timely preparation of MTDs is crucial to increase the efficiency, effectiveness, and feelings of satisfaction amongst those involved in the MTD. Specifically, case discussions should be prepared by providing sufficient information to those involved in advance. Professionals can

apply various methods to collect input for an MTD from stakeholders involved, for example by means of a questionnaire, in dialogue, or by group discussions.

5. Follow the general structure of MTDs and decide on the working approach

MTDs should be guided by an agenda. In general, this agenda should include the following general structure of MTDs: (1) introduction of the goals and structure of the MTD, (2) short reprise of the preparatory assignment, (3) in depth evaluation and reflection on a topic, (4) concrete agreements or follow-up steps, and (5) a summary with the highlights of the MTD. The structure of MTDs can be improved by choosing a working approach based on a clear and short format that fits the purpose, group, and subject of the MTD (e.g., a SWOT analysis or the Signs of Safety model).

6. Allocate tasks to ensure structured MTDs

Clear allocation of tasks is needed to safeguard the structure of the MTDs and share responsibility among those involved. The four general tasks during an MTD are: (1) a process guard, responsible for planning the MTDs, inform those involved/attending, and send out the preparatory assignments, (2) a chair, guiding the team through the agenda and structure of the MTD, (3) a secretary, writing down the actions and highlights of the MTD and (4) a time guard, responsible for time monitoring during MTDs.

7. Ensure a safe team climate during the MTD

A safe team climate is essential for professionals to speak out during the MTD, to learn, and improve their practice. A safe climate can be recognized by an open atmosphere, in which professionals feel that there is room for reflection on limitations and doubts. To achieve a safe climate, all those involved should hold a basic attitude of equity, mutual respect, integrity, and trust. Also, the team climate can be improved by explicitly discussing the intention of an MTD in advance and by paying attention to eventual changes in team composition.

8. Ask reflective questions and provide constructive feedback during the MTD

Professionals should ask reflective questions with the intention to discover the underlying considerations of the other, instead of directly proposing a solution. Reflective questioning and constructive feedback does not imply that one should not be critical, as long as the feedback is objective and focused on increasing awareness on one's own actions, improvement, and learning.

9. Register and monitor follow-up steps at the end of the MTD

There should be sufficient time at the end of the MTD to repeat key lessons and register concrete follow-up steps. To ensure a learning process, keep follow-up steps simple and concrete (specific, measurable, achievable, relevant, and time-bound) and regularly monitor these steps by planning follow up evaluations.

DISCUSSION

This study's action research resulted in nine practical recommendations for professionals in Youth Care to improve evaluation and reflection in MTDs. These recommendations include preparatory activities to ensure purpose, timing, and relevant stakeholders involved; specific points of attention during MTDs to ensure effectiveness (e.g., a shared working approach, clear tasks and roles, a safe team climate, and reflective questioning); and tracking follow up steps after MTDs to ensure a learning process. By closely collaborating with professionals when developing the recommendations, professionals judged the recommendations as recognizable and applicable to existing MTDs. Professionals reported that applying these recommendations guided them to improve structure, process, and effectiveness of MTDs and led to increased feelings of satisfaction among those involved. By discussing the current situation based on the recommendations, professionals developed a continuous learning process to improve evaluation and reflection in their daily practice.

Our recommendations partly corroborate with recommendations from previous research to MTDs in adult mental health care (Raine et al., 2015). However, in that research, MTDs within one organization were studied, while in Youth Care various professionals from different organizations are commonly involved in care processes. Hence, MTDs in Youth Care are not only used to discuss care processes and treatment plans, but also to evaluate interprofessional collaboration within and outside the multidisciplinary team, and to reflect on one's own working approach. As previous research points out, discussing such a broad range of topics in a limited amount of time can lead to a lack of purpose, structure, and depth in the MTD (Nooteboom et al., 2020; Raine et al., 2014). Therefore, it is crucial that professionals in Youth Care formulate the purpose of an MTD beforehand. Moreover, corroborating previous research (Raine et al., 2014; Rosell et al., 2018), our study implicates that attendance of MTDs should be limited, since too many professionals attending hinders effectiveness (e.g., lengthy decision-making progress and an unsafe team climate). Unfortunately, there is no golden standard for the number of professionals attending an MTD, since the number of professionals involved varies on families' needs and the purpose of the MTD. However, gathering relevant feedback from all those involved beforehand and provide feedback afterwards might help to limit high attendance rates during MTDs.

As suggested by professionals during project team meetings, MTDs were not the only moment of evaluation and reflection in their daily practice: professionals also reflected with families, policy makers, and collaborative partners. We believe that further application of recommendations in daily practice of Youth Care professionals is easy, since they are applicable during regular work processes, and therefore, require a minimum amount of time and no additional financial resources. However, additional implementation activities are required to improve transferability and implement the recommendations in other multidisciplinary teams in Youth Care. As we know from previous implementation studies, various factors play a role in implementation and there is no comprehensive strategy applicable to all settings (Fixsen, Blase, Metz, & Van Dyke, 2013). In our study, the members of the project team served as ambassadors, with the formal task to involve their

colleagues in the study and implement the lessons learned within their own teams. To implement the results in other settings, we recommend designating a local implementation ambassador with the responsibility to inform and support professionals in applying the recommendations.

Strengths and limitations

The key strength of our study lays in its participatory approach involving over 60 professionals from six different teams in Youth Care with a variety of working experience, professional disciplines, and working approaches. Additionally, we included the perspectives of families, managers, and policy makers. This participant triangulation, together with triangulation in research methods (e.g., interviews, observations, and focus groups), enabled us to gain a rich and in-depth view of facilitators and barriers to evaluation and reflection in MTDs (Bekhet & Zauszniewski, 2012). The non-participant unstructured observations enabled the researchers to study MTDs without predetermined notion (Mulhall, 2003). Furthermore, we ensured feasibility and applicability of the recommendations in practice by collaboratively developing recommendations during project team meetings. The project team meetings and steering committee were essential components of this action research study's implementation process. Specifically, members of the steering committee held key functions within their organizations and could therefore easily spread and implement the results of this study. The focus group with professionals of other multidisciplinary teams in Youth Care enabled us to confirm the credibility, applicability, and transferability of the recommendations in teams who were unfamiliar with the research project.

This study also has its limitations. We systematically compared observational data and interview fragments of a multidisciplinary group of professionals, managers, policy makers, and families with different values and preferences. We concluded that most facilitators and barriers corresponded between sources and research methods. However, all project team members and participants in the interviews were related to Youth Teams in the Netherlands. We studied a typical Western setting, and since cultural norms might vary across countries,

we cannot conclude that the recommendations are globally applicable. Moreover, no formal consensus methods were used to formulate the recommendations, such as a Delphi method. Hence it would be interesting to focus on differences between various stakeholders and settings regarding these recommendations, to improve transferability.

Importantly, the effect of applying these recommendations on the quality of care should be evaluated through further investigation. We believe that the recommendations guide professionals to structure MTDs, however, the importance of informal interpersonal contact during MTDs should also be considered when assessing interprofessional collaboration and quality of care in future studies. Also, although triangulation of research methods was applied, the effect of each recommendation in practice is understudied and we were unable to calculate the strength of evidence for each recommendation. Based on our observations we suggest that the recommendations might be interrelated, however we did not measure the correlation between recommendations and their effect in practice or in which order the recommendations can be best applied. For example, from our study it remains unclear whether professionals should work on a safe team climate first, before discussing the structure of an MTD. Therefore, to measure their effectiveness in practice, implementation and application of the recommendations should be systematically monitored.

CONCLUSION

In conclusion, the nine recommendations formulated and implemented in this study are designed to improve effectiveness of evaluation and reflection in MTDs and thereby increase satisfaction among professionals, improve interprofessional collaboration, and eventually strengthen quality of care. We believe this is of major importance in the broad field of Youth Care, where MTDs are crucial to evaluate and reflect on care processes, interprofessional collaboration, and one's own working approach.