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

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6 Summary and General Discussion

DISCUSSSION

Integrated care is considered the ultimate solution to overcome fragmentation in support for families with multiple needs. By providing coherent, continuous, and coordinated support, integrated care can improve support for families with regard to access, quality, efficiency, and user satisfaction (World Health Organization, 2016). The last decade, there has been a global trend of reconstructing health care systems in order to organize integrated care. Similarly, a major decentralization of the Youth Care system took place in the Netherlands. In 2015, municipalities became responsible for organizing all support for children and their families with psychosocial needs (e.g., universal, primary, secondary, and tertiary support). By forming local, multidisciplinary Youth Teams as the core of the renewed Youth Care system, municipalities aimed to provide integrated care within families' own environment.

However, despite these organizational reforms, providing integrated care in practice remains challenging. As we know from previous research, top-down reforms tend to overlook the dynamic and complex process of providing integrated care in practice (Valentijn, Schepman, Opheij, & Bruijnzeels, 2013). Although the aim of the renewed Youth Care system was to ensure integrated support with a strong focus on family empowerment and shared decision making, it remained unclear how exactly professionals should accomplish this in practice. The variety of definitions and applications of integrated care in different contexts hampers general understanding of facilitators and barriers. As a result, professionals struggle to implement an integrated approach in their daily practice, leading to inadequate support of families. A bottom-up approach is considered vital to accomplish effective integrated care, with an emphasis on evaluation, reflection, and collaborative learning (Tsasis, Evans, Rush, & Diamond, 2013).

In this dissertation, integrated care on a professional level was studied from multiple perspectives. The main aim was to contribute to a better understanding of facilitators and barriers for professionals, which was

studied in several ways. First, we conducted a systematic review of international studies to facilitators and barriers for professionals to provide integrated care (chapter 2). Second, two qualitative studies were conducted to unravel parental perspectives (chapter 3) and professional perspectives on integrated care (chapter 4). An additional aim was to guide professionals in improving evaluation, reflection, and collaborative learning, by means of a four-year action-based research study in six Youth Teams in the Netherlands (chapter 5).

In this general discussion, main findings of the four studies are summarized. Subsequently, methodological considerations are discussed, followed by a reflection on theoretical implications. This will lead to implications for policy, practice, education, and future research.

Main findings

In chapter 2, we conducted an extensive systematic literature review to identify facilitators and barriers for professionals to provide integrated care. In total, 55 studies from a variety of settings, models, and populations seen in Youth Care were included for data extraction and qualitative data synthesis. Identified facilitators and barriers were often opposing, and therefore, clustered in seven themes and 24 subthemes. Despite the diversity of studies included, the strength of evidence rating showed that the reported barriers and facilitators were generally consistent across studies and thereby applicable in a variety of settings. Most studies reported facilitators and barriers regarding interprofessional collaboration, including various forms of integrated care provision, information exchange, flexible professional roles, and shared responsibility. In addition, multiple facilitators and barriers regarding broad assessment of problems, a holistic, family centered approach, timely identification of problems, and prioritizing the needs of families were identified. The broad variety of facilitators and barriers identified in the review clearly shows that providing integrated care is a multicomponent and complex process, that requires consideration in practice, policy, education, and organizations.

To enable professionals to tailor integrated care to family's needs, we furthered our understanding of facilitators and barriers from a parental perspective in chapter 3. This qualitative study set two objectives: (1) to identify what parents considered key components of integrated care, and (2) to describe facilitators and barriers according to parents. From the 21 semi-structured interviews with parents, we concluded that parents have a strong desire for a family-centered approach and active participation in decision making over their care process. In total, we identified six key components of integrated care that were of importance according to parents: (1) a holistic, family centered approach, (2) addressing a broad range of needs in a timely manner, (3) shared decision making, (4) interprofessional collaboration, (5) referral and warm handoffs to ensure continuity, and (6) privacy. Parents described several facilitators, including transparent communication, involvement in the care process, freedom of choice, comprehensive and up to date shared care plans, and clear allocation of responsibilities. A perceived lack of access to services, long waiting lists, and difficulties in interprofessional collaboration hindered integrated care. Importantly, parents reported that an integrated approach does not mean that all needs should be addressed simultaneously, since this can lead to overburdening of families. Moreover, although parents considered active participation in decision making processes as important, they held somewhat opposing expectations concerning their own role in shared decision making. Based on the interviews, we concluded that roles in shared decision making were not fixed, and therefore, frequent evaluation of the care process, roles, and responsibilities is needed. In that, professionals should explicitly discuss mutual expectations and transparently propose different options for support.

In chapter 4, we studied facilitators and barriers professionals encounter when providing integrated care. Based on the analysis of interviews with 24 professionals from multidisciplinary teams in the Netherlands, we formed six themes covering facilitators and barriers: (1) early identification and broad assessment to timely recognize problems, (2) multidisciplinary expertise by specialist professionals in a generalist team, (3) continuous pathways to ensure flexible support

throughout the entire continuum of care, (4) stepped and matched care as current approaches in integrated care provision, (5) autonomy of professionals to tailor support and follow guidelines, and (6) evaluation of care processes to discuss progress and alter support if needed. Professionals reported that providing integrated care to families with multiple needs is complex, often due to the long-lasting, unpredictable nature of co-occurring and interacting problems of multiple family members. Professionals emphasized the need for flexible support across life domains, with varying intensity and matched to families changing needs. Facilitators reported by professionals were working in multidisciplinary teams, co-location, and being able to prioritize problems. Also, professionals described the importance of a balance between the use of guidelines and their autonomy to tailor support to families' needs. Moreover, professionals described the importance of evaluation of care processes. In fact, multidisciplinary team discussions enabled them to gain an objective approach of a care process, gain insight in potential blind spots, benefit from the broad expertise represented in their team, involve multiple perspectives in decision making, share responsibility, and learn from each other.

Previous studies (chapter 2), parents (chapter 3), and professionals (chapter 4) all acknowledge the importance of evaluation and reflection in relation to integrated care. In chapter 2, several studies described evaluation as a necessity to learn from each other's' expertise, increase feelings of self-efficacy, and improve familiarity between professionals. Moreover, according to parents (chapter 3), evaluation of the care process can improve insight in their own needs and is crucial for them to engage in shared decision making. In chapter 5, we discussed barriers and facilitators to evaluation and reflection during professionals' weekly multidisciplinary team discussions (MTDs). During MTDs, professionals discuss progression of individual care processes, interprofessional collaboration, team development, and issues in their daily practice. Based on a four-year action research with observations, semi-structured interviews, and interactive sessions, we concluded that each multidisciplinary team had its own working approach for evaluation and reflection. However, facilitators

and barriers to evaluation in MTDs were similar for all teams. Overall, barriers to effective and efficient evaluation included a lack of structure and preparation, an unclear subject and purpose of the MTD, too many professionals attending an MTD, an unsafe team climate, lengthy decision-making processes, unclear tasks during evaluation, and a lack of time to formulate follow up steps at the end of an MTD. Facilitators included allocation of tasks and sufficient preparation, a positive atmosphere with a focus on learning, and a clear purpose, structure, and working approach of the MTD. Based on the facilitators and barriers, nine practical recommendations were formulated in collaboration with professionals, parent representatives, and policy makers. These recommendations included preparatory activities to ensure purpose, timing, and relevant stakeholder involvement; reflective questioning, a safe team climate, and structure during MTDs to ensure effectiveness; and tracking follow up steps after MTDs to ensure a learning process. By applying these recommendations in practice, professionals can develop a continuous learning process to improve integrated care.

Methodological considerations

This section addresses the following general methodological considerations: (1) the conceptual ambiguity of integrated care, (2) reflections on qualitative research methods, and (3) evidence-based practice. Then, three general limitations of this dissertation are discussed.

Conceptual ambiguity of integrated care

A well-known difficulty with studying integrated care is its conceptual ambiguity and variation in applicability (Peek & The National Integration Academy Council, 2013; Valentijn et al., 2013). Integrated care is associated with a broad variety of terms, models, programs, and approaches, and is strongly related to the context in which it is applied. As a result, comparative studies to integrated care are difficult to perform. Being aware of these conceptual differences, integrated care was broadly defined throughout this dissertation as: coherent, continuous, and coordinated support, organized across services, and wrapped around families' needs (Kodner, 2009; Peek & The National

Integration Academy Council, 2013; World Health Organization, 2016). Moreover, a strength of our systematic literature review (chapter 2) was the standardized approach to control for different definitions, contexts, and applications of integrated care across studies. By using standardized extraction forms to keep track of these differences, it was possible to conduct an objective review, resulting in comparable elements across integrated care models, settings, and professional disciplines. Furthermore, with a semi-structured, qualitative approach, the heterogeneity of interpretations across participants has been recognized (chapter 3 and 4). Specifically, at the start of each interview we asked participants to define the concept of integrated care. Then, guided by a topic list, various aspects of integrated care were discussed in the interviews. This approach enabled us to gain insight in participants' associations with the concept of integrated care, and to study integrated care as a multicomponent concept.

Qualitative research methods

As shown by the large number of qualitative studies included in the systematic review, a qualitative approach to study integrated care is often preferred over quantitative research methods. Whereas quantitative research methods are valuable to quantify and classify, to test hypotheses, and to predict trends, qualitative research methods are most suitable to study the 'what, how and why' questions behind these numbers (McCusker & Gunaydin, 2015). Qualitative research provides a powerful research methodology to explore multicomponent and dynamic concepts in its context, such as integrated care (Smith & Furth, 2011). In chapter 3, 4, and 5, qualitative research methods including interviews, observations, action research, and focus groups enabled us to uncover and understand lived experiences with integrated care from various participants' perspectives. To ensure high-quality and objective qualitative research, studies in this dissertation met the following criteria: (1) a structured and systematic approach; (2) triangulation of research methods, researchers, and participants; and (3) continuous reflection on findings and interpretations.

First, various guidelines were applied to ensure a structured and systematic approach: the PRISMA guidelines (chapter 2; Liberati et al., 2009), COREQ guidelines (chapters 3 and 4; Tong, Sainsbury, & Craig, 2007), and RIGHT statement (chapter 5; Chen et al., 2017). These guidelines limited the risk of reporting bias and promoted transparent, systematic, and comprehensive interpretation and reporting of results.

Second, by means of triangulation in research methods and participants, comprehensive information was gathered (Thurmond, 2001). By combining results from interviews, observations, and focus groups, we were able to compare findings, leading to a better understanding of integrated care. Also, participant triangulation enabled us to study integrated care from multiple perspectives, including parents and professionals. To limit potential bias in interpretation of the data, researcher triangulation was applied in this dissertation (Thurmond, 2001). Thus, while coding and interpreting data, value of the findings was increased by cross-checking between researchers.

Third, to ensure confirmability and avoid interpretation bias, we continuously reflected on findings and interpretation during reflexive meetings with the research team. Reflexivity in qualitative research increases rigor and multidisciplinary insights (Barry, Britten, Barber, Bradley, & Stevenson, 1999).

Evidence-based practice

According to the principles of evidence-based practice, combining client perspectives, clinical experiences, and evidence from research is needed to organize high-quality care (Kuiper, Munten, & Verhoef, 2016). Specifically in integrated care, where multiple stakeholders are involved, this multi-perspective and participatory approach is crucial. After all, families are experts over their own care process and in combination with experiences of professionals, their insights are critical to ensure sustainable change in practice. A strength of this dissertation is its participatory character and focus on combining insights from research (chapter 2), clients (chapter 3 and 5), and clinical experiences (chapter 4 and 5). The various research methods with a strong practice-based

focus led to in depth and rich information about facilitators and barriers from multiple perspectives.

Moreover, throughout the entire research process we closely collaborated with representatives of families, practice, and policy within a project team. This project team met approximately every six weeks and played an important role in developing study methods, verifying results, and reflecting on the interpretation of findings. This approach not only encouraged discussion to reveal multiple perspectives, it also increased the credibility and applicability of our study outcomes and limited potential negative effects of interpretation bias (Abma et al., 2017; Femdal & Solbjør, 2018; Migchelbrink, 2007; Nyström, Karltun, Keller, & Andersson Gäre, 2018). In addition to the project team, a steering committee advised the researchers twice a year, by reviewing the recommendations and study progress. This committee consisted of representatives from practice, families, research, education, and policy, and played an important role in the dissemination of the study outcomes in their own organizations and network.

Limitations

Besides specific study limitations described in earlier chapters of this dissertation, there are three general limitations that should be considered. First, although the qualitative approach enabled us to gain a comprehensive overview of facilitators and barriers and thereby contributes to a better understanding of integrated care on a professional level, we did not measure the actual effects of these barriers and facilitators in practice. Specifically, we now know what facilitators and barriers are important to consider when providing integrated care, but we are still unaware how they impact practice. Hence, it is not possible to draw any conclusions to what extent our findings affect practice, or to scrutinize if and how the facilitators and barriers interact with each other. The need for high-quality studies to the effects of integrated care in practice is widely recognized (Hetrick et al., 2017; Strandberg-Larsen & Krasnik, 2009). Insights in the effects of integrated care are crucial to guide practice and policy to develop targeted interventions to improve integrated care. Furthermore, to

provide personalized support, we should further our understanding of general aspects of integrated care and individual differences based on characteristics of families and professionals ('who').

Second, this study was conducted in a restricted period and setting, within a highly changing context, with multiple organizational reforms ahead. Hence, we included a relatively small number of participants from Youth Teams with a lack of geographic spread across the country, in a typical Dutch context and within a western society. Moreover, in the qualitative part of this study we solely focused on professionals, parents, and policy makers involved in Youth Teams, and approached integrated care from that perspective. Consequently, we overlooked the interpretation of facilitators and barriers from for example the perspective of professionals in tertiary support or in universal services. Since integrated care is such a context-dependent process, results from this dissertation cannot be transferred to other contexts or integrated care initiatives without reservations. However, we suggest that the outcomes of this dissertation can be seen as generic for the broad setting of Youth Care, since the results were consistent across studies, and complementary to the results of previous research to integrated care (chapter 2).

Third, although practice-based research is crucial to improve practice, it is also time consuming and requires an open attitude of all those involved. Moreover, improvement as an outcome of practice-based research can be difficult to quantify. Since professionals were closely involved during all phases of the research, some professionals became unaware that a learning process was stimulated as a result from participating in this study. Consequently, it was difficult to keep these professionals involved: they felt that there was no need for additional support and were demotivated to participate in for example learning sessions. To keep practice involved and to avoid misunderstanding, confusion, and motivation problems across participants, it is crucial that researchers frequently discuss preliminary results with practice, adjust activities to professionals' needs, and critically reflect on their own behavior and attitudes as a researcher.

Table 1. *Core components of integrated care on a professional level*

	Core components	Systematic review (chapter 2)	Parental perspectives (chapter 3)	Professional perspectives (chapter 4)
1	Family-centered focus	A holistic focus to address a broad range of needs, with both a generalist view on the entire family's welfare and a specific focus on individual needs.	Problems of one family member often influence the entire family's wellbeing. The needs of family members can vary. The importance of a holistic approach should be discussed with families.	Problems of one family member often influence the entire family's wellbeing. Family-centered support can be challenging due to chronic, interacting, and unpredictable problems.
2	Prioritize problems and needs to decide on the focus of support	Prioritize problems is crucial to decide on the focus of support and to respond to often changing needs of families. Professionals should be able to incorporate different viewpoints into a coherent plan.	Not all needs should be addressed simultaneously, too many treatment goals lead to overburdening of families. Joint assessment and shared decision making is needed, with active involvement of parents.	Professionals do not need to solve all problems, they must identify needs, prioritize problems, and timely involve other expertise. Shared decision making is crucial to tailor support to families' needs.
3	Flexible care provision across domains, responsive to the needs of families (e.g., step up and scale down)	Support should be flexible throughout the entire continuum of care, to respond to the changing needs of families.	To be involved in the care process and increase consensus on the focus of support, families need insight in the care process through up to date care plans with focus on current and future goals.	Varying intensity of support is needed to respond to the changing needs of families. Requires frequent evaluation and timely involvement of other professionals.
4	Knowledge and expertise (e.g., generalist and specialist knowledge)	There is no consensus on the knowledge and skills professionals should possess (both generalist and specialist expertise). Unrealistic that one professional can learn and apply all knowledge needed to provide a broad range of support. Need for joint learning on the job.	Multidisciplinary teams broaden the scope of expertise needed to provide a broad range of support.	Both generalist and specialist knowledge required. Multidisciplinary teams deploy a broad range of expertise to provide integrated support. Joint learning can be improved by evaluation and learning on the job.

	Core components	Systematic review (chapter 2)	Parental perspectives (chapter 3)	Professional perspectives (chapter 4)
5	Self-efficacy (i.e., feeling comfortable and competent to assess a broad range of problems)	Feeling comfortable and competent to assess a broad spectrum of problems and collaborate with various professionals. Providing support outside a professionals' scope of expertise decreases feelings of self-efficacy.		High working demands force professionals to provide support outside their scope of expertise, leading to decreased feelings of self-efficacy.
6	Tools for integrated care (e.g., screening tools, shared care plans, and guidelines)	Adequate application of screening tools for broad assessment. A shared care plan should be flexible and adjustable to family's needs. Guidelines can support professionals in recognition of needs, and in interprofessional collaboration.	The aim of broad assessment, including the use of screening tools, should be explained to parents. Shared care plans can improve insight in a care process, professionals should keep these plans up to date.	Broad assessment can be burdensome for parents and is time consuming. Guidelines can assist professionals in providing integrated support, if there is sufficient room for professional autonomy to tailor support to family's needs.
7	Preconditions for integrated care (e.g., time, funding streams, and availability of support)	Integrated funding streams, time for interprofessional collaboration, and time for broad assessment. Availability of professionals is crucial; however, it is challenging to estimate the amount of time and number of professionals required. High-turnover rates hinder integrated care.	Integrated funding streams and agreements between services. A lack of access and availability are major barriers. Transparent communication on the availability of support positively influences the perceived waiting time. High-turnover rates hinder integrated care.	Sufficient time for integrated care and availability of professionals important to timely step up and refer to other services. Lack of availability forces professionals to provide support outside scope of expertise. High-turnover rates hinder integrated care.

	Core components	Systematic review (chapter 2)	Parental perspectives (chapter 3)	Professional perspectives (chapter 4)
8	Forms of integrated care (e.g., multidisciplinary teams, colocation, consultation, and coordination)	Colocation, consultation, multidisciplinary case discussions, multidisciplinary teams, and care coordination are forms of integrated care that can broaden the scope of care provided, improve opportunities for learning, and stimulate interprofessional collaboration.	Colocation and care coordination can reduce fragmentation and increase coherence, collaboration, accessibility, familiarity, and early support. By working in multidisciplinary teams, diverse expertise is easily accessible, leading to increased efficiency.	Colocation and multidisciplinary teams can improve familiarity, learning from one's others expertise, and interprofessional collaboration. Multidisciplinary case discussions are crucial for collaborative learning and to make use of other professionals' expertise.
9	Collaboration between services	Schools are important collaborative partners. Warm handoffs, timely involvement of other expertise, agreements on frequency and content of sharing information facilitate collaboration. Potential confidentiality issues should be discussed with families to overcome privacy issues.	Schools and general practitioners are important collaborative partners. Warm handoffs, a contact person during transition from one care provider to another, and agreements between professionals about the content and frequency of sharing information facilitate collaboration. Privacy of separate family members should be considered during family meetings.	Schools, general practitioners, and adult care providers are important collaborative partners. Warm handoffs, timely involvement of other expertise, and share adequate information facilitate collaboration. Potential privacy issues should be discussed with families.
10	Familiarity between professionals	Familiarity with other professionals, mutual respect, and appreciation of diversity needed to make use of each other's expertise (attitudes), and to incorporate multiple perspectives into a care plan.	Familiarity between professionals, and with families, improves communication and accessibility of support.	Familiarity with other professionals is crucial to make use of each other's expertise and leads to increased trust and improved collaboration. Respectful attitude towards other professionals.

	Core components	Systematic review (chapter 2)	Parental perspectives (chapter 3)	Professional perspectives (chapter 4)
11	Roles, responsibilities, and professional identity	Recognize (boundaries of) one's own expertise, roles, responsibilities, and tasks. Unclear whether roles and responsibilities should be set of flexible. Shared thinking and positive attitude towards integrated care are facilitators.	Clear tasks, roles, and responsibilities are required for coordinated support, as well as a contact person for families to ensure continuity.	Recognize (boundaries of) one's own expertise, roles, responsibilities, and tasks and timely involve other professionals if needed.
12	Evaluation and reflection	Evaluation increases familiarity, and is a necessity to recognize roles, responsibilities, and learn from each other expertise. Improves self-efficacy and shared decision making.	Multidisciplinary case discussions can increase insight in care processes and are essential for families to be involved in shared decision making. Attending these discussions can be burdensome for parents.	Evaluation and reflection improve insight in roles and responsibilities, shared decision making, and interprofessional learning, and helps to timely involve other expertise.

Theoretical implications

This study has several theoretical implications. First, we reflect on core components of integrated care on a professional level based on the facilitators and barriers identified in chapter 2, 3, and 4 of this dissertation. Then, we further discuss theoretical implications regarding multidisciplinary expertise, followed by a reflection on the importance of prioritizing needs in collaboration with families.

Core components of integrated care

Our findings confirm previous statements that providing integrated care is more than forming networks and organizing interprofessional collaboration (Goodwin, 2013; Valentijn et al., 2013). In Table 1, a thematic clustering of barriers and facilitators identified in the systematic review (chapter 2), parental perspectives (chapter 3), and professional perspectives (chapter 4) is presented. As can be concluded from Table 1, integrated care on a professional level can occur in different forms, and is related to a family-centered focus, interprofessional collaboration, organizational preconditions, and tools for integrated care. Moreover, our findings demonstrate that integrated care requires specific competencies, expertise, attitudes, and behavior of professionals, with a strong focus on interprofessional learning and shared decision making. Importantly, and often overlooked when developing integrated care initiatives, core components of integrated care also include self-efficacy and feelings of familiarity with other professionals. In fact, professionals should feel comfortable and competent to provide holistic, family-centered support, they should recognize the boundaries of their expertise, and timely involve others if needed.

Moreover, as can be concluded from Table 1, most facilitators and barriers identified in the systematic literature review (chapter 2), were also described by parents (chapter 3) and professionals (chapter 4). Given this high correspondence, we are confident that the twelve core components from Table 1 should always be considered when organizing or developing integrated care initiatives in practice:

1. A family-centered focus
2. Prioritize problems and needs to decide on the focus of support
3. Flexible care provision across domains, responsive to the needs of families (e.g., step up and scale down)
4. Knowledge and expertise (e.g., generalist and specialist knowledge)
5. Self-efficacy (i.e., feeling comfortable and competent to assess a broad range of problems and engage in interprofessional collaboration)
6. Tools for integrated care (e.g., screening instruments, shared care plans, and guidelines)
7. Preconditions for integrated care (e.g., time, funding, and availability)
8. Forms of integrated care (e.g., multidisciplinary teams, colocation, consultation, coordination)
9. Collaboration between services
10. Familiarity between professionals
11. Roles, responsibilities, and professional identity
12. Evaluation and reflection

The increased understanding of integrated care on a professional level makes an important contribution to guide professionals, organizations, and policy makers in improving high-quality and sustainable integrated care initiatives in practice. This dissertation clearly demonstrates that providing integrated care is a dynamic process. Further development of current and future integrated care initiatives requires continuous evaluation of the twelve core components by all stakeholders involved: families, professionals, researchers, policy makers, and organizations. This is important, since it is to be expected that the interpretation, application, and effects of each core component slightly vary per situation. For example, although both parents (chapter 3) and professionals (chapter 4) valued clear roles and responsibilities in a care process, we also found subtle differences in their perspectives on who should take certain responsibilities. Moreover, we assume that there might be differences in perspective between professionals about their roles in individual care processes, that highly depend on family's needs. Corroborating previous research (Baxter et al., 2018; Curry &

Ham, 2010; Patel et al., 2013), there is no 'one size fits all' approach to integrated care. Therefore, contextual variations, the individual needs of families, and professionals' characteristics should always be considered when evaluating core components of integrated care to further develop integrated care initiatives.

Multidisciplinary expertise

In chapter 2, we found that various specialist knowledge and expertise are needed to address the broad range of problems families in Youth Care encounter. However, from the systematic review it remained unclear what this knowledge or expertise of professionals should look like. Moreover, it seems unrealistic that one individual professional can learn and apply all available knowledge and expertise that is needed to provide integrated care. Therefore, to ensure multidisciplinary expertise, there has been an increased focus on organizing integrated care in multidisciplinary teams (Briggs, Valentijn, Thiyagarajan, & Araujo de Carvalho, 2018; Wodchis, Dixon, Anderson, & Goodwin, 2015). Findings in this dissertation confirm the importance of multidisciplinary teams to provide integrated care. Multiple studies in chapter 2 reported that multidisciplinary teams can increase the scope of care provided. Moreover, parents in chapter 3 confirmed this finding, stating that multidisciplinary Youth Teams improved local interprofessional collaboration and increased accessibility of support. Also, professionals in chapter 4 reported that working in multidisciplinary teams enables them to learn from each other's expertise and to take different roles in a care process. These findings all provide evidence that multidisciplinary teams such as the local Youth Teams in the Netherlands, can be a step forward to provide integrated care.

However, as already stated by Goodwin (2013), integrated care requires more than establishing multidisciplinary teams. Even though multidisciplinary teams can broaden the scope of care provided, teams that solely consist of professionals with specialist expertise seem insufficient to realize integrated care in practice. Specifically, if each professional focusses on its own specialism and a restricted number of problems within a multidisciplinary team, the interrelatedness of

problems and needs can still be overlooked (Hawkins, 2009; Kodner, 2009). On the other hand, it is vital to keep specialist expertise up to date, to avoid a multidisciplinary team full of generalists (chapter 4). Hence, two issues need further consideration.

First, we suggest that all professionals in Youth Care should possess generic competencies to be able to maintain a holistic, family-centered focus during care trajectories (chapter 2, 3, and 4), to recognize the boundaries of one's own expertise (chapter 4), and to timely involve other professionals if needed (chapter 4). For example, professionals should be able to evaluate and reflect on a care process in multidisciplinary team discussions, collaborate with other professionals, and contribute to shared decision-making processes. These competencies can be expanded by for example joint learning on the job (chapter 2 and 4) and improving multidisciplinary team discussions (chapter 5).

However, it is important to critically reflect on how much we can ask from professionals in Youth Care. Providing integrated care is a time-consuming process, while professionals' availability is often limited (chapter 2, 3, and 4). As a result, it can be difficult for professionals to prioritize learning activities (chapter 2 and 4). Moreover, professionals in chapter 4 reported that combining a specialist and a generalist approach to maintain a holistic, family-centered focus, hindered them to recognize the limits of their own abilities and timely involve other professionals, and led to unclear roles and responsibilities. Also, providing integrated care often forced professionals to provide support outside their scope of expertise, leading to feelings of incompetence and uncertainty (chapter 4). Hence, it seems that providing integrated care requires more than increasing generic competencies of all professionals in Youth Care and keeping specific specialist expertise up to date.

This brings us to our second issue of consideration. The multitude of components and the complexity of tasks related to integrated care provision poses the question whether being a generalist in integrated

care should be an area of expertise in itself. For example, being able to assess and prioritize needs, ensure flexible care provision and a family-centered approach, timely involve specific expertise, incorporate multiple perspectives into a comprehensive plan, and familiarity with a broad variety of services might require specific generalist expertise.

In this light, it would be interesting to learn from recent developments within other settings, for example from the role of a hospital physician in the medical setting. Since 2014, the specialism of hospital physician is officially recognized as a response to differentiation and specialization of medical doctors. This increased specialization led to fragmentation of care within the hospital setting. There was a need for a specialist with a generalist focus, whose main task was to ensure patient-centered, holistic, coherent, continuous, and high-quality support for patients with multiple (complex) needs. Currently, medical doctors can apply for the three-year specialist training to become a hospital physician (Regts, van Offenbeek, Roemeling, Bakker, & Vos, 2019). Generalist knowledge and expertise in the field of medicine will be obtained through learning on the job at various departments within the hospital setting. We believe that a similar specialism could be applicable to the Youth Care setting to facilitate integrated care for families with multiple, complex needs. For example, this can be a generalist trained within different domains in Youth Care (e.g., universal, primary, secondary, and tertiary care), and who can facilitate an integrated approach based on the needs of families. It would be interesting to further investigate the possibilities and added value of a so-called generalist profession in Youth Care. For example, we should study what role this specialist can play in multidisciplinary teams, and what knowledge, skills, and education they need to have to deliver high-quality integrated care.

Prioritizing needs in collaboration with families: shared decision making and evaluation

Another important finding of this dissertation is that to provide integrated care, professionals should be able to prioritize needs in collaboration with families. Specifically, families with multiple needs often encounter a broad variety of interacting problems (chapter

2). These problems cannot be addressed simultaneously, since this can lead to overburdening of families (chapter 3). As we know from previous research to families with multiple needs, broad assessment is needed to gain insight in problems, needs, and strengths across life domains (Tausendfreund, Knot-Dickscheit, Schulze, & Knorth, 2015; Van der Steege & Zoon, 2015). However, professionals in our study reported that it was difficult to prioritize needs based on this broad assessment (chapter 4). Furthermore, although professionals did not feel that they had to solve all problems, it was difficult for them to decide on the most appropriate focus of support (chapter 4). For example, difficulties in prioritizing occurred when needs of individual members seemed incompatible (chapter 2), or when professionals held different views on the most appropriate support (chapter 2, 3, 4). Moreover, the interaction of problems families in Youth Care encounter is still poorly understood, leading to difficulties in deciding the order in which needs should be addressed to achieve the best outcomes for families. This is a major knowledge gap that requires further research to improve integrated support for families with multiple needs.

In addition, to guide professionals in prioritizing needs, two aspects of prioritizing in integrated care should be further considered: (1) shared decision making and (2) evaluation and reflection.

First, shared decision making, defined as the process in which professionals and families jointly assess needs and decide on the focus of support (Bunn et al., 2017; Smits & Jukema, 2016). Previous studies reported shared decision making as a facilitator to decide on the type and intensity of support (Axelsson & Axelsson, 2009; Cohen et al., 2015). Moreover, parents (chapter 3) and professionals (chapter 4) in our study confirm the importance of shared decision making in integrated care. They underlined the need to provide different options for support, explicitly discuss mutual expectations, and taking all perspectives into account when deciding on the focus of support. According to parents, shared decision making can increase families' feelings of empowerment, and thereby positively influence a care process. However, both parents and professionals reported difficulties

in shared decision making. Specifically, it became increasingly clear that shared decision making was not something fixed, but a context-dependent process, in which parental and professional roles differ per family and change over time.

In our study, both parents and professionals reported the need for guidance in shared decision making. Currently, there are already multiple guidelines available to support professionals in shared decision making, for example the Dutch guideline 'Richtlijn samen met ouders en jeugdige beslissen over passende hulp' (Bartelink, Meuwissen, & Eijgenraam, 2015) and the NHS 'Shared Decision-making Guide' (2019). However, based on the interviews in chapter 4, we suggest that these guidelines might not be implemented sufficiently in professionals' daily practice. It is possible that professionals are unaware of the existence of these guidelines, or that there is some controversy about the applicability. On the one hand, professionals indicated that the use of guidelines can support them in their daily practice. On the other hand, they also reported that strict guidelines hinder the application in practice, since it leads to a lack of professional autonomy to tailor support to family's needs. Hence, there should be a focus on appropriate implementation of existing guidelines in current practice, training, and education. In that, there should be a balance between the use of guidelines, and professionals' autonomy to tailor support to family's needs.

The second aspect to guide professionals in prioritizing needs is to consider the importance of evaluation. Based on this dissertation, we conclude that evaluation of care and care processes is crucial to prioritize families changing needs, to make use of the broad range of expertise in multidisciplinary teams, and to improve interprofessional collaboration (chapter 3, 4, and 5). Moreover, the needs of families often change over time and therefore, require continuous monitoring and evaluation to ensure tailored support (Firth, Barkham, & Kellet, 2015). Although professionals and organizations are often aware of the need to monitor and evaluate care processes, in practice this is often hampered by a perceived lack of time for evaluation, crisis-oriented focus of evaluations, and lack of structure during evaluations (chapter

4 and 5). The practical guidelines in this dissertation (chapter 5) are an important contribution to improve evaluation in practice, and thereby facilitate the process of prioritizing needs.

Implications

In this section, we further discuss implications for policy and organizations, practice, education, and future research.

Implications for policy and organizations

Policy makers and organizations in Youth Care play an important role in organizing integrated care, and thereby substantially influence integrated care provision in practice (Valentijn et al., 2013). A first evaluation of the decentralized Youth Care system in the Netherlands shows that despite organizational reforms, integrated support for families with multiple, complex needs is still lacking (Friele et al., 2018). Although there are positive developments as a result of the local organization of Youth Care, including shorter lines between local services, there is still a lack of coordination between care providers, a lack of availability of support, and limited coherence in the care process of families. Policy makers admit that we are not there yet (De Jonge & Dekker, 2020). Currently, families with multiple needs all too often do not receive the support they need and professionals still encounter difficulties in providing integrated support. As a solution, policy makers and organizations again focus on interventions at the organizational level, intended to support existing structures or forming new networks. Examples of this organizational focus are the development of local integrated teams for specialist support that operate alongside the existing Youth Teams, and the organization of supra-regional expertise centers that should improve care for the most vulnerable families in the country.

However, these are again solutions sought in structure and organization of integrated support. Although it is important that there is a certain structure at the organizational level to organize integrated care, this is only a starting point. This dissertation clearly shows that integrated care is not something you merely organize, but a process that requires

continuous development in practice. Corroborating previous research (Wodchis et al., 2015), initiatives to improve integrated care should be bottom up to ensure sustainability, with top-down (organizational) support. Therefore, to stimulate substantial improvement of integrated care in practice, we strongly recommend policy makers and organizations to focus on integrated care on a professional level, in addition to ensuring organizational preconditions. In that, the twelve core components that emerged from this dissertation should be the basis to further evaluate and develop integrated care initiatives in collaboration with practice.

Implications for practice

This dissertation has a strong practice-based focus. Therefore, multiple implications for practice are addressed in the separate chapters. A critical issue that professionals should be aware of is that providing integrated care is not 'something that you do or organize'. As Miller and Stein stated (2018): 'Integrated care is a highly complex intervention and adopting its principles can take time, flexibility, and understanding'. Therefore, professionals should consider integrated care as a profession that requires both collaborative working and collaborative learning.

First, professionals should pay attention to collaborative working as a facilitator to provide integrated care. To address a broad range of needs, it is crucial that professionals can collaborate with a variety of partners in the field of Youth Care, including general practitioners and schools. To ensure interprofessional collaboration, professionals must be aware of the boundaries of one's own expertise, acknowledge when additional expertise is needed, and timely involve other professionals. In addition, to provide integrated support to families with complex needs, professionals should appreciate other professionals' expertise and working approach, there should be mutual trust, transparency, continuous communication, and feedback (Bevington, Fuggle, Cracknell, & Fonagy, 2017). Furthermore, professionals should be aware that collaboration in integrated care does not only apply to interprofessional collaboration. In fact, collaboration with families is just as important. To be able to provide integrated care tailored to

family's needs, involving family's perspectives is a necessity. In that, professionals should always discuss the importance of an integrated approach to families, ensure an up to date care plan, and guide families in shared decision making.

Second, professionals should pay attention to collaborative learning as a facilitator to provide integrated care. Integrated care is a dynamic and complex process, that requires multidisciplinary expertise and continuous evaluation of the care process to respond to the changing needs of families. To make use of the multidisciplinary expertise in for example a Youth Team and facilitate interprofessional collaboration, it is important to frequently discuss both clinical cases and team functioning during Multidisciplinary Team Discussions (MTDs). To ensure collaborative learning during these meetings, professionals should consider the practical recommendations for evaluation from chapter 5. Specifically, professionals should pay attention to preparatory activities, a safe team climate, and monitoring progress to ensure learning. During these MTDs, the twelve core components of integrated care described in this dissertation can be discussed to further develop integrated care initiatives. Importantly, organizations should stimulate collaborative learning activities by incorporating these activities in their policies and in their own working approach.

Implications for education

This dissertation has a primary focus on professionals that are currently employed in Youth Care. However, we strongly recommend to also invest in future professionals. In line with Stein (2016), we suggest that it is not only needed to introduce the concept of integrated care intro curricula of a broad range of mental health-oriented studies (e.g., Psychiatry, Psychology, Social Work), but also to make interprofessional education and training the norm. Corroborating Miller and Stein (2018), we suggest that there should be a shift from uniprofessional education to interprofessional education. Of course, specialist training is needed to prepare future professionals and ensure the required specialisms in the broad field of Youth Care. However, it would be valuable to also invest in interprofessional courses, to improve feelings of familiarity

with other professions. For example, students from various faculties (e.g., Medicine, Psychology, Social Work) can collaboratively learn from clinical case discussions. In that, a strong focus should be on increasing generic competencies to provide integrated care, such as holding a holistic view on family functioning, being able to collaborate with other professionals, and shared decision making.

Implications for future research

This dissertation has thrown up various new research questions discussed in the separate chapters. In addition, the following two topics need further consideration: (1) in depth research to the 'how' and 'who' of integrated care, and (2) studying and learning from various integrated care initiatives in practice.

First, there is a need for in depth research to the 'how' and 'who' of integrated care. Although this dissertation contributes to increased understanding of 'what' barriers and facilitators should be considered when providing integrated care, we are still unaware of how these core components affect practice and for who, how they interact with each other, and how they can be applied by various professionals. For example, it remains unclear how, under what conditions, and for who shared decision making and evaluation positively affect the process of prioritizing. To further our understanding of integrated care on a professional level, we suggest future studies to work from a realist evaluation approach. This approach can guide researchers in unraveling what works, how and why, and under what circumstances when providing integrated care (Marchal, van Belle, Olmen, Hoerée, & Kegels, 2012; Pawson & Tiley, 1997). Realist evaluation not only focusses on the implementation and effectiveness of interventions and processes, but also on contextual factors and casual mechanisms that underlie change (Marchal et al., 2012). Based on the findings of this dissertation, theories can be formulated, discussed, and tested in practice, by both quantitative and qualitative research methods.

Second, future research should focus on studying and learning from various integrated care initiatives in practice. Since integrated care is a

context-dependent process, there is a substantial variety of integrated care initiatives. To prevent fragmentation in knowledge and to learn across domains, it is crucial that these small-scale initiatives are further studied and compared from multiple perspectives. If not, these initiatives will only have a limited impact on a small scale, and each new initiative has to reinvent the wheel. Learning from various integrated care initiatives can be stimulated in so-called communities of practice (Wenger, 2011), such as the Academic Workplaces in the Netherlands. In these communities, representatives from practice, families, organizations, policy, and research share knowledge and experiences, and reflect on current practice to stimulate collaborative learning. We suggest that to study and further develop integrated care initiatives, it is crucial to collaborate across domains, and learn from for example the medical sector, public administration, and adult care initiatives. Additionally, integrated care initiatives should be systematically monitored and compared to study generic elements, applicable to all integrated care initiatives, and elements that can only be applied under certain circumstances. In that, Qualitative Comparative Analysis can be a helpful research method (QCA; Thomann & Maggetti, 2017). With QCA, patterns can be systematically discovered in small groups and complex situations, enabling comparison between integrated care initiatives in different contexts.

CONCLUSION

Providing integrated care is crucial to support families with multiple needs and should be considered as a profession on its own. There is no one size fits all approach, and solely organizing integrated care on an organizational level is insufficient to facilitate professionals in providing integrated care. This dissertation aimed to increase our understanding of integrated care on a professional level from various perspectives. The twelve core components described in this dissertation should be the basis to further develop integrated care initiatives, for both policy and practice. However, the core components should not be considered as a checklist, but as guidance for collaboratively discussing and developing integrated care initiatives. This requires continuous evaluation and

reflection in a learning environment, including professionals and their organizations, families, policy makers, and researchers, with a focus on improving integrated care for families with multiple needs.