



Understanding the Impact of Family-Focused Youth Care: Examining Outcomes, Effective Elements and Tipping Points as Experienced by Parents and Youth

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Abstract

Amid ongoing concerns about the effectiveness and enduring outcomes of youth care, this study investigated the perceived impact of family-focused youth care from the perspectives of parents and youth. The research aimed to explore perceived effects, to identify effective elements of care, and to examine tipping points that marked significant changes during the care trajectory. Quantitative data from the BESTE questionnaire (N = 75; n = 60 parents; n = 15 youth) and qualitative data from interviews (N=14 families) were combined. Quantitative findings indicated that most parents (70.0%) and youth (73.4%) perceived the care as effective in terms of improvements in child, parent and family functioning. Qualitative data also revealed meaningful changes in child, parent and family functioning, alongside persistent vulnerabilities—especially in parental well-being and complex family contextual factors. Therapeutic alliance, intervention content, and organizational factors were confirmed as effective elements of care. Facilitating elements were mostly found in therapeutic alliance and intervention content. Organizational factors, including bureaucracy, waiting lists and fragmented collaboration, were frequently cited as hindrances. Tipping points were often linked to respectful professional interactions, diagnostic insights, and extra-therapeutic events such as changes in relationships or school settings. Findings underscore the importance of a systemic approach that includes attention to parental needs, contextual stressors and to informal support networks. Implications for practice include a holistic approach to incorporate systemic factors, including integrated parental support in youth care, strengthening alliance-building competencies, improving interdisciplinary collaboration and reducing organizational barriers. Further research is needed to examine the sequencing and integration of youth and parental care to enhance long-term outcomes.

Keywords Family-focused youth care · Perceived effects · Effective elements · Tipping points · Systemic approach · Interviews

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Introduction

Evaluating outcomes of youth care is essential with a view to enhancing the quality of care and accounting the use of public funds (Flynn et al., 2024). Due to rising costs and ongoing critical reflections on the efficacy and sustainability of youth care, its effectiveness has been the subject of debate for an extended period (De Swart et al., 2012; Guterswijk et al., 2020; Souverein et al., 2013; Strijbosch et al., 2015). To prevent re-referral, keep costs low and achieve positive outcomes for families, it is imperative to know what works for families involved in youth care (Visscher et al., 2022). Besides being important for policymakers and funders, it is especially crucial for the families themselves, as youth care is often an intense and time-consuming process. To gain insight into the impact of youth care and the factors shaping it, this study examines (1) the effects of family-focused youth care from the perspective of parents and youth, (2) perceived effective elements, and (3) the critical tipping points that decisively may have influenced perceived effects.

Family's Perspectives on Perceived Effects, Effective Elements, and Tipping Points

Understanding the perspectives of families regarding experienced effects of care and the aspects they find helpful or unhelpful is essential for tailoring services to better meet their needs, intending to lead to more effective and durable outcomes (Bjørknes & Ortiz-Barreda, 2021; Van Bijleveld et al., 2014). Moreover, actively involving families increases a sense of empowerment, which may boost their satisfaction and motivation (Tilbury & Ramsay, 2018). Knowing which events or care elements are regarded as tipping points may enable professionals in future trajectories to stimulate these elements and initiate positive change for families earlier in their care trajectory. Furthermore, investigating the conditions under which possible tipping points emerge, as well as the factors that contribute to their onset, may provide valuable insights for optimizing the effects of youth care interventions.

Family-Focused Youth Care

Family-focused youth care addresses children—including younger children and adolescents—and their parents who experience severe developmental, emotional, or behavioral problems in the child in conjunction with substantial parenting problems. These challenges are frequently compounded by multiple chronic stressors, including financial hardship, health problems, and relational instability (Tausendfreund et al., 2016; Visscher et al., 2020b). Family systems theory

(Minuchin, 1974) and the Bioecological model of human development (Bronfenbrenner & Morris, 2007) both offer a relevant framework for understanding these complex needs, emphasizing that individuals must be considered within their broader environment and context (Tong & An, 2024; Willemse, 2015).

According to Family systems theory, families function as interconnected systems in which changes in one member affect the entire unit (Bowen, 1978; Gavazzi & Lim, 2023). Additionally, the Bioecological model posits that children's development is shaped by reciprocal interactions between the individual and multiple, nested environmental systems, ranging from the immediate family and school context to broader cultural and societal influences (Tong & An, 2024).

Accordingly, family-focused youth care interventions adopt a systemic perspective by involving not only the child but also parents and other key family members (Willemse, 2015). In addition to improving child functioning—such as reducing emotional and behavioral problems and enhancing social skills—these interventions aim to improve parenting skills, to strengthen family mutual relationships and resilience and to activate the family's social network (Damen et al., 2021; Evenboer et al., 2018; Visscher et al., 2020b). Examples of family-focused, systemic interventions are mostly home-based interventions such as Intensive Family Treatment (Visscher et al., 2020a), Functional Family Therapy (Alexander et al., 2013), and Multisystemic Therapy (Henggeler et al., 1998), however, they can also be delivered in residential and semi-residential settings (Blanckstein et al., 2022).

Perceived Effects of Family-Focused Youth Care

Definition

Perceived effects of youth care refer to changes in child, parent, and family functioning as subjectively experienced and reported by youth and parents themselves. These perceived effects extend beyond symptom reduction (Ladmanová et al., 2025; Nooteboom et al., 2020) and may encompass changes in daily functioning following care, such as emotional and relational functioning, well-being and self-insight, affecting the child's, parent's or the family's functioning as a whole.

Prior Research on Youth Care Effects

Examining prior research on youth care effects—encompassing both quantitative and qualitative studies and various intervention types—mostly beneficial results were found. Positive effects of family-focused youth care interventions on child, parent and family functioning were found in systematic reviews by Janssen et al. (2025) and Pederson et

al. (2019). Based on interviews with youth, Paradisopoulos et al. (2015) found positive outcomes of Multi Systemic Therapy (MST), like improved family relations, recognizing consequences of their behavior and healthier peer relations. Improved family communication was also reported by Celinska et al. (2015) and Morino (2018), who both qualitatively examined perspectives of parents and youth on forms of family therapy.

Effective Elements of Youth Care

International research examining family perspectives on youth care outcomes consistently highlights effective factors within the care process (e.g., Soenen et al., 2013; Todd et al., 2025; Visscher et al., 2022). These factors tend to converge around three core components of effective care: therapeutic alliance, intervention elements and organizational factors.

Therapeutic Alliance

The first core element, the establishment of a strong therapeutic alliance—between the child and the professional, as well as between the parent and the professional (De Greeff et al., 2018; Pölkki & Vornanen, 2015). —emerges as one of the most consistently recognized elements contributing to positive outcomes. A therapeutic alliance refers to a collaborative and trust-based working relationship between the care providers and the client (youth and/or parents), characterized by mutual agreement on goals, shared understanding of tasks, and an emotional bond (De Greeff et al., 2018). This alliance is fostered through active listening, availability, genuine interest, and the promotion of mutual trust and engagement (Morino, 2018; Paradisopoulos et al., 2015; Pölkki & Vornanen, 2015; Soenen et al., 2013; Todd et al., 2025; Tranquilla, 2013). Practical and emotional support, a respectful and non-judgmental attitude of the professional (Morino, 2018; Tilbury & Ramsay, 2018; Visscher et al., 2022), and the serious consideration of the child's and parents' views are also essential components of the alliance (Bouma et al., 2019; Pölkki & Vornanen, 2015; Tilbury & Ramsay, 2018; Visscher et al., 2022). Children and parents stress the importance of being actively involved in decision-making processes related to their care trajectory (Barnhoorn et al., 2025; Furrer et al., 2023; McLoughlin et al., 2020; Morino, 2018; Tilbury & Ramsay, 2018; Todd et al., 2025; Van Bijleveld et al., 2014). While families appreciate being consulted and having their opinions considered in final decisions, they report that such involvement is not yet standard practice within the youth care system (Peper et al., 2025; Van Bijleveld et al., 2014). Transparency, clear communication, and honesty are further identified as critical to building trust (Doelman et al., 2024; McLoughlin et al.,

2020; Morino, 2018; Tilbury & Ramsay, 2018). Regarding the parent-professional alliance, a positive collaboration is facilitated when professionals and parents share a common understanding of the care need (Doelman et al., 2024) and when professionals demonstrate cultural competence and a comprehensive understanding of the family's background and circumstances (Bouma et al., 2019; McLoughlin et al., 2020; Pölkki & Vornanen, 2015; Todd et al., 2025). Families also value decisiveness (Bouma et al., 2019; Doelman et al., 2024) and reliability, noting the importance of professionals following through on commitments (Tilbury & Ramsay, 2018).

Intervention related factors

A second core element of effective youth care concerns intervention-related factors, which entails the methodological content of the provided care. The methodological content refers to the specific intervention components, techniques and methods through which change is intended to be achieved. A central concern expressed by families is the need for children to be recognized as individuals with distinct needs, strengths, and circumstances. Effective care must be tailored accordingly, emphasizing a personalized approach (McLoughlin et al., 2020; Visscher et al., 2022). Additionally, when the intervention is strength-based, this increases the motivation to actively take part in the intervention (Todd et al., 2025). Families also highlight the importance of addressing all relevant care needs rather than focusing on a single issue. A systemic approach that includes the child's broader social environment – such as family, school, and community systems – is considered essential for meaningful and durable outcomes (McLoughlin et al., 2020; Todd et al., 2025; Visscher et al., 2022). A focus on increasing the child's social network is essential for peer support and fostering a sense of identity (Paradisopoulos et al., 2015). For children and adolescents, youth care fosters the development of perspective-taking and enhancing their capacity to recognize the impact of their behavior on other family members (Paradisopoulos et al., 2015). This interpersonal awareness is considered an important therapeutic objective within youth care interventions. For parents specifically, support in developing parenting skills, understanding child development, and managing behavior is highly valued (Fernandez, 2004; Todd et al., 2025). Finally, in residential youth care, youth emphasized the availability and nearness of professionals as important factors, as well as clear routines, structures and boundaries (Soenen et al., 2013).

Organizational Factors

Organizational and team-level factors are also recognized by families as the third core element of youth care. A first organizational factor is the professional's capacity to implement the intervention effectively, supported by competencies that foster communication, emotional expression, and perspective-taking within the family system (Bouma et al., 2019; Todd et al., 2025). Second, a clearly articulated organization vision, supported by consistent supervision, peer consultation, and opportunities for ongoing professional development, is essential for enabling professionals to work effectively (Pölkki & Vornanen, 2015; McLoughlin et al., 2020). However, systemic factors such as long waiting lists (Doelman et al., 2024; Tilbury & Ramsay, 2018) and high staff turnover (Bouma et al., 2019; Doelman et al., 2024; Pölkki & Vornanen, 2015; Tilbury & Ramsay, 2018; Vliet et al., 2020) are frequently cited as barriers to care. High turnover disrupts continuity, making it difficult for children to establish stable, trusting relationships with professionals. Every change in practitioner may be experienced as a new loss (Vliet et al., 2020), potentially leading to delays in care and diminished motivation or trust in the system (Sanders, 2019). A final organizational factor identified as essential for achieving positive outcomes—particularly given the multiple and complex challenges faced by families in youth care—is the need for coordinated, interdisciplinary collaboration among service providers (McLoughlin et al., 2020; Pölkki & Vornanen, 2015; Tranquilla, 2013).

Tipping Points

The third thematic dimension addressed in this study—alongside perceived effects and effective elements—focuses on the identification of tipping points in the youth care process. A tipping point is defined as “the first point across identical observations when people conclude that a pattern is no longer an anomaly” (O'Brien, 2020 p. 55). Put differently, a tipping point is the point at which someone decides that small, repeated signs add up to a bigger, lasting change. A tipping point or turning point can also be a specific event or situation that causes a redirection of the path someone is on, as perceived by that person (Taussig et al., 2022). Regarding youth care, a tipping point may reflect an event, intervention or situation that redirects the youth care path or changes the youth care outcomes. This event or intervention may be an intentional or unintentional intervention performed by the youth care professional, or may arise in the parent's or child's life, like a new relationship for a parent or adolescent, a new home or change of school.

Study Objectives

Collectively, this study aims to explore families' experiences with youth care by examining perceived effects and effective elements, and by generating deeper insight into the key tipping points within family-focused youth care. Although youth care research has largely focused on quantitative outcomes in child, parent, and family functioning (e.g., Janssen et al., 2025), comparatively less is known about how families themselves perceive these changes and which elements they experience as helpful. In particular, insight into mechanisms of change—such as the processes or factors that facilitate or hinder progress—require further investigation (Tang et al., 2024). Integrating quantitative outcomes with qualitative insights, this study aims to provide a more comprehensive understanding of how youth care contributes to change within families.

Methods

For this study, quantitative and qualitative data from the research project ‘*What happens afterwards?*’ were used. The research project investigates the experiences of parents and youth with the family-focused youth care they received. The research project was approved by the Ethics Review Board of Tilburg University (Reference number RP245). In this study, the term ‘youth’ is used broadly and contextually to refer to both children and adolescents receiving family-focused care.

Settings

The project *What Happens Afterwards?* was implemented across four youth care organizations in the Netherlands, all of which are affiliated with the Academic Collaborative Center for Youth at Tilburg University. These organizations deliver a continuum of family-focused services underpinned by systemic intervention frameworks, engaging not only the child but also parents and other significant persons in the family's network, in order to comprehensively address the needs of both the child and the family. Their care provisions encompass intensive home-based support, semi-residential programs, and residential placements for children, adolescents and young adults, aged 0 to 27 years, as well as their parents and other family members. Broadly, the youth care within these organizations can be categorized into three types: home-based care, in which professionals work with the family in their home environment to achieve established goals; semi-residential care, in which the child attends a treatment group during a part of the day while continuing to live at home; and residential care, in which the child

temporarily or permanently resides in a treatment setting. Both semi-residential and residential care are in all trajectories combined with intensive home-based care.

Systemic interventions entail for example parenting support (Nuntavisit & Porter, 2022), addressing intergenerational issues (Mooren et al., 2023) and mapping and activating the social network of the family (Visscher et al., 2022). Additionally to systemic interventions, when needed, the organizations have the possibility to offer forms of child-focused therapy like EMDR, Cognitive Behavioral Therapy or creative arts therapies.

Quantitative Data

Participants

Parents of children aged 6 to 16 years at the start of care, who were referred to one of the four participating youth care organizations were invited to participate in the study at the outset of a new care trajectory. In addition, children aged 11 years and older were also invited to take part. Consequently, the study sample comprises families initiating a new trajectory within one of the four organizations, involving either intensive home-based care, semi-residential care, or residential care services.

Following inclusion, 86 families—comprising a total of 88 children and adolescents receiving youth care—participated in the research project *What Happens Afterwards?*. Two adolescents participated without their parent(s), whereas in all other cases at least one parent took part, resulting in a total of 89 participating parents. At post-care measurement, 60 parents contributed to the quantitative component of this study. Attrition among parents can be partly explained by the fact that, at the end of data collection in July 2024, care had not yet concluded for eight families. Furthermore, 21 parents did not complete the questionnaire at the end of treatment, either due to non-response or because they indicated they were no longer willing to participate. Analyses of attrition bias indicated no significant differences between respondents and non-respondents in terms of child age, sex, or type of intervention.

Additionally, 23 adolescents participated in the research project, of whom 15 took part in the quantitative component of this study. By that point, 22 adolescents had completed their care trajectory; however, seven of them did not respond to the invitation for completing the questionnaire.

Procedure and Data Collection

Within the research project *What Happens Afterwards?*, participating parents and children completed questionnaires at the start and end of their youth care trajectory. For this

study, cross-sectional quantitative data from one questionnaire (BESTE), measured at the conclusion of the care trajectory, were used.

Quantitative data collection with the instrument BESTE took place between February 2021 and July 2024.

Measurement: Instrument BESTE

The instrument BESTE (*BEoordelingsSchaal voor Tevredenheid en Effect* or *Assessment Scale for Satisfaction and Effects*) (De Meyer et al., 2004), is a practice-based questionnaire completed by parents and youth post-care, to evaluate their experiences with the child's youth care trajectory. The scale comprises seven items and assesses both the perceived effectiveness of the intervention and overall parental or youth satisfaction with the care provided. Most items' response options were rated on a 4-point Likert scale, ranging from 1 (*worsened rather than improved*), 2 (*no change*), 3 (*some improvement*), to 4 (*clear improvement*). Item examples are *Has your child's behavior changed as a result of the treatment?* (BESTE-O = parents version) or *Has the functioning of the family you are part of changed as a result of the treatment?* (BESTE-J = youth version).

The perceived effects of the intervention measured with the instrument BESTE are determined by the mean score of the first four items. A mean score of 3.00 or higher is indicative of a positive effect-score of treatment. The four items used in both the parent and youth versions are fully reported in Table 2.

Internal consistency of the first four items was found to be acceptable to good ($\alpha = .69$ for parents' version; $\alpha = .91$ for youth' version). Construct validity was found to be sufficient (De Meyer et al., 2004).

Data Analysis

To assess the perceived effects of youth care, the mean scores of the first four items from the BESTE-O (parents) and BESTE-J (youth) instruments were used, with a threshold of 3.0 or higher indicating positive effects. Besides considering the mean score of the four items, to gain insight into the specific areas where parents and youth perceived effects, we also examined the percentage of respondents scoring 3 or higher on each item.

BESTE Sample Characteristics

Of the 60 participating parents, 73.3% were mothers ($n = 44$) and 25.0% were fathers ($n = 15$). In one case (1.7%), both parents jointly completed the BESTE-O. The sample included slightly more boys than girls (53.3% vs. 46.7%), with a mean age of 12.1 years ($SD = 2.8$). Regarding the

type of intervention, 50.0% of participants received home-based care, 23.3% received semi-residential care, and 26.7% received residential care.

Of the 15 participating adolescents, 33.3% were boys ($n = 5$) and 66.7% were girls ($n = 10$), with a mean age of 14.2 years ($SD = 2.4$). With regard to the type of intervention, 46.7% ($n = 7$) received home-based care, while the proportions for semi-residential and residential care were equal (each $n = 4$; 26.7%).

Qualitative Data

Participants

For qualitative data collection, parents participating in the research project *What Happens Afterwards?* were approached. In line with the overall study, this resulted in the inclusion of parents of children aged 6 to 16 years at the start of care, having received a family-focused youth care trajectory in one of the four involved organizations. Eventually, 11 families of the research project sample participated. Additional recruitment efforts, as described under *procedure and data collection*, resulted in three more families. A total of 14 families consented to participate in the interview, including five children and adolescents, of whom one younger than 11 years, with appropriate consent.

Procedure and Data Collection

Interviews were held between April 2022 and November 2023.

For qualitative data collection, between three and six months following the end of the youth care trajectory, the researcher contacted all participating parents via email, messaging app or telephone to invite them to participate in a semi-structured interview regarding their experiences with the care process and outcomes. In addition to their previous consent, parents gave separate informed consent for their participation in the interview.

Due to challenges in including participants from the existing research sample, additional parents from the participating organizations beyond the initial sample were approached to participate in the interviews. The same inclusion criteria were used: parents with children between 6 and 16 years of age at the start of care, who had received some form of intensive home-based or (semi-)residential care, and had completed their care trajectory three to six months ago.

Given the time required for participant recruitment and scheduling, all interviews were conducted between six and nine months following the conclusion of care.

Based on the parent's preference, the interview was held online or face to face at the parent's home. Depending on

the depth and detail of the parent's narrative, interviews lasted between 1.5 and 2 hours. All interviews were audio-recorded. Parents received a gift card for their participation worth 25 euros. To incorporate the child's perspective on the care received, the researcher asked parents—at the conclusion of their interview—whether they consented to their child's participation in a separate interview. If parental consent was granted, either the researcher or the parent subsequently requested the child's consent. The interview with the child was then scheduled independently at a later time, or immediately following the parent's interview if the child was present and willing to participate. Children received a gift card worth ten euros.

Recruitment for qualitative data collection through interviews began in March 2022. At that time, from the 86 participating families, 24 families had completed care more than six months earlier and were therefore excluded from participation. Of the 47 families invited to participate in the interview, 27 did not respond and 9 declined the invitation. A total of 14 families of which 11 families from the study's sample participated in the interviews.

We aimed to include a range of perspectives to achieve a rich and contextualized understanding of care processes and perceived effects, including those of mothers, fathers, and children, as well as variation in child age and gender, family structure, intervention type, and the voluntary or mandatory nature of care. In November 2023, recruitment was discontinued, given the observation that no substantially new insights into experiences or outcomes of youth care emerged in later interviews. At this point, data saturation was considered to have been reached.

At the end of recruitment, in November 2023, 15 families were still receiving care. The inclusion of additional parents and youth, which yielded three additional families, was carried out in May and June 2023.

Measurement: Interview Format

The interview format was based on a phenomenological approach, which focuses on the lived experience of individuals as they perceive and attribute meaning to a given situation or phenomenon (Hossain et al., 2024; Kars, 2023). In our study, the studied phenomenon consisted of parents' and youth's experiences about their youth care trajectory, including the course of the trajectory, experienced positive or negative effects of care, facilitating and hindering elements, and tipping points. For this purpose, we constructed a semi-structured interview topic list, developed through a four-stage process. First, the client council of one of the participating organizations was consulted to provide input on the primary interview topics. Second, with this input and based on research aims, the first author of this article

constructed the first version of the semi-structured topic list, starting with headline questions following successive stages of the youth care process: i.e. the course of referral, previously received care and start of care, the content of care, ending of care, the current child's, parents' and family's functioning, and need for after-care. As an initial step in examining perceived effects, open-ended questions were added about hope and expectations before the start of the youth care trajectory, followed by open-ended questions about perceived effects of care, effective elements during the care process, possible tipping points and the contribution of social networks to family well-being during and after care. To minimize bias and avoid leading questions during the interviews, questions regarding the perceived effects of care were not directly formulated. Instead, information on these topics were included through prompts about the extent to which initial hopes and expectations had been fulfilled, and whether care-related goals had been achieved.

Third, the research team reviewed, discussed and complemented the topic list. This led to additional open-ended questions about current child, parent, and family functioning, including expectations for the future. Fourth, the topic list was piloted in a first interview with one parent. Based on the verbatim transcription of this pilot, the research team concluded that the interview format adequately captured the key topics necessary to address the research aims.

Data Analysis

Reflexive Thematic Analysis (Braun & Clarke, 2021) guided the coding and analysis process, for which ATLAS.ti (ATLAS.ti, 2023) was used. First, all interviews were transcribed verbatim and thoroughly read. Second, the first author deductively developed a primary codebook based on dichotomous interview questions and initial codes related to the interview topics, based on relevant literature. Next, the first and second author jointly coded three interviews, inductively adding new codes and discussing quotations to reach consensus. The first author and a research assistant proceeded to code the remaining interviews, reviewing and adding new codes when necessary. To ensure coding saturation and to check for potential bias, the second author independently coded two randomly selected interviews using the established codebook. Most codes demonstrated strong agreement between coders, with the exception of identifying an overarching code related to the perceived sustainability of effects. This code was added to the codebook and applied across all transcripts. In the third step, the first author reviewed and grouped initial codes into overarching code groups, merging overlapping codes to enhance clarity and reduce redundancy. In the fourth step, two members of the research team independently and critically reviewed all

code groups and assigned codes, reaching consensus with the first author on consolidating code groups where appropriate. Last, prior to reporting the results, the core content and naming of all code groups were reviewed and revised when required.

Interview Sample Characteristics

The interview sample consisted of fourteen families, who received specialized forms of family-focused youth care in one of the four participating organizations. The interviewers spoke with ten mothers, two fathers and two parent couples. Additionally, three children, aged 9, 12, and 14 years, were interviewed separately from their parent(s), providing them with the opportunity to discuss their experiences without parental presence. In two families, adolescents were partly present during the conversations and gradually joined the interviews, contributing their perspectives alongside those of their parents. During these interviews, the interviewer explicitly invited and verified the child's perspective and opinions to ensure that they felt comfortable expressing their own experiences.

Each of the 14 participating families included one child directly involved in the intervention, comprising seven boys and seven girls. Six families received intensive home-based care, in three families the child visited semi-residential care and five adolescents were temporarily placed in a residential treatment group. The two latter forms of care were combined with intensive home-based care. The intensive home-based care encompassed multiple components, including parenting support, assistance with separation-related issues like restoration of parent-child contact, therapeutic conversations with children, and interventions aimed at enhancing safety, tailored to the family's needs. For seven families, the intervention was complemented with child-focused therapy, for example EMDR. Four families in the sample received mandatory care, 10 families were voluntarily referred. All families had received some form of youth care prior to the trajectory that was the focus of the interview, mostly in forms of psycho-diagnostic testing of the child, involvement of the child protection system or parenting support. At the time of the interview, twelve families were receiving some form of follow-up care. Regarding family structure, three parent couples were still together, while parental separation had occurred in 11 families, with eight of these cases involving complex separation-related issues such as parental substance use, domestic violence, and/or loss of contact with one parent. In two of these separated families, two parents had passed away. An overview of the sample characteristics is shown in Table 1.

Table 1 Qualitative sample characteristics

Client	Sex	Age	Informant	Intervention	Intervention duration (months)
1	m	11	mother	HBC	9
2	m	12	mother and child separately	HBC	24
3	f	12	mother	HBC	12
4	f	16	father	RC + HBC	10
5	m	11	mother	SRC + HBC	10
6	f	16	father	RC + HBC + CFT	18
7	m	11	mother	SRC + HBC + CFT	18
8	f	18	mother with child	RC + HBC	18
9	m	16	mother	RC + HBC	12
10	f	14	mother and child separately	HBC + CFT	18
11	f	9	mother and child separately	HBC + CFT	Unknown
12	f	16	both parents with child	HBC + CFT	18
13	m	13	both parents	SRC + HBC + CFT	12
14	m	13	mother	RC + HBC + CFT	24

HBC=intensive home based care; SRC=semi-residential care; RC=residential care; CFT=child focused therapy. Intervention duration of participant 11 was not covered in the interview

Results

Quantitative Data

With the instrument BESTE, perceived effects of the provided youth care according to parents and youth were quantitatively investigated. Of the participating parents and youths, 60 parents and 15 adolescents completed the BESTE at the end of care.

Mean score of parents ($n = 57$), as for three parents no mean score was calculated due to missing item-scores, on the items reflecting perceived effects (BESTE-O) was $M=3.28$ ($SD=0.74$). The majority of parents (70.0%) reported mean positive effects of treatment ($M>3.00$). Of this group, 23.3% reported full score on perceived effects ($M=4.00$). Mean score of youth ($n = 15$) on the BESTE-J was $M=3.56$ (with $SD=0.37$). Of youth, 73.4% reported mean positive effects of treatment ($M>3.00$). Of this group, 13.3% reported full score on perceived effects ($M=4.00$). Table 2 lists the percentages of positive effects of treatment per question, indicating effects on child functioning, parent skills and family functioning, and the perceived effect-score of the four items for both parents and youth.

Qualitative data

Identified overarching themes and subthemes

Using reflexive thematic analysis, we identified several overarching themes and subthemes during the coding process. Regarding perceived effects of care, three overarching themes emerged: perceived effects at the end of care, limited effects, and sustained effects. Within the themes of perceived and sustained effects, subthemes captured changes at the level of child, parent, and family functioning, which were closely related to initial hopes and expectations, also described across these domains. Additionally, within the theme of sustainability, subthemes included sustained effects, ongoing vulnerability, and setbacks in functioning.

Findings related to perceived effective elements of care largely corresponded with classifications identified in the literature, including therapeutic alliance, intervention-related factors, and organizational factors. During the coding process, perceived effective elements were classified as

Table 2 BESTE: Mean scores, SD and percentages positive effect per question and all four items BESTE

		Parents (N = 57)			Youth (N = 15)			
Question		Mean	SD	% positive effect		Mean	SD	% positive effect
1	Has your child's behavior changed as a result of the treatment?	3.28	1.04	75.0	Has your behavior changed as a result of the treatment?	3.57	.65	86.7
2	Has the treatment changed anything in the functioning of the family?	3.27	.92	78.0	Has the treatment changed anything in the functioning of the family you are part of?	3.46	.52	86.7
3	Has the treatment changed anything in the way you raise your child?	3.27	.84	76.7	Has the treatment changed anything in the way your parents raise you?	3.36	.67	71.4
4	Has the treatment clarified your understanding of your child's behavior?	3.30	.76	81.6	Has the treatment clarified your view of your own behavior?	3.50	.67	73.4
Effect-score (Questions 1–4)		3.28	.74	70.0		3.56	.37	73.4

BESTE: Assessment Scale for Satisfaction and Effects. Mean score and SD of all four items = effect-score. Score > 3 indicates positive effects

either facilitating or hindering. A fourth overarching theme concerned individual factors, such as motivation.

When analyzing tipping points, similar overarching themes were identified, including therapeutic alliance, intervention-related factors, organizational factors, and individual factors. Finally, an additional overarching theme captured external influences on perceived effects of care, such as financial difficulties and the role of the social network.

Interview Findings

The experiences of parents and children with the provided youth care are presented below, structured around the research aims, containing the overarching themes and sub-themes as identified in the coding process.

Start of care: initial expectations and care needs. As an initial step in examining perceived effects, interviewers invited participating parents and children to reflect on their initial hopes and expectations prior to the start of care, as well as the specific care needs that prompted them to seek support. Most expectations and care needs concerned improving *child functioning* associated with internalizing and externalizing behavioral problems, or trauma-related symptoms.

“More self-confidence and a better self-image, and that I wouldn’t lie awake at night because of my traumas anymore.” (Child 10).

A parent described escalating conflicts with his daughter as a manifestation of externalizing problem behavior as the reason for seeking support.

“Oh, well, first of all, the doors would get damaged. Secondly, upstairs she (daughter) could really turn everything upside down. And in extreme cases, she would just run away. That happened a few times—I had to drive after her, because at that moment she was faster than me.” (Parent 6).

Regarding *parental functioning*, strengthening parenting skills and gaining control over their child’s behavior was a key theme, as well as reducing parenting burden.

“ADHD and things like that were unfamiliar to me. I remember thinking, ‘How am I supposed to deal with this?’ That’s why I sought help—so they could support me, because at that moment I really needed it. His (son’s) behavior wasn’t always easy to handle.” (Parent 2).

Improving interpersonal relations and family climate was frequently mentioned as a primary goal regarding *family functioning*.

“It always felt like we were waiting for a bomb to go off at home. What we hoped for was simply to create a calm environment, where we could all move around peacefully and put the children to bed with a smile on their faces, instead of being surrounded by a constant atmosphere of gloom.” (Parents 13).

“My son stopped inviting friends over because he was ashamed of his sister. There were constant arguments in the house. My daughter was always anxious. (...). Our lives were completely shaped by her behavior. There was unrest in the home, constant conflict.” (Parent 8).

Some parents, based on previous experiences with youth care services, indicated that they had no expectations at all regarding the care that was offered.

“At that point, I didn’t really have any expectations anymore. I thought, ‘Let’s just see what happens.’ If I don’t expect anything, it can’t be a disappointment either.” (Parent 11).

Perceived effects of youth care. Findings about the perceived effects of the youth care provided are described in three subthemes: (1) perceived effects of provided care, (2) perceived limited effects of provided care and (3) sustainability of perceived effects.

Perceived effects of provided care. Nine parents and two children indicated that, in their view, the goals or expectations set beforehand had been achieved.

“I have far fewer traumas now and they affect me much less. I don’t think about them as much anymore. Only sometimes, when I’m alone, I still think about them—but it’s no longer as intense.” (Child 10).

Reported effects of care were related to child, parent, and family functioning. The most frequently reported improvements concerned *child functioning*, including enhanced communication skills, better emotion regulation, improved social interactions, increased well-being, and greater self-confidence.

“He used to get angry a lot, but not anymore. (...). When we explain what we have to do and what’s going on, he says, ‘Okay, I understand.’ It used to be much worse. So he also learned about emotions.” (Parent 5).

"I witnessed this girl (daughter) truly flourish—from a shy, withdrawn child, through a phase of defiance, gradually finding more calm, and eventually growing into a confident young woman who clearly knows what she wants and is steadily working towards it." (Parent 4).

"Things are going better at home now. I used to get angry quickly, but not anymore. I still get angry sometimes, but I think that's something everyone experiences." (Child 10).

Regarding improvements in *parent functioning*, two overall components were reported: improvements regarding an enhanced sense of well-being of the parent, and increased parenting competence, e.g., providing structure and setting boundaries.

Regarding an enhanced sense of well-being, parent 1 reported:

"R: More calmness, really. (...). I can be myself, (...). I don't feel the need to justify myself to others. That [son's], behavior—how he acts—is simply part of his age. And that when he lashes out at me, it's because I'm close to him, and he feels like he can say and do anything with me."

Overall, the most frequently reported effect on parenting competence is a better insight into strategies for understanding and responding to the child's needs.

"A family counselor came to our home and provided psychoeducation about ADD and ADHD—how to deal with it. (...). That person gave me extra tools—how to respond to certain situations or how to handle them. Things like that. You really get support with that. So yes, I definitely learned from it." (Parent 2).

"I can really see it now—now I see the adolescent side of [daughter], the social-emotional aspect, and I've started to look at that differently. That has definitely changed. Before, I just saw [daughter] as a 16-year-old. We were really shocked when we got the results [of the psychological test]—like, wow, we truly didn't expect that. And then you start to look differently at everything she's been through, and how she's dealt with it." (Parents 12).

Last, effects of care on *family functioning* were mostly described as improvements in family relations and family climate.

"At a certain point I thought: this isn't healthy, you (son) standing up for me like that. It's incredibly sweet, but you also need to take on your own role. That's something I worked on together with [professional] at [organization]." (Parent 10).

"It also made me reflect on how I spoke to and treated my children(...). Like, yeah, some things really weren't okay. Like calling your kids names—'brat,' 'little shits,' things like that. She (professional) said, 'That's just not okay.' And I thought, yeah, she's right. I've really started to reflect on that." (Parent 3).

Perceived limited effects of provided care. While some families reported that their initial hopes or expectations were not fulfilled, they nonetheless experienced other meaningful effects of care. Overall, all but one family identified one or more outcomes concerning child, parent, or family functioning. In addition to the effects that were reported, several parents noted that the perceived impact of care was limited—particularly in terms of improvements in their child's development or their own parenting capacities.

"R: It wasn't suitable for him. (...) Maybe it was the other children around him. There were a lot of depressed kids there (...). The staff were good—he was making jokes again. He got along better with the staff than with the other kids." (Parent 9).

"I've become a bit calmer—that's really the only change. But apart from that, no, it hasn't brought about many changes for me." (Parent 6)

One parent reported no perceived effects from the care provided, as her primary hope and expectation was to secure a long-term residential placement for her son following multiple unsuccessful stays in foster families and temporary care settings.

"[Son] is now left to deal with the consequences again, because the additional care didn't start in time. He became angry and ended up hitting the group home caregiver. Of course, that's not acceptable behavior—but I do understand where it's coming from. And then, he had to leave immediately." (Parent 14).

Sustainability of perceived effects. All interviews were conducted approximately between six and nine months after the conclusion of the youth care trajectory. Exploring the current well-being of the child, parent, and family functioning at the time of the interview was one of the interview topics, leading to information about the sustainability of outcomes.

Of the 14 interviews conducted, eight parents and three children reported that the *child* was functioning well.

“Good. He’s really made huge progress. (...). Mainly with school and things like that. He’s feeling better about himself. He’s also starting to connect more with friends — you know, the kind of things that are typical for his age.” (Parent 2).

“She’s going to school again. She’s smiling, walking around the house cheerfully — not always cheerful, of course, but she’s moving around the house. She goes to school, she goes to her internship, she meets up with friends, and you can have a conversation with her. She’s much more independent, she’s become a lot more mature. So in that sense, she’s grown enormously.” (Parent 8).

Additionally, seven parents and two children described the overall *family functioning* as positive. In response to a question regarding ongoing contact with the referring professional, Parent 10 reported the following:

“She (referring professional) said: ‘Things are going well for you, so there’s nothing more I can do for you. The children are safe, they’re doing well — apart from the usual ups and downs — and you’re doing fine too. You don’t have a care need anymore, so I’m going to close this case.’ And that’s fine, because things really are going well.”

“Things are going well for me now. I have friends with whom I do a lot of fun things, and things are going well at home. Of course, there are still some challenges or setbacks, but everyone has those.” (Child 10).

Regarding *parent functioning*, three parents reported positively about their own current well-being.

“I decided to start studying again. I contacted the UWV (Dutch Employee Insurance Agency) myself and said: I’ve been declared 100% unfit for work, but I really want to be part of society again — not just someone who’s been written off, going to psychologist appointments and constantly dealing with the past and problems. (...) I just want to participate again, to focus on healthy things.” (Parent 11).

In addition to the majority of parents and children who reported positive sustained outcomes, the interviews also revealed ongoing vulnerabilities in both child and parent functioning. With regard to *child functioning*, this mostly

refers to the persistence of problems that continued to have an impact despite the conclusion of care.

“That (handling social interactions) was really his biggest stumbling block — he finds it very difficult to engage in free play moments. That’s where the challenge lies for him. It’s still hard, actually. He still needs guidance to play football, and during PE lessons, an extra teacher is usually required because that’s often where things go wrong.” (Parent 7).

She’s come a long way, but she’s not there yet. That’s how you should see it. And I don’t think she’ll ever fully get there either. (...). She’ll always carry questions with her and will always need continuous attention and support.” (Parent 8).

In terms of *parent functioning*, the predominant theme of vulnerability was related to the parent’s sense of well-being, e.g., parenting burden and being mentally preoccupied with the child’s and their own well-being.

“Back when I was talking with [professional], I had to see a psychologist — also for myself, because, as I said, I wasn’t feeling well, and I still don’t. I just don’t have time right now to make those appointments. But she didn’t want to hear that. She said: ‘What do you mean you don’t have time to do something for yourself? You have to make time for that.’ Now that she’s no longer coming, that part has quieted down. But I still don’t have the space for it — my head is too full, too busy. Once things pick up again, I do think things will run more smoothly here. Because I can feel it: I’m just not feeling well within myself.” (Parent 3).

“I can really feel that my tank is empty now, especially since I’ve started working again. After 10 — no, 13 — years, now that there’s more peace at home, everything is coming loose. I get tired more quickly, I feel stressed more easily. And for her (daughter), it feels like she can’t come to me, she says that herself. I try to be there for her, but I also have a son who needs me — he’s starting to run into things too. So now I need to be more present for him. I feel that she’s giving me space to do that, but at the same time, I feel I’m running out of space for myself.” (Parent 8).

Vulnerability in *family functioning* was related to complex separation issues and persisting complex family relations, which also influences parenting burden.

“At times I’ve reached a point where I just don’t know what to do with her anymore — where I think: you’re really unbearable right now. I say things like that. It’s not weekly or daily, but every now and then it happens. (...). I’m constantly switched on for her.” (Parent 10).

Besides current positive well-being and vulnerabilities, some answers of parents revealed a setback in functioning. This was however reported less often than positive well-being and vulnerability. No setbacks in *child functioning* were reported. One parent described a setback experienced by her co-parent involving substance use which influenced family functioning, and two parents reported a deterioration in family functioning.

“Now that [professional] is no longer coming, I do notice that they (children) are starting to push back a bit more against mom and dad. But to be fair, I also tend to slip back into nagging and communicating in that way with them.” (Parent 3).

Table 3 gives an oversight of sustainability of outcomes in terms of current child, parent and family functioning.

Effective elements. Reflecting on factors that contributed to either positive or negative outcomes, both parents and children formulated facilitators as well as barriers. Figure 1 gives an overview of these facilitators and barriers per theme as mentioned by parents and children. The fourth identified subtheme within contributing elements concerned individual client characteristics. All four factors are described below.

Therapeutic alliance. Therapeutic elements were frequently mentioned as facilitators of perceived effects, e.g., a good match with the professional and a pleasant warm contact.

“R: Yes, I really had a connection with that woman. (...). At first I was like, “I really don’t feel like telling my story.” But when someone comes into your home regularly, you start to build a bond. She was just really kind—and also a single parent of two children. She knows what she’s talking about, you know?” (Parent 2).

Shared decision making contributes to the therapeutic process:

“It was all very much discussed with us—like, “What are you struggling with the most?” and “What would you like to address first?” So really, everything was done in consultation with us.” (Parent 12).

Table 3 Sustainability of perceived effects

	1	2	2-C	3	4	5	6	7	8	9	10	10-C	11	11-C	12	13	14
Positive functioning	Child	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Parent	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Family	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Vulnerability	Child	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Parent	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Family	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Setback	Child	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Parent	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
	Family	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x

Numbers 1–14 refer to respondents. -C refers to child as respondent

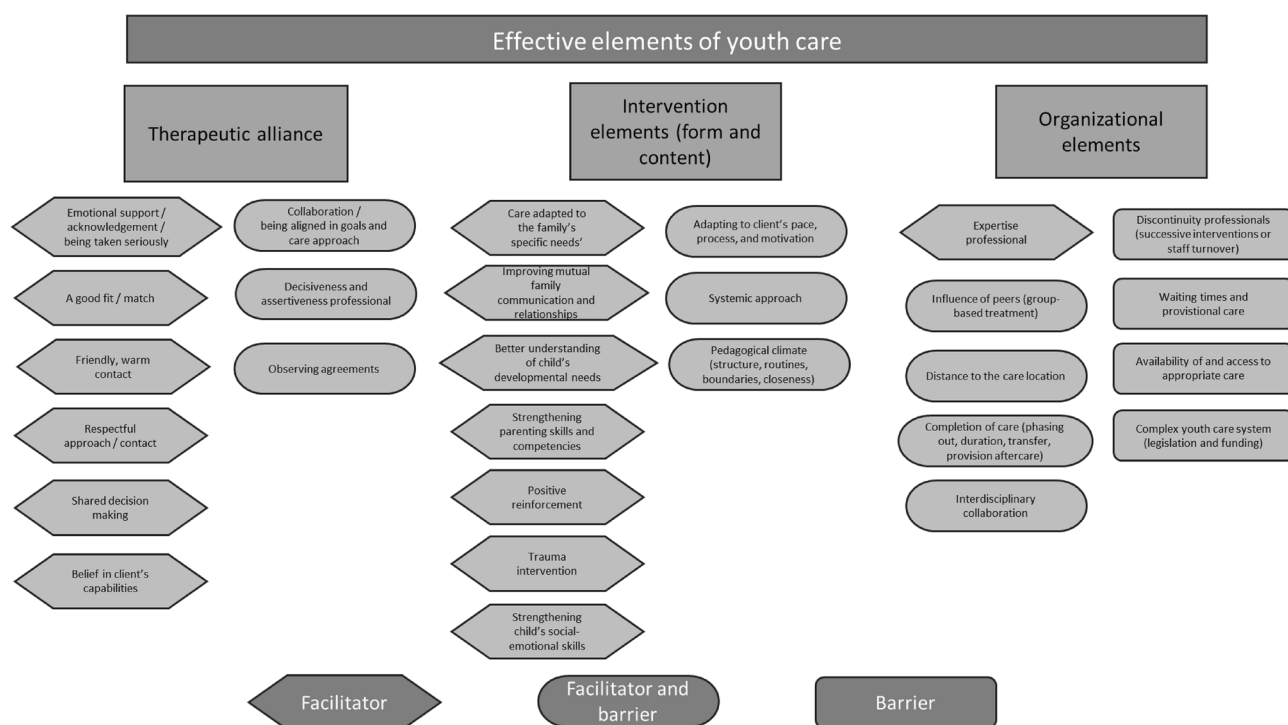


Fig. 1 Overview facilitators and barriers regarding effective elements of youth care, as identified by participants

“She asked a lot of questions, and if I didn’t want to answer, I could choose not to answer—or if it was too difficult.” (Child 10).

Also a respectful, non-judgmental attitude and faith in the client’s strengths were mentioned as facilitators.

“What made the collaboration so pleasant was the mutual respect for the work they do as professionals and me as a father. My role as a father wasn’t questioned—it was simply acknowledged”. (Parent 4).

Parent 7 experienced a non-judgmental attitude towards her son: *“I think [name] was genuinely seen for who he is, and not viewed as a difficult child. At school, he’s often labeled — seen as a troublemaker, a problematic child. He’s constantly taken out of the group. But that wasn’t the case at [organization].”*

Parent 1 named all previous aspects in one: *“The person sitting across from me was just really nice. We immediately had things in common, and she said, “I’m not here to judge you”—that was one of the first things she said. “I’m just here to look along with you and to help you.” And that already comes across very differently than, “We’re here to point out your mistakes.”*

No therapeutic alliance elements mentioned by parents and children were formulated as barriers only. Some elements were perceived as both facilitators and barriers, depending on the individual respondent’s experience. The most frequently mentioned element that functioned both as a facilitator and a barrier was the collaboration between parent and professional. In most accounts, this referred to the extent to which both parties were aligned on care goals and approaches.

“We’ve often found ourselves at odds with [organization]: when he had an outburst there, we would impose consequences at home to show that we were aligned with [organization] and that we do not tolerate aggressive behavior. But [organization] didn’t agree with that approach.” (Parent 14).

“You get tips and tricks, and yes, you’re guided to some extent—but always with the intention of mutual respect. What mattered most to me was that we were all focused on [daughter]. She was the central point—not me, not the professionals. My daughter was at the heart of it all, and that was the most important part of the collaboration for me.” (Parent 4).

Intervention-related factors. In discussing their experiences with the provided care, both parents and children identified several intervention-related elements. Most of them were

perceived as facilitators. Positive reinforcement was mentioned in nine interviews.

“I have more confidence in myself. I’m a good mother—I’ve given [son] a good upbringing. In the past, I could feel like a bad mother, but the home support from [organization] told me: “No, listen, you’re doing really well.” They said I could always put on the ‘autism lens’ and that I know exactly what my child needs.” (Parent 5).

“I could share everything with her, and we talked a lot about what I had done that week. She (professional) told me I could be proud of myself and things like that.” (Child 10).

Psycho-education and gaining insight into the child's individual needs and behavioral patterns was identified as a facilitator of the perceived effectiveness of care.

“It was mainly about [daughter], who at that time was 14. She might look like she’s 18, but emotionally and socially, she’s more like 6 to 9 years old. And how do you deal with that? Because she’s also a teenager—she wants to push boundaries like other teens. But actually, we need to impose boundaries, to limit her, because emotionally she just can’t handle them. That’s what we’ve mostly been working on: how do we, as parents, deal with that?” (Parents 12).

Some intervention elements were experienced both as facilitators and barriers, e.g., a systemic approach. Most parents described that they were actively involved in the provided care.

“From the very beginning, we were connected with the family counselor who visited us at home either weekly or biweekly, depending on our needs and the issues at hand. These sessions provided tailored support through regular conversations.” (Parents 13).

However, parent 6 pointed out that he had missed a systemic approach. *“I think they’re more focused on supporting children, like through care services and psychiatrists. But for parents, it’s very limited. You basically have to take initiative yourself — like I did at one point, when I went to see a psychiatrist. But that was really just for myself.”*

Other elements of a systemic approach, like involving social network and intergenerational issues, were labeled as helpful.

“And especially how our own past has shaped things up to now—and that our past doesn’t have to define our future. That’s been a major learning point for both of us, and still is, because it always plays a role in your mind.” (Parents 13).

“There was a time when we (professional and child) had a meeting at school with my mentor because I was often very tired. We discussed whether there was something the school could do to help, and that led to a series of conversations at school.” (Child 10).

Organizational factors. Several elements perceived exclusively as barriers were related to organizational structures and processes, e.g., bureaucracy and complex laws and regulations and waiting lists.

“Yes, but they (organization) don’t have the capacity for that (psychological testing). Then it has to go through another channel, another level, and all sorts of things — and that’s exactly what they lack. They could do it, but only if it’s an acute case.” (Parent 6).

“We were essentially crying out for help, and all we were told was: ‘You’re on the waiting list.’ (...) And then you wonder — what are you supposed to do in the meantime? Both children and parents are left to deal with it on their own. There really needs to be something in place to bridge that gap during the waiting period.” (Parents 13).

From several parents’ perspectives, coordinated interdisciplinary collaboration among professionals involved with the family was mostly perceived as a barrier.

“The common thread was really the communication (between several care professionals involved), which she (professional) also found very poor. She said: ‘You’re the one pulling all the strings, you’re carrying the entire system, and everyone else just leans back — including the guardian. You’re the one asking: when will appointments be made, when will someone else finally take the initiative?’ She struggled with that too.” (Parent 1).

The duration of the care trajectory and the transfer to follow-up care was perceived both as facilitator and barrier. The influence of residential group members was likewise experienced both as positive peer support and as a negative influence on the child’s behavior and well-being. Additionally, the knowledge and skills of the professional were specifically mentioned as a facilitator.

"The behavior that the children (in therapeutic group) showed — he (son) would often get angry or have outbursts. That doesn't mean it was tolerated, but the staff remained calm. And maybe, in a way, they (children) were allowed to express their anger. They were allowed to show they were upset, and the staff knew exactly how to bring [name] back at the right moment, saying something like: '[Name], what happened? How could you handle that differently next time?'" (Parent 7).

Individual factors. Parents described individual characteristics of themselves or their child as either facilitating or hindering outcomes. Specifically, they referred to factors such as motivation to engage in care, perseverance and the capacity for self-reflection.

"He was supposed to meet with a care professional once a week, but he hasn't done so at all. He simply doesn't want to. When I ask him why, he says, 'What am I supposed to do there?' I tell him, '[Son], you're required to go. If you make the appointment, the worker will explain what you'll be doing and what you'll talk about.' But he just wasn't interested. He only wanted to hang out with his friends." (Parent 9).

"I've always been very involved, very consistent with therapy — never missed an appointment. I've always reflected, remained open to help, to advice, to suggestions. And when things got stuck, I tried to get the train back on track. I never walked away from responsibility, nor from the problems. And even though we've faced a lot of distrust and setbacks within the care system, I've still managed to find trust again in something new — to say, 'Okay, let's go for it.' I've also allowed myself to be vulnerable in that process." (Parent 11).

Tipping points. Ten families reported experiencing a clear tipping point during the youth care trajectory. In addition, three families—partly overlapping with the aforementioned group—described an indirect tipping point. Although they did not explicitly label it as such, their narratives indicated a moment that marked a significant shift in the course of care. Three families, however, reported no distinct tipping point, instead describing changes as having occurred gradually over time.

After coding tipping points, codes were divided into the same themes as perceived facilitators and barriers: (1) therapeutic alliance, (2) intervention-related factors and (3) organizational factors. Individual factors were also identified as a theme within tipping points.

Alliance-related elements identified as tipping points included respectful and supportive interactions, a sense of being heard, and the perception that the professional did not give up on the client. In some cases, these qualities were evident from the initial contact, which helped transform initial reluctance or resistance into trust and engagement.

"The fear and stigma around seeking help were significant. But our care professional managed to completely dispel that during the very first visit. She gave us real confidence in the support process, (...) just by being honest, straightforward, and not beating around the bush." (Parents 13).

Experiencing the professional's support, acknowledgement and decisiveness was named as a tipping point:

"She (professional) said: 'This is a large meeting, and I'll join you.' Throughout the entire process, she was the first to speak up and say: 'We're sitting here with so many people, and you keep discussing this report. I've read it — my colleagues and I have gone through it seven times — and we still can't make sense of it. How can you continue debating a report that is completely incoherent?' (...) It felt like a bomb had gone off in the room. That was the moment we truly entered into dialogue — not just talking, but actually having a meaningful conversation." (Parent 4).

Intervention-related tipping points varied from results of a psychological assessment providing valuable insights into the child's cognitive, emotional and social development, the start of behavior-regulating medication, and a specific intervention to enhance safety. Both parents and children were able to describe those tipping points:

"R1: Yes, medication. That really made a difference. (...) I just became much calmer. The medication I have now helps me concentrate better, I make fewer mistakes." R2: "At school, right. Fewer mistakes, less angry, that's it. Less dramatic." (Parent and child 2).

"At one point, several professionals [organization], Safe at Home (the Dutch domestic violence and child protection agency), and police sent a message to the father stating that any form of contact — in any way — would be harmful to the child and to me. So the request was to leave us alone and not to initiate any further contact. (...). We don't see him anymore, and that brings a great sense of peace." (Parent 11).

“They (professionals) also sent a letter saying he (father) is no longer allowed to see me, and that if I do want to see him, I have to say so myself. Since they sent that letter, things have been much better.” (Child 11).

Organizational factors were not so much perceived as a tipping point. However, as the previous quotation illustrates, interdisciplinary collaboration also emerged as a critical tipping point.

“Eventually, [organization] reached out to both the police and Safe at Home to say: ‘Let’s join forces — something needs to happen.’ That’s when you really feel strengthened.” (parent 11).

Individual factors. The adolescent in interview 8 described a tipping point within herself.

“I really had a turning point. That was around June, I think. (...). I was stuck in a negative spiral, and at some point something clicked. I realized that if I kept going like this, things wouldn’t end well. I didn’t want to live like that anymore — it was just all negative. And then I thought: damn. I’m really done with this. That was the moment I knew I had to change something. From then on, I had that switch moment. It didn’t go well right away, but I did start trying to turn things around in a more positive direction.” (Child 8).

Extra-therapeutic factors influencing well-being and outcomes. Besides care related factors influencing positive or negative outcomes, parents and children reported about events or conditions outside the scope of youth care that nonetheless influenced the well-being of the child, parent, or family system, thereby positively or negatively influencing outcomes of care. During the coding process, this theme was identified as an additional influencing factor on perceived effects of care and the child’s, parent’s or family’s well-being. Four main subthemes were identified (1) complex separation issues, (2) financial problems and poverty, (3) school and collaboration between school and parents and (4) the families social network, including partner relationships and peer contact.

In several families, *complex separation issues* influenced the child’s or family’s well-being during and after care.

“I still don’t think he (son) is over his problem. (...). The fear is still there. He says he doesn’t want to sleep there (with father) anymore. The fear is that if no one is around, dad might start drinking again — even if he says he won’t, he’ll still do it. ‘When I go to bed,

that’s when he starts,’ he says. So he hasn’t let go of that fear, and he definitely hasn’t regained trust. That part isn’t where it needs to be yet. And I think that can only change if the situation arises again.” (Parent 1).

“That evening, he (son) called my partner to ask if he could call him ‘dad.’ I think that was his way of closing that chapter for himself. Since then, he hasn’t talked about it at all. They never really grew up with him, so they don’t truly know him. I think he feels like: it doesn’t matter anymore. That’s what he just said (in the interview) too. It still hurts, of course — because he is his father.” (Parent 2).

Financial problems and poverty are an extra-therapeutic factor influencing family functioning.

“Financially, we’ve been struggling for years. I don’t work — I’ve been declared unfit for work — but I’m now trying to start working again. Financial worries have played a major role, especially for [daughter]. Probably for [son] as well, but he expresses it less. But [daughter] is really affected by it. She wants to work, even though she’s not actually able to. I’ve also started working again, even though physically I’m not really capable. So yes, that’s a major factor that brings a lot of unrest into our lives.” (Parent 8).

School and collaboration between school and parents was mentioned both as a positive and a negative factor.

“He (son) transferred from a mainstream school to a special education setting, which has significantly boosted his self-confidence. He used to be the lowest-performing student in his class, and now he’s the top of his class. That has really helped him gain confidence and become more assertive — so yes, it’s made a real difference.” (Parent 1).

“The problem was that after that (following EMDR), he (son) was still often sent out of the classroom or removed from the group. So in a way, he was building up a new trauma. Each time, he was confronted again with that old pain. Sometimes I think we should start over, so he can regain some trust in himself. Right now, he’s often seen as the one causing trouble. He’s actually quite damaged in that sense.” (Parent 7).

Social networks involved with the child or family are important for emotional and practical support.

"We have a couple who are very close friends of mine. They are also the legal guardians of my children and the godparents of [daughter]. From the very beginning, he has been a father figure to my children and a key source of support. When [daughter] moved back home and I was struggling to cope, she could go to them. They would have meals with her and provide emotional support. They've taken on a lot, also for my son. Whenever he faces challenges, he talks to them. They truly provide a safety net for both of my children." (Parent 8).

"My aunt — because [professional] left at that time — became someone I could turn to. Together with [professional], I looked for someone in my environment I felt comfortable talking to, someone I could reach out to when I was struggling. I had a conversation with my aunt, and we agreed to do something together every two weeks or once a month, like going for a walk with the dog or spending time together." (Child 10).

However, social network relations can also be a barrier, as reported by parent 14.

"It's a difficult situation with the grandparents from Rotterdam — my ex-partner's parents. At the moment, we're in serious conflict (...). Their parenting style, in particular — a very permissive approach — is something I fundamentally disagree with, especially because that simply doesn't work for [son]."

As part of social network, a (new) relationship for the parent or child and positive peer contact were frequently mentioned factors, mostly specified as a facilitator.

"He (son) has a very close friend. Initially he had several friends, but you can see that he's now focusing on one particular friendship, which has a calming and uplifting effect on him." (Parent 7).

"I've been with him (new partner) for about three and a half years now. He's a very calm and composed person, and the children draw a great deal of support from him — it's something they truly need." (Parent 2).

Discussion

The research aims of this study were threefold. First, to gain in-depth insight into the perceived effects of family-focused youth care and second, into perceived effective elements.

A third aim was to explore tipping points as retrospectively experienced by both parents and children. Conclusions regarding perceived effects should be interpreted as exploratory, given that the quantitative data were restricted to a post-care, practice-based measurement and the limited youth sample size.

Perceived effects of provided care

Both quantitative and qualitative findings indicate that the majority of parents reported positive outcomes of the youth care provided. Most perceived effects relate to child functioning and family functioning, and to a lesser extent to parent functioning. Parents' and youths' reports were largely consistent in the quantitative data, with comparable proportions of positive effect-scores in both groups. Similarly, the qualitative data showed considerable overlap between parents' and youths' reports regarding improvements, helpful intervention elements, and key tipping points.

However, differences between parents' and youth's perspectives were also observed. Specifically, vulnerabilities and setbacks in functioning were reported by parents but not by children. One possible explanation may be that children tend to adopt a more present-oriented perspective and may be less likely to anticipate future consequences, whereas parents are more inclined to take a longer-term, risk-sensitive perspective (Steinberg et al., 2009).

Our findings about perceived effects correspond with previous research, both quantitative (e.g., Blankenstein et al., 2018; Damen et al., 2021; Nuntavisit & Porter, 2022) and qualitative (e.g., Hurley et al., 2020; Paradisopoulos et al., 2015), which also found comparable positive effects of family-focused youth care on child, parent or family functioning.

Examining the sustainability of perceived effects, positive outcomes in child and family functioning generally appeared to be maintained. Multiple parents and children reported ongoing noticeable improvements in the child's self-esteem and daily functioning, including consistent school attendance and positive peer interactions.

Despite positive changes, parents also reported vulnerabilities in child and family functioning. Regarding child functioning, developmental or behavioral problems did not disappear but became more manageable, due to a lessening of the child's behavioral or emotional problems or because parents were supported in better recognizing and responding to their child's needs. Helping parents understand the child's developmental needs is an important focus in youth care, as caregiver's psychoeducation and improving caregiver's coping skills lead to positive care outcomes (Pedersen et al., 2019). This intervention aims to further empower families, building a greater sense of control over family life and

reducing parental burden (Damen et al., 2021). Other ongoing difficulties concerned the child's social interactions, school functioning or unresolved trauma issues. Vulnerability in family functioning was mostly indicated as fragile mutual relations or ongoing complex separation issues, influencing the child's and family's well-being. Notably, parents mainly reported vulnerabilities in their own functioning regarding their sense of well-being, including high levels of parenting stress and a need for therapeutic support for themselves. This suggests that while youth care tends to have positive effects on child and family functioning, its impact on the individual well-being of parents is more limited.

In addition to persisting behavioral child problems, vulnerabilities in the functioning of individual family members and the family system as a whole were influenced by extra-therapeutic factors, such as complex separation issues and financial hardship. Loss of contact between a child and a parent after separation, co-parenting problems, parental substance use and ongoing violence were mostly mentioned. Beyond the inherent risks that divorce poses to children's development (Caksen, 2022; D'Onofrio & Emery, 2019), ongoing parental conflict or co-parenting problems following separation further exacerbate stress levels, negatively impacting the well-being of both children and their parents (Van der Valk et al., 2020). Poverty and financial hardship are risk factors for positive child and family outcomes as well (Chaudry & Wimer, 2016). Conversely, protective factors mentioned for child, parent and family well-being included access to a suitable school environment, a new supportive relationship, and the presence of an engaged informal support network for both child and parents. A supportive social network may contribute to reducing parental stress and improving children's emotional and behavioral functioning (Negi & Sattler, 2024; Nunes et al., 2022). Activating the social network is found to be an effective element of care (Visscher et al., 2022).

The persistent parental vulnerabilities question the systemic approach of the family-focused youth care provided. Although parents were closely involved in almost all trajectories, the topics that were covered seemed to focus mainly on improving child and family functioning and helping parents understand the child's developmental needs. Complex separation issues were addressed but could often not be resolved, so that their negative influence on child and family functioning remained. Other factors influencing the whole system's functioning, like parent's individual needs or the family's financial problems, were not explicitly part of the care process. Although a systemic approach is central to family-focused youth care, the present findings suggest that its implementation in practice may remain partial. The ongoing parents' vulnerability regarding their own

well-being may be a risk factor for a setback in child and family functioning, as parent functioning is related to both (Crnic, 2024; Packerd et al., 2020; Schleider et al., 2015). Moreover, activating the family's social network is widely considered a key component in strengthening familial resilience and, consequently, in enhancing the sustainability of care outcomes. However, the present interview findings suggest that this component was not addressed sufficiently explicitly within the care trajectories. Future research could therefore examine more systematically the extent to which social network engagement is implemented in practice and how this relates to perceived longer-term effects of youth care.

Effective Elements

The findings of this study are in line with previously identified effective elements of youth care, thereby reinforcing existing evidence on what contributes to positive outcomes in family-focused interventions (Soenen et al., 2013; Todd et al., 2025; Visscher et al., 2022). Focusing on perceived effective elements, most facilitating factors were related to the therapeutic alliance and intervention content. Parents and youth generally felt well supported, and the care provided mostly aligned with their needs. By contrast, hindering factors were primarily associated with organizational issues such as waiting lists, bureaucratic procedures, and the involvement of multiple care professionals, due to sequential trajectories or staff turnover. A concept perceived as both hindering and facilitating is the validation of parents and youth ('being heard'). When perceived positively, parents and youth felt acknowledged, understood and taken seriously (Wasson Simpson et al., 2022), by professionals showing empathy, respect, and genuine interest in parents' and youth's experiences and perspectives (Persson et al., 2016). Conversely, parents experiencing invalidation ('not being heard') suggests a lack of acknowledgement and recognition of their expertise and concern about their child (Nooteboom et al., 2020), which may lead to diverging views between parents and professionals, thus hindering parent-professional collaboration (Barnhoorn-Bos et al., 2025) and consequently hampering the effects of care. Parent-professional and child-professional alignment and engagement are essential for identifying care needs and ensuring effective interventions (De Greef et al., 2016; Roest et al., 2023).

Tipping Points

Tipping (or turning) points reported by parents and children were primarily associated with factors related to the therapeutic alliance and intervention content. The professional's

attitude—characterized by friendliness, empowerment, respect and a non-judgmental approach—was more than once experienced as a positive tipping point at the onset of care. Diagnostic assessment and recognition of the child's developmental needs were mentioned as interventional tipping points. However, other influences—such as behavioral medication, a new supportive relationship or a person's individual motivation—also contributed to these shifts, despite being less directly within the control of care services. Overall, no unambiguous themes or elements regarding tipping points could be identified. This aligns with O'Brien (2020), who found that the experience of a tipping point is subjective and differently identified and interpreted by different people, even when talking about the same situation.

To better understand critical turning points in youth care trajectories, it is essential to directly engage children and families at the end of care in reflecting on whether, when, and how they experienced such pivotal moments during their care trajectory.

Practical Implications

Although almost all families were actively involved in the process and experienced a family-focused approach, the systemic method in youth care remains a point of concern. A holistic approach seems needed to incorporate systemic factors such as poverty, school influence, and social networks into the intervention. Previous research revealed a link between parental engagement in mental health treatment and youth care utilization (Batterink & Van Plaggenhoef, 2022). Attention to parental well-being, poverty, and complex separation issues is therefore critical, as these factors influence child functioning which in turn may influence the sustainability of care outcomes. Collaboration with schools and informal networks should be integral to this approach. While some cases may demonstrate such integration, it does not yet seem to be standard practice. A multidisciplinary care team is needed to address these factors, support families facing persistent vulnerabilities, and enhance long-term impact.

The number of families experiencing complex separation issues is notable. This aligns with findings by Batterink & Van Plaggenhoef (2022), which show that children of divorced parents use youth care significantly more often than those from intact families. Interviews in this study reveal that the impact of these issues persists beyond the termination of care, as both parents remain—visibly or invisibly—linked to the child (Harman et al., 2022; Xerxa et al., 2020). It is therefore essential that the ability to cope with these separation-related challenges is monitored by or addressed in after-care services for both children and parents.

While parents reported satisfaction with the care received and observed positive outcomes, persistent vulnerabilities remained, affecting child, parent, and family functioning and posing risks of deterioration. Continued support or monitoring appears essential to prevent setbacks. Re-referral within youth care is not inherently problematic, as new child developmental phases may require renewed assistance. However, serious decline can be mitigated if families remain visible for services and timely intervention is possible when needed.

The significance of gaining insight into the child's behavior and needs as an interventional element was evident in both the quantitative and qualitative data. This seems specifically important and of added value in youth care, for both parents and children, with a view to empowerment and the sustainability of effects (Damen et al., 2021; Pederson et al., 2019).

This study indicates the importance of a positive therapeutic alliance and appropriate intervention content. For future professionals, training should explicitly focus on developing alliance-building and methodological competencies. Soliciting interim feedback through feedback-informed treatment supports alignment and consensus between parents, children and professionals, thereby boosting care outcomes (Tam & Ronan, 2017).

As a last implication, policy and organizational structures must address barriers to care, which were primarily linked to organizational factors. Improving collaboration between adult mental health services for parents and child and youth mental health services for their children is recommended, while also addressing other contextual factors (Stolper et al., 2024). Moreover, offering provisional care during waiting periods may strengthen parents' and youths' sense of support, readiness and motivation for the, forthcoming intervention.

Strengths and Limitations

In this study, both quantitative and qualitative methods were used to gain insight into perceived effects of youth care. The qualitative component was intentionally prioritized over the quantitative component. In evaluating multi-component interventions, subjective experiences of care recipients are essential alongside quantitative data, as a qualitative narrative approach uncovers aspects of care that are not captured by quantitative measures, like feelings of experienced trust and acknowledgement (Busetto et al., 2020; Verheijen et al., 2025).

The sample reflected diverse perspectives, including families with younger and older children receiving outpatient, residential, or semi-residential care. Both voluntary and mandated care experiences were represented. This approach

aimed to capture a broad range of parent and youth experiences regarding outcomes and perceived effective elements of care.

Recruiting a sufficient number of families for qualitative data proved challenging, as many did not respond to the invitation or declined participation. Nevertheless, fourteen families agreed to share their experiences, most of which were positive regarding perceived effects and effective elements. This could suggest a sample bias, possibly reflecting lower parenting stress and more favorable outcomes among participating families. However, several aspects appear to mitigate this bias. First, to broaden the scope in advance, a questionnaire was used alongside interviews, yielding a wider range of responses. The quantitative data also indicated positive effects as reported by parents and youth. Additionally, recruitment efforts explicitly invited families with both positive and negative experiences. Several families shared not only positive outcomes but also challenges in care and ongoing vulnerabilities post-intervention, suggesting a balanced representation of experiences. Last, the qualitative sample reflected broader patterns seen in youth care data, such as prior care histories and continued care needs among families in youth care (Statistics Netherlands, 2024). However, caution is warranted regarding the representativeness of the sample for the broader population of families in family-focused youth care.

In addition to parents' experiences, it was considered important to include youth perspectives on perceived effects, effective elements, and tipping points. However, the youth sample was small for both the quantitative and qualitative components. Although valuable insights into their experiences were obtained, the limited sample size suggests that these findings should be interpreted with caution and viewed as preliminary.

Implications for Further Research

Given the limited impact of youth care on parental functioning—despite the well-established relationship between parental well-being and child outcomes (Batterink & Van Plaggenhoef, 2022; Crnic, 2024)—future research should further investigate how youth care affects parents individually. A key question is why youth care appears to be less beneficial for parents' sense of well-being. For a deeper understanding, it is important to examine cases where parents receive individual care alongside youth care, and to determine how both affect parental functioning.

In particular, research should identify facilitating and hindering factors in parental individual care when provided in conjunction with youth care, and determine whether these factors are related to the therapeutic alliance, the intervention itself, or organizational aspects (e.g., waiting lists,

timing, or the content of the parental intervention). The timing of parental care in relation to youth care also warrants attention. Hypothetically, addressing parental stressors—such as parental mental health concerns or financial difficulties—prior to the initiation of youth care could foster more favorable outcomes for parents, thereby creating conditions that support growth within youth care trajectories. Alternatively, starting with youth care first might alleviate parental burden, thereby enhancing parental functioning and increasing the effects of subsequent individual care.

Further research should investigate which sequence—parental individual care followed by youth care, or vice versa—yields the most sustainable outcomes for children and families. Additionally, the added value of recently started integrated parental and youth care in the Netherlands (Stolper et al., 2024) should be examined in terms of its impact on child, parent, and overall family functioning.

Conclusion

This study explored the experienced impact of family-focused youth care from the perspectives of parents and children, focusing on perceived effects, facilitating and hindering elements, and tipping points. Quantitative findings indicate that the majority of participants perceive the care as effective, particularly in terms of improvements in child and family functioning and parenting skills. Qualitative data reveal that while most families experience meaningful changes, vulnerabilities in child and family functioning and especially in parental well-being persist beyond the care trajectory. Effective elements are primarily related to therapeutic alliance and intervention content, whereas organizational barriers such as waiting lists and complex laws and regulations hinder outcomes. Perceived tipping points are linked to respectful professional interactions, diagnostic insights, and extra-therapeutic events. The results of this study underscore the importance of a systemic approach that includes attention for parental needs and contextual factors. To further understand the perceived effects and tipping points, it is essential to directly engage children and families in reflecting on youth care.

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Data Availability In accordance with ethics approval statement, research data are not shared to protect study participant privacy.

Materials and/or code availability Materials and/or codes are available upon request from the authors.

Declarations

Competing Interest The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Ethics Approval The research project ‘What happens afterwards?’ was approved by the Ethics Review Board of Tilburg University (Reference number RP 245).

Patient Consent All parents and children participating in the project ‘What happens afterwards?’ signed for informed consent to participate in the project.

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