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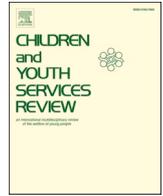
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# Evaluating the effectiveness of the systemic practice model of children's social care – A pilot study on child- and family-level outcomes

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## ABSTRACT

The Systemic Practice Model (SPM) is a Finnish adaptation of the Reclaiming Social Work (RSW) model, which incorporates systemic ideas and practice into children's social care. This study is the first attempt to evaluate the effectiveness of the RSW model outside England. The study employed a quasi-experimental repeated measures design. Questionnaires assessing child- and family-level outcomes and the quantity (i.e., number of meetings) and quality (i.e., service user feedback) of the practice were administered to social workers, children and parents twice over a six-month follow-up period. Outcome data comprise 112 cases (SPM cases  $n = 56$ , service-as-usual cases  $n = 56$ ) from 18 child protection teams (SPM teams  $n = 9$ , service-as-usual teams  $n = 9$ ) at three sites. The overall need for child protection decreased across the sample during the follow-up period. While the intensiveness of practice was higher in the SPM group, no significant differences were found between the study groups in practice outcomes or service user satisfaction with child protection. The limitations and implications of the study for future research are discussed.

## 1. Introduction

During the past decade, children's social care and child protection systems have been criticised as inefficient and dysfunctional. For instance, the demands of bureaucracy have reduced practitioners' capacity to work directly with service users in England (Munro, 2011). To improve services, Munro (2011) suggested that, to work effectively with children, young people and families, the child protection system should value and develop professional expertise. In Finland, similar demands were expressed after the high-profile death of an 8-year-old girl under a child protection plan in 2012. Following this event, the Finnish government commissioned a report on the state of children's social care (Kananaja et al., 2013). The problems identified included excessive bureaucracy, high staff turnover, poor management, insufficient early interventions, and high caseloads. In addition, service-user participation and a comprehensive understanding of families' needs were poor. As part of a broader programme to reform child and family services, the Finnish Government funded the development and dissemination of the Systemic Practice Model (SPM), a Finnish adaptation of the *Reclaiming Social Work* (RSW) model originally developed in England (Goodman & Trowler, 2012). The aim of these models is to incorporate systemic ideas and practice into children's social care. The SPM has multiple goals in

relation to improving the quality and quantity of practice and the wellbeing of children and families in children's social care services (Lahtinen et al., 2018). In Finland, 31 municipal children's services sites implemented the SPM between Autumn 2017 and Summer 2018.

The purpose of this study was to assess the child- and family-level outcomes of the SPM during the first stage of its implementation. Despite the promising results of the RSW in improving the quality of local practice (Bostock et al., 2017; Bostock et al., 2019; Forrester et al., 2013), no evidence exists on the effectiveness of the original RSW model or its adaptations either within or outside England. The present study addresses this research gap. This pilot study compared the effects of systemic practice in an SPM group with changes in a service-as-usual control group in three sites participating in the national implementation project in 2018. The pilot study also tested the outcome measures, data collection strategy and study design to gain information for a future full evaluation of the SPM.

For this study, hypotheses on the expected outcomes of the SPM were initially formulated based on a description of the SPM (Lahtinen et al., 2018) and then discussed in two SPM-related steering groups, one in charge of the national evaluation and one in charge of the national training of trainers. The main hypothesis was that systemic practice should improve family dynamics and the subjective well-being of a

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child, and decrease child abuse and neglect and the overall need for child protection. The systemic approach was expected to achieve these goals by improving the quantity and quality of child protection practice. The service was to be relationship-based. Social workers were expected to meet children and families more frequently than usual, and families should feel that they had been part of the process, could trust their social worker, and had received help.

The research questions were: What changes were found regarding the child's wellbeing, safety (i.e., signs of abuse or neglect, need for child protection), family dynamics, and the quality and quantity of services during the follow-up? What differences, if any, were observed between the two study groups, i.e., families supported by the SPM and families receiving service as usual?

### 1.1. The Finnish and English systems of children's social care

The Finnish child protection system has been described as a family service system with 'a best interest of the child' focus whereas England has a hybrid system that is risk-oriented but also supports vulnerable families (Gilbert et al., 2011). The Finnish system is deregulated, with more professional discretion in decision-making than the English system (Berrick et al., 2015). An international survey (Berrick et al., 2016) comparing time use and institutional support found that decision-making more frequently involved coworkers or a team in Finland than in England. However, Finnish social workers had over double the caseload and experienced higher work pressure than their English counterparts.

### 1.2. Reclaiming social work

The original RSW model was developed in the London Borough of Hackney, starting in 2007. It is not licensed or manualised, but a description of the model's general ideas, values, theories and systemic practice has been published by its co-founders (Goodman & Trowler, 2012). According to Trowler & Goodman (2012, pp. 14-25), the RSW changed the whole services system by establishing a shared value base (e.g., collaboration and respect) and creating structures and systems that facilitate effective working with families, improve leadership and the recruitment of competent staff. The RSW included a training programme designed to enhance the skills and knowledge base of the staff, and introduced the use of small multi-disciplinary units. These systemic units consist of a social worker, a children's practitioner, a family therapist, a unit coordinator providing administrative support, and a consultant social worker, who leads the unit and has overall case responsibility. Units hold weekly meetings in which they discuss all the children allocated to the unit. These meetings serve as the main mechanism for case supervision. Practitioners are trained to embed the systemic approach in their social work, while the family therapist ensures that the approach is maintained (Pendry, 2012). The key idea of systemic practice is that problems are embedded in relationships and that family members' actions are a response to others' actions. In this relational frame, the social worker is not expected to fix the family but instead resolve the problem with members of the family's system.

Based on their observational study, Forrester et al. (2013) outlined six features that distinguish the original Hackney units from conventional teams: shared work, in-depth case discussion, a shared systemic approach, skills development, special roles, and low caseloads. In other agencies in England, the RSW has not been implemented in quite the same way. For example, systemic units have been replaced by larger systemic teams with three to four case-holding social workers and, in some cases, without a clinician (Bostock et al., 2017). The RSW is sometimes used alongside another practice model, Signs of Safety (Baginsky et al., 2020).

### 1.3. The Finnish systemic practice model

The Finnish adaptation of the RSW model was outlined in 2016 during a workshop organised by the Finnish Institute for Health and Welfare (THL). The core values and ideas of the Systemic Practice Model are based on the original RSW model (Goodman & Trowler, 2012). In the SPM, teams consist of a consultant social worker, a family therapist, a unit coordinator, social workers and occasionally also child or family practitioners (Lahtinen et al., 2017). The recommended team size was between six and eight members in total. The content of the SPM was fleshed out in more detail during the Training of Trainers programme, which included an introduction to systemic thinking and family therapy, the composition and functioning of a systemic team, the structure of systemic weekly meetings, principles of systemic practice, and an introduction to selected methods and techniques. The training applied the description of systemic family therapy proposed by Leeds Family Therapy Research Center and reported in Lorås et al. (2017). According to this definition, systemic family therapy involves 11 specific competences: focusing on the system rather than the individual; seeing behavioral patterns within systems as circular and always evolving, identifying connections between circular patterns of behaviour and connections between beliefs and behavior within systems; paying attention to narratives and language; applying the ideas of constructivism and social constructionism; considering the importance of cultural context; taking a reflexive stance toward power differentials; acknowledging that reality is constructed between the therapist and the service user; applying self-reflexivity; and focusing on strengths and solutions (Lorås et al., 2017). However, it was acknowledged that child protection is not therapy. As applied in the child protection context, systemic practice involved collaborating and sharing expertise with families and other professionals, and formulating goals and creating meanings together with families while acknowledging the social worker's authority position.

The SPM training programme did not follow the RSW training curriculum. Hence, the content of these models differed. While both models shared similar systemic ideas and techniques (e.g., genograms, formulating hypotheses), the Finnish training programme included new tools and ideas (such as the possibility to invite families to weekly team meetings) and lacked some of the content of the original RSW model (e.g., social learning theory). In addition, the concrete measures that were taken to disseminate the SPM were targeted at the team level whereas the original RSW was a reform of the whole system.

Based on an initial process evaluation (Aaltio & Isokuortti, 2019), the majority of the social workers participating in the first stage of SPM implementation were willing to continue with the model. However, the implementation process was in many ways challenging, as, for example, caseloads were high (on average, 37 children per caseholding social worker) and the training lacked specificity. A study (Isokuortti & Aaltio, 2020) evaluating the implementation fidelity of the SPM revealed high variability across sites and individual teams. Shortcomings in training, lack of resources and leadership, and imprecision of the SPM all hindered its implementation. Overall, however, practitioners were very satisfied with the SPM and valued the contribution of a family therapist in team meetings. Based on these findings, it was expected that the SPM would already have had positive effects on practice even if it had not been fully implemented when the data for this study were collected.

### 1.4. Previous outcome evaluations of the RSW model and its adaptations

Previous evaluations of the RSW model have concluded that its implementation increases the quality of children's services compared to the conventional approach. During implementation, social workers in the original RSW units in Hackney expressed greater satisfaction with their work environment, social-work processes and work-related wellbeing, while the number of looked-after children decreased by 30 percent (Cross et al., 2010). In their realist-informed mixed-method

evaluation conducted in Hackney, Forrester et al. (2013) found that the practitioners in the RSW units spent more time with families, provided them with more intensive help, demonstrated high levels of direct practice skills, and made high-quality assessments compared to those in conventional teams. In a study that quantified and paired observations of supervision ( $n = 14$ ) with observations of direct practice ( $n = 18$ ), Bostock et al. (2019) found a statistically significant association between systemic supervision and high quality practice with families. However, as no full evaluation of the effectiveness of the RSW model has been conducted, the evidence base on the effectiveness of the RSW remains limited (Isokuortti et al., 2020).

## 2. Material and methods

### 2.1. Study design and conditions

This study used a quasi-experimental, repeated measures design. The time between the baseline and follow-up measurements was approximately six months. The aim was to compare changes in child protection outcomes and process indicators between SPM teams and service-as-usual (SAU) teams.

The development and dissemination of the SPM was organised by the Finnish National Institute for Health and Welfare (THL). THL also conducted a national evaluation of the dissemination and local implementation of the SPM. The decision to adopt RSW in Finland was made within a government-funded project (LAPE 2016–2018) aimed at reforming Finnish child and family services as a whole. The author of the study did not participate in any way in the decision-making process or LAPE preparation phase. It was not until the decision of the dissemination of the SPM had been made that, as part of the national evaluation process, the author prepared the research plan for this study.

During 2017–2018, THL trained fifty-eight ( $n = 58$ ) social workers or family therapists to work in pairs as local trainers. The Training of Trainers programme consisted of seven training days and four supervision sessions. By the summer of 2018, these trainers had trained fifty-two ( $n = 52$ ) local teams at 31 sites in use of the systemic practice model. While the local teams implementing the SPM covered all stages of children's social care from assessment to out-of-home care, the majority of the teams ( $n = 22$ ) dealt with child protection. Local training consisted of six days of team training and subsequent group supervision sessions provided by the trainers. Next, teams implemented these components in their daily practice by holding systemic weekly meetings and applying systemic orientation and methods in their casework.

Caseloads in the SPM teams were high, with an average of 38 children per social worker, compared to the 20 children per social worker recommended by THL. However, the high caseloads of the pilot teams were comparable with those of the SAU group, where social workers

were individually responsible for 37 children on average.

### 2.2. Sample

To compare systemic practice with SAU, two samples of families were drawn, one supported by social workers in SPM teams and the other supported by social workers in SAU teams. Data were collected from nine ( $n = 9$ ) SPM teams and nine ( $n = 9$ ) SAU teams at three ( $n = 3$ ) municipal children's services sites.

The sites were selected from all the sites that had signed up to participate in the national implementation of the SPM by autumn 2017. The selection criteria were: 1) the organization had enough children's services teams to be able to assign some for SPM training (SPM teams), leaving others to continue providing services as usual (SAU teams); and 2) the organization would be able to implement the SPM in March 2018 at latest, enabling baseline and follow-up data to be collected by the end of 2018. Three suitable sites were identified and all were willing to participate in the study. One site, with four ( $n = 4$ ) SPM teams and four ( $n = 4$ ) SAU teams, was in the metropolitan area of Finland. The second site, with four ( $n = 4$ ) SPM teams and two ( $n = 2$ ) SAU teams, was a medium-sized regional center in Central Finland, and the third site, with one ( $n = 1$ ) SPM team and three ( $n = 3$ ) SAU teams, was a medium-sized regional-center in Eastern Finland.

The SAU group comprised teams working with a similar population at the same site. These teams held their usual team meetings, which focused on case allocation and general administrative tasks. The SAU teams did not receive any particular training and did not implement any specific model to guide their practice during the study.

In two of the participating organisations, the SPM and SAU teams worked with child protection cases. In one organization, the SPM and SAU teams worked with both child protection cases and children in need of less demanding social care. In this organisation, only the child protection cases received systemic practice and participated in the study.

The socio-demographic characteristics of the study groups are presented in Table 1. The only significant difference between the study groups was that the children in the SAU group were on average older ( $U = 2023, p = .004$ ).

### 2.3. Procedure

The study used purposive sampling. Social workers were asked to fill in assessment questionnaires concerning the families they were actively working with at the time of the first data collection. To decrease selection bias, social workers were instructed not to exclude cases they might perceive as challenging, such as non-Finnish-speaking or un-cooperative families. Both new and older cases were included in the study due to the small number of new cases per team per month. Randomisation of cases

**Table 1**  
Baseline (T1) socio-demographic characteristics of the children in the SPM and SAU groups participating in the study.

	Total $N = 112$	SMP group $n = 56$	SAU group $n = 56$	Significant difference SPM vs SAU group $p$
Age				
Median (Range)	13.0 (1–17)	11.0 (1–17)	13.5 (5–17)	.004
Sex				
Female	56 (50 %)	33 (59 %)	23 (41 %)	ns.
Male	56 (50 %)	23 (41 %)	33 (59 %)	
First language				
Finnish	103 (93 %)	54 (96 %)	49 (89 %)	ns.
Other	8 (7 %)	2 (4 %)	6 (11 %)	
Living arrangements				
Child living with birth parents	28 (25 %)	12 (21 %)	16 (29 %)	ns.
Parents separated, child living with one parent	65 (58 %)	36 (64 %)	29 (52 %)	
Parents separated, child living alternately with each parent	7 (6 %)	4 (7 %)	3 (5 %)	
Out-of-home care	8 (7 %)	2 (4 %)	6 (11 %)	
Other	4 (4 %)	2 (4 %)	2 (4 %)	

was not feasible, as the SPM was being implemented under real-life circumstances, meaning that families were allocated to social workers based on their home address. Interfering in the official allocation protocols would have entailed high-level decisions beyond the scope of this project.

The first data collection (T1), a period of three months, was conducted at each site in spring 2018 after the SPM team had been trained in systemic practice and the weekly team meetings with a clinician had started. Prior to the data collection, the researcher visited each participating team twice to give oral and written instructions on how to select cases, fill in the research questionnaires and recruit service users to the study. First, the social workers were asked to fill in case assessment forms based on their direct observations, discussions with the family and any information they possessed on the child and the child's parents. They were then asked to deliver the research materials, i.e., the self-assessment forms, information letters and consent forms, to the child and the child's parents. In some cases, this task was performed by family practitioners. This was in line with practice at the time, as most face-to-face practice was done by family practitioners rather than social workers. The practitioners were instructed to deliver and fill in the research forms as part of their everyday practice so that the information collected from and with the families would simultaneously support their casework. Children's forms were to be completed during a meeting with a social worker or a child practitioner whereas adolescents and parents could choose to complete the form alone or during a meeting.

The second stage of the data collection (T2) started approximately six months after the end of first stage. The social workers were asked to assess the same cases and deliver the research material to them. Participation in the research was voluntary for children and parents. All the children and parents who had been assessed by their social worker or family practitioner at T1 were asked to fill-in the self-assessment questionnaires at T2 irrespective of their participation at T1 or whether the follow-up assessment had been made.

Ethical approval was granted by the National Institute of Health and Welfare Research Ethics Committee (2017–09).

#### 2.4. Instruments

Data were collected from three groups of informants (practitioners, children, and parents) with questionnaires on wellbeing and the need for child protection and on the number of meetings and service-user feedback. The social workers' questionnaire included items on child and parent demographics, child protection process indicators (i.e., duration of the client relationship, number of meetings, interventions), and selected outcome measures. The self-assessment questionnaires included subjective outcome measures and, at T2, feedback items on the child protection process. Two versions of the children's questionnaire were in use, one for 7- to 12-year-olds and one for 13- to 17-year-olds. Both versions included the same item content but with simpler wording for the younger participants.

#### 2.5. Measures

*Child subjective well-being* was measured by KINDL-R, a generic instrument for assessing health-related quality of life in children and adolescents (Ravens-Sieberer & Bullinger, 1998). This study used two versions of the questionnaire, one for 7- to 12-year-olds and one for 13- to 17-year-olds. Both versions contain 24 items with 5-point response scale: never, seldom, sometimes, often, all the time. The respondent is asked how they have felt during the past week with respect to six dimensions: physical well-being (e.g., "I felt ill"), emotional well-being (e.g., "I felt alone"), self-esteem (e.g., "I was proud of myself"), family (e.g., "I got on with my parents"), friends (e.g., "I played with friends"), and everyday functioning in school or nursery (e.g., "I enjoyed my lessons"). The sub-scales were combined to produce a total score ranging from 0 to 100. Higher scores indicate higher well-being. [T1:  $\alpha = 0.84$ , T2:  $\alpha =$

0.84].

*Family dynamics according to the child and to the parent* were measured using the SCORE-15, an instrument developed to monitor progress and outcome in systemic family therapy (Carr & Stratton, 2017). The SCORE-15 consists of 15 items describing aspects of family functioning (e.g., "It feels risky to disagree in our family", "We trust each other"). Responses were given on five point Likert-scales ranging from 1, describes my family very well to 5, describes my family not at all. The total score is the mean score for all the items in the scale, and thus ranges from one to five. Low scores indicate better adjustment, as in the original measure. [Mothers T1:  $\alpha = 0.90$ , T2:  $\alpha = 0.89$ , children T1:  $\alpha = 0.84$ , T2  $\alpha = 0.86$ ].

*Need for outsider help according to the child and parent* was measured with a single question developed for this study: "Think about your family's overall situation at present. How much outsider help do you think you need?" Answers were given on a 11-point response scale from 0 = none, to 10 = very much.

*Need for child protection according to the social worker* was measured with a single question developed for this study: "Based on your overall judgement, how much in need of child protection is the child at present?" Answers were given on a 11-point response scale from 0 = no need, to 10 = the child's safety is seriously endangered.

*Signs of abuse or neglect* were measured in the social worker questionnaire with a set of 21 items concerning different types of abuse or neglect. The wording was positive (e.g. "The child's daily activities are done in safe surroundings", "The parent treats the child age-appropriately"). Responses were given on 4-point scale (0, No signs of abuse or neglect, 1, Some signs, 2, Serious signs, 3, Can't say). Excluding value 3, these variables were combined into a sum variable ranging from 0 to 42. The measure was originally developed in a previous research project aimed at creating a structural assessment form for assessing the need for child protection (Aaltio, 2015). For the present study, the phrasing and number of items was modified based on previous experience and consultation with national experts in child protection and child psychiatry. [T1:  $\alpha = 0.88$ , T2  $\alpha = 0.89$ ].

*The number of meetings* during the past six months was measured in the social worker questionnaire. Respondents were asked how many times a) a social worker and b) a child practitioner had had a meeting i) with the child without the parents, ii) with the parents without the child, or iii) with the child and the parent(s). Based on this information, the responses were recoded into four variables, two for social workers and two for child practitioners: the number of meetings the social worker/child practitioner had had with the child or with any/all family members (including all meetings with the child, parent(s) or both). These measures indicated the intensiveness of face-to-face practice.

Items on *service user feedback* were included in the follow-up self-assessment questionnaires for children and parents. A trustful relationship was measured with one question "I can openly share all kinds of issues with my social worker" and participation in the process with one question "My social worker has listened to my thoughts and wishes." Responses were given on a 5-point Likert-scale ranging from 1 = strongly disagree to 5 = strongly agree. Overall satisfaction with practice was measured with these and two further statements ("I have received help from child protection", "I have met my social worker often enough"). The score for the four variables were combined to produce a total score ranging from 4 to 20, with higher scores indicating more satisfaction with the child protection process. [Mothers  $\alpha = 0.81$ , children  $\alpha = 0.76$ ].

*SPM fidelity* was measured in the social worker questionnaire with four questions. Respondents were asked whether one or several of the following methods included in the SPM had been applied in the case at hand: 1) genogram, 2) formulating systemic hypotheses, 3) having the family/some of the family members present in a weekly team meeting, and 4) a meeting between a family therapist and the family/some of the family members. Since the idea was to tailor systemic practice case by case, practitioners were expected to apply at least one of these methods,

but not necessarily all of them, in each case. Hence, a dichotomous variable was computed indicating whether at least one of the listed methods had been applied in a given case. Given the small sample size, a scale variable indicating the dose of systemic practice was not used in this study.

## 2.6. Sample size and attrition

A total of 65 cases were assessed by social workers at both T1 and T2. The rate of attrition between T1 and T2 was 42 percent. In 10 cases, the case had been closed or referred to another team before T2. The remaining attrition was related to staff changes. These resulted in gaps in the data collection due to poor motivation to participate in the study amid the difficulties of implementing the SPM or to experiencing a stressful work situation.

Missing data analyses showed that the data missing from the social workers' forms were not related to study group or the child's age, sex, language or living arrangements. The children's questionnaire was completed at both measurement points by 50 children, or half of all the eligible children aged 7–17 ( $n = 100$ ). The data missing from the children's forms were not related to study group or child demographics. A total of 43 mothers completed the parent self-assessment questionnaire at both measurement points. Non-Finnish-speaking mothers were less likely to participate at both measurement points ( $X^2(1) = 4.09, p = .043$ ). The data missing from the mothers' forms were not related to study group, child demographics or mother's age, education, employment status, relationship with the father (i.e., marriage, cohabitation or divorced) or relationship with the child (i.e., birth parent or step-mother). A total of nine ( $n = 9$ ) fathers completed the parent self-assessment questionnaire at both measurement points. Here, the missing data were related to living arrangements: in cases where children lived with both birth parents, fathers were more active than in cases in which parents were separated or a child had been placed in out-of-home care ( $X^2(3) = 13.9, p = .003$ ). Additionally, fathers who were cohabiting with or married to the child's mother participated more often than divorced fathers ( $n = 52$ ) ( $X^2(1) = 11.9, p = .001$ ). Fathers who did not participate throughout the study were older ( $M = 44.9, SD = 9.3$ ) than participating fathers ( $M = 38.3, SD = 4.9, t(17.7) = 3.254, p = .004$ ). Fathers' missing data were not related to study group or other child or father demographics. Due to the small number of fathers in the study groups ( $n = 3$  in SPM group and  $n = 6$  in SAU group), fathers' subjective outcome and feedback measures were omitted from the analysis.

Additional attrition analysis conducted to explore whether missing data were associated with the primary outcome measures at T1 showed that the missing data were related to only one of the outcome variables at baseline: the amount of neglect and abuse assessed by social worker was higher at T1 among those participating at both measurement points ( $M = 9.2$ ) compared to those participating only at T1 ( $M = 6.8$ ) ( $t(108.50) = 2.28, p = .025$ ). This finding indicates that the cases

participating at both measurement points were more severe than those participating only at the baseline. While it is possible that a number of the less severe cases had already been successfully closed by the time of the T2 data collection, this could not be confirmed as no information on the reason for dropping out was available in 37 cases. Only six of the ten cases for which the reason for attrition was known were reported as closed before the follow-up. Three of the ten cases had been referred to out-of-home care and in one case the family had relocated.

## 2.7. Statistical analyses

The analysis were carried out in the following steps. First, missing data analysis was performed using Chi-square-test for nominal variables and independent sample t-tests for continuous variables. Second, baseline differences between the two groups were tested using t-test or the Mann-Whitney  $U$  test for continuous variables and Chi-square-test for nominal variables. Third, to answer the research question on changes in outcomes, the effect of time and group, and the time\*group interaction term for the variables of interest was tested using repeated measures analysis of variance. In cases where the assumption of normality was not met, additional non-parametric tests, i.e., the Mann-Whitney  $U$  test and Wilcoxon signed-rank test, were conducted. Fourth, to examine the differences in the frequency of meetings and service user feedback between the study groups at T2, the Mann-Whitney  $U$  test was applied. To elaborate the association between the number of meetings and feedback variables, Pearson's Product-Moment correlation was used. The SPSS Statistics 26 package was used for all analyses.

## 3. Results

### 3.1. Preliminary analysis

The baseline characteristics of the study groups with respect to the child protection process indicators and outcome scores are shown in Table 2. The only significant difference between the groups was in re-referrals, with more re-referred cases in the SAU group ( $X^2(1) = 7.80; p = .005$ ).

### 3.2. Changes in children, parents and families in the whole sample and groups

Table 3 presents the means and standard deviations of the child- and family-level outcome variables of the SPM and SAU group for cases that participated in the study at both measurement points (T1 and T2).

#### 3.2.1. Child's well-being

The child's well-being according to the child showed no effect of time (Wilks'  $\Lambda = 0.98, F(1, 39) = 0.77, p = .39, \eta_p^2 = 0.019$ ) or of time\*group (Wilks'  $\Lambda = 0.94, F(1, 39) = 2.53, p = .12, \eta_p^2 = 0.061$ ).

**Table 2**  
Baseline characteristics in the SPM and SAU groups.

	Total ( $N = 112$ ) $n$ (%)	SPM group ( $n = 56$ ) $n$ (%)	SAU group ( $n = 56$ ) $n$ (%)	Significant difference SPM vs SAU group $p$
Re-referred case	67 (60)	26 (47)	41 (73)	.005
	Total	SPM group	SAU group	
Length of current episode, months	$M$ (SD) 15.0 (22.4)	$M$ (SD) 15.1 (21.5)	$M$ (SD) 14.9 (23.4)	$p$ ns.
Total length of previous involvement in child protection before current episode, months	39.1 (35.7)	45.3 (39.4)	35.0 (33.0)	ns.
Need for child protection (0–10) according to the SW	6.2 (2.4)	6.6 (2.1)	5.9 (2.6)	ns.
Signs of abuse or neglect according to the SW	8.2 (5.9)	8.0 (5.4)	8.4 (6.5)	ns.
Subjective well-being according to the child	69.8 (12.9)	72.3 (12.6)	68.2 (13.0)	ns.
Family dynamics according to the child	2.0 (0.6)	2.0 (0.6)	2.1 (0.6)	ns.
Family dynamics according to the mother	2.1 (0.6)	2.2 (0.7)	2.1 (0.6)	ns.

**Table 3**

Means and standard deviations of the outcome variables in the SPM and SAU groups at T1 and T2.

Variable	SPM group		SAU group	
	T1 M (SD)	T2 M (SD)	T1 M (SD)	T2 M (SD)
Subjective well-being, child	75.2 (11.5)	74.0 (9.5)	68.0 (12.4)	72.2 (13.4)
Family dynamics, child	1.9 (0.6)	1.9 (0.6)	2.0 (0.5)	2.1 (0.6)
Need for help, child	3.0 (2.4)	2.9 (2.3)	3.3 (2.8)	3.5 (3.0)
Family dynamics, mother	2.2 (0.7)	2.0 (0.6)	2.2 (0.5)	2.0 (0.5)
Need for help, mother	5.9 (2.8)	4.6 (2.2)	5.5 (2.9)	5.5 (3.2)
Need for child protection, social worker	7.0 (1.8)	4.6 (2.5)	6.1 (2.4)	4.6 (2.9)
Signs of abuse or neglect, social worker	9.1 (6.1)	6.3 (5.6)	9.3 (7.3)	9.3 (8.1)

### 3.2.2. Family dynamics

Family dynamics according to the child showed no significant effect of time (Wilks'  $\Lambda = 1.00$ ,  $F(1, 40) = 0.02$ ,  $p = .9$ ,  $\eta_p^2 = 0.000$ ) or effect of time\*group (Wilks'  $\Lambda = 1.00$ ,  $F(1, 40) = 0.03$ ,  $p = .87$ ,  $\eta_p^2 = 0.001$ ). Family dynamics according to the mother showed a main effect of time (Wilks'  $\Lambda = 0.82$ ,  $F(1, 41) = 9.14$ ,  $p = .004$ ,  $\eta_p^2 = 0.182$ ). The mean score decreased from 2.2 to 2.0, indicating an improvement in family functioning as assessed by mothers. However, no significant effect of time\*group was observed (Wilks'  $\Lambda = 1.00$ ,  $F(1, 41) = 0.00$ ,  $p = 1.0$ ,  $\eta_p^2 = 0.000$ ), indicating that both approaches were equally effective in changing family dynamics.

### 3.2.3. Need for help

Need for help according to the child showed no significant effect of time (Wilks'  $\Lambda = 1.00$ ,  $F(1, 38) = 0.07$ ,  $p = .94$ ,  $\eta_p^2 = 0.000$ ), or effect of time\*group (Wilks'  $\Lambda = 1.00$ ,  $F(1, 38) = 0.17$ ,  $p = .69$ ,  $\eta_p^2 = 0.004$ ). Need for help according to the mother also showed no significant effect of time (Wilks'  $\Lambda = 0.94$ ,  $F(1, 40) = 2.60$ ,  $p = .11$ ,  $\eta_p^2 = 0.061$ ) or of time\*group (Wilks'  $\Lambda = 0.93$ ,  $F(1, 40) = 3.02$ ,  $p = .09$ ,  $\eta_p^2 = 0.07$ ).

### 3.2.4. Need for child protection

Need for child protection according to the social worker showed a main effect of time (Wilks'  $\Lambda = 0.64$ ,  $F(1, 63) = 34.8$ ,  $p < .001$ ,  $\eta_p^2 = 0.356$ ). Across the sample, the mean decreased from 6.5 to 4.6, indicating an improvement in the child's situation. However, no significant effect of time\*group was observed, meaning that both approaches were equally effective in reducing the need for child protection (Wilks'  $\Lambda = 0.97$ ,  $F(1, 63) = 1.74$ ,  $p = 0.19$ ,  $\eta_p^2 = 0.027$ ).

**Table 4**

Means, standard deviations and medians for variables on the number of meetings during follow-up.

	SPM group		SAU group		U	p
	M (SD)	Mdn	M (SD)	Mdn		
Meetings, child and social worker	2.3 (2.2)	2.0	1.1 (1.2)	1.0	321.0	.016
Total n of meetings, any/all family member(s) and social worker	11.1 (6.5)	9.0	5.0 (2.3)	5.0	166.0	<.001
Total n of meetings, any/all family member(s) and any practitioner	22.6 (17.6)	16.0	8.5 (12.2)	5.0	115.5	<.001

**Table 5**

Means, standard deviations and medians for variables on feedback from children and parents at T2.

	SPM group		SAU group		U	p
	M (SD)	Mdn	M (SD)	Mdn		
Child						
Sense of participation	3.5 (1.2)	4.0	3.9 (1.0)	4.0	243.5	.268
Sense of trust	3.4 (1.3)	3.0	3.7 (1.1)	4.0	250.0	.350
Overall satisfaction	14.3 (3.9)	15.0	15.1 (2.9)	16.0	255.5	.432
Mother						
Sense of participation	4.3 (1.1)	5.0	4.5 (1.0)	5.0	257.0	.636
Sense of trust	4.3 (1.1)	5.0	4.6 (0.9)	5.0	257.0	.457
Overall satisfaction	17.0 (3.3)	18.0	17.9 (2.7)	19.0	238.5	.300

to participate in the process, thereby creating a trustful relationship between the social worker and family.

Meeting children without the presence of other family members was infrequent in both groups (Table 4). However, the social workers in the SPM group had more private meetings with children than the social workers in the SAU group. Analysis of the total of all meetings between a case holding social worker and families showed that the number of meetings in the SPM cases was more than double that in the SAU cases. Moreover, the mean total number of all meetings between any child protection practitioner (social worker or family practitioner) and a family in the SPM group was nearly threefold that in the SAU group. Half (52 %) of the families in the SAU group had met their child protection practitioner less than once a month, compared to only one in ten in the SPM group (9 %). These results reveal that systemic practice was more intensive than service as usual.

However, no differences were detected in service user experiences between two approaches (Table 5). In general, mothers were more satisfied than children with the child protection process. Surprisingly, the number of private meetings between the child and a social worker correlated negatively with the child's sense of trust ( $r(41) = -0.34, p = .025$ ). Moreover, the number of such meetings correlated negatively with mothers' sense of participation ( $r(37) = -0.50, p = .001$ ), sense of trust ( $r(38) = -0.43, p = .006$ ) and overall satisfaction with services ( $r(38) = -0.47, p = .002$ ). In contrast, the total number of all types of meetings did not correlate with any of the feedback variables. To elaborate this further, the correlation analysis was run separately for the two study groups. In the SPM group, correlations were found between the number of private meetings with a child and the mother's sense of participation ( $r(19) = -0.49, p = .024$ ) and sense of trust ( $r(19) = -.49, p = .024$ ). However, no correlation was observed between the child's feedback variables and the number of meetings. In the SAU group, no correlation was found between the feedback variables and the number of meetings of any type.

#### 4. Discussion

This study evaluated child- and family-level outcomes of the SPM during the first stage of its implementation at three children's services sites in Finland. The study was exploratory in nature given that the development strategy of the SPM was collaborative and iterative, i.e., the content and the delivery of the model was defined and negotiated during the process based on discussions in various forums, e.g., steering group of the national Training of Trainers, Training of Trainers moduls, and national workshops organised for managers responsible for local implementation. Nevertheless, the steering group in charge of the national evaluation of the SPM hoped for some estimation of the potential benefits of the SPM. The pilot study was conducted to test the outcome measures, data collection strategy and study design to gain information for a future full evaluation. Given that experimental and quasi-experimental research is rarely applied in the field of social work research (Holosko, 2010; see also Isokuortti et al., 2020; Olsson and Sundell, 2016; Sheehan et al., 2018), only a limited number of valid instruments and data collection strategies found to be effective are currently available for the purpose of conducting an outcome evaluation. Hence, the present findings can help to improve the study design of any future full evaluation of the SPM.

Despite its limitations, this pilot study showed that it is possible to measure and detect changes in wellbeing, family dynamics, safety, and service quality. The quasi-experimental study design also showed that it is possible to compare these changes between the SPM and service-as-usual teams under real-life conditions.

Across the whole sample, the results indicate a statistically significant decrease in the need for child protection assessed by a social worker during the 6-month follow-up. However, this positive change was not observed in the service user data: the need for outside help as assessed by children and mothers did not change over time. The mothers reported a

slight improvement in their family dynamics whereas the children did not. In addition, the subjective well-being of the children participating in this study did not improve during the follow-up. No significant differences were detected between the study groups in child's wellbeing, safety or family dynamics.

However, the systemic teams differed from service as usual in terms of the intensiveness of the children's social care process. On average, a case holding social worker had met the child alone twice in the SPM group and once in the SAU group during the past six months. Although this could indicate a more child-focused orientation in the SPM group, it is noteworthy that meetings of this type were rare in both groups. On the other hand, the frequency of other meetings was relatively high in the SPM group, especially when compared to service as usual. Nevertheless, the intensiveness of the process did not improve families' satisfaction with the help received. The finding that mothers were more satisfied with the process than children could be linked to the finding that children seldom met their social worker. However, the number of private meetings between a child and a case holding social worker correlated negatively with the child's trust in her or his social worker. Even more surprisingly, this variable was negatively correlated with mothers' satisfaction with services. When the study groups were analysed separately, this correlation was no longer found in the SAU group. In the SPM group, the negative correlation between the social worker's meetings with the child and mothers' sense of trust and participation remained. One possible explanation for this could be that service users have reservations about social workers building a direct relationship with the child in a context where meeting children individually is not typically practised by social workers. If so, social workers should better explain the purposes of these meetings to both children and parents in order to create trust along with greater intensiveness.

The present findings suggest that systemic practice was not more effective than service as usual in improving child- and family-level outcomes. Several factors may explain this overall finding. First, it is possible that the first stage of SPM implementation did not have sufficient leverage to induce the intended changes in practice in the SPM teams. Based on a fidelity analysis performed in a parallel sub-study (Isokuortti & Aaltio, 2020), wide variation in the content, dose and coverage of the SPM was found. While some SPM teams had adopted systemic thinking and techniques, others had not. In addition, variation was found between individuals in the same team. The key barriers to quality implementation were lack of clarity on the concrete meaning of systemic practice, insufficient training, high caseloads and staff turnover, and lack of commitment to change by organisations. On the other hand, a positive learning environment and hands-on coaching facilitated the implementation of the SPM. Some teams had been able to apply systemic practice despite the barriers. In general, the majority of the practitioners (79 %) participating in the fidelity study wished to continue using the model despite the challenges presented by its implementation. Second, it is possible that the quality of service-as-usual equals that of the SPM, even if fully implemented. However, In England, Bostock et al. (2019) found an association between truly systemic case discussion in weekly team meetings and better quality practice. This would indicate that at least some components of the practice model, e.g., case supervision, should outperform service-as-usual. Before this hypotheses can be tested in Finland, the quality of SPM implementation should improve. Third, it is possible that the outcomes of systemic practice are not observable with the outcome measures used in this study. In the field of children's social care practice and research, no consensus exists on outcomes or how to measure them (Forrester, 2017; Hood, 2019). This makes finding suitable validated instruments challenging. This study used the SCORE-15, a measure designed especially to assess outcomes in systemic family therapy. However, since systemic social work is not therapy, this measure might be inappropriate outside of the therapy context. The main outcome measure, KINDL-R, is a generic instrument for assessing health-related quality of life in children and adolescents. It may be that this type of generic measure is not

sensitive enough to detect the specific needs and experiences of children in need of protection.

## 5. Strengths and limitations

This pilot study was the first attempt to evaluate the outcomes of applying the SPM in Finland. The study used a quasi-experimental, repeated measures design, and collected outcome data from three groups of informants. However, it has several limitations. First, the sample size was small and attrition high. The attrition analysis showed that, in this sample, the cases participating at both measurement points were more severe than those participating only at the baseline. Hence, it is possible that some of the attrition is explained by successful case closures. Unfortunately, information on the reasons for dropout was only available in 10 out of 47 cases. The data collection strategy needs improvement before a full evaluation with larger samples can be conducted, and more meaningful comparisons between sites and fidelity groups can be made. Second, the interval between the baseline and follow-up measurement was approximately six months. This was considered to be a period during which the first positive changes in the wellbeing and living conditions of a child should become visible. In future research, a third measurement point should be used to assess long-term change. Third, neither the practitioners nor families in the study groups were randomly selected. Since the intervention in question is a team-level reform in the context of statutory children's services, random assignment would have entailed high-level decisions outside the scope of this study. Fourth, SPM fidelity was only assessed with a practitioner-reported indicator listing the application of key SPM tools and methods. Thus, more thorough information on changes in practitioners' reasoning and observations on direct practice would be needed to fully assess the level of SPM fidelity and its effect on outcomes. While the adoption of systemic thinking was assessed earlier in a parallel study (Isokuortti & Aaltio, 2020), this was done only on the team level and not the practitioner level. Since the team-level analysis revealed variation among individuals in the same team, this information could not be analysed in relation to the outcome data. Despite the several challenges this research presented, it is a much-needed step in accumulating knowledge about a model that has gained notable nation-wide attention and popularity.

## 6. Implications for future research and innovations

An important lesson of the pilot study concerns the context in which the SPM is being implemented and evaluated. According to the findings, the implementation strategy of the first stage of SPM implementation did not have sufficient leverage to change practice in a way that would produce the desired outcomes. Based on a parallel study (Isokuortti & Aaltio, 2020), the factors that hindered SPM implementation were lack of clarity about systemic practice, insufficient training, and inadequate resources and leadership.

As noted in the Discussion, social care, unlike health care, has few examples of experimental research. For this reason, there is no tradition to guide the design of interventional studies in which the implementation of an innovation must be controlled for in order to successfully compare study groups. The argument against the use of manuals or other concrete guidelines could be interpreted as demonstrating a preference not to 'tie the hands' of practitioners and prevent them from making tailored decisions. If the aim is to improve the quality of practice based on research and evidence, the stakeholders responsible for developing new interventions for social work should reconsider their reasoning. Some degree of compromise between participative approaches and more hierarchically operated study designs is needed. Similar tendencies have also been identified in other countries. For instance, a study (Baginsky et al., 2020) on the adoption of practice models (or practice frameworks) in England found that the majority of local authorities had adopted these models. Unfortunately, most of these were applying elements of

different practice frameworks, making it difficult to investigate the correlation between a specific framework and better outcomes for children.

During the data collection, it became evident that some of the social workers implementing the SPM were heavily burdened, and that this impaired their motivation to participate in the study. Some of their frustration seemed to be related to the disordered nature of the SPM implementation process – an observation supported by the findings of a fidelity analysis (Isokuortti & Aaltio, 2020). High caseloads and recruitment problems burdened practitioners and hindered them in changing their practice. In addition, concurrent national policy reforms and local organization reforms at two of the research sites prevented managers from supporting their teams in collecting data and implementing the SPM. Even when it is not possible – or even desirable – to create a sheltered environment for implementation, it is necessary to ensure that organisations have a reasonable chance to implement a new model with sufficiently high fidelity. To improve data collection, new strategies aimed at decreasing the burden on social workers need to be considered.

## 7. Conclusions

While there is strong interest in steering social work practice in accordance with research evidence (Hodge 2012; Julien-Chinn & Lietz, 2019), empirical evidence on the current effectiveness of many social work interventions and other psychosocial interventions directed at children and families is lacking (Isokuortti et al., 2020; Breivik et al., 2021; Sheehan et al., 2018). Pilot studies can provide useful insights regarding the next steps in research and implementation. However, to produce robust study designs and strong evidence requires effort not only from researchers but also from the stakeholders responsible for disseminating and implementing these services. It is also essential to conduct a process evaluation in parallel with the outcome evaluation to assess changes in service delivery and reflect on these findings together with changes in outcomes.

## CRedit authorship contribution statement

**Elina Aaltio:** Conceptualization, Methodology, Formal analysis, Investigation, Writing – original draft, Writing – review & editing, Visualization, Project administration.

## Declaration of 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.

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