

Effectiveness and cost-effectiveness of a solution-focused intervention in child protection services

Antonio Medina^a, Mark Beyebach^{b,*}, Felipe E. García^c

^a Child Protection Service of La Laguna, Tenerife, Spain

^b Health Sciences Department, Universidad Pública de Navarra, Pamplona, Spain

^c Department of Psychiatry and Mental Health, Medical School, Universidad de Concepción, Concepción, Chile

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ABSTRACT

The purpose of this research was to evaluate the impact on child welfare of introducing solution-focused principles and intervention techniques in the local child protection service of the island of Tenerife, Spain. 152 workers from 34 local child protection teams participated in the study. Goal achievement, parents' and children's self-reported well-being, and statutory child welfare measures were recorded during one year. Then the child protection teams were randomly assigned to a control or an experimental condition. 73 workers in the experimental condition, serving 271 families, received 30 h of training and 30 h of supervision in solution-focused brief therapy (SFBT). 79 workers in the control condition, serving 206 families, continued to intervene as usual. The dependent variables were evaluated again in the experimental and in the control group one year after the supervision in SFBT had finished. Results indicate that the experimental and the control group had equivalent outcomes at pre-test. At post-test, the experimental group achieved better outcomes than the control group: workers' and parents' goal achievement ratings as well as parents' and children well-being ratings were higher, fewer cases had been referred to risk teams, fewer children had been removed from their homes and recidivism was lower. The effects were small for goal achievement, medium for recidivism, and large for well-being and child removal. The teams that used SFBT reached these outcomes with fewer sessions and allocating fewer additional resources than the control group.

1. Introduction

Childhood abuse and neglect are still pressing problems internationally, as their negative effects have been well-documented. Childhood maltreatment can leave substantial emotional, cognitive, behavioral, and neurological sequelae (Dunn et al., 2017; Teicher & Sampson, 2016) that affect children's adjustment and development not only at the time of abuse-but also into young adulthood and beyond (Green et al., 2010; Hughes et al., 2017). Thus, child maltreatment is a serious problem and its primary (i.e., before the first maltreatment report) and secondary prevention (after a first maltreatment report), are of the utmost importance. Child protection services worldwide have been built to respond to this need (Browne et al., 2005; Finan et al., 2018).

The field of child protection has traditionally been dominated by approaches that focused on the shortcomings of service users and considered them to lack personal resources and parenting skills (Blundo,

2001; Rodrigo et al., 2008; Weick, 1992). The weight of statutory obligations and government guidelines, as well as the bureaucratization and fragmentation of services often lead child protection workers to classify children and families according to problem typologies and to refer them routinely to programs or interventions without taking into account the unique circumstances of each case (Gallagher et al., 2011; Howell et al., 2004; Van Veelen et al., 2018). In this way, service users became passive recipients of their workers' actions; if they did not accept the interventions, they risked being described as uncooperative or even resistant. These practices often lead to user dissatisfaction and alienation (Buckley et al., 2011) and to opposition and distrust between users and workers (Arbeiter & Toros, 2017), compromising the success of interventions (Gladstone et al., 2012). This, in turn, increases the risk for negative outcomes like the recidivism of child maltreatment, a critically important issue in child protection (US DHHS, 2010). For instance, in their five-year prospective cohort study on a sample of 2578 children reported to child protection who remained home after an abuse report,

* Corresponding author.

E-mail addresses: amedmac@lalaguna.es (A. Medina), mark.beyebach@unavarra.es (M. Beyebach), fgarciam@udec.cl (F.E. García).

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Dakil et al. (2011) found that 44 % were re-reported within the follow-up period.

The emergence of child-centered and family-centered approaches in child welfare (Pecora et al., 2009) challenged the paradigm we have just outlined. Child and family-centered approaches invite workers to deliver tailor-made services and to develop intervention plans that fulfill the unique needs of children and their families (Van Veelen et al., 2017). In a context of active cooperation with users, the strengths perspective (Rapp, 1998; Saleebey, 2006) emphasizes the capabilities and resources of families. Strength-based practices (Florida DChF, 2020; Williamson & Gray, 2011) hold an empowerment orientation that builds on parents' competencies, promotes collaborative relationships between workers and users, trusts users' capacity for change, and aims to enhance family autonomy (Kemp, 2014). Users are seen as people "worth doing business with" (Turnell & Edwards, 1999) and families are considered to have resources upon which protection work should build.

Despite the widespread promotion of family-centered and strength-based practices in child protection, empirical studies show that their implementation in child protection services has been inconsistent (Baginsky et al., 2019; Kemp et al., 2014; Lietz, 2011). This is not surprising given the role ambiguity of child welfare workers (Walsh, 2006), the need to balance the reduction of risks with the strengthening of family capacities within a mandated relationship (Oliver & Charles, 2015, 2016), and the inevitable challenges inherent in largescale system change (Van Veelen et al., 2018). However, consistent implementation of strength-based practices is also hampered by the fact that there is not enough research evidence on them (Finan et al., 2018; Woods et al., 2011). Particularly needed are efforts to better understand whether and how strength-based practices influence short-term (e.g., engagement with workers), intermediate (e.g., participation and retention in services), and longer-term (permanency) child welfare outcomes (Kemp et al., 2014).

The Solution-focused approach is one of the frameworks that fit into a strengths perspective of child protection (Berg, 1994; Berg & Kelly, 2000). It originated in the 1980s, outside the child protection field, as Steve de Shazer, Insoo Kim Berg and their colleagues developed their own model of brief family therapy, Solution-focused Brief Therapy (SFBT). In SFBT, the focus shifted from what clients do that does not work to what clients do that works, to exceptions that serve as building blocks for further progress (de Shazer et al., 1986). The focus of SFBT broadened gradually to include detailed discussions of clients' preferred futures and other interviewing techniques designed to co-construct feasible solutions in therapy (de Shazer, 1994). The solution-focused therapists' job is understood as asking useful questions from a stance of cooperation and "leading from one step behind" (Cantwell & Holmes, 1994). This does not deny the expertise of the therapist, who is expected to organize and lead the conversation in useful ways, to compliment strategically, and to offer suggestions to promote change (Berg & Kelly, 2000).

The appeal of this collaborative and empowering approach has led to a quick expansion of solution-focused practices to a variety of intervention contexts, from psychotherapy to organizational consultation, orthopedic rehabilitation, education, or social work. In solution-focused child protection (Berg, 1994; Berg & Kelly, 2000; Gilbert & Lee, 2011) workers are actively involved in dialogues with their users to establish the goals of their partnership, elicit the description of clients' preferred futures, highlight and discuss steps already taken (exceptions and solutions), and describe next small steps in detail. The emphasis is on offering clients choice and voice, and on speaking the users' language. Although the solution-focused approach is usually presented as a radical alternative to problem-focused approaches (George et al., 2006), in practice it can be combined with more traditional problem-focused models (e.g., Beyebach, 2009; Quick, 2008; Selekman, 2005). In child welfare, Solution-focused Trauma-Informed Care (Krause et al., 2018) is an example of one such integration.

Despite its promise to revolutionize child protection, the solution

focused approach has so far produced only limited empirical evidence. Furthermore, some authors have raised concerns that the solution-focused emphasis on clients' self-determination could compromise mandated authority and generate risks for children's safety (Haringey Local Safeguarding Children Board, 2010; Oliver & Charles, 2015; Woods et al., 2011). The studies that examine pure solution-focused interventions have so far only researched them in foster care situations (Cepukiene & Pakrosnis, 2011; Kazi et al., 2015; Koob & Love, 2010). In child preservation, only integrative approaches have been researched. Forrester et al. (2008) combined solution-focused brief therapy with motivational interviewing in a quasi-experimental study on families with drug-abusing parents whose children were at risk of entering care. Antle and her colleagues, in a series of large-scale studies (Antle et al., 2008, 2009, 2010; Barbee et al., 2011), demonstrated the feasibility, effectiveness, and cost-efficiency of "Solution-based Casework", a combination of SFBT with relapse prevention that in fact reduced the recidivism in their sample. Therefore, as to this writing, no study has researched the effectiveness of solution-focused practices *per se* in a large child protection service. The aim of the study was to evaluate the impact of a solution-focused approach to child protection by comparing the performance of a group of workers who received training in SFBT with that of child protection workers who employed treatment-as-usual. Research was guided by three primary questions:

1.-What is the impact of solution-focused practice on goal achievement and subjective well-being as perceived by workers, parents, and children?

2.-What is the impact of solution-focused practice on child welfare outcomes such as referral for further intervention, child placement or recidivism?

3.-What is the cost-efficiency of solution-focused practice, as compared to treatment-as-usual, in terms of length of the intervention, number of sessions used, and number of additional resources deployed (home assistance, day care, specialized mental health services, etc.).

It was expected that SFBT would produce superior results than treatment as usual both in therapist and user-rated outcomes and in child welfare outcomes. It was also expected that SFBT would result in shorter interventions, with fewer sessions, and the activation of fewer additional resources.

2. Method

2.1. Design

A quasi experimental design was followed. Two equivalent blocks of child protection teams were created by balancing the number of teams that served rural versus urban areas and the size of the populations they served. The two blocks were then randomized to the control or experimental group. Team members and parents of the children were evaluated before and after the intervention.

2.2. Participants

2.2.1. Child protection workers.

The sample of workers was recruited by inviting all local child protection workers in Tenerife (Spain) to participate. The first author approached the workers and offered them the chance to participate in the study and to receive free training plus supervision in SFBT. Participation in the study or in the training in SFBT was not a requirement for the job. Workers were informed that they would receive the training and supervision either during the study (workers in the experimental condition) or after its completion (workers in the control condition). The final sample at Time 1 consisted of 152 workers from 34 teams of the Child Protection Services on the island of Tenerife, 84 % of the workers in the service. The average age of workers was 36 years ($SD = 5.4$), 79.60 % were females and 20.40 % were males. 41.50 % of the sample were social workers, 34 % were family educators, and 24.5 % were

psychologists. The workers' professional experience in the Tenerife child protection service averaged 75 months in the experimental group and 79 months in the control group, a non-significant difference ($t = 0.672$; $p < .50$). There were also no significant differences between the workers in the experimental and the control group in relation to age ($t = 0.801$; $p = .42$), professional degree ($\chi^2 = 0.651$; $p = .72$), or workers' gender ($\chi^2 = 2.280$; $p = .13$). Participants had received no previous training in SFBT.

All 152 workers who participated in the study filled out the pre-test measures. At Time 2, 139 workers filled out the post-test measures and 13 workers were lost because they had left the service due to personnel reductions. Fig. 1 shows the randomization diagram according to the CONSORT protocol (Begg et al., 1996; Moher et al., 2001).

2.2.2. Families

Family uptake was higher in the experimental group ($n = 271$) than in the control group ($n = 206$), but all 477 families serviced by the child protection teams during the duration of the study accepted to participate and filled in informed consent according to the Helsinki declaration. All families filled in the Time 1 pre-test measures (0 % refusal rate). Overall, 329 families filled in the Time 2 post-test measures when the cases were closed or at study termination (69 % of the participating families) and 148 families were lost to the study (31 %). The attrition rate in the

control group (36 %) and in the experimental group (25 %) was statistically equivalent ($\chi^2_{(2)} = 1.910$, $p < .167$).

Table 1
Demographic data of participating service users at pretreatment evaluation.

	EG	CG	Total
Age of parents	$M = 37.42 \pm 9.05$	38.26 ± 8.78	37.74 ± 8.94
Age of children	$M = 12.17 \pm 3.16$	11.39 ± 3.12	11.92 ± 3.16
Family type			
- Nuclear	33.50 %	26.40 %	30.90 %
- Single-parent	47.10 %	45.10 %	46.30 %
- Reconstituted	12.90 %	15.70 %	14.00 %
- Polinuclear	5.30 %	6.90 %	5.90 %
- Other	1.20 %	5.90 %	2.90 %
Gender of reporting parent			
- Female	83.2 %	93.0 %	86.90 %
- Male	16.8 %	7.0 %	13.10 %
Length of involvement with social services			
- Up to 6 months	24.00 %	14.00 %	20.40 %
- 6 months-24 months	40.50 %	32.70 %	37.40 %
- More than 24 months	35.50 %	53.30 %	42.20 %

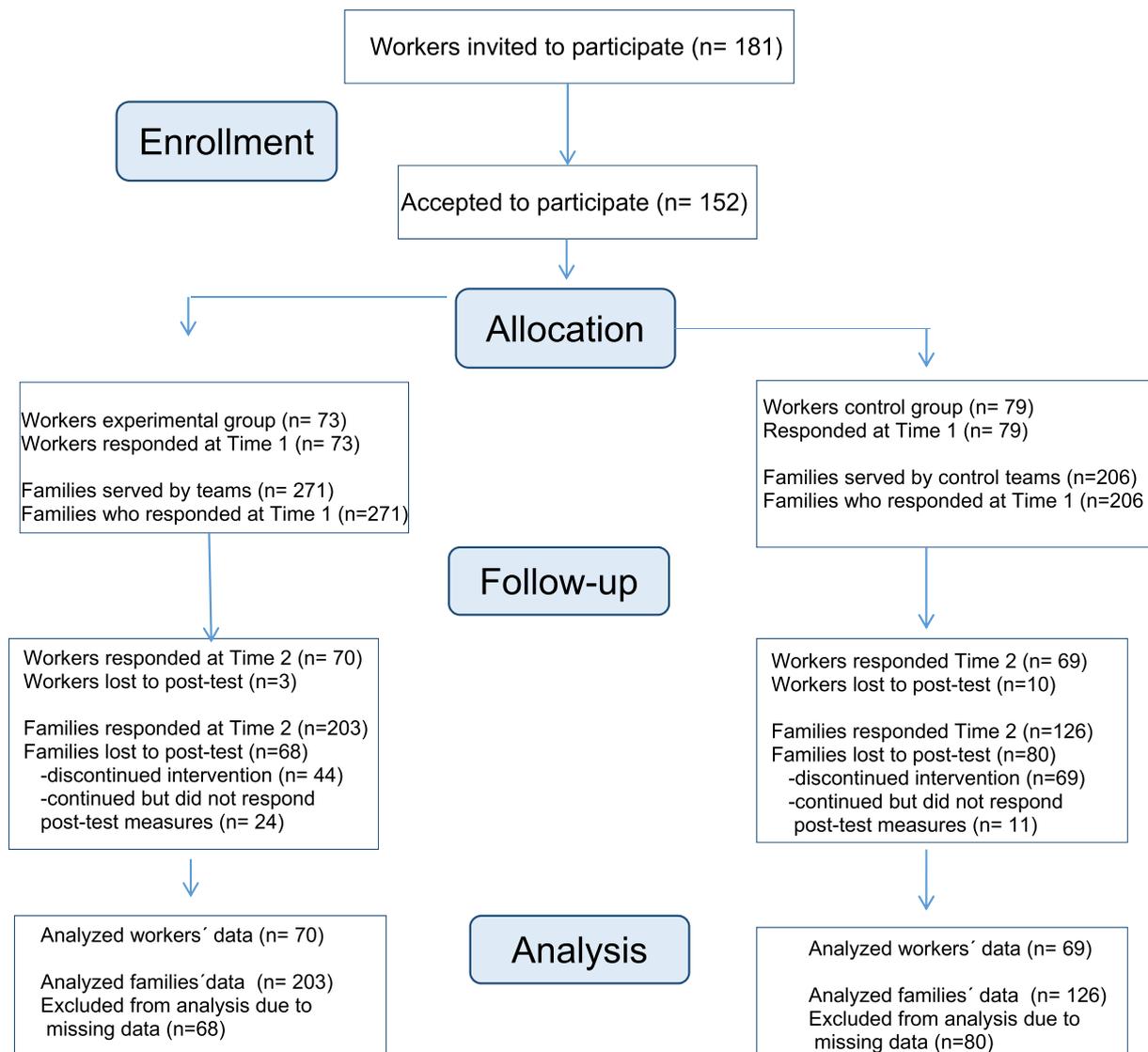


Fig. 1. Consort diagram of participating child protection workers and families.

Table 1 shows the descriptive data of the families who participated in the study: almost half of them were single-parent families, with mothers as the reporters in almost nine out of every ten cases; at pretest, almost half of the families had already been involved with child protection services for more than two years. Referred children were always under the age of 18. No statistical differences were found on these variables between the control and the experimental group, except for the length of involvement with child protection services, with a slightly higher percentage of cases who had been involved with child protection for more than two years ($\chi^2_{(2)} = 8.983, p < .011$) in the control group. No statistically differences were found between the families that dropped out of the study and those who did not.

-HERE Table 1-.

2.3. Measures

A number of variables addressing the intervention of the workers, goal attainment, child welfare outcomes and cost-efficiency were measured. To that end the following instruments were used:

Use of solution-focused principles and techniques was measured with the Solution-Focused Treatment Fidelity Questionnaire (SFTFQ; Medina & Beyebach, 2014). This measure is a translation into Spanish and adaptation to the child protection context of Lehmann and Patton (2012) Solution-Focused Fidelity Instrument. The SFTFQ is a 18-item questionnaire that asks workers how frequently they perform a number of solution-focused practices in their work with users (e.g., "I cooperate with users in order to create a conjoint intervention project", "I ask users what is better", "I ask users about those moments when the problem was expected but did not happen" "I explicitly compliment users on their effort and successes"). Items are rated between 1 ("Not at all") and 5 ("Very often"), so that the total score for the SFTFQ ranges from 18 to 90. The internal consistency of the SFTFQ in our Spanish sample was excellent, 0.96.

Goal achievement as rated by parents was measured asking parents to rate on a 1–10 scale to what extent their goals had been met during the intervention (1 "not at all", 10 "completely"). This item is routinely included in the Family Intervention Plans used by the child-protection services on Tenerife Island.

Goal achievement as rated by workers was measured asking workers to rate on a 1–10 scale to what extent goals had been met during the intervention (1 "not at all", 10 "completely"). This item is routinely included in the Family Intervention Plans used by the child-protection services on Tenerife Island.

Parents' well-being was measured with the Spanish version of the Outcome Rating Scale provided by the creators of this scale (ORS; Miller et al., 2003). The ORS is a 4-item visual analog scale providing a total score (40) based on 4 subscale domain scores (each with a possible score ranging from 0 to 10) that reflect key areas of client functioning: *individually* (personal well-being), *interpersonally* (family, close relationships), *socially* (work, school, friendships), and *overall* (general sense of well-being). The ORS has good internal consistency (Miller et al., 2003; 0.93; Anker et al., 0.83) and concurrent validity with the Outcome Questionnaire 45 (Lambert et al., 1996; $r = 0.59$; Miller et al., 2003), the Symptom Checklist-90- Revised (Derogatis, 1992; $r = 0.57$; Reese et al., 2009), and the Clinical Outcomes in Routine Evaluation (Barkham et al., 2001; $r = 0.67$; Miller & Duncan, 2004). In this study, internal consistency was 0.80.

Children's well-being was measured with the Spanish version of the Child Outcome Rating Scale developed by the creators of this scale (CORS; Duncan et al., 2006), a 4-item visual analog scale that adapts the ORS to its use with children and adolescents. Psychometric studies on clinical samples have reported adequate internal consistency (Duncan et al., 2006; 0.84) and concurrent validity with the Youth Outcome Questionnaire 30 (YOQ, Burlingame et al., 2001; $r = 0.61$). In this study, internal consistency was 0.69.

Referral to risk teams was registered in the child protection services

case records. It indicates if a given case was referred by the local child protection team to the supra-local child protection teams. The latter deal only with the most serious cases; in this sense, referral to risk teams is an indicator of the deterioration of safety in a family. The percentage of cases referred to risk teams is reported.

Child removal was registered in the case records, which specified if children were removed from their homes by the local child protection team intervention. The percentage of cases in which children were removed is reported.

Recidivism was defined as the re-referral of a family to child protection after the case had been closed. Cases were defined as recidivists on the basis of case records. The average percentage of recidivism is reported.

Length of the intervention was operationalized as the difference in months between the recorded beginning of the team intervention with any given case and the termination of the intervention, as recorded in the case reports.

Number of sessions. Number of sessions provided by the team to any of the family members or the family as a whole, as recorded in the case reports.

Number of additional resources activated. The number of additional resources provided by other professionals and activated during the teams intervention for any given case, as recorded in the case reports. Examples of additional resources in the context of the child welfare system in Tenerife are: day care, specialized mental health services, family mediation, in-home assistance.

2.4. Procedure

All child protection workers of the municipal child protection services in Tenerife were invited to participate in the study. 152 workers from 34 teams (84 % of the total population of workers) accepted to participate and were followed-up during one year in order to gather pretest data on all measures. These pretest data were obtained through a protocol of questionnaires and scales filled out by all participating workers and also by those families serviced by them who accepted to participate in the study, prior to the randomization. The SFTFQ was applied to all participating workers (and not only to the workers in the experimental group) as a way to control for possible pretest differences in the use of solution-focused techniques, and also to control for the possible adoption of solution-focused interventions at Time 2 by workers assigned to the control condition.

After the first year of data-gathering, the 34 teams were distributed by the first author into two blocks of teams, so that both blocks included an equivalent numbers of teams and service users, with an equivalent distribution of teams serving rural versus urban areas. One block of teams was randomly allocated to the experimental group and the other became the control group. The workers who were assigned to the experimental group received two months of training and six months of supervision in solution-focused brief therapy, while the workers in the control condition continued offering treatment as usual.

By the end of the supervision, the degree to which solution-focused principles and practices were used by the child protection workers was measured again with the SFTFQ. The other post-test variables (goal attainment, well-being, child welfare measures, and efficiency variables) were measured again in the experimental and the control group over the course of one year after the supervision in SFBT had finished. The exact timing of these Time 2 measures varied according to when a given case was closed, as they were administered on termination. Relapses were recorded at any time during the one-year span.

2.5. Intervention

The second author provided the initial training in SFBT, 30 h distributed over two 15-hour workshops, taught two months apart to the whole experimental group. 30 h were offered because the existing

evidence suggests that at least 20 h are necessary to make a difference in training professionals in the solution-focused approach (Gingerich et al., 2012).

The training focused on solution-focused principles (e.g., the value of collaboration with users; viewing users as resourceful persons; the emphasis on preferred futures and safety) and intervention techniques (e.g., the miracle question, exceptions and pre-treatment changes questions, scaling questions, safety questions, compliments, and solution-focused homework tasks) by showing videotapes of actual therapy sessions, exercising the techniques in role-plays and having group discussions. No other brief therapy procedures (strategic, narrative, etc.) were taught. The methodology of the training was in itself solution-focused: participants were invited to list their own goals for the training and their professional resources were valued and promoted. Workers’ “baby steps” in a solution-focused direction in their professional practices after the first 15-hour workshop were reviewed in the second 15-hour workshop two months later: the workers were given credit for their efforts and it was discussed how to expand these changes further. To that end, new solution-focused techniques were taught and practiced.

All workers who had received the training received another 30 h of group supervision from the first author. Supervision consisted of monthly-five-hour sessions with the whole experimental group over six months. Supervision was also solution-focused: each session started by reviewing positive changes and “stories of success”, highlighting families and workers resources; stuck cases were discussed in the group in a variety of solution-focused formats. The aims of the supervision were to promote workers’ use of the solution-focused techniques they had been trained in, to consolidate and amplify the changes they had started during the training, and to ensure a safe practice.

This training plus supervision process was not meant to replace the participating workers’ usual child protection interventions with a completely different set of solution-focused practices. Rather, the emphasis was on integrating the solution-focused approach in their interventions with users while fulfilling statutory obligations such as assessing children’s risk and safety and monitoring intervention plans. This meant highlighting families resources and exceptions to maltreatment, and capitalizing on those things parents were already doing to ensure safety.

Teams in the control group continued to intervene as usual. Intervention as usual typically started with the workers establishing goals for their users, based on a diagnosis of the deficits of the families and of the risk factors for the children. Then workers would try to correct families’ deficiencies by providing education, teaching parenting skills, or triggering relational changes within the families. The focus was more on preventing risks than on building safety.

2.6. Data analysis

An intergroup comparison between the experimental and control groups was conducted at Time 1 on a number of demographic variables using Student’s *t*-test for independent samples or Chi-square tests.

For the dependent variables inter-group comparisons were conducted between the experimental and control groups both at Time 1 and at Time 2, using ANCOVA to look at differences at Time 2 controlling for scores at Time 1.

To calculate effect sizes for the inter-group comparison at Time 2, η^2p , *r* or Cohen’s *d* was used, depending on the statistical test used and the distribution of the variable. η -values over 0.01, 0.06, and 0.14 are considered as a small, a medium, and a large effect size, respectively (Téllez et al., 2015). According to Cohen (1992), a *r* value over 0.10 can be interpreted as a small effect, over 0.30 as a medium effect, over 0.50 as a large effect, and 0.70 as a very large effect. Cohen’s *d* values over 0.20, over 0.50 and over 0.80 are considered a small, a medium and a large effect, respectively. All analyses were performed using SPSS Version 22.0 (IBM Corp., 2013).

3. Results

Table 2 shows the pre-test data for the total sample. Table 3 shows the values for the means and SDs; η^2p , *d* or *r* values; and ANCOVA, *t* or *U* tests of each dependent variable in both the experimental and the control group at pre-test (T1) and post-test (T2). Cost-efficiency variables were only measured at Time 2.

Comparison of the pre-test scores of the experimental and control groups revealed that all measurements were equivalent for both groups at Time 1, which indicates a successful randomization of the sample. The only exception was recidivism, which was significantly higher at Time 1 in the experimental than in the control group.

Regarding the scores obtained at Time 2, the use of solution-focused practices became significantly higher in the experimental group, almost tripling the SFTFQ value of the control group, a very large effect ($\eta^2p = .88$). In the four goal attainment variables there were also significant intergroup differences at Time 2. At post-test, parent well-being measured with the ORS was higher in the experimental than in the control group ($\eta^2p = .19$, a large effect) and children’s well-being measured with the CORS also became higher in the experimental group than in the control group ($\eta^2p = .23$ a large effect). Goal attainment was also higher in the experimental group than in the control group at post-test, both as rated by parents ($\eta^2p = .04$ a small effect) and as rated by the workers ($\eta^2p = .08$, a medium effect).

There were also significant differences between the experimental and the control groups at Time 2 for the three child welfare outcomes. In the experimental group there were significantly less cases than in the control group that had to be referred to the supra-local child protection “risk teams” ($\eta^2p = -0.64$, a large effect). There were significantly fewer children removals from home in the experimental group (1.10 % of the cases) than in the control group (4.83 % of the cases), a significant difference with a large effect size ($\eta^2p = -0.60$). Recidivism at Time 2 was also significantly lower in the experimental group (1.80 % of the cases) than in the control group (6.97 % of the cases), with a medium effect size ($\eta^2p = .41$).

Finally, cost-effectiveness variables also showed significant differences at Time 2. The number of sessions was almost 40 % lower in the experimental group (on average 14.48 sessions per case) than in the control group (on average 22.12 sessions per case), a small effect (*r* = -0.26). The number of complementary resources that had to be allocated to cases was lower in the experimental than in the control group (*d* = -0.37, a small effect). The length of the intervention in months turned out to be three times shorter in the experimental than in the control group, but due to the high dispersion on this variable (see Table 3) this did not translate into a significant difference.

Table 2

Descriptive Statistics at pretest for the whole sample: Sample Size, Minimum Score, Maximum Score, Means and SDs.

Variables	N	Min	Max	M	SD
<i>Use of SFBT principles and techniques</i>					
SFTFQ	329	18	24	20.68	1.03
<i>Goal attainment</i>					
Goal achievement (rated by parents)	261	1	10	5.40	2.39
Parents well-being (ORS)	267	1	10	6.78	2.51
Goal achievement (rated by workers)	267	1	9	5.09	1.83
Children’s well-being (CORS)	194	1	10	7.57	2.23
<i>Child welfare outcomes</i>					
Referral to risk teams	309	0	39	9.71	7.26
Child removal proposal	309	0	15	4.68	4.60
Recidivism	200	0	45	11.32	8.81
<i>Cost-efficiency variables</i>					
Length of the intervention (months)	69	1	160	18.03	30.65
Number of sessions	188	2	115	17.24	14.30
Number of complementary resources	196	1	7	3.06	1.57

Table 3

Means, SDs, Effect Size of the Intervention (η^2_p , r or Cohens d), Contrast (ANCOVA, U Mann-Whitney or t -value) and Significance (p-value) for the Comparison between the Experimental and Control Group in Pre- and Post-intervention Measurements.

Variable	Time	control group M (SD)	experimental group M (SD)	Effect size	Contrast	p value
<i>Use of SFBT principles and techniques</i>						
SFTFQ	T1	20.84 (1.31)	20.70 (0.82)		0.02	0.884
	T2	22.05 (2.33)	65.53 (9.32)	$\eta^2_p = 0.88$	1220.46	< 0.001
<i>Goal attainment</i>						
Wellbeing parents (ORS)	T1	25.50 (8.64)	27.03 (7.91)		-1.777	0.076
	T2	29.96 (6.93)	32.72 (1.63)	$\eta^2_p = 0.19$	19.94	< 0.001
Goal achievement (rated by parents)	T1	5.05 (2.42)	5.35 (2.44)		-1.248	0.212
	T2	7.28 (2.64)	8.07 (1.75)	$\eta^2_p = 0.04$	3.57	0.040
Goal achievement (rated by therapists)	T1	5.20 (2.00)	5.02 (1.74)		-1.015	0.310
	T2	6.80 (1.66)	7.30 (1.78)	$\eta^2_p = 0.08$	9.08	< 0.001
Wellbeing children (CORS)	T1	28.55 (6.66)	27.35 (7.43)		-1.053	0.292
	T2	31.59 (6.50)	32.40 (5.83)	$\eta^2_p = 0.23$	15.57	< 0.001
<i>Child welfare outcomes</i>						
Cases referred to risk teams	T1	9.22 (7.88)	10.00 (6.8)		-0.883	0.378
	T2	9.85 (10.62)	6.47 (4.86)	$\eta^2_p = 0.64$	270.98	< 0.001
Child removal	T1	4.19 (3.76)	4.98 (5.03)		1.574	0.117
	T2	4.83 (4.41)	1.10 (1.11)	$\eta^2_p = 0.60$	227.04	< 0.001
Recidivism	T1	8.24 (2.85)	12.91 (10.31)		-6.373	< 0.001
	T2	6.97 (4.70)	1.80 (3.54)	$\eta^2_p = 0.41$	53.20	< 0.001
<i>Cost-efficiency variables</i>						
Length of the intervention (in months)	T2	35.29 (49.74)	10.48 (10.72)	$r = -0.16$	-1.343	0.179
Number of sessions	T2	22.12 (19.34)	14.48 (9.45)	$r = -0.26$	-3.564	< 0.001
Number of complementary resources	T2	3.42 (1.77)	2.83 (1.40)	$d = -0.37$	-2.452	0.015

4. Discussion

4.1. Main findings

The very large effect in the inter-group comparison of the degree to which solution-focused practices were implemented at post-test demonstrates that the child protection workers of our sample who received the training and supervision changed their self-reported practices in a solution-focused direction. As a result, they conducted their interventions in a much more solution-focused manner than their counterparts in the control condition. This suggests that the child protection workers in our sample found SFBT an applicable and useful approach with their users, in spite of the potential conflicts that a rethinking of service provision might have created (Van Veelen et al., 2017). Furthermore, our results demonstrate the feasibility of disseminating solution-focused principles and techniques in a child protection system, in line with the existing literature on solution-focused child protection practices (Antle et al., 2008; Sundman, 1997).

Although at Time 1 the experimental group and the control group had equivalent scores on all goal achievement measures, at Time 2 the cases in the solution-focused group achieved superior outcomes. At post-test the workers who participated in the SFBT training and supervision rated the goal achievement of their cases as higher than those who did not; likewise, parents in the experimental group rated their goal achievement higher than those in the control group. Parents self-reported well-being on the ORS and children's CORS results were also both superior in the experimental than in the control group, with a large effect. These results are comparable to those of Antle et al. (2008).

A similar pattern of large effects emerged for the child welfare outcomes. The experimental group and the control group were equivalent in their percentages of referred cases at Time 1, but at Time 2 fewer cases in the experimental group had to be referred to the supra-local risk teams than in the control group. This suggests that the teams trained in SFBT felt more capable to handle their cases themselves.

Of special interest is the large effect found for the removal of children from their homes. Although the experimental and the control group were equivalent at Time 1, at Time 2 children removals had dropped to one-fourth of the initial figure in the experimental group, which led to significantly fewer children removals than in the control group, with a

large effect size. Children removal places the emotional burden of separation on families and increases the risk of depletion of resources in the child protection system. It also seems to be associated with higher recidivism rates than providing therapy for the parent(s) and keeping the child at home (Solomon & Asberg, 2012). This is why one of the missions of child protection worldwide is to avoid the need for children removal by improving the way families handle their difficulties (Berg & Kelly, 2000), so that both safety and family preservation are accomplished. The findings of this study suggest that the child protection teams in the solution-focused group became more able to help families without having to remove children from their homes. To our knowledge this is the first time that a positive effect on this variable is documented for a SFBT intervention.

An alternative interpretation of the reduction in children removals could be that the solution focused approach of the workers who received the training and supervision increased the trust between workers and parents, but without translating into real safety for the children (Har-ingley Local Safeguarding Children Board, 2009; Woods et al., 2011). If this had been the case, it would be expected that at some later point the initial referring source would again detect risk and re-refer the family to child protection. In our view, this alternative explanation can be ruled out by our data. In our sample the recidivism rate in this sample at Time 1 was higher in the experimental than in the control group, but at Time 2 became significantly lower in the experimental than in the control group, with a large effect size. This finding is consistent with Antle et al. (2009), who found significantly fewer recidivism in cases in which a Solution-Based Casework model was used than in cases of treatment as usual. In our study recidivism was reduced although the training in SFBT did not include a formal relapse prevention module, in contrast to the Solution-based Casework model tested by Antle and her team (2008). Another result that allows ruling out the hypothesis that the solution-focused intervention left children unprotected is the fact that children's perceived well-being was higher in the experimental group than in the control group at Time 2.

The superior outcomes of the experimental group were achieved with significantly fewer sessions than those used by the control group. This is coherent with the literature on SFBT in clinical settings, that suggest that SFBT may be as effective but briefer than comparative treatments (Bond et al., 2013; Corcoran, 2012; Gingerich & Peterson,

2012; Knekt et al., 2008) something that until now had not been found in child protection samples. Therefore, this study provides some initial support for the cost-efficiency of solution-focused child protection practices.

Finally, the results of this study show that at Time 2 the workers who received the SFBT training and supervision allocated fewer additional social services resources to the families they served than the workers in the control group. This may suggest that the solution-focused approach helped to counteract the bureaucratization and fragmentation so often found in the child protection field (Van Veelen et al., 2018). It could be hypothesized that the reduction in the use of complementary resources is related to the holistic, family-centered perspective of the solution-focused approach, and maybe to the adoption of a more *trans*-disciplinary stance among solution-focused child protection workers (Medina & Beyebach, 2014). The achievement of outcomes with shorter interventions and less complementary resources might generate worries about the maintenance of the changes (DePanfilis & Zuravin, 2002) but, as mentioned before, our data show that there was less recidivism in the experimental than in the control group.

4.2. Strengths and limitations

Some strengths of this research are that it is a prospective study and was carried out in a naturalistic setting, the local child protection services of the island of Tenerife, with a high participation both of workers and of users. Data were taken during almost three years and reports from various sources (parents, children, and workers) were used; the inclusion of child well-being self-reports and cost-effectiveness measures is especially relevant. Furthermore, the data on self-reported SFBT use show that the SFBT-trained workers applied the principles and techniques as intended.

There are also several limitations that need to be acknowledged. One limitation lies in the randomization of the sample. Although we randomized two blocks of equivalent child protection teams, there was a greater uptake of families in the experimental group than in the control group... In addition, the comparison of the pretest characteristics of the two groups of cases revealed that in the control group there was a higher proportion of cases with more than two years of involvement with child protection than in the experimental group. It is unclear to what extent this may have moderated the effect of the SFBT intervention. On the hand, this imbalance could mean that the control group cases were more chronic and therefore more challenging than those in the experimental group, but it could also be contended that cases with a longer involvement with child protection services have a reduced risk of maltreatment recurrence (Jonson-Reid, 2003). In any case, in spite of these differences between the families in the control and in the experimental group, our analyses show that the two groups were equivalent at Time 1 on all dependent variables, which supports the accuracy of the assignment procedure. The only dependent variable that was unevenly distributed between the groups was recidivism, but this was initially higher in the experimental group than in the control group.. However, the possibility that the two groups differed in some other unknown third variable cannot be ruled out.

Another limitation is that, although initially all families served by the participating child protection teams accepted to participate in the study, almost one third of them dropped out, either by discontinuing their contact with social services or by not filling in the measures at Time 2. Although the comparison between dropouts and continuers did not find any statistical differences between them, there can still be doubts as to whether the families who stayed in the study and those who were lost differed in some other unknown variables.

The difficulties of data gathering in a multi-site service lead to missing data on a number of variables. This applies especially to the children well-being measure, which was filled out only by a minority of the sample, so that the children's perspective is probably under-represented in this study. In addition, in order to avoid statistical

independence issues, the CORS was filled out only by the child that had motivated the intervention in the first place (and not his/her siblings). The inclusion of feedback from siblings and the analysis of children age as a possible moderator should be one of the priorities of replications of this study.

There are also some limitations related to the measures, as some of them were taken with *ad hoc* instruments developed for this study. Our translation and adaptation of the SFTFQ had not been used in previous studies, although in our sample it worked psychometrically well. In addition, the measures filled in by the users were not administered by independent researchers, but by the workers themselves, probably generating a social desirability effect. However, if this was the case, it happened in both the control and the experimental group, so that it should not have skewed the results.

Another concern is that this study does not provide follow-up data beyond the twelve-month post-test. Although this is not a short time span, it is not enough to evaluate the long-term maintenance of the positive changes in the solution-focused condition and to know how the child welfare situation developed in the long run.

One last limitation of our study is that the generalizability of our results is unclear. Our sample is very homogeneous in ethnic terms, so that our results might not be generalizable to ethnically more diverse child protection samples that might pose some additional challenges in terms of possible racial imbalances within a mandated context. In addition, although the aims and missions of the child protection services in industrialized, educated countries are arguably similar, the specific ways in which child protections systems are structured vary widely, not only between but also within countries. In the region where our study took place child protection is organized in two layers, at the local (municipal) and at the province level; cases that do not respond to the local level interventions are referred to the "risk teams" at the provincial level. International replications need to examine to what extent the positive effects of solution-focused interventions can also be achieved in child protection systems that are organized in a different way.

4.3. Future research

One major issue to be addressed by future research is the long-term maintenance of the child welfare outcomes produced by solution-focused practices. To that end, future studies should take a longitudinal perspective and include long-term follow-ups, if possible over the course of several years.

In addition, this study opens up a number of new research questions. It would be interesting to investigate the pathways through which the solution-focused intervention achieved its effect, as Van Zyl et al. (2014) did examining the components of "solution-based casework" that predicted positive outcomes. One might wonder if in our study the effect was produced by the specific solution-focused interviewing techniques in which the participating professionals were trained (Miracle Question, exception talk, scales...) or by the overall position of trusting more the resources of the families and of establishing strong working alliances with users. Following the example of Carnochan et al. (2018), we intend to carry out some data mining in the case records of our sample in order to answer this question and to identify those practices that might have contributed most to the positive results. In addition, future research could illuminate if there are family, problem, or contextual factors that moderate the effects of solution-focused practices in child protection.

The effect of the intervention could be explained not by the implementation of solution-focused practice *per se*, but by the fact that the teams of the experimental group had the chance to support each other by taking part in the training and supervision sessions. This may have counteracted professional burnout and engendered enthusiasm and hope in the child protection workers, which would have translated into improved outcomes. Future studies could rule out this possibility by having the teams in the control condition engage in group discussions and peer supervision during the same number of hours as the

experimental group.

Another open question is the relative contribution of the training and the supervision parts of the intervention. Although supervision is presumed to be a crucial element in the implementation of new approaches in child protection services (Barbee et al., 2011; Baginsky et al., 2019), it would be interesting to research to what extent solution-focused supervision actually increases the impact of solution-focused training.

4.4. Implications for policy and practice

This study adds to the evidence on the effectiveness of solution-focused child welfare practices in child protection settings. In this study, introducing solution-focused practices did not increase the risk for children and had a number positive effects from the perspective of both users and professionals, increasing goal attainment and well-being, and decreasing children removals and recidivism. This suggests that, in spite of the difficulties of applying strength-based perspectives in mandated relationships (Oliver & Charles, 2015, 2016), the priority given in child protection to safety and statutory work is compatible with the solution-focused emphasis on the expectations of families and on their capacity and resources.

This study shows that solution focused practices can be disseminated at low cost, with a reduced number of training and supervision hours. In addition, the use of a solution-focused approach was found to be more cost-efficient than treatment as usual, reducing the number of sessions and the number of complementary resources that had to be deployed. This may encourage policy makers to promote the training of child protection workers in solution-focused practices as a means to provide better services to their users.

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CRediT authorship contribution statement

Antonio Medina: Conceptualization, Methodology, Investigation, Data curation. **Mark Beyebach:** Conceptualization, Methodology, Writing – original draft, Writing – review & editing. **Felipe E. García:** Formal analysis, Visualization.

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.

Data availability

Data will be made available on request.

Appendix A. Supplementary material

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.chidyouth.2022.106703>.

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