Implementation of a solution based approach for child protection: A professionals' perspective

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ABSTRACT

A child protection system is not just about minimizing child abuse but also maximizing welfare (Munro, 2008). Therefore, the new Youth Act in the Netherlands promotes empowerment in child protection (Ministry of Health, Welfare and Sport & Ministry of Security and Justice, 2014). The last decade, empowering child protection services was dominated by the Signs of Safety (SoS) approach of Andrew Turnell and Steve Edwards (1999), a strength-based method with a strong client focused perspective.

The current study evaluates a multilevel implementation process of a SoS approach within a Child Protection Service (CPS) in the Netherlands as perceived by professionals. Since 2014, the CPS is implementing its own SoS-version called Safe Together Step by Step (STSS). The study comprised a cross-sectional survey (n = 138) with an experimental and control group and was part of a larger evaluation study on the STSS approach.

We analysed a multilevel approach, using Cretin's chain of action, dividing professional level, team level, organisational level and contextual level determinants of implementation. Results show that the implementation of STSS within current CPS is still in an early adoption stage. The study provides some support for a multilevel implementation strategy with 38% explained variance. However the professional level is the largest contributor (25%) to the use of STSS, especially knowledge necessary for implementation and influences of important others (subjective norm), contribute to the use of STSS.

A multilevel implementation strategy should include activities on all levels in order to improve the determinants. With an integrated multilevel strategy chances for implementation success increases. In addition, the multilevel strategy should include a long term process with continues feedback on the implementation and adjustments in implementation strategies if needed. Moreover, knowledge from literature and practical experience should meet to further develop the implementation strategy for SoS approach in order to improve empowerment based working within child protection services.

1. Introduction

Child maltreatment is a universal phenomenon causing harm to millions of children all over the world (Stoltenborgh, Bakermans-Kranenburg, Alink, & Van IJzendoorn, 2014). In the United Nation's Convention on the Rights of the Child (1989) 194 countries explicitly stated that they will take all measures in order to protect children from maltreatment. The aim of a child protection system like that is not just about minimizing child abuse but also maximizing welfare (Munro, 2008). Therefore, the new Youth Act in the Netherlands promotes empowerment in child protection (Ministry of Health, Welfare and Sport, & Ministry of Security and Justice, 2014). Research shows that empowerment makes child protection services more efficient and decreases the need for specialized care (Bosscher, 2014). Moreover,

empowered families are less likely to be involved in maltreatment (Browne & Winkelman, 2007). Empowerment gives control to individuals and their lives and helps families to deal with problems (Rappaport, 1987). It reinforces the ability to solve future problems, which makes them less dependent on care agencies (Graves & Shelton, 2007; Jones & Meleis, 1993; Resendez, Quist, & Matshazi, 2000). Therefore, improving empowerment is a central ambition in the new youth care system in the Netherlands (Bosscher, 2014; Hilverdink, 2013).

During the last decade, empowering child protection services was dominated by the Signs of Safety (SoS) approach of Turnell and Edwards (1999), a strength-based method with a strong client focused perspective. The approach assumes that families are able to change. In addition, it strongly focuses on collaboration between child protection

workers and families (Bartelink, 2013). Some research shows promising results and states that professionals and scientists are generally positive about the development of the SoS approach (De Wolff & Vink, 2012). However, studies to the effectiveness are still missing.

Implementation of the SoS approach is not easy and a clear implementation protocol is lacking (Bartelink, 2010). In addition, no research to a successful implementation strategy for the SoS approach was found. However, some research shows that the implementation of SoS is a long-term process (Anthonijsz, Van Julsingha, Van der Sluijs, Kleinjan-van Zwet, & Mobach, 2014; De Wolff & Vink, 2012) and should be seen as an 'organisational journey' (Turnell, 2010). Several characteristics, such as the organisation, its teams and professionals, seem to influence the implementation process (De Wolff & Vink, 2012; Salveron et al., 2015; Turnell, 2010).

These findings are in line with implementation models that point out the importance of a multilevel approach in which individual, team, organisational and contextual success factors are integrated (Cretin, Shortell, & Keeler, 2004; Fleuren, Wiefferink, & Paulussen, 2004). Although, some theories about multilevel implementation are available, most studies focus on only one level of the implementation strategy (Proctor et al., 2011). In addition, potential interactions between these determinants on different levels have not been analysed yet (Grol, Bosch, Hulscher, Eccles, & Wensing, 2007). Therefore, determinants on each level should be derived from theories about single determinants and need to be tested.

To gain deeper understanding of a multilevel implementation strategy for SoS more research is needed to investigate success determinants and the interaction of all determinants on all levels. The current study tries to contribute to this knowledge gap by evaluating a multilevel implementation process of a SoS approach within a Child Protection Service in the Netherlands as perceived by professionals. The first aim is to analyse the multilevel implementation process. The second aim is to gain understanding of the direct effect of each determinant on the implementation and thirdly to explore the relations between determinants to find their indirect effects.

1.1. Case setting

This study took place in one out of fourteen Child Protection Services (CPS) in the Netherlands. According to the CPS characteristics, provided by the CPS, the organisation gave supervision to 11,540 children and employed about 400 child protection workers in 2014. Since 2014, the CPS is implementing their own SoS-version called Safe Together Step by Step (STSS), as Turnell obtained the intellectual property rights on SoS in 2013 (Resolutions Consultancy, 2015). The implementation of STSS aimed to improve empowerment based working within child protection workers.

An implementation manager was appointed in 2014 and an implementation plan was made. The implementation started with constructing a concept guideline, developed by a selected group of professionals, who were previously trained in the original SoS approach. Although SoS offers no specific guideline it does offer practical instruments (Bartelink, 2010). The current STSS guideline included the following instruments: a tool guided conversation with the child(ren), drawing a genogram, a round table conference with formal and informal network and a safety plan designed with parents.

Next, implementation took place in several stages starting with four teams out of sixteen. These were appointed as experimental teams for current study. All members of these four teams were trained in STSS during late 2014 and early 2015. The STSS training consisted of three days, two incompany days focussing on theory and practise and one day focussing on professionals' experiences with STSS. Further, four consultation sessions each year were provided by the internal experts who also developed the guideline.

In addition to the experimental teams, four teams were appointed as the control condition in which no STSS training or implementation took place during the measurement of this study. However, in the beginning of 2015 the transition led to major changes within the CPS. A re-organisation allocated many professionals from one team to another. This resulted in untrained professionals in the experimental teams and trained professionals in the control team by the time of measurement in April 2015.

2. Theory

Implementing an intervention is often difficult in practice (Breuk et al., 2006; Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004; Grimshaw et al., 2004). Mostly because an implementation process is influenced by determinants on several levels (Cretin et al., 2004; Fleuren et al., 2004; Grol & Wensing, 2011; Van Everdingen, Assendelft, & Burgers, 2004). Further, a successful implementation of a SoS approach requires a multicomponent implementation approach (Wheeler & Hogg, 2011). Cretin et al. (2004) offers a model that outlines several levels, called the chain of action, stating that the contextual, organisational and team level factors influence professionals' behaviour and therefore influence healthcare process. Grol and Wensing (2011) confirm that an implementation process should include each level in order to complete a successful implementation. The implementation model by Fleuren et al. (2004) includes socio-political context, organisational and professional determinants, and innovation characteristics.

The current study uses the multilevel approach of Cretin et al. (2004) and conceptualises the levels of Fleuren et al. (2004) shown in Fig. 1. However, this study centralises the position of the individual professional because the SoS approach strongly depends on the collaboration between client and professional (Turnell & Edwards, 1999). Therefore, the conceptual model starts with the professionals' abilities and explores the surrounding of the professionals in their teams, organisation and contextual determinants in order to fully adopt the SoS approach. The arrows symbolise the direct effects determinants have on the outcome, but also the indirect effect that they have on each other.

2.1. Professional determinants

The individual level determinants describe the characteristics of professionals that give insight in the ability to adopt a SoS approach (Fleuren et al., 2004). Professionals are able to adopt when they are capable and willing to use it (Stals, Van Yperen, Reith, & Stams, 2008). The current study, therefore, includes competences and willingness to change as individual determinants.

Competences of professionals strongly influence the success of implementation (Astroth, Garza, & Taylor, 2004; Mildon & Shlonsky, 2011; Stals et al., 2008). Competences can be defined as "distinct sets of behaviours applied to reliably complete a critical task that is directly linked to a critical outcome" (Ricciardi, 2005). Skills and knowledge about a new intervention are crucial for a successful implementation (Oosterlaken, 2015; Smith, 2011; Stals et al., 2008). Van Rossum, Ten Berge, and Anthonijsz (2008) defined specific competences for child protection with knowledge, skills and attitudes on several levels, distinguishing signalling, acting, cooperating, evaluating and attitude
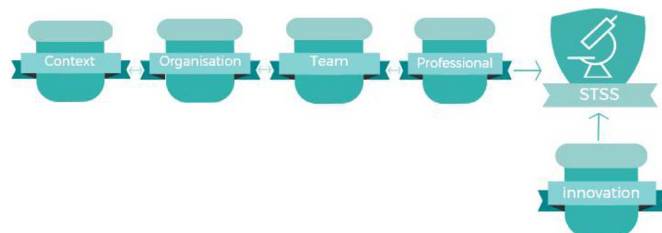

Fig. 1. Multilevel implementation model for STSS.

(Van Rossum et al., 2008). Moreover, SoS describes several competences in detail, like looking for exceptions to the abuse, identifying family strengths and resources, and scaling levels of safety, willingness, capacity and confidence (Turnell & Edwards, 1997). A professional should be open and honest about their power, authority and work process (Turnell, 2004).

Next to competence, the willingness to change facilitates a successful implementation (Armenakis, Harris, & Mossholder, 1993; Holt, Helfrich, Hall, & Weiner, 2010; Jones, Jimmieson, & Griffiths, 2005; Metselaar, Cozijnsen, & Van Delft, 2011). Reflective professionals are more willing to initiate and support a change (Shaw et al., 2013; Weiner, Amick, & Lee, 2008). Research found strong relations between individual and organisation levels of willingness to change which confirms the need for a multilevel approach (Madsen, Cameron, & Miller, 2006; Smith, 2005). In addition, the SoS approach is strongly depending on reflective professionals who are open to new experiences (Bartelink, 2013; Quick, 2011; Turnell, 2008; Turnell & Edwards, 1999; Wheeler & Hogg, 2011).

2.2. Team determinants

Individual child protection workers often work alone in complex situations and are therefore in need of support from their teams. Effective teams have a certain extent of team reflexivity (Schippers, Den Hartog, & Koopman, 2005), depending on how group members reflect upon their work, strategies and processes and how they adapt to changing circumstances (West, Garrod, & Carletta, 1997). Research shows that reflective teams stimulate decision-making processes (Schippers et al., 2005) and improve possible change (Cretin et al., 2004; Lemieux-Charles & McGuire, 2006). In addition, research confirms that providing feedback, creating learning and emotional support can improve quality of care (Buljac-Samardzic, Van Woerkom, & Van Wijngaarden, 2013). The solution focused and safety-grounded way of working requires working in a safe and cohesive team that is reflective and supportive (Buljac-Samardzic, 2012; De Wolff & Vink, 2012; Turnell, 2010). This study includes team reflexivity as a success team determinant for the implementation of SoS.

2.3. Organisational determinants

Successful implementation requires support by the organisation and leadership (De Wolff & Vink, 2012; Fleuren et al., 2004; Smith, 2011; Stals, 2012; Stals et al., 2008; Turnell, 2010). Supportive organisations create a general desire to change (Chong, White, & Prybutok, 2001). An organisation can support an implementation by management support, and practical facilitation like capacity, financial resources, time, materials like guidelines and tools and information (Fleuren, Paulussen, Van Dommelen, & Van Buuren, 2012). A supportive organisation influences professionals' commitment and improves their work attitude and performance (Laschinger, Purdy, Cho, & Almost, 2006; Rhoades & Eisenberger, 2002). This suggests that an implementation of SoS heavily depends on the support by the organisation.

In addition to management support, leadership appears to be of great importance for implementation (Grol et al., 2007; Øvretveit, 2005; Salveron et al., 2015). Effective leaders provide adequate structure and minimize resistance (Grol et al., 2007; Grol & Wensing, 2011; Øvretveit, 2005; Van den Nieuwenhof, 2013). Research shows that transformational leaders support implementation and change (Øvretveit, 2005; Schmid, 2008). They are people-oriented (Schmid, 2008), build relations and help an organisation to be flexible or to adapt to change (Øvretveit, 2005). A transformational leader generates change through bottom-up efforts, which fits the strengthening approach of SoS. Therefore, the current study includes transformational leadership as a success factor of the implementation of a SoS approach.

2.4. Contextual determinants

An implementation is often more complicated because the setting of the innovation, otherwise referred to as contextual determinants, influences a process (Fleuren, Paulussen, Van Dommelen, & Van Buuren, 2014; Grol et al., 2007). However, these determinants are often hard to change (Grol et al., 2007). According to contextual theories the wider environment could influence the innovation by setting regulations, systems and markets (Grol et al., 2007). For instance, Fleuren et al. (2014) includes the social and political context, referring to laws and legislations. The new Youth Act encourages the implementation of SoS because it explicitly calls for more empowerment based working in youth health care (Ministry of Health, Welfare and Sport, & Ministry of Security and Justice, 2014).

Next to laws, partner organisations could influence the implementation (Grol et al., 2007). Research shows that professionals find it easier to adopt SoS if partner organisations work with the same approach (De Wolff & Vink, 2012). Therefore, the current study includes laws and partners as contextual success factors.

3. Methods

3.1. Research design

The study comprised a cross-sectional survey with an experimental and control group and was part of a larger evaluation study on the STSS approach. The larger study consisted of an effect evaluation of the STSS approach and an explorative study to the problem- and protective factors of the child protection population, financed by The Netherlands Organisation for Health Research and Development (ZonMw). The Medical Ethics Committee of Erasmus University Medical Centre, Rotterdam has approved the research protocol (MEC-2-14-020).

3.2. Data collection procedure

Eight CPS teams were selected for this study. 157 child protection workers were approached and 138 filled in a questionnaire. In total 19 were not returned, due to holiday, maternity leave, illness or refusal to participate (n = 3). The response rate for the experimental group was 86.5% and for the control condition 89%. Participants received a questionnaire in March and April 2015. The data were collected in team meetings, set up by the team manager. One researcher introduced the study and explained the details of the research and questionnaire. The questionnaire consisted of four parts that were introduced by the researcher, followed by a timeframe and a small break. To fill in an individual questionnaire took on average 60 to 70 min. In between questions were addressed to the researchers and replied. Completed questionnaires were checked for missing data and if needed returned to respondents. Few missing data were found. During and after the session small presents were handed out. If respondents were not able to join a team group meeting they were asked to join another team and if needed were asked to fill in the questionnaire by e-mail. In total, 22 members filled in their questionnaire by e-mail. All respondents participated with passive consent because the CPS board argues that participating in research is part of developing your profession.

3.3. Participants

Four experimental teams (n = 64) implemented STSS and four control teams participated (n = 74). No cases were excluded. The average age of participants was 40.6 years (SD = 10.9), 79% were female and 97% were Dutch. Most professionals were employed full time (85.4%) and had an average of 10.0 years (SD = 5.8) experience in youth health care work. Most participants had a Bachelor's or Master's degree in social science or law (96.4%). No group differences were found (tables available on request). Significant differences with respect

to training were found in both groups ($\chi^2 = 25.8$, p < 0.00) with 71.4% trained professionals in the experimental teams and 26.9% in the control teams.

3.4. Measurements

Below, the instruments are described.

3.4.1. Measurement of determinants for Innovation

The Measurement of Determinants for Innovation (MIDI) investigates determinants for the use of an innovation (Fleuren et al., 2014). It reflects on an implementation processes and therefore helps to optimise innovation strategies (Fleuren et al., 2014). It distinguishes four levels: the innovation characteristics, the professional level, the organisational level and socio-political context. Researchers, policy advisors and implementation managers can use the MIDI before and after implementation by creating their own questionnaire based on the determinants (Fleuren et al., 2014). In this study, 23 determinants of the MIDI are examined with 69 questions namely 'determinants of the innovation' (6 items; α = 0.79), determinants of the 'user of the innovation' (39 items; α = 0.93), determinants of 'the organisation of the innovation' (23 items; α = 0.70) and determinants of the 'social-political context of the innovation' (1 item). The MIDI has not yet been validated, however research suggests that determinants retrieved from a literature review and a Delphi study are good (Fleuren et al., 2014).

3.4.2. Measurements for additional determinants

This study measured additional single determinants on individual, team, organisational and contextual level.

3.4.2.1. Professional determinants.
The professional determinants were measured with competences and willingness to change. The self-report competence instrument examined child protection workers' competences and was developed for the current study. The questionnaire consists of 80 items divided into 5 subscales based on the competency model for child protection workers by Van Rossum et al. (2008) namely (1) 'professional attitude' assesses a child protection worker's attitude and perspective on a child, (2) 'signalling' assesses the ability to detect signs of child abuse, (3) 'acting' evaluates reporting and procedural skills, (4) 'cooperating' reflects on the worker's ability to share information with others, taking rules and regulations into account, and the ability to cooperate with other professionals, (5) 'evaluating' assesses the worker's ability to reflect on own actions or those of others. A total score named 'general child protection competence' was conducted by adding all subscales (α = 0.95). One additional scale was conducted namely 'Signs of Safety' (15 items; α = 0.85) which was based on Signs of Safety competences described by Turnell (2010), Bartelink (2010), and Wheeler and Hogg (2011).

Willingness to change was measured with the DINAMO instrument by Metselaar and Cozijnsen (1997). It consists of 44 items with a 3-point Likert scale. Four sub-scales were distinguished: 'wanting to change' (16 items; α = 0.82), 'needing to change' (4 items; α = 0.71), 'being able to change' (20 items; α = 0.86) and 'willingness to change' (4 items; α = 0.71).

3.4.2.2. Team determinants.
Team reflexivity was measured with a Dutch questionnaire developed by Schippers et al. (2005). The questionnaire consists of 49 items with a 5-point Likert scale and measures team reflexivity and team functioning. Total scores were conducted by adding all items into a scale 'total team reflexivity' (α = 0.93).

3.4.2.3. Organisational determinants.
Leadership was measured using the Human System Audit Transformational Leadership Short Scale (HAS-TFL) by Berger and Zwikker (2010). This single-factor

questionnaire with 8 items on a 5-point Likert scale was based on the validated Multifactor Leadership Questionnaire and measures participants' perceptions of their supervisors' transformational leadership (α = 0.89).

3.4.2.4. Contextual determinants.
Contextual questions focused on direct colleagues of a child protection worker from other institutes. Two questions were asked about partners; 1) "Do you think partners are involved in the implementation of STSS?" and 2) "Do you experience that partners are using STSS?" (inter-item Pearson correlation = 0.43, p = 0.01).

3.4.3. Outcome

The dependent variable was measured with one question namely "In how many cases do you use STSS?". A five point Likert scale was used separating 'none', 'seldom', 'half', 'almost always', and 'always'. For the analysis a four point answer category variable was computed combining 'almost always' and 'always'.

3.5. Analyses

The data were analysed with SPSS version 24. Analyses of the determinants started with descriptive statistics identifying frequencies, means, standard deviations and distributions. Independent variables were interpreted as low for mean scores between 1 and 3, medium for scores between 3 and 4 and high for scores of 4 or higher. One exception was made for willingness to change as (Metselaar & Cozijnsen, 1997 suggest scores below 2 can be seen as behaviour that does not promote innovation and scores above 2 as implementation supporting behaviour. Next, group differences were analysed with Independent *t*-test for all ratio variables like total and sub-scale scores of instruments and χ^2 for the ordinal outcome variable. Correlation analyses were executed to identify relationships between outcome and independent variables using a one-tail Spearmen's rho. Cohen's effect size was used to interpret the strength of the relationships and effects (1997).

To analyse the multilevel strategy of the implementation regression analyses were executed. Since we have nested data for professionals (lowest level) within teams (higher level) we first tested the amount of variance in the outcome variables that can be attributed to the team level. Of the total variance in 'the use of STSS' 9.01% can be attributed to the team level and the remaining variance is attributed to the individual level. For this reason no multilevel regression techniques have to be used and ordinary linear regression analysis is sufficient. Due to the moderate sample size and due to the theoretical model we used a stepwise approach for entering the independent variables in the regression. MIDI's subscale 'innovation characteristics' was excluded as correlations show overlap with 'user of innovation'.

Linear regression analyses were conducted in two rounds, to find both direct and indirect effects of determinants on outcome. In the first round, the direct relations between outcome and determinants have been analysed in four steps (regression A). Based on the previous correlational analyses, only significant correlating variables were included and corrected for training (yes/no) and group (experimental/control). The second step adds the individual determinant, the third the organisational determinants and the fourth the contextual determinants.

To obtain deeper understanding of the direct effects of the determinants that were found significant on the outcome, these determinants were subdivided into their underlying subscales. Again only subscales that significantly correlated with the outcome variable were than included as independent variables in the second round of analyses (regression B), correcting for training and group in the first step again.

Finally, indirect effects were analyses by exploring the effects of determinants on the contributing determinants that were found in regression B. The Pearson correlation first analysed relations and included all determinants with correlations of 0.2 or higher. Linear regression analyses were conducted using the stepwise approach as

Table 1

Descriptive statistics, alphas and group differences of determinants (N = 138).

Determinants	M (SD)	Group diff. t
Innovation characteristics (MIDI)	3.55 (0.57)	0.73
Individual level		
User of implementation (MIDI)	3.04 (0.54)	2.79**
General child protection competences	3.92 (0.29)	− 0.36
Signs of Safety	4.07 (0.35)	− 0.37
Willingness to change		
Wanting	2.24 (0.35)	0.06
Need	2.35 (0.42)	− 1.94
Being able	1.81 (0.36)	− 1.33
Willingness	3.62 (0.53)	− 2.32*
Team level		
Team reflexivity total score	3.34 (0.39)	− 0.95
Organisational level		
Organisation of implementation (MIDI)	2.63 (0.54)	0.73
Transformational Leadership total score	3.50 (0.64)	0.13
Contextual level		
Social-political context of implementation (MIDI)	3.04 (0.54)	2.79**
Partners	2.52 (0.71)	1.20

* $P < 0.05$.
** $P < 0.01$.

described above.

4. Results

Following the three aims of this study the results are presented in three stages.

4.1. Multilevel implementation with descriptives and group differences

The first aim of this study is to gain understanding of the multilevel implementation of STSS. Therefore, the descriptives of the determinants were investigated and differences with respect to determinants were examined between the experiment and control group. With respect to the determinants measured by the MIDI, results show a medium degree of 'user of implementation' (see Table 1). According to professionals, the organisational and socio-political context of implementation are low. More specifically, within the 'organisation of implementation' low scores are found on items about time, coordination, information and feedback. Using interdependent samples *t*-tests, group differences are found for 'user of implementation' only, with higher scores for the experimental group (mean 3.17 vs 2.92 for the control group). Analyses on subscale level of this determinant 'user of implementation' reveal more social support, colleagues using it, effect for themselves, knowledge and information about STSS in the experimental group.

The current study added single determinants on all levels of the multilevel model. The individual level shows medium degrees on 'general child protection competences' and high degrees on 'Signs of Safety' with no group differences. According to cut-off values established by Metselaar and Cozijnsen (1997) wanting to change, needing to change and willingness to change can be interpreted as sufficient. Being able to change is low. Group differences are found for the subscale 'willingness to change' with significantly higher scores for the control group (3.72 vs 3.50 for experimental group). In addition, team level determinants show a medium degree on 'team reflexivity' with no group differences. The organisational determinant 'transformational leadership' shows a medium degree with no group differences and the contextual level shows a low degree on 'partners' in both groups.

4.1.1. Outcome measure descriptives and group differences

The outcome measure 'extent of STSS use' was analysed (see Table 2). Both groups show that one in five professionals use STSS half or (almost) always. Nearly 80% of the teams use STSS seldom or not at all. No significant group differences are found. Further analyses of

Table 2

Descriptive statistics of ordinal outcome measures (N = 138).

Extent of STSS use	Exp. (n = 63)	Contr. (n = 74)	Trained (n = 63)	Untrained (n = 67)
Mean	1.86	1.70	2.01	1.52
	(SD = 0.86)	(SD = 0.89)	(SD = 0.90)	(SD = 0.77)
1. None	39.7%	54.1%	28.62.7	72.7
2. Seldom	39.7%	25.7%	42.9	23.9.3
3. Half	15.9%	16.2%	20.6	11.9
4. (Almost) always	4.8%	4.1%	7.9	1.5
χ^2	3.60, p = 0.31		16.16, p < 0.00	

Note: Exp. = experimental group; Contr. = control group.

group differences between trained and untrained professionals show significant more STSS use for professionals who were trained in STSS ($\chi^2 = 16.16$, Cohen's d was 0.73 and indicates a large effect size).

In sum, in line with the multilevel implementation strategy of the STSS approach, most determinants are present at moderate level except for 'being able to change', 'organisation of implementation' and 'partners'. No major group differences were found.

4.2. Analysing direct relations between outcome and determinants

Further analyses are executed to gain understanding of the direct effects of the determinants on the outcome. First, relations between the outcome and determinants are measured with a one-tailed Spearman's rho (see Appendix 1). According to the results the 'extent of STSS use' relates significantly to 'user of implementation' (r = 0.60), 'organisation of implementation' (r = 0.30) and 'context of implementation' (r = 0.18). In addition, significant correlations are found between the 'extent of STSS use' and individual level determinants 'general child protection competences' (r = 0.27), 'Signs of Safety' (r = 0.16) and willingness to change subscales 'wanting' (r = 0.16), 'being able' (r = 0.15) and 'willingness' (r = 0.21) to change. On organisational level significant correlations are found for 'transformational leadership' (r = 0.18) and on contextual level for 'partners' (r = 0.16). No further significant correlations are found. Following Cohen's guidelines correlations between 0.10 and 0.30 indicate small effect size, correlations between 0.30 and 0.50 moderate and above 0.50 large. In sum, only a few significant correlations had a medium or large effect size.

4.2.1. Analysing direct relations with multivariate regressions

For the linear regression only determinants that correlate significantly with the 'extent of STSS use' are included (see Table 3). The regression model is found to be significant and explains 37.9% of the total variance. The first model corrects for STSS training and experimental or control group. It explains 11.8% of the model with a significant effect for STSS training. The second step adds the individual level determinants 'user of implementation', 'general competences', 'Signs of Safety', 'wanting', 'being able' and 'willingness' to change. These determinants increase the variance by 24.6% with a significant regression coefficient for 'user of implementation' only.

The third step adds the organisational determinant 'organisation of implementation' and 'leadership'; this increases the variance significantly with 0.8% with no significant determinants. The last step adds contextual determinant 'social and political context' and increases the variance with only 0.7%.

Additionally, to gain deeper understanding of the specific effects of the 'user of implementation' we performed linear regression analyses with the outcome as dependent variable and the subscales of 'user of implementation' as independent variables. The model only included significantly correlating subscales with the outcome measure namely benefits (r = 0.17), task interpretation (r = 0.23), social support (r = 0.46), observed colleagues' behaviour (r = 0.18), subjective norm

Table 3
Linear regression with hierarchical model for outcome 'extent of STSS use' (regression A).

Model	Model 1	Model 2	Model 3	Model 4
	β	β	β	β
STSS training	0.37**	0.22*	0.22*	0.21
Experimental/control group	0.10	0.14	0.14	0.15
General child protection competences		0.04	0.05	0.03
Signs of Safety		0.09	0.06	0.06
Wanting to change		− 0.17	− 0.18	− 0.19
Being able to change		0.15	0.13	0.15
Willingness to change		0.05	0.07	0.07
User of implementation (MIDI)		0.48**	0.51**	0.54**
Organisation of implementation (MIDI)			− 0.09	− 0.09
Leadership			0.06	0.07
Social and political context (MIDI)				0.06
Partners				− 0.07
R^2	0.118	0.364	0.372	0.379
F (df1, df2)	7.503 (2, 112)**	7.584 (8, 106)**	6.168 (10, 104)**	5.179 (12, 102)**

* $P < 0.05$.
** $P < 0.01$.

($r = 0.45$), expected effect ($r = 0.48$), knowledge ($r = 0.63$) and information ($r = 0.62$) (see Appendix 2). The model explains 42.7% of total variance (see Appendix 3, regression B). Significant effects are found for 'subjective norm' ($β = 0.21$) and 'knowledge' ($β = 0.34$) explaining 32.2% of the total variance which can be interpreted as a medium to large effect size. 'Knowledge' stands for knowledge necessary for implementation and 'subjective norm' for influence of important others.

In sum, the direct relation between the use of STSS and the implementation determinants can be explained by the individual level determinants only and in specific by knowledge and subjective norm. However, as mentioned in the theory section, the use of STSS could have been influenced indirectly by other determinants. Therefore, the following paragraph explores the potential indirect effects from determinants on the contributing determinants knowledge and subjective norm.

4.3. Analysing indirect relations between outcome and determinants with multivariate regressions

For knowledge positive correlations are found with MIDI's 'innovation of characteristics', 'organisation of implementation' and 'social and political context of innovation'. Also positive correlations are found for 'general child protection competences', 'Signs of Safety', 'wanting to change', 'willingness to change', 'transformational leadership' and 'partners'. Linear regression (see Table 4) using the stepwise approach shows that 63% could be explained with significant effects for training ($β = 0.65$, $p < 0.00$).

For subjective norm correlations were found with MIDI's 'innovation characteristics' and 'organisation of implementation'. Also positive correlations were found for additional determinants 'general competences', 'Signs of Safety', 'wanting to change', 'willingness to change', 'transformational leadership' and 'partners'. Linear regression using the stepwise approach shows that 26.5% could be explained. Significant effects of MIDI 'organisation of innovation' ($β = 0.25$, $p = 0.01$) and 'transformational leadership' ($β = 0.21$, $p = 0.04$) were found.

5. Discussion

The current study evaluates a multilevel implementation process of a SoS approach within a Child Protection Service in the Netherlands as perceived by professionals. Since 2014, the CPS is implementing their own SoS-version called Safe Together Step by Step (STSS). The study comprised a cross-sectional survey with an experimental and control group and was part of a larger evaluation study on the STSS approach.

The study shows that the implementation of STSS within this CPS is still in an early adoption stage. The study provides some support for a multilevel implementation strategy. However the professional level is the largest contributor to the use of STSS. The study first analysed the multilevel implementation process and has found moderate scores for most determinants in both groups except for 'being able to change' on professional level, 'organisation of innovation' on organisational level and 'partners' on contextual levels. This indicates that most determinants on all levels are available and therefore could influence the implementation. Second, direct effects between outcome and the multilevel determinants model are analysed. 38% of the variance could be explained by the model with significant influence of the professional level determinants (25%), especially knowledge necessary for implementation and influences of important others (subjective norm). Final analyses examine the indirect effects of other determinants on knowledge and the subjective norm. Knowledge was indirectly affected by training only and the subjective norm was effected by the organisation of the implementation and leadership.

The findings suggest that the implementation of STSS is in an early stage with only 20% of professionals using STSS. According to the diffusion of innovation theory of Rogers (1995), a 20% adoption rate indicates that an implementation has reached the so-called early-adaptors level. This signals that the implementation is already spreading out but is not finished yet. This is in line with the implementation theories that view an implementation as a time taking process than (Greenhalgh et al., 2004; Grol et al., 2007; Van Everdingen et al., 2004) and confirms earlier SoS implementation experiences validate that it takes time (Turnell, 2010; Wolff & Vink, 2012).

The professional level is the largest contributor to the use of STSS, confirming this study's assumption that professionals have a central position in the implementation. In particular trained professionals use STSS, which is in line with theories that state knowledge is a large contributor to implementation success (Fleuren et al., 2004; Greenhalgh et al., 2004). Trained professionals can be seen as experts and can therefore fulfil a local missionary role (Rogers, 1995). According to earlier SoS implementation studies, the professionals claim that working in an environment with trained professionals increases the use of the approach (Wolff & Vink, 2012).

A multilevel implementation strategy was not found and therefore Cretin's chain of action cannot be confirmed. However, many studies indicate that a multilevel strategy is required and takes changes in the system, organisation and individual (Grimshaw et al., 2004). In this study the team level did not correlate with the use of STSS although the team reflexivity was moderate. According to the implementation plan no specific attention to team feedback was made and results show that feedback and information are low. This could have influenced the relation between the team level and the use of STSS as Schipper et al. (2005) argue that team reflexivity increases participation. In addition, the organisational facilitation was low which could hamper the implementation as theories state that the facilitation of an implementation is a major success factor (Greenhalgh et al., 2004; Grimshaw et al., 2004). Moreover, in a previous SoS implementation evaluation professionals confirmed the importance of organisational support (Wolff & Vink, 2012). Finally, on contextual level laws can stimulate certain implementations (Fleuren et al., 2014; Grol & Wensing, 2011). The new Youth Act promotes the use of SoS, however the current study found no impact on the use of STSS in this CPS. Moreover, the partner organisations seem to have very small influence on the use of STSS while according to Greenhalgh et al. (2004) horizontal peer, like other professionals in partner organisations, could gain implementation success.

Table 4
Linear regression with hierarchical model for 'knowledge' and 'subjective norm' (regression C).

Model	Knowledge				Subjective norm			
	Model 1	Model 2	Model 3	Model 4	Model 1	Model 2	Model 3	Model 4
	β	β	β	β	β	β	β	β
STSS training	0.65**	0.66**	0.65**	0.65**	0.03	0.13	0.12	0.12
Experimental/control group	0.05	−0.05	−0.05	−0.04	−0.14	−0.14	−0.14	−0.13
General child protection competences		0.31**	0.24*	0.24		0.23*	0.11	0.12
Signs of Safety		−0.05	0.00	0.00		0.03	0.12	0.12
Wanting to change		0.14	0.01	0.01		−0.12	−0.12	−0.12
Willingness to change		0.01	0.05	0.05		0.07	0.07	0.07
Organisation of implementation (MIDI)			0.16*	0.12			0.28**	0.25*
Transformational leadership			0.15*	0.13			0.23*	0.21*
Social and political context (MIDI)				0.06				
Partners				0.08				0.10
R^2	0.45	0.58	0.62	0.63	0.05	0.15	0.26	0.27
F (df1, df2)	45.43 (2, 112)**	24.81 (6, 108)**	21.40 (8, 106)**	17.48 (10, 104)**	3.01 (2, 107)	3.00 (6, 103)	4.34 (8, 101)**	4.01 (9, 100)**

* $P < 0.05$.
** $P < 0.01$.

5.1. Limitations

Our study had certain limitations to consider. Firstly, the cross-sectional design limited our ability to draw causal conclusions. Causal assumptions in our cross-sectional study were based on Cretin et al.'s (2004) chain of action and operationalized with success determinants based on literature findings. We used a controlled design which gave insight in the influence of the determinants on the implementation. However, a before and after design could give more insight in the actual effect of the determinants on the use of STSS. Further research could benefit from a RCT design although research shows that a design like that is hard to accomplish as many factors are changing during an implementation process (Cretin et al., 2004).

Secondly, for this study used validated questionnaires with sufficient reliability. One exception was made for the competences instrument as no validated questionnaire was available. Therefore a questionnaire was composed using a theoretical model. Although self-constructed questionnaires may have limited validity (Holmbeck & Devine, 2009), factor analyses and reliability analyses showed that the instrument has good psychometric properties.

Thirdly, the sample itself has limitations. The response rate was sufficient but distortions occurred due to the allocation of professionals. This resulted in 20% STSS trained professionals in the control group. However, corrections took place on both training and group. Further research could benefit from collecting data from several CPSs.

Finally, we only collected data of professionals because they have a major role in implementing. To improve the response rate the study collected data within the team meetings. Further, to avoid socially desirable answers and to guarantee anonymity team managers were not present during the session. However, including different stakeholders' perspective may strengthen the findings. Therefore, the results of this study must be regarded with some reservation. However, to the best of our knowledge, there is no other research that has focused on the perspective of professionals.

5.2. Practical impact

This study points out the importance of a multilevel implementation strategy for the implementation of a SoS approach. It is important to acknowledge the complexity of implementation processes and to include a carefully designed multistakeholder approach with a longer timeframe. The individual level should focus on training all professionals, use already trained professionals as missionaries and support the implementation with peer consultation or consultation and team feedback. Especially, the organisational level determinants could be improved with better organisational facilitation, like time, capacity and materials (Fleuren et al., 2012). In addition, an organisation can increase the implementation success by providing information and feedback. Further, support from management and proper coordination of the implementation is needed. A project leader can coordinate the process properly by support, practical sources and protection against internal and/or external turbulence. In addition, a transformational leader can stimulate the participation of professionals through building trust, promoting empowerment and giving supports when needed. Furthermore, closer cooperation between partner organisations and the CPS improves connection between work processes which can stimulate the use of SoS. Finally, supporting laws and legislation, like the new Youth Act, can stimulate the need for change within an organisation and their professionals.

A multilevel implementation strategy should improve all determinants and connect them to the implementation purpose, the use of a SoS approach. In addition, the multilevel strategy should include a long term process with continues feedback on the implementation and adjustments in implementation strategies if needed. Moreover, knowledge from literature and practical experience should meet to further develop the SoS approach in order to improves empowerment based working within child protection services.

Appendix 1. Spearman's Rho correlations between outcome and determinants

Determinants	Use of STSS
Individual level	
User of implementation (MIDI)	0.56**
General child protection competences	0.27**
Signs of Safety	0.16*
Willingness to change	
Wanting	0.16*
Need	− 0.04
Being able	0.15*
Willingness	0.21**
Team level	
Team reflexivity total score	0.08
Organisational level	
Organisation of implementation (MIDI)	0.30**
Transformational Leadership total score	0.18
Contextual level	
Social-political context of implementation (MIDI)	0.18*
Partners	0.16*

* P < 0.05.
** P < 0.01.

Appendix 2. Spearman's Rho correlations between outcome and 'user of innovation'

Determinants	Use of STSS
Benefits for user	0.17*
Results for user	0.12
Task interpretation	0.23
Satisfaction professional	0.11
Social support	0.46**
Descriptive norm	0.18*
Subjective norm	0.45**
Expected effect of oneself	0.48
Knowledge about implementation	0.63**
Information about implementation	0.62**

* P < 0.05.
** P < 0.01.

Appendix 3. Linear regression for outcome 'extent of STSS use' (regression B)

Model	Model 1 β	Model 2 β
STSS training	0.36**	0.04
Experimental/control group	0.09	0.11
Benefits		0.01
Task interpretation		0.11
Social support		0.05
Observed colleagues behaviour		− 0.10
Subjective norm		0.21*
Expected effect		0.03
Knowledge		0.34*
Information		0.12
R^2	0.109	0.427
F (df1, df2)	7.161 (2, 117)**	8.118 (10, 109)**

* P < 0.05.
** P < 0.01.

Appendix 4. Correlations between explaining variables and other determinants

Model	Subjective norm	Knowledge

	R	R
Innovation characteristics	0.41**	0.40**
General competences	0.39**	0.32**
Signs of Safety	0.25**	0.28**
Wanting to change	0.23**	0.25**
Needing to change	− 0.05	0.08
Being able to change	0.11	0.16*
Willingness to change	0.21**	0.21**
Team functioning	0.01	0.17*
Organisation of implementation (MIDI)	0.40**	0.32**
Leadership	0.20**	0.32**
Social and political context (MIDI)	0.24**	0.12
Partners	0.23**	0.26**

* P < 0.05.
** P < 0.01.

References

Anthonijsz, I., Van Julsingha, K., Van der Sluijs, C., Kleinjan-van Zwet, M., & Mobach, C. (2014). *Kinderen blijvend veilig. Bouwstenen voor verder werken aan vernieuwing in de jeugdbescherming in het nieuwe jeugdstelsel*. Utrecht: Nederlands Jeugdinstituut. Retrieved from http://www.nji.nl/nl/Download-NJi/Publicatie-NJi/rapport-kinderen-blijvend-veilig.pdf.

Armenakis, A. A., Harris, S. G., & Mossholder, K. W. (1993). Creating readiness for organizational change. *Human Relations, 46*(3), 681–703. http://dx.doi.org/10.1177/001872679304600601.

Astroth, K. A., Garza, P., & Taylor, B. (2004). Getting down to business: Defining competencies for entry-level youth workers. *New Directions for Youth Development, 104*, 25–37. http://dx.doi.org/10.1002/yd.96.

Bartelink, C. (2010). *Signs of Safety*. Utrecht: Nederlands Jeugdinstituut. Retrieved from http://www.nji.nl/nl/Download-NJi/SignsOfSafety.pdf.

Bartelink, C. (2013). *Wat werkt: Oplossingsgerichte therapie?* Utrecht: Nederlands Jeugdinstituut. Retrieved from http://www.nji.nl/nl/Download-NJi/(311053)-nji-dossierDownloads-Watwerkt_Oplossingsgerichtetherapie.pdf.

Berger, M., & Zwikker, N. (2010). Professionalisering van de jeugdzorg. *Jeugd En Co Kennis, 4*(2), 38–48. http://dx.doi.org/10.1007/BF03089323.

Bosscher, N. (2014). *The decentralization and transformation of the Dutch youth care system*. Utrecht: Nederlands Jeugdinstituut. Retrieved from http://nji.nl/nl/Download-NJi/Decentralisation-Dutch-youth-care-system-update-june-2014.pdf.

Breuk, R. E., Sexton, T. L., Van Dam, A., Disse, C., Dorelijers, T. A. H., Slot, W. N., & Rowland, M. K. (2006). The implementation and the cultural adjustment of functional family therapy in a Dutch psychiatric day-treatment center. *Journal of Marital and Family Therapy, 32*(4), 515–529. http://dx.doi.org/10.1111/j.1752-0606.2006.tb01625.x.

Browne, C., & Winkelman, C. (2007). The effect of childhood trauma on later psychological adjustment. *Journal of Interpersonal Violence, 22*(6), 684–697. http://dx.doi.org/10.1177/0886260507300207.

Buljac-Samardzic, M. (2012). *Healthy teams: Analyzing and improving team performance in long-term care*. Doctoral dissertation Rotterdam, The Netherlands: Erasmus Universiteit Rotterdam. Retrieved from http://repub.eur.nl/pub/31784/Proefschrift_Martina_Buljac.pdf.

Buljac-Samardzic, M., Van Woerkom, M., & Van Wijngaarden, J. D. H. (2013). Are real teams healthy teams? *Journal of Healthcare Management, 58*(2), 92–107. Retrieved from https://search-proquest-com.eur.idm.oclc.org/docview/1348130173?accountid=13598.

Chong, H., White, R. E., & Prybutok, V. (2001). Relationship among organizational support, JIT implementation, and performance. *Industrial Management & Data Systems, 101*(6), 273–281.

Cretin, S., Shortell, S. M., & Keeler, E. B. (2004). An evaluation of collaborative interventions to improve chronic illness care. Framework and study design. *Evaluation Review, 28*(1), 28–51. http://dx.doi.org/10.1177/0193841X03256298.

De Wolff, M. S., & Vink, R. M. (2012). Signs of Safety. Werkzame bestanddelen volgens literatuur en medewerkers. Bevorderende en belemmerende factoren voor implementatie (TNO Report No. 2012.023). Retrieved from https://www.tno.nl/media/1289/signs_of_safety_tno_2012023.pdf.

Fleuren, M., Wiefferink, K., & Paulussen, T. (2004). Determinants of innovation within health care organizations: Literature review and Delphi study. *International Journal for Quality in Health Care, 16*(2), 107–123. http://dx.doi.org/10.1093/intqhc/mzh030.

Fleuren, M. A. H., Paulussen, T. G. W. M., Van Dommelen, P., & Van Buuren, S. (2012). Meetinstrument voor Determinanten van Innovaties (MIDI). 2014 In M. A. H. Fleuren, T. G. W. M. Paulussen, P. Van Dommelen, & S. Van Buuren (Vol. Eds.), *International Journal for Quality in Health Care: . 26*(5). *Towards a measurement instrument for determinants of innovations* (pp. 501–510). . http://dx.doi.org/10.1093/intqhc/mzu060.

Fleuren, M. A. H., Paulussen, T. G. W. M., Van Dommelen, P., & Van Buuren, S. (2014). Towards a measurement instrument for determinants of innovations. *International*

Journal for Quality in Health Care, 26(5), 501–510. http://dx.doi.org/10.1093/intqhc/mzu060.

Graves, K. N., & Shelton, T. L. (2007). Family empowerment as a mediator between family-centered systems of care and changes in child functioning: Identifying an important mechanism of change. *Journal of Child and Family Studies, 16*(4), 556–566. http://dx.doi.org/10.1007/s10826-006-9106-1.

Greenhalgh, T., Robert, G., MacFarlane, F., Bate, P., & Kyriakidou, O. (2004). Diffusion of innovation in service organizations: Systematic review. *Milbank Quarterly, 82*(4), 581–629.

Grimshaw, J. M., Thomas, R. E., MacLennan, G., Fraser, C., Ramsay, C. R., Vale, L., ... Donaldson, C. (2004). Effectiveness and efficiency of guideline dissemination and implementation strategies. *Health Technology Assessment, 8*(6).

Grol, R., & Wensing, M. (2011). *Implementatie. Effectieve verbetering van de patiëntenzorg*. Amsterdam: Reed Business.

Grol, R. P., Bosch, M. C., Hulscher, M. E., Eccles, M. P., & Wensing, M. (2007). Planning and studying improvement in patient care: The use of theoretical perspectives. *Milbank Quarterly, 85*(1), 93–138. http://dx.doi.org/10.1111/j.1468-0009.2007.00478.x.

Hilverdink, P. (2013). *Generalist working with youth and families in the Netherlands*. Utrecht: Nederlands Jeugdinstituut. Retrieved from http://www.youthpolicy.nl/yp/downloadsyp/Generalist-working-with-youth-and-families-in-The-Netherlands.pdf.

Holmbeck, G. N., & Devine, K. A (2009 Aug). Editorial: An Author's Checklist for Measure Development and Validation Manuscripts. *Journal of Pediatric Psychology, 34*(7), 691–696. http://dx.doi.org/10.1093/jpepsy/jsp046.

Holt, D. T., Helfrich, C. D., Hall, C. G., & Weiner, B. J. (2010). Are you ready? How health professionals can comprehensively conceptualize readiness for change. *Journal of General Internal Medicine, 25*(1), 50–55. http://dx.doi.org/10.1007/s11606-009-1112-8.

Jones, P. S., & Meleis, A. I. (1993). Health is empowerment. *Advances in Nursing Science, 15*(3), 1–14. Retrieved from http://journals.lww.com/advancesinnursingscience/Abstract/1993/03000/Health_is_empowerment.3.aspx.

Jones, R. A., Jimmieson, N. L., & Griffiths, A. (2005). The impact of organizational culture and reshaping capabilities on change implementation success: The mediating role of readiness for change. *Journal of Management Studies, 42*(2), 361–386. http://dx.doi.org/10.1111/j.1467-6486.2005.00500.x.

Laschinger, H. K. S., Purdy, N., Cho, J., & Almost, J. (2006). Antecedents and consequences of nurse managers' perceptions of organizational support. *Nursing Economics, 24*(1), 20–29. Retrieved from http://www.nursingeconomics.net/cgi-bin/WebObjects/NECJournal.woa.

Lemieux-Charles, L., & McGuire, W. L. (2006). What do we know about health care team effectiveness? A review of the literature. *Medical Care Research and Review, 63*(3), 263–300. http://dx.doi.org/10.1177/1077558706287003.

Madsen, S. R., Cameron, R. J., & Miller, D. (2006). Influential factors in individual readiness for change. *Journal of Business and Management, 12*(2), 93–110. Retrieved from https://search-proquest-com.eur.idm.oclc.org/docview/211508168?accountid=13598.

Metselaar, E. E., & Cozijnsen, A. J. (1997). *Van weerstand naar veranderbereidheid: over willen, moeten en kunnen veranderen*. Heemstede: Holland Business Publications.

Metselaar, E. E., Cozijnsen, A. J., & Van Delft, P. (2011). *Van weerstand naar veranderbereidheid: over willen, moeten en kunnen veranderen*. Heemstede: Holland Business Publications.

Mildon, R., & Shlonsky, A. (2011). Bridge over troubled water: Using implementation science to facilitate effective services in child welfare. *Child Abuse & Neglect, 35*(9), 753–756. http://dx.doi.org/10.1016/j.chiabu.2011.07.001.

Ministry of Health, Welfare and Sport, & Ministry of Security and Justice (2014). Jeugdwet [Youth act]. Retrieved from http://www.nji.nl/nl/Download-NJi/Jeugdwet-publicatie-Staatsblad-14-3-2014.pdf.

Munro, E. (2008). *Effective child protection*. London: Sage.

Oosterlaken, K. M. (2015). *Socialisatie: dát is oplossingsgericht: een studie naar faciliterende en belemmerende factoren in het socialisatieproces van professionals met betrekking tot oplossingsgericht werken*. Master's Thesis Enschede, The Netherlands: Universiteit Twente. Retrieved from http://essay.utwente.nl/68678/.

Øvretveit, J. (2005). The leaders role in quality and safety improvement. A review of research and guidance. The 'Improving improvement action evaluation project'. Fourth report. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi= 10.1.1.505.8511&rep=rep1&type=pdf.

Proctor, E., Silmere, H., Raghaven, R., Hovmand, P., Aarons, G., Bunger, A., & Hensley, M. (2011). Outcomes for implementation research: Conceptual distinctions, measurement challenges, and research agenda. *Administration and Policy in Mental Health, 38*, 65–76.

Quick, E. K. (2011). *Core competencies in the solution-focused and strategic therapies: Becoming a highly competent solution-focused and strategic therapist.* New York/London: Routledge Taylor & Francis Group. Retrieved from http://tandfbis.s3.amazonaws. com/rt-media/pp/common/sample-chapters/9780415885300.pdf.

Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory for community psychology. *American Journal of Community Psychology, 15*(2), 121–148 (doi:0091-0562/87/040o-0121505.0o/0).

Resendez, M. G., Quist, R. M., & Matshazi, D. G. M. (2000). A longitudinal analysis of family empowerment and client outcomes. *Journal of Child and Family Studies, 9*(4), 449–460. http://dx.doi.org/10.1023/A:1009483425999.

Resolutions Consultancy (2015). Licensing FAQ. Retrieved from http:// resolutionsconsultancy.com/licensing-faq/.

Rhoades, L., & Eisenberger, R. (2002). Perceived organizational support: A review of the literature. *Journal of Applied Psychology, 87*(4), 698–714. http://dx.doi.org/10.1037/ 0021-9010.87.4.698.

Ricciardi, J. (2005). Achieving human service outcomes through competency-based training: A guide for managers. *Behavior Modification, 29*(3), 488–507. http://dx.doi. org/10.1177/0145445504273281.

Rogers, E. M. (1995). *Diffusion of innovations.* New York: The Free Press.

Salveron, M., Bromfield, L., Kirika, C., Simmons, J., Murphy, T., & Turnell, A. (2015). 'Changing the way we do child protection': The implementation of Signs of Safety® within the Western Australia Department for Child Protection and Family Support. *Children and Youth Services Review, 48*, 126–139. http://dx.doi.org/10.1016/j. childyouth.2014.11.011.

Schippers, M. C., Den Hartog, D. N., & Koopman, P. L. (2005). Reflexiviteit van teams: ontwikkeling van een instrument. *Gedrag en Organisatie, 18*(2), 83–102. Retrieved from https://www.researchgate.net/profile/Michaela_Schippers/publication/ 241867545_Reflexiviteit_van_teams_ontwikkeling_van_een_instrument/links/ 540411940cf23d9765a5dc0a.pdf.

Schmid, H. (2008). Leadership styles and leadership change in human and community service organizations. In R. A. Cnaan, & C. Milofsky (Eds.), *Handbook of community movements and local organzations* (pp. 395–409). . http://dx.doi.org/10.1007/978-0- 387-32933-8_26.

Shaw, R. J., Kaufman, M. A., Bosworth, H. B., Weiner, B. J., Zullig, L. L., Lee, S. Y., ... Jackson, G. L. (2013). Organizational factors associated with readiness to implement and translate a primary care telemedicine behavioural program to improve blood pressure control: The HTN-IMPROVE study. *Implementation Science, 8*(106), 1–13. http://dx.doi.org/10.1186/1748-5908-8-106.

Smith, I. (2005). Achieving readiness for organisational change. *Library Management, 26*(6/7), 408–412. http://dx.doi.org/10.1108/01435120510623764.

Smith, I. C. (2011). A qualitative investigation into the effects of brief training in solution-focused therapy in a social work team. *Psychology and Psychotherapy: Theory, Research and Practice, 84*(3), 335–348. http://dx.doi.org/10.1111/j.2044-8341.2010.02000.x.

Stals, K. (2012). *De cirkel is rond. Onderzoek naar succesvolle implementatie van interventies in de jeugdzorg.* Doctoral dissertation Utrecht, The Netherlands: Universiteit Utrecht. Retrieved from dspace.library.uu.nl/bitstream/handle/1874/242465/stals.pdf? sequence=2.

Stals, K., Van Yperen, T., Reith, W., & Stams, G. (2008). *Effectieve en duurzame implementatie in de jeugdzorg. Een literatuurrapportage over belemmerende en bevorderende factoren op implementatie van interventies in de jeugdzorg.* Utrecht: Universiteit Utrecht. Retrieved from http://www.aanpakkindermishandeling.nl/nl/Download-NJi/ Publicatie-NJi/Effectieve_en_duurzame_implementatie_in_de_jeugdzorg.pdf.

Stoltenborgh, M., Bakermans-Kranenburg, M. J., Alink, L. R. A., & Van IJzendoorn, M. H. (2014). The prevalence of child maltreatment across the globe: Review of a series of meta-analyses. [Special issue]. *Child Abuse Review, 24*(1), 37–50. http://dx.doi.org/ 10.1002/car.2353.

Turnell, A. (2004). Relationship-grounded, safety-organized child protection practice: Dreamtime or real-time option for child welfare? *Protecting Children, 19*(2), 14–25.

Turnell, A. (2008). *Adoption of the signs of afety as the Department for Child Protection's child protection practice framework: Background paper.* Perth, West Australia: Department for Child Protection.

Turnell, A. (2010). *The Signs of Safety: A comprehensive briefing paper.* Resolutions Consultancy Pty Ltd.

Turnell, A., & Edwards, S. (1997). Aspiring to partnership. The Signs of Safety approach to child protection. *Child Abuse Review, 6*(3), 179–190. http://dx.doi.org/10.1002/ (SICI)1099-0852(199708)6:3<179::AID-CAR324>3.0.CO;2-J.

Turnell, A., & Edwards, S. (1999). *Signs of Safety: A solution and safety oriented approach to child protection casework.* New York, USA: W.W. Norton & Company.

United Nations (1989). *Convention on the Rights of the Child.* retrieved from http://www. ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx.

Van den Nieuwenhof (2013). *De taal van verandering* (2nd ed.). Amsterdam: ZENO Organisatieontwikkeling.

Van Everdingen, J. J. E., Assendelft, W. J. J., & Burgers, J. (2004). *Evidence-based richtlijnontwikkeling: een leidraad voor de praktijk.* Houten: Bohn Stafleu Van Loghum. Retrieved from https://www.ntvg.nl/artikelen/evidence-based- richtlijnontwikkeling.

Van Rossum, J., Ten Berge, I., & Anthonijsz, I. (2008). *Competenties in relatie tot de aanpak van kindermishandeling.* Utrecht: Nederlands Jeugdinstituut. Retrieved from http:// www.nji.nl/nl10/Download-NJi/Publicatie-NJi/(301990)-Competenties_aanpak_ kindermishandeling.pdf.

Weiner, B. J., Amick, H., & Lee, S. Y. (2008). Conceptualization and measurement of organizational readiness for change: A review of the literature in health services research and other fields. *Medical Care Research and Review, 65*(4), 379–436. http:// dx.doi.org/10.1177/1077558708317802.

West, M. A., Garrod, S., & Carletta, J. (1997). Group decision-making and effectiveness: Unexplored boundaries. In C. L. Cooper, & S. E. Jackson (Eds.). *Creating tomorrow's organizations: A handbook for future research in organizational behaviour* (pp. 293–316). Chicester: John Wiley & Sons.

Wheeler, J., & Hogg, V. (2011). Signs of Safety and the child protection movement. In C. Franklin, T. S. Trepper, E. E. McCollum, & W. J. Gingerich (Eds.). *Solution-focused brief therapy: A handbook of evidence-based practice* (pp. 203–315). London: Oxford University Press.

Wolff, M. S., & Vink, R. M. (2012). *Signs of Safety. Werkzame bestanddelen volgens literatuur en medewerkers. Bevorderende en belemmerende factoren voor implementatie.* TNO.