**ANGLIA RUSKIN UNIVERSITY**

**FACULTY OF HEALTH, EDUCATION AND SOCIAL CARE**

**THE ROLE OF LEADERSHIP AND ENVIRONMENTAL CONTEXT IN THE IMPLEMENTATION OF AN EVIDENCE BASED PROGRAMME: A QUALITATIVE ANALYSIS OF THREE LOCAL GOVERNMENT SERVICES WHICH IMPLEMENTED MULTI SYSTEMIC THERAPY IN 2008**

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**Abstract**

This is a qualitative study examining three of the ten English Local Authorities who implemented the intervention Multi Systemic Therapy (MST) in their Children’s Services Department in 2008. The research considers the implementation of MST and the consequent organisational impact as the services mobilised and then matured. One service closed at two years, another at five years and a third service was sustained and expanded. The research explores the concept of ‘evidence based practice’ in contemporary social work before considering and applying implementation science theory to understand the implementation process in the three sites. A grounded theory methodological approach (Charmaz, 2006, 2014) was taken to analyse twelve participant interviews across the three Authorities, including one with the national programme lead for MST.

The findings propose new theoretical categories which extend understanding of implementation: The high collaborative environment and The hostile environment. These two environmental categories are especially relevant when linked to leadership. Both categories demonstrate the importance of the contextual setting within which implementation takes place. The high collaborative environment enabled the facilitation of the strategic and operational space for the intervention to successfully embed and sustain itself in the Authority continuing to provide MST. Taking a values based approach connecting to both operational practice and desired strategic outcomes significantly assisted in the implementation. A hostile environment is conceptualised as a context of threat, strategic change and uncertainty where the intervention is poorly placed. In the first setting this led to early closure as the service could not find a fit within the Authority. In the second setting, a successful mobilisation followed by a period of positive performance, could not sustain MST in the long term as the strategic and operational context changed negatively.

The findings support and contribute to the understanding of the category of Leadership for implementation (Aarons 2016). Leadership which is attentive, relational, collaborative and perseverant appears most conducive to the successful implementation outcomes. Consistent leadership at the MST steering group is identified as vital as it is in this forum where the high collaborative environment and leadership for implementation were evident. In conclusion the research considers the implications of the findings and what these mean for practice and for the implementation of evidence based interventions in new settings as well as for the sustainability of interventions post mobilisation.

**Keywords**

Implementation, leadership, Multi Systemic Therapy, implementation science, environmental context, evidence based interventions, edge of care

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**Glossary**

**ARC.** Availability Responsiveness and Continuity organisational development programme

**Association of Directors of Children’s Services** A national professional association which coordinates policy and lobbies on behalf of Directors of Children’s Services.

**CAMHS** Child and Adolescent Mental Health Services

**CFIR** Consolidated Framework for Implementation Research

**Child and Adolescent Mental Health Services** Mental health services for children and young people, provided by the National Health Service, usually clinic based including Psychological and Psychiatric services

**Corporate Parent.** The responsibility placed upon Local Authorities to act as if a parent of children who are in public care. Often expressed through committees and actions directed by Local Authority elected Councillors and their officers.

**Department for Education.** The Government department with responsibility for national policy and part funding for Children’s Social Care.

**Director of Children’s Services**. The most senior executive manager with responsibility for the Children’s Services Department in a Local Authority who reports to the Chief Executive.

**DSF**. Dynamic Sustainability Framework

**EPIS** Exploration Preparation Implementation Sustainment framework

**Evidence Based Practice.**  Thisrefers to interventionswhich have a clear theoretical underpinning and have been trialled and evaluated, often but not always using Randomised Controlled Trials. Such practices are usually well described in a practice manual and should be possible to replicate with sufficient adherence to the practice model.

**FEMA.** The Federal Emergency Management Administration, USA

**Government Office**. A regional office of central government department representatives, now disbanded

**HCPC.** The Health Care Professions Council, a registrant body for social workers and health care professionals

**Leaving Care Act**. Legislation which places statutory obligations on Local Children’s Services Departments to support young people who have resided in public care for more that 13 weeks.

**Local Authorities.** Local Government, politically led providers of statutory services across England and Wales.

**LOCI** Leadership and Organisational Change for Implementation scale

**Multi Systemic Therapy (MST)** A well-known evidence based practice designed for adolescents with conduct disorder. Developed in the USA by Hengeller et al.

**National Implementation Service** The National Implementation Service is a centre of excellence, established to provide training and support for evidence based and research informed programmes for children’s social care, youth offending services and children’s mental health teams.

**NHS.** The National Health Service, government funded healthcare provision

**Ofsted.** A national inspectorate body responsible for inspection and grading of schools, children’s residential care and children’s services in England.

**PARIHS** Promoting Action on Research Implementation in Health Services framework

**Private Finance Initiative (PFI)** A means of using private capital to invest in national infrastructure, repayable over subsequent years through taxation.

**Public Law Outline**. The procedural process which social workers follow in considering legal means to intervene in a child’s life, from initial pre-planning to Court based work

**RCT.** Randomised Controlled Trial

**Social Impact Bond**. A form of payment by results in which an investor seeks to create a socially desirable outcome through long term capital investment in a new service which is the incentivised to deliver better performance than existing services. Ultimately creating a return on capital once the commissioner pays for the outcomes achieved. If not then capital is lost.

**Special Purpose Vehicle Company**. A restricted form of a registered legal company, usually created for the single purpose of holding a contract between parties.

**START Trial Systemic Therapy for At-Risk Teens.** A large-scale randomised controlled trial assessing the effectiveness of Multi Systemic Therapy for reducing out-of-home placement and offending behaviour in young people in 9 sites across England, compared to management as usual. Data collection for the trial concluded in Autumn 2017 with first results published in 2018. Principal Investigator Prof Peter Fonagy.

**Troubled Families Programme**. A nationally funded programme to reduce involvement of families in the criminal justice system and to address families with inter-generational worklessness.

**UK MST Network Partnership** A national coordinating body for training, consultation and site development established by the NHS to hold the national contract between MST Services in the USA and MST teams operating in the UK.

**What Works Network** A group of policy institutions funded by a combination of government and non-government sources including the Economic and Social Research Council (ESRC) and the Big Lottery Fund. Led by the What Works National Adviser, Dr David Halpern.

**Youth Justice Board.** An executive agency of the Ministry of Justice with responsibility for policy for youth offending

**Chapter 1 Introduction**

**Introduction and key concepts**

This thesis argues that the implementation of an evidence based intervention in a Local Authority children’s social care setting is only fully achievable when strategic and operational leadership is clearly harnessed to the implementation process. Implementation requires leadership both at the mobilisation stage and beyond, as the intervention matures within the setting and progresses towards long term sustainability. Simultaneous with the leadership effort, the contextual environment of the operational setting into which the intervention has been introduced must be aligned, directed and adapted in order to facilitate the optimal conditions for the intervention to fulfil its potential and to achieve the desired outcomes for families and for commissioners. Therefore, this research focuses upon the twin concepts of implementation leadership and of environmental context as the drivers for the successful implementation of interventions into complex systems so that intended outcomes can be realised.

The UK Implementation Society web site defines implementation as

“The process of putting a service, a policy, or a set of practices into application so that it achieves its intended outcomes to provide socially significant benefits to individuals and society.” <https://www.ukimplementation.org.uk/>

Whilst further acknowledging that

“Even the best-designed services and programmes will fail if they are implemented poorly. Across the world, scientists, policy makers, funders and practitioners recognise that there is an implementation gap between what is known about effective services and how they are delivered in practice.” Ibid

This definition leads from the emerging academic discipline of implementation science, which is described later, but already highlights a dissonance between the potential of innovations and new technologies and of their real world application.

In this research, implementation describes the process of commissioning an evidence based practice intervention (MST) and then introducing it into an operational setting, in this case Local Authority Children’s Social Care Departments in England. This involved actors and agencies from both within and outside of the various tiers of the operational system, jointly engaging in a process of change management and system adaptation. In this case with the aim of enhancing social work practice to deliver improved outcomes for families in regard to their life chances and well-being. For the cohort of young people identified with high needs and at risk of care entry the key outcomes were; to offend less, to attain better at school and for their relationships with their families to improve. For the service commissioner outcomes are additionally expressed in terms of cost savings, benefits and efficiencies through the dissemination of the procured innovation.

The term ‘evidence based intervention’ itself lacks agreed definition nor is it a neutral label without controversy, as will be explored later. In this research the evidence based intervention being described is Multi Systemic Therapy (MST) which is the common link to all three research sites. As an intervention model, originally designed as a juvenile justice intervention in the USA, MST is constructed as a hybrid of behavioural therapy, cognitive behavioural therapy and structural family therapy. It has a robust clinical and theoretical underpinning and an internal logic model, drawing on the social ecology framework proposed by Bronfenbrenner (1979). MST specifically targets adolescents who are anti-social or whom have conduct disorder (Hengeller et al 1999) as an intensive, time limited, home and community delivered intervention. It has been created by the developers as an intervention with trademarked, protected intellectual property and a unique quality assurance process which requires sites to operate under a commercial licence granted by MST Services Inc. in the USA. This creates a continuing relationship between the operational site and MST Services for training, consultation and the achievement of ratings of fidelity.

Typically, an MST team will be led by a clinical psychologist as the MST team Supervisor with three or four full time therapists who are often social workers, psychology graduates with higher practice skills or mental health nurses. Therapists will hold a caseload of 4 or 5 cases of young people where conduct disorder, offending behaviour or significant family disfunction is present. Parental engagement is a fundamental requirement of MST as much of the intervention is concerned with supporting parents to gain or restore a position of confidence in their parenting capacity. This is often expressed in terms of consistency and boundary setting. Therefore the young person must be living at home. The therapist will establish overarching clinical goals with the family to achieve in the 3-5 month intervention period and then develop strategies to achieve these. Individual and family meetings, coaching of new skills for behaviour management and building on existing family strengths are core techniques. Therapists see families several times a week and are on call for support out of hours too. Weekly written case reviews identify barriers to goal attainment and intermediate steps to take to overcome them are established. The MST Supervisor reviews each case summary weekly, before a live consultation with an offsite MST Consultant takes place with a moderated team conference call. The MST model requires continuous feedback and assurance measures to be gathered. These measures are used to assess core fidelity to the methodology. Following initial training the therapists are supported by quarterly training sessions and clinical reviews which are led by the MST Consultant. Of note is the accountability placed on therapists for the engagement of young people and families and the expectation that the therapist will do ‘whatever it takes’ to deliver the overarching goals. Further operational description of MST is outlined in the context chapter.

Whilst the intrinsic value of MST as a composite of therapeutic interventions attracts little clinical criticism, the application, promulgation and expansion of it as an intervention and as a business which makes claims for being effective certainly does, for example Littel (2006) who considers that published MST research has been selective in reporting, can be biased when conducted by the developers and that the success of outcomes can and has been overclaimed. There is certainly a strong counter narrative against the promotion of MST, and indeed other evidence based interventions, and of their growth within social care in particular. The exploration of this less favourable view of MST as something to be resisted or as having no place in publicly funded services is a continuous theme of this research.

**My position**

From the outset it is important to acknowledge one’s own position as a researcher when embarking on doctoral study. I must therefore state my pre-existing support for MST as an intervention before the research began. In the first years of my post social work qualifying experience, and then first line management in youth justice, I was unsatisfied with the practice skills which I had learned, often feeling unprepared for the challenges in case work with offending adolescents and in my ability to create sustainable change for them and for their families. Whilst able to assess the needs of young offenders for Pre-Sentence Court reports I was concerned at the weaknesses in my practice skills to deliver within the interventions proposed to the Courts. As a first line manager I was uncomfortable with the inconsistencies in practice in staff whom I supervised, with a wide variation in approaches taken from the highly individual to more family based interventions. I was drawn to the emerging evidence based practices as a means of seeking to address these perceived deficits in practice. I was intrigued by the reported outcomes of effectiveness of MST, considering that if my team could attain results half as good here in the UK as those reported in the USA trials, outcomes would be significantly better than the services offered at the time. Indeed at that point evidence of successful outcomes and re-offending rates were not tracked by the service. I was aware of the differences in setting between the UK and USA youth justice systems so knew that replication might involve cultural and system adjustment.

I established a MST service in 2000/1, initially with Youth Justice Board funding, as the first in England, which was then supported through my career with Cambridgeshire County Council. Therefore I have been a long term advocate of MST and have been seen as such by peers. This has sometimes been a double bind in that whilst I have had to defend and sometimes actively protect MST from budget cuts and other threats, I have also considered critical, clinical, practical and political concerns about how MST is delivered, managed and promoted. These concerns have largely been expressed in private and with professional colleagues only, as I have engaged in the public defence of both MST and other evidence based interventions, particularly in regard to their reception and consideration in social work practice in the UK.

My position is one of general support for MST but with critical thinking and experience in regard to how it is delivered, adapted and implemented. This means that I support the evidence based movement, the coaching of practice skills, clinical accountability, outcome and data tracking and the use of research to both innovate and to end ineffective practices. My orientation is towards family based systemic interventions, rather than to individual work in isolation. This position is revisited again in the methodology in consideration of my own potential bias as a researcher whilst my reflections at the post research stage are recorded in the conclusion.

**START trial**

The MST sites being researched were also being evaluated in a large scale Randomised Controlled Trial (RCT) into conduct disorder known as the Systemic Therapy for At-Risk Teens (START trial) (Fonagy et al 2013, 2018). The RCT was seeking to establish if long term outcomes for young people who received MST were superior to those who received treatment as usual. However, this thesis was not directly related to the START trial research process nor funded by it although I was a member of the research reference steering group because of my history and experience with MST. There is a discussion of the START trial in regard to the additional operational procedures and blind assignment which it required of the three sites as this had an impact upon the implementation of the three services at appendix 5. The START trial was widely supported by the research community when it was established, in the hope that a well-constructed research trial would both endorse the use of MST and begin to create UK based evidence of effectiveness. In fact neither of these hopes were realised when the first results were published (Fonagy et al 2018) with limited statistical significance in the main findings and the trial being seen as confirmatory evidence of ineffectiveness by many.

The START trial did not have a particular focus on the implementation of MST. Researchers began to randomly select and take cases for assessment and outcome tracking once the MST teams had been mobilised and had been operational for at least 6 months. This was to ensure that the referral pipeline was working and that the operational system was becoming used to consistently identifying suitable cases for blind assignment. This was considered to be the point of relative stability for the research to begin.

The first published outcomes of the START Trial (Fonagy et al 2018) have reported results overall from the MST condition compared to treatment as usual cohort. Further research to explore the variations in results between sites in the START trial may examine differences in setting, context and implementation, to which this thesis offers insights and a conceptual understanding. One finding from this thesis is the highly varied contextual differences between the three sites and the likelihood that these contexts may change positively or negatively when leadership changes. Even though these sites were purposely selected it is suggested that variations between the remaining sites are likely to be wide and by implication, will have affected the outcomes. The passage of time and the discontinuation of several sites may make this even harder to evaluate any further than this thesis using qualitative methods but statistical reanalysis of the START results is being undertaken now.

**Leadership**

There are many definitions and settings for leadership and there is a wide conceptual understanding of it in public services, business, military and political domains. Academic literature continues to debate the differences and similarities between management and leadership (Schedlitzki and Edwards 2018). Whilst Hunt (1991) identifies four major schools of thought concerning the differences between leadership and management which range from entirely undifferentiated roles to the complete separation between managers and leaders. In this research leadership is referring both to strategic and operational leadership and management of Children’s Services Departments. In a Local Authority setting leadership is one of the many roles of management (Bass 1985), whereby leadership is enacted by senior executives and managers whose office requires them to lead their teams, departments or the Authority as a whole. This is constrained and regulated by the statutory boundaries, expectations and obligations of Local Government, including responding to democratic accountability. Leadership then is more than the daily decision making, bureaucratic and personnel functions of general service management alone. It requires anticipation of new challenges, development of strategic vision and the ability to drive and lead an organisation as a figurehead, culture carrier and as the most senior accountable person. As shall be explored, leadership draws not only on intellectual and political skills but upon personal qualities too and the exercise of power.

Environmental context describes the climate, culture, prevailing norms and values of an organisation and operational system. The environmental context is constructed through the actions of the participants who comprise it as they react in turn to the cultural, political and economic circumstances in which they find themselves living and working in at the time. Acknowledging that this has an almost limitless boundary which would include the whole of the global economy, for example, the focus of this research is largely within the setting of the respective children’s services departments as they are placed within the Local Authority. Of interest is how the environmental context responds to the threats and opportunities of implementation of an evidence based intervention, specifically for young people on the ‘edge of care’.

**The context of adolescents on the edge of care**

On 31st March 2017 there were 72,670 children looked after in England which was 3% higher than in 2016. 46% of these young people entered care over the age of 10 with 17% entering care at age 16 or over. Care entry has a significant adolescent cohort (Department for Education, 2017). Continued fiscal restraint has created pressures on Local Authorities for adolescents described as being on ‘the edge of care’. (Department for Education, 2011), commonly identified as those whose needs place them as being at risk of entering public care but for whom alternatives to care entry may be sought. Often this involves rapid efforts by Social Care to intervene before circumstances further deteriorate (Ward, Brown and Hyde-Dryden 2014). Some services support the adolescent alone, e.g. Youth Offending interventions (Wilson 2013); some involve the immediate family, e.g. Parenting Under Pressure model (Harnett and Dawe, 2008); or wider family networks, e.g. Family Group Conferencing (Morris and Connolly 2012).

Care entry commits Local Authorities to long term funding support including the period after which a young person leaves their care placement (Leaving Care Act, 2000). Care entry necessitates intervention and intrusion by the state into family life, either voluntarily in agreement with parents or statutorily by Court Order (Children and Families Act 2014, Ministry of Justice Public Law Outline 2014). Conversely, if retaining a young person in the community then social care services must mitigate the risk of the young person coming to significant harm (Laming, 2003, Working Together, 2010,2015,2018). Understandably, social care senior managers pay close attention to the circumstances and risks which may precipitate a young person’s reception into care and commit resources to support alternative courses of action.

Higher tier Local Authorities are required to provide statutory and non-statutory services in the form of early help and social care for children and families living in their area, either mandated by the Family Proceeding Court under civil law, or provided on a voluntary basis without statutory underpinning. However constructed and configured, the majority of interventions are guided by the principles of working enshrined by the Children Act 1989 and delivered by a multitude of professional disciplines. Young people whose offending behaviour places them at risk of remand or custodial sentencing will be case managed by the youth offending service (Crime and Disorder Act 1998) under the jurisdiction of the Youth or Crown Court in criminal proceedings. Cases may be highly complex in nature as many young people’s needs will straddle both welfare and criminal justice domains (Rogowski 2014). Close cooperation between youth offending services and social care are imperative if service responses are to be effective although tensions between the services regarding both resources and responsibilities persist (Arnull 2014).

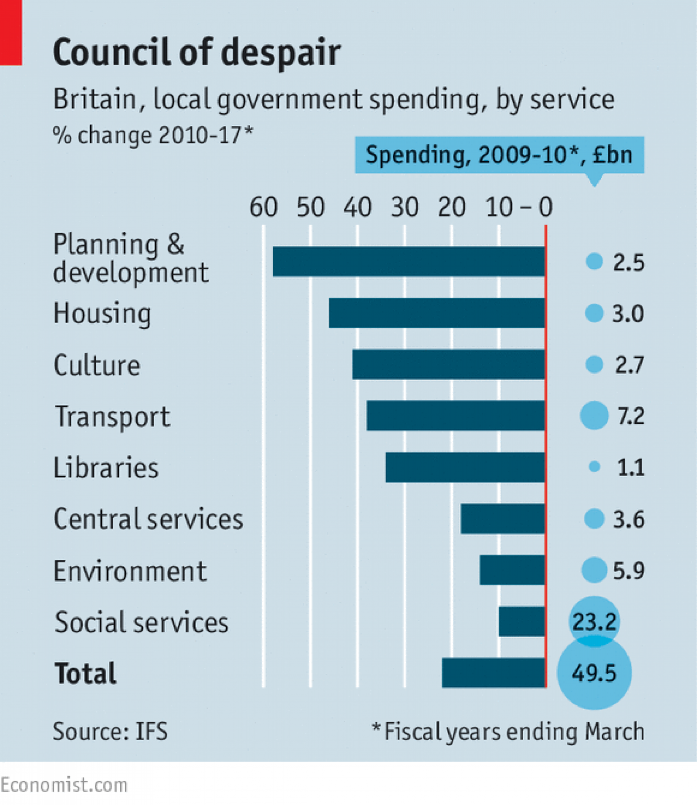
The map of Local Authority and NHS service provision varies as a result of history, geography, demography, political hue and commissioning cultures. The priorities and investments made into children’s service provision may be described at the bandwidth of the service offer and dictates the spread, eligibility and quality of services delivered, as judged by inspections (Ofsted 2017) and annual data returns (Department for Education 2017).

Unquestionably, Children’s Services are affected by the grading awarded in inspections (Ofsted 2017) although successive variants of performance regimes have been criticised for concentrating on outputs rather than outcomes or the experiences of families (Tilbury 2004, Hood et al 2016). Authorities rated by Ofsted as ‘Good’ or ‘Outstanding’ tend to be characterised by stable leadership, confident risk management and effective service provision (Ofsted 2015) whilst poorly graded services may be disrupted by successive change programmes, high turnover of both leadership and operational staff, instability and risk aversion (Ofsted Annual Report 2016). A poor inspection grading may result in a negative downward spiral of staff vacancies, less confident management of risk by social care leading to higher care placements and therefore poorer outcomes and higher costs. Authorities are affected by the impact of child deaths, e.g. Baby P case, (London Borough of Haringey LSCB 2009, Jones 2014) or systemic failure to protect and safeguard children at risk of significant harm e.g. Rotherham child sexual exploitation scandal (Jay 2014).

Whilst ‘edge of care’ has become common parlance in social care it lacks definition and is considered to have wide application and meaning. Asserting that a young person is on the ‘edge of care’ is a matter of professional judgment and opinion, not least as young people present with myriad complexities and needs (Smith 2016). Some professionals narrowly construct ‘edge of care’ to define circumstances where care entry is inevitable, with decisions made and legal proceedings in train. The professional system may already be almost unanimous of this viewpoint with few contrary opinions being expressed. ‘Edge of care’ is however often a working shorthand description of a wider cohort of young people whose risk factors and attributes suggest a likelihood of care entry but whose chances of progression towards this outcome may yet be reduced through intervention. ‘Edge of care’ may additionally be understood in temporal terms as in days, or months from the discussion with the Local Authority gatekeeper, most likely a senior social care manager, to agree to care entry.

The ‘edge of care’ label may be used inappropriately by professionals, wrongly identifying young people, their family or their community. Families may be flagged for the most intrusive state intervention when other services could provide support preventing this label becoming a self-fulfilling prophecy. Young people may live on the ‘edge of care’ for long periods and yet never cross the threshold to the care system, whilst other young people may enter care as a result of a single trigger incident or because of a sudden change of circumstances.

Since the global financial crisis of 2007/8, the amount of funding available to Local Government declined by 22% between 2010 and 2017 according to the Economist (2017) as table one demonstrates.



Public financial restraint, as the state effectively shrinks in size, has fundamentally changed how Local Government operates with continued re-configuration of services and retrenchment, as Local Authorities have struggled to meet their statutory obligations in a context of rising need, (Hastings et al 2015). This financial pressure has led to attention being placed upon the general efficiency of Children’s Services, particularly in regard to outcomes that can be achieved for children and families with high and enduring needs. Unsurprisingly focus draws to the ‘edge of care’, with questions raised about the cost of care placements and of the viability of either kinship or community based alternatives. This shines light not only on the costs of care placements, but on long term outcomes attained by young people in care. These outcomes have tended to be much poorer across a suite of indicators with the growing view that Local Authorities are found wanting as corporate parents (Bullock et al 2006, Sinclair et al 2007). Across a basket of outcome measures Looked After Children, compared to their peers in the community, have worse life chances. These are often worse than young people classed as Child in Need who remain at home. (National Statistical Release, Department for Education 2017). Poor outcomes are more marked for those who enter care as adolescents, than those who enter care earlier in life, in terms of educational outcomes (O’Higgins et al 2015, Children’s Commissioner Report 2017) and in both mental health and offending (Jones et al 2011).

Responding to the Association of Directors of Children’s Services (2013) concerning adolescent care entrants, a grant funding prospectus set out by the Department for Education for the Innovation Programme (2014) stated the desire to

‘Find innovative ways to improve and re-design service delivery to achieve higher quality, improved outcomes and better value for money. The aim of the Innovation Programme is to provide support to local authorities and other organisations to develop, test and spread more effective approaches to supporting adolescents in or on the edge of care.’ (Department for Education 2014)

Signposting the direction of policy towards the effectiveness of interventions in the best long term interests of the young person and to those with the potential to save money for the public purse. (Sen 2016, Ashmore and Fox 2017). The Local Authority children’s placement budget funds foster care placements and residential care and is often scrutinised closely given the pressure placed upon it. The mean cost of a week of a private residential home for a young person in 2016 was £2594 and for in house Local Authority fostering the mean was £579 per week, excluding social work case management costs (Kent University 2016).

**The what works movement**

Calls for greater efficiency and for improved outcomes for young people on the edge of care, as well as for those already within the care system, are not new (Sulimani-Aidan 2015). However, concerns have become sharper and more central to public discourse in the last eight years, since the financial crash (Forrester et al 2012). The question of ‘what works’ has become a driver for public policy and has seen the rise of new investment and new institutions created to support the search for the answers to these questions. In the face of the challenges facing contemporary social work, the profession has remained slow in adapting to the opportunities afforded by evidence based interventions as Wike et al (2014) found in their review of the individual and organisational barriers which social workers encountered when seeking to introduce evidence based practice.

The question may have been re-invented for the modern age of austerity in seeking evidence of the effectiveness of interventions, but the roots of what became known as ‘the what works movement’ trace back to the declaration by Martinson that research into effectiveness in criminology and criminal justice proved that

‘Nothing works, that we haven’t the faintest clue about how to rehabilitate offenders and to reduce recidivism’ (Martinson p48 1974)

This assertion was based upon an attempt by Martinson and his colleagues to conduct one of the first systematic reviews into research of recidivism. Although now considered a flawed conclusion, based upon methodological weaknesses, Cullen and Gendreau (2001) identify the trend of pessimism and the self-defeating crisis for criminologists since Martinson, which

‘Had the unfortunate consequence of legitimating “knowledge destruction” (showing what does not work) as the core intellectual project of criminology and thus of undermining efforts at “knowledge construction” (showing what does work).’

(Cullen and Gendreau p313 2001)

Cullen and Gendreau contend that only recently has the focus shifted towards a more positive and constructive search for effectiveness in criminology. No doubt the damage was done and, as Sarre points out, Martinson’s article, was

‘Probably the least frequently read but most frequently quoted and cited article in the rehabilitation literature’ (Sarre p38 2001)

The ‘what works movement’, much as it could be described as such, began post-Martinson, as researchers and criminologists developed counter narratives with more robust systematic reviews of evidence (Lipsey 1992, Sherman et al 2006) that could demonstrate intervention effects. This is helpfully reviewed and by Weisburd et al (2017) who note two important issues.

The first is the high value accorded to the debate of effectiveness through the creation of cost benefit analyses in establishing the investment to outcome ratio of programmes and interventions. The work of economists led by Steve Aos (Aos et al 1999, 2004) at the Washington State Institute of Public Policy is of particular importance given the strength of the methodology and economic analyses used. The second concerns the importance of studies that demonstrate the tools and processes for the effective replication and scaling up of interventions, also known as Type 2 studies. Weisburd showed concern at the distinct lack of these in contemporary criminology. This leads towards a requirement for researchers, policy makers and commissioners to develop specific knowledge regarding the implementation of evidence based interventions. This dilemma is neatly described by Mihalic and Irwin as they arrived at the same point,

“With a list of model or best-practice programmes that produced favourable outcomes during research trials but very little information available about how to implement these programmes. In other words, we now know what to implement but we know very little about how.” (Mihalic and Irwin 2003 p308)

Biglan and Ogden (2008) recorded similar sentiments in their review of emerging evidence-based practice in Norway, stating that from 30 years of research

“We know far more about how to affect young people than we know about how to influence the social systems that will have to adopt evidence-based practices if the fruits of recent discoveries are going to be realised.” (Biglan and Ogden 2008 p81)

This stresses the importance of implementation as a distinct process and of the preparedness of professionals and organisational systems to adapt to new practice and to actively facilitate innovation. For this knowledge to be built requires a reorientation towards more rigorous research design. Outcome evaluations, which were commonly demanded of grant funded projects in the 1990’s and 2000’s, were often required by commissioners, but usually fell considerably short of academic standards. Evaluations were used as a form of process summation of performance management indicators, more for the purpose of seeking grant renewal than for advancing understanding of effectiveness with any independent rigour nor creating knowledge regarding successful replication. What was often ignored was firstly the relationship between the processes employed and the specificity of the desired outcomes. Secondly, the assessment of the core elements of the intervention, coupled with how it had become established in the setting in which it was created.

Whilst the ‘what works movement’ was principally related to adult criminal justice and later youth justice, this had relevance to effective interventions for adolescents on the ‘edge of care’, not least as this cohort display similar common attributes, presentations and needs with their offending peers. As stated, MST (Henggeler et al 1990), began as a juvenile justice programme and over time began to be used for ‘edge of care’ adolescents rather than as a youth justice intervention only. This change in focus from the original setting reflects the fact that the juvenile justice system in the USA has much greater reach than in the UK with many more young people drawn into it and is a clear reflection of the lower investment in social welfare in the USA compared to the UK. Therefore, young people in the UK who may be anti-social, offending at a low level or are diagnosed with conduct disorder are more likely to be managed by Social Care than by the criminal justice system alone, as they would be in the USA.

The debate regarding ‘what works’ within social care settings, and in regard to interventions for young people specifically, continues as the literature and reporting of research expands (Barlow and McMillan-Schrader 2010, Fonagy et al 2015, Boaz et al 2019). However, the general utilisation of evidence based interventions remains low and this issue has itself become an area of research as to the reasons this might be (Atkins et al 2016, Palinkas 2017). One argument is that there remains a sense of skepticism in the UK regarding interventions which promote themselves as effective (Fisher 2016). This isn’t confined to the criminal justice system but sweeps across adults and children’s services, health, policing and education. Central Government appears ambivalent too in regard to the promotion of a more research informed or evidence led policy making agenda (Cairney 2019). This is evidenced by continuing to invest in politically led rather than evidence led initiatives.

An example of this is the *Troubled Families Programme*, championed by Prime Minister David Cameron in 2010 and led by Dame Louise Casey. Based on the Dundee family intervention programme and developed nationally by New Labour as the *Family Intervention Project.* (Dillane et al 2011).The Coalition Government expanded the programme with a criteria for referral targeting workless families and cycles of deprivation with a political target to ‘turn around 120,000 families’ which was given a new impetus by Cameron following the London riots (Cameron 2011). However, the *Troubled Families Programme* had no specific methodological underpinning nor did it take any account of research of its effectiveness. Instead the programme encouraged Authorities to establish interagency teams and to challenge traditional statutory services to be more assertive and intrusive into the lives of the long term unemployed, backed by increasingly strident political commentary regarding the poorest in society whilst claimed significant successes (Crossley 2015). However, the national evaluation showed little long term impact (Bewley et al 2016).

Conversely, during this period, Government was also building an infrastructure to develop evidence informed policy and research practice. Following the early intervention independent reviews led by Graham Allen MP with cross party support (2011a, 2011b) the Government established the *What Works Network* (2013) under the leadership of Sir David Halpern, the What Works National Adviser. The Network drew together newly created bodies e.g. the Early Intervention Foundation (2013), with existing institutions such as the highly regarded National Institute for Health and Care Excellence (1999), whose remit expanded to include public health (2006) and social care (2012). The stated intention of the Network being to generate independent evidence of effectiveness that could be trusted by both the public and by commissioners alike although as Nutley et al (2019) have shown, the variance of standards continues to hamper this endeavour.

It may be too early to tell if the Network is having the impact it was designed to do as it reaches the fifth anniversary. The individual What Works Centres are certainly prolific in their generation of publications, guides and research evidence but how far this is influencing decision making in public policy is harder to determine at this point. Sir David accepted this in his introduction to the 2014 review of the Network, stating that whilst the Network can set out what the best available evidence is

‘It is for the professional or commissioner to make the final judgment on what to do. Commissioners and practitioners will always need to consider additional factors, such as public sentiment and local context’ (Halpern p7 2014)

This continues to leave the option open for those who commission services to ignore evidence, if they wish to, and to continue to follow their own beliefs and preferences. How much the status quo of the current service map will persist is unknown given the pressures described for radical change and efficiency. It also perhaps demonstrates the work needed to engage others in the public understanding and acceptance of evidence informed policy, although as Cairney (2019) discusses, the nature of political decision making remains a long way away from rational evaluations of scientific evidence. Indeed, he argues that the positivist assumptions of evidence generation continues to reinforce the view that evidence is generated by scientists in universities, far removed from practice.

The top down policy approach of presenting evidence, and evidence which privileges RCT research in particular predominates discourse on effectiveness. In the USA the move towards evidence informed policy making has been supported by the establishment of intervention and programme registries such as the Blueprints for Violence Prevention established at the University of Colorado in 1996. Initially funded by the Office for Juvenile Justice, Blueprints was set up to identify and to replicate effective youth violence reduction programmes (Elliott and Mihalic 2004). Over time it has expanded to become a nationally recognised clearing house for evidence based interventions and a source of technical assistance for replication. Interventions are graded according to the strength of the research evidence and their dissemination capability. The full criteria (Blueprints 2007) sets this out in detail but is not without controversy in regard to those interventions which are or are not given the higher gradings. There is more than a suggestion of bias towards USA developers. In the UK several hierarchies of evidential standards of research have been developed (Puttick and Ludlow 2013, Ward et al 2014) whilst there has been a considerable proliferation of evidence based registries. Each with their own inclusionary criteria and standards for research, for example the California Clearing House for Child Welfare <http://www.cebc4cw.org> and the Substance Abuse and Mental Health Service USA registry <https://www.samhsa.gov/nrepp> In the UK there is the investing in children registry which has been established by the Dartington Social Research Unit <http://investinginchildren.eu>

The linear approach of taking research created evidence from universities and seeking to make it work in practice has wide appeal. However, it is increasingly obvious that implementing evidence based practice is not simply about commissioning better services through purchasing a more sophisticated product in the market place and adding it to an unreformed system. It is about a process of organisational, operational and systemic reform that will necessitate change throughout public services. As will be demonstrated, to achieve a more evidence informed policy requires leadership, the pursuit of cultural change and adaptation as much as wholesale reform and attention to context. Creating change in conflicted and resource constrained environments when public services are already coping with substantial change, demand pressures and further budget reductions means that whilst this is a good time to promote notions of system reform the capacity to achieve it may be limited.

**Developing the research question**

Having attempted to establish if an intervention can produce positive outcomes or not through an efficacy trial, the next step is to test if it can be successfully replicated and implemented elsewhere. In thinking about the development of a research question a sequential list of overarching questions was developed. The questions successively build from each other with increasing depth and are posed to assist in the definition of the research:

1. Does this intervention work
2. Can the outcomes of this intervention be successfully replicated by others
3. Does it work and can it be successfully replicated by others in this particular setting
4. Does it work and can it be successfully replicated by others in this particular setting and be funded through social investment or outcome based commissioning

Each question can be further deconstructed. For example question one may be broken down into; Works for whom?, In what circumstances?, How long is the effect sustained?, Compared to what other interventions? What standards of evidence are being considered etc. The first two questions have become the abiding pre-occupations of the registries, programme developers and researchers into evidence based practice, evidence generation and efficacy. The third question is the one of central interest to this research and also to the field of implementation science. The fourth question is a more contemporary one and speaks to the emerging use of evidence based interventions being established and implemented funded by social investment. This may be via a Social Impact Bond and outcome based commissioning models in which financial risk is held by an investor under a specific outcome based contract (Social Finance 2009). Practice experience suggests that whilst an investor or provider who has implemented an evidence based programme before in another setting may be pre-occupied with questions 3 and 4, the organisation that is running the programme may only just be grappling with question 1 and be seeking evidence in support or rejection of this question.

Therefore, the research question is to determine what factors may contribute to the successful or unsuccessful implementation of an evidence based intervention in a Local Authority setting. The question is seeking to find out how Local Authorities consider a proprietary and licensed intervention and then implement it into their context and system. This calls upon the political, financial, contextual and cultural dimensions of how the organisation operates and how leadership is exerted. The question considers the definition of success in two parts: Firstly, how Local Authorities manage to mobilise the implementation of the intervention to the point of delivering desired outcomes for young people. Secondly, if and how Local Authorities are willing and able to adopt a strategy for the intervention as a long term and sustainable part of their core service offer. In essence, ‘If this works will we sustain it?’

**Evidence based interventions**

My interest in evidence based interventions began in 2000 whilst an operational manager in the Cambridgeshire youth offending service. The service experienced rapid changes to the youth justice system and the investment by New Labour following the Crime and Disorder Act 1998. With the new Youth Justice Board ready to support innovation in practice, development funding was sought for the establishment of the first Multi Systemic Therapy MST service in England as an alternative to custody programme (Jefford 2013). The experience initiated a long term interest in implementation science.

The new MST team connected to a MST team in Belfast run by the Extern Organisation and funded following the Good Friday Agreement and established six months prior, and also to a team in London established as a Randomised Controlled Trial (Butler et al 2011). Training was shared and experience between ourselves became a source of mutual support, not least in how implementation challenges in our respective organisational settings were approached and what solutions were proposed.

The introduction of MST teams into the UK is an example of the organic, bottom up nature of the dissemination and development of evidence-based practice in the UK, in contrast to the state created What Works Network (2013). It demonstrates how evidence-based practice has been initially spread in the UK via practitioners rather than by more formal networks. Palinkas, et al. (2011) have highlighted the importance of informal networks between individuals and organisations to the adoption of new behaviours using diffusion of innovation theory (after Rogers 2003). There are examples of a state led top down approach, which is how evidence-based practice developed in Norway. Biglan and Ogden (2008) described the approach of the Norwegian Health Ministry who invited international experts to a conference on conduct disorder by young people in 1997 to review available evidence. A national child behavioural research centre was founded and commissioned to pilot promising approaches using the best international practice at the time. Early evidence from the pilots was evaluated independently prior to a national roll out of selected programmes: MST, Treatment Foster Care and Functional Family Therapy. This was funded as part of a 10-year investment plan which received cross party political support. This is a funding structure and a policy consensus which appears unlikely to be supported in UK politics.

**The expansion of evidence based practice in the UK**

Growth of evidence-based practice in the UK was encouraged by national policy leads at the Departments of Health and of Education when in 2007 10 new sites for MST were established. A condition of grant included participation in the START Trial (Fonagy et al 2013, 2018). Originally due to report in 2014, the START research period was extended for 2 further years to generate longer term follow up data with the first paper published in 2018 showing little difference between the MST and Treatment as Usual cohorts at 18 months post treatment. There are currently over 30 MST teams in England listed <http://www.mstuk.org/> . The MST methodology has been used as a basis for the creation of new clinical variants of MST for substance abuse, problematic sexual behaviour and also for child abuse and neglect, many of which have been trialled in the UK.

As Government policy explored evidence based interventions, the emerging Social Investment market was too. Social Finance Limited, working with Essex County Council, created a Social Impact Bond to establish two MST teams in Essex. A contract placed the social investors capital at risk under a payment by results mechanism with the outcome metric to reduce the number of days in care spent by the cohort, tracked for two years post intervention (Barclay and Mak 2011).

I was a Non-Executive Director in Essex, providing a working link between the financial investors, service contractor and public sector. Perhaps the most important learning points were in regard to the private sector discipline of performance management of the service which was far more robust and performance data driven than anything encountered before in a Local Authority setting. Because capital was at risk, the investors were focussed on outcomes throughout the life of the project to ensure that the service was well utilised, staff were sufficiently motivated and the system activated to ensure a flow of suitable referrals. Operational until December 2018 an interim evaluation has been published (Cameron and Roberts 2015) Whilst as the world’s first children’s services’ social impact bond there is much at stake for public policy, practice and for investors, as described by Goldberg (2013) .

There are risks as well as opportunities to consider for this new market. One is that commissioners make unreasonable demands or have unrealistic expectations in the establishment of outcome based contracts. Another is that there is a relatively small provider market at present in the UK and there is also a skills gap of qualified staff who have trained in the specific methodologies. This means that providers need to resource initial training before a programme can begin. It also takes time for a team to become proficient in a methodology and to win the confidence of the system or setting into which it is placed. The payment of funds upon outcomes being achieved post intervention can create cash flow pressures and uneven budget cycles which can cause difficulty to all parties.

However, the greater risk is one of implementation failure. That is, the failure to adapt to the intervention by the operating system or the rejection of the service before it has had a chance to gain a foothold of trust. Poor utilisation of the service and the absence of suitable referrals can lead a new service to run into trouble very quickly, not least if volume targets fall behind from the outset and pressure is exerted to catch up. There is a risk too that a flawed understanding of what an outcome based contract is seeking to deliver and how it is structured by first and second tier managers will lead to confusion. Referring managers may then either refuse to refer cases to it or who seek out the most difficult in the hope that they will fail. All of these circumstances were witnessed in practice in Essex and were also found through the research interviews. The ideal scenario should be a successful outcome for all of the four main beneficiaries: The Local Authority, the provider, the investor and most importantly for the young people and their families, whose outcomes have been improved.

Commissioners might wish to believe in the simplicity of a ‘plug and play model’, that is they buy something off the shelf, plug it in and it works first time. Nor does an intervention arrive like a prefabricated McDonald’s restaurant on the back of a low loader, ready to be plumbed in and operational the following day (Britspace 2008). The complicated reality requires system reorganisation, consistent attention and skilled leadership to even get close to achieving the potential of the expensive and specialist product which has been procured. Effective implementation takes longer to mobilise and requires far more adaptation on behalf of the organisational system than commissioners are usually prepared to initially accept.

As a practice reflection, one danger is that commissioners force through implementation without due regard to the necessary processes and milestones. This may create an insecure foundation on which to start, with the intervention failing to thrive and being rejected and blamed as either unsuitable to the system or regarded as a waste of money. Rarely does one hear a commissioner state that the intervention was effective but that they had failed to implement it well.

The aim of this research is to learn more of the difficulties and of the potential rewards of implementing evidence based practice. In doing so the ambition is to discover learning for practice. By developing skills and techniques, by anticipating problems and by paying attention to core organisational issues there is every reason that evidence based interventions can flourish and succeed. The ultimate prize is for cost efficient interventions which deliver long term and sustainable outcomes for young people and their families

**Thesis structure**

Chapter Two is a narrative literature review which briefly describes the history and development of evidence based practice and its place in public policy. The development of implementation science as an academic discipline is introduced and the creation of implementation frameworks and their relationship to social work practice is explored. The reaction of the social work profession to evidence based practice is discussed. The importance of the role of leadership in public services is described and the relevance of this to the implementation process is introduced.

Chapter Three describes the research methodology and why a qualitative design was used. The development of the research question and is outlined and described. The methodological choices and rationale for taking a grounded theory approach is detailed, drawing on the work of Charmaz (2014). The subject interviews and the interview as a method of research is discussed. The coding strategy employed and the development of the analytic process is set out with the coding analysis of the subject interviews presented. The analysis describes the significant factors relating to leadership and to the contextual environment in the process of implementing an evidence-based programme. It identifies the major categories from the coding and describes their relevance to implementation. At the end of the chapter a brief description of the research journey is discussed.

Chapter Four describes the environmental context for the research and explores the initial challenges faced by those who were seeking to implement the intervention from the grant agreement and through the initial implementation phase. The contexts for the three Local Authorities are detailed as these descriptions frame the implementation experiences of the interview participants. The leadership of the implementation process is also described.

Chapter Five sets out the main findings from the interviews. How the intervention was received by staff in the three Authorities and how the intervention interacted with the context over time is described. The leadership of the three Authorities is discussed and how this impacted upon the journey from mobilisation through to either closure or sustainability. The final section outlines the complexity of delivery over time in each of the Authorities and how the shifts in the operational environmental context supported or impeded the intervention, how risks and threats were managed and how partners support influenced decision making.

Chapter Six is the discussion section in which the findings are reflected through new implementation research and their application is discussed. Chapter Seven is the conclusion which draws together the findings from the research with implications for practice and for future research.

**Chapter 2** **Literature review, theoretical frameworks and leadership**

This chapter is a narrative literature review which sets out how implementation science has evolved and what the major themes of interest are in the national and international literature. The development of theoretical implementation frameworks and their utility and application will be explored. How implementation research has been received and applied in contemporary social work practice will then be described, including the reaction of social work towards evidence based practice. The second half of the chapter will discuss concepts of leadership and the role of leadership in organisations as this is a central feature of implementation research and pertinent to the research findings for this thesis.

In conducting this literature review a research strategy was developed to ensure that literature relevant to the research proposal was identified, not least because the structure of the professional doctorate requires an initial literature review to be completed as a stage one paper before the research fieldwork has taken place. The purpose and intention of the literature review being to review, understand and synthesise

‘Theory and research relating to (the) field of interest that outlines what is already known and that frames and justifies (the) research question’

(Bryman 2012 p91)

In the first phase the Damschroder et al (2009) Consolidated Framework for Implementation Research (CFIR) was a starting point for developing understanding of implementation concepts and themes. Ideas and reflections were written up in notes to begin and think through what form the research questions might take. The article references cited by Damschroder were sourced and read in order to develop understanding of the theoretical underpinning of both the CFIR and wider implementation science core texts. The next step was to find citations of the application of the CFIR. References were sought in the journal Implementation Science, a peer reviewed journal, and these were followed up. Keyword searches were undertaken for Implementation Frameworks, Implementation Leadership and Implementation Context using the academic library.

The volume of implementation articles meant that it was necessary to exclude articles which were primarily concerned with international development, adult health care, in patient health care and educational settings. There was a low level of research found in published journals concerning implementation in Social Care settings.

As the research phase progressed new articles were accessed as they were published with a focus on leadership, CFIR and context. A wider search for literature was made beyond peer review journals to books, conference presentations at the Global Implementation Conferences (GIC) and the proceedings of the Society for Implementation Research Collaboration (SIRC). Internet publications, think tank and policy institute reports such as NESTA, NICE and Research in Practice and policy documents in a grey literature search took place as familiarity with the field became more confident and leading authors and researchers were identified. Later key word searches began to explore social work and implementation, social work training and leadership in Local Authorities as the focus narrowed towards the developing research questions. Attendance at conferences, networks and seminars enabled access to implementation researchers to discuss ideas with as the forming themes from the research began to emerge.

As the findings were being prepared and the write up phase of the doctorate was entered, a return was made to the literature review to check for accuracy and to ensure that a strong enough connection was made to the research whilst creating a readable narrative. Inevitably considerable material from a wide range of sources was accessed and read but which did not make it into the literature review as the focus and depth of the research findings narrowed to the most salient points. The newest literature is referred to in the discussion to ensure that the thesis is as up to date as possible at the point of submission.

The timing of literature reviews in research using grounded theory approaches has been a matter of debate (de Lacey, Giles and King 2013) given how much prior theory does or does not influence the intended discovery of knowledge from the research process. This literature review has been a process of continued updating and revision rather than being fixed and completed at a single stage, early in the doctoral research process (Silverman 2011, Bryman 2012). One of the noticeable gaps in the literature is research concerning the implementation of evidence based interventions into social care settings, to which this thesis makes a contribution.

As an emerging academic discipline, implementation science has been defined by the Editorial Board of Implementation Science Journal as a discipline which examines

“The implementation of evidence-based healthcare interventions, practices or policies or the de-implementation of those demonstrated to be of low or no clinical benefit or even harmful” (Wilson et al 2017)

Whilst Wilson and Sheldon (2019) extend this definition to include

“The study of professional, patient and organisational behaviour change, and…increased use of theoretical approaches to understanding, guiding and evaluating the processes of translating research into practice. (Wilson and Sheldon 2019 p 78)

Implementation science emerges as a discipline following the work of epidemiologist Archie Cochrane (1972) (Cochrane Collaboration 1993) and development of systematic reviews, (Harper, Gannon and Robinson 2012). Key texts include Diffusions of Innovations Theory (Rogers, 1995, 2003) and the systematic review by Greenhalgh (Greenhalgh et al 2004) concerning innovation and knowledge transfer in healthcare in the NHS. Greenhalgh drawing particularly on constructs from social psychology, organisational behaviour and management theories. She concluded that the research prior to her review lacked robustness and tended to confuse the diffusion of knowledge, implementation and change management, setting two questions for future implementation research

“By what processes are particular innovations in health service delivery and organisations implemented and sustained (or not) in particular contexts and settings, and can these processes be enhanced...are there any additional lessons from the mainstream change management literature…for implementing and sustaining innovations in health care organisations?” (Greenhalgh et al 2004 p620)

The concerns of contemporary implementation science were summarised and defined by Nilsen (2010) as

‘Part of a diffusion-dissemination-implementation continuum: diffusion is the passive, untargeted and unplanned spread of new practices; dissemination is the active spread of new practices to the target audience using planned strategies; and implementation is the process of putting to use or integrating new practices within a setting’ (Nilsen 2010 p8)

The systematic review of implementation research (Fixen et al 2005) at the National Implementation Research Network, USA, described how the preparation of the team, service, professional disciplines, wider stakeholders and community are central to successful implementation. Applying a schematic Active Implementation Framework (Fixen et al 2005) demonstrated how deficits in any of the core implementation domains led to reduced outcomes for the evidence-based programme being implemented.

The review also provided an example of false positives in implementation (West and O’Neal 2004) where a poorly designed programme with little integrity was implemented effectively. *Drug Abuse Resistance Education* reached millions of high school children despite studies showing no long term effects (Lynam et al 1999). DARE continues, with the organisers seemingly impervious to the challenges of the evidence of outcomes. The inverse position is more common where a strong programme is implemented poorly or with insecure funding and then closes (Raghavan et al 2007, Ringle et al 2015). Lipsey et al (2010) identified in a review of USA youth justice programmes that an intervention which was well constructed but which was implemented and delivered badly could have worse outcomes than a less robust intervention which was delivered well.

Whilst evidence based practice registries rejected DARE, some US states in the USA continue to fund programmes considered harmful, e.g. the widely condemned ‘Scared Straight programmes’ where young people meet adult prisoners who deliver graphic descriptions of prison life. The Washington State Institute for Public Policy, (Aos 2001) assessed these as part of a comprehensive cost benefit analysis of youth justice prevention programmes and found negative outcomes for both the individual and taxpayer. The persistence of ineffective practice is an interesting dynamic and stopping the continuation of ineffective interventions could have clear beneficial effects. NHS England’s decision to remove 17 ineffective treatments, such as knee arthroscopy for osteoarthritis, was however greeted with political and public suspicion of cost cutting rather than appreciation of clinical evidence of the ineffective use of resources (Robinson 2018).

As will be discussed later, public policy continues to debate notions of effectiveness and standards of evidence (Gottfredson et al 2015, Puttick 2018) but research evidence in human services will not deliver universal truths as in natural sciences and there is a danger in stating evidence-based practice as such for all those involved. As Axford and Morpeth (2012) discuss,

‘Scientists disagree on the findings that emerge from RCTs and on how much and what type of evidence is needed to certify something as ‘evidence-based’

(Axford and Morpeth 2012 p269)

Implementation science therefore seeks to address a wide range of questions at an organisational and at a system level regarding the transfer of knowledge, diffusion of innovations and change management. For this thesis this includes the role of leadership in implementing and sustaining evidence-based practice (Lavis et al 2008, Aarons et al 2015, 2016) and as the next section demonstrates, considerable attention has been placed upon the development of implementation frameworks.

**Implementation Frameworks**

Implementation science has seen the development of increasingly sophisticated conceptual frameworks (Kitson et al, 2008, Damschroder et al 2009, Aarons et al 2011, Flottorp et al 2013). Frameworks seek to understand and conceptualise the barriers and facilitators of implementation, particularly but not exclusively in regard to the adoption of evidence based interventions, innovations and change. The majority of models

‘Include multiple ecological levels and emphasise that effective implementation requires consideration of both provider and organizational levels. Successful implementation requires providers who view EBP [Evidence Based Practices] favourably and possess the knowledge and skill to deliver core components of interventions with fidelity, as well as organizational contexts that are sufficiently supportive of EBPs. (Powell et al 2017 p2)

A review of implementation frameworks (Tabak et al 2012), found over 60 had been published, each with research teams developing concepts and models for implementation research. The frameworks explore the implementation process as a series of interrelated events and processes both within the organisation and outside of it. These tend to be co-occurring rather than linear or sequential in nature. What are described are individual, professional and organisational attitudes, processes and behaviours over time. These may be understood as the inter relationship between systems and sub-systems from micro to meso to macro systems. These may be within an organisation as well as between organisations, (Nilsen 2015)

Well known contemporary implementation frameworks (Kitson et al. 2008, Damschroder et al. 2009, Aarons et al 2011), offer the researcher a set of predefined concepts from which to start to understand implementation terms and processes at an abstract and at a conceptual level. The Promoting Action on Research Implementation in Health Services framework (PARIHS) was built out of the proposition originally put forward from a health and nursing perspective (Kitson, Harvey and McCormack 1998), that implementation is an inter-relationship between three core domains, evidence, context and facilitation, which may be expressed in the following equation:

**Table 2 PARIHS equation 1998 Kitson et al**

|  |
| --- |
| SI = f (E, C, F)  where SI =Successful Implementation, E = evidence, C= context, F = facilitation and f=function of. |

These three core domains were described by the sub-elements which they comprised. Kitson et al (1998) described characteristics of these domains and their inter-relationship using research examples from healthcare and clinical settings. Ten years later, Kitson et al (2008) described the stages of theory building and development that led to the publication of the (PARIHS) as both an implementation framework and as an evaluative tool for use by health practitioners. The refinement of the model to the Integrated or I-PARIHS in 2016 reflected critiques of the original and advances in research so that the equation now became:

**Table 3 I-PARIHS equation Kitson et al 2016**

|  |
| --- |
| SI = Facilitation (I, R,C) where I = Innovation, R = Recipients, C=Context (inner and outer) |

The revised model replaces E -Evidence with I - Innovation to allow for the introduction of clinical skill and greater recognition of practice based knowledge into this construct. The creation of a Recipient construct brings the role and influence of stakeholders, individually and collectively to the fore. The Context construct expands

‘From the micro through the meso and macro levels, that can act to enable or constrain implementation’ (Harvey and Kitson 2016 p5)

Which allows for the wider health system and external drivers to be given greater prominence and acknowledgement in regard to their impact on implementation. Successful Implementation (SI) changes to become F- Facilitation and by doing so moves to be a construct of action and enablement that drives the three main constructs. The Facilitation skills of participants are described at novice, experienced and expert levels.

Damschroder et al (2009) created an ambitious synthesis of frameworks and concepts, drawing together research from 19 principle frameworks, including the original PARiHS model, to establish the influential Consolidated Framework for Implementation Research (CFIR), as a ‘meta-theoretical model’. The aim of this work was to create

‘An overarching typology to promote implementation theory development and verification about what works where and why across multiple contexts’

(Damschroder et al 2009, p50)

The CFIR set out a revised taxonomy and definition of constructs in implementation research. Damschroder then set out an invitation to researchers to explore and refine concepts and to

‘Select constructs from the CFIR that are more relevant for their particular study setting and use these to guide diagnostic assessments of implementation context, evaluate implementation progress and help explain findings in research studies.’ (Damschroder et al 2009, p51)

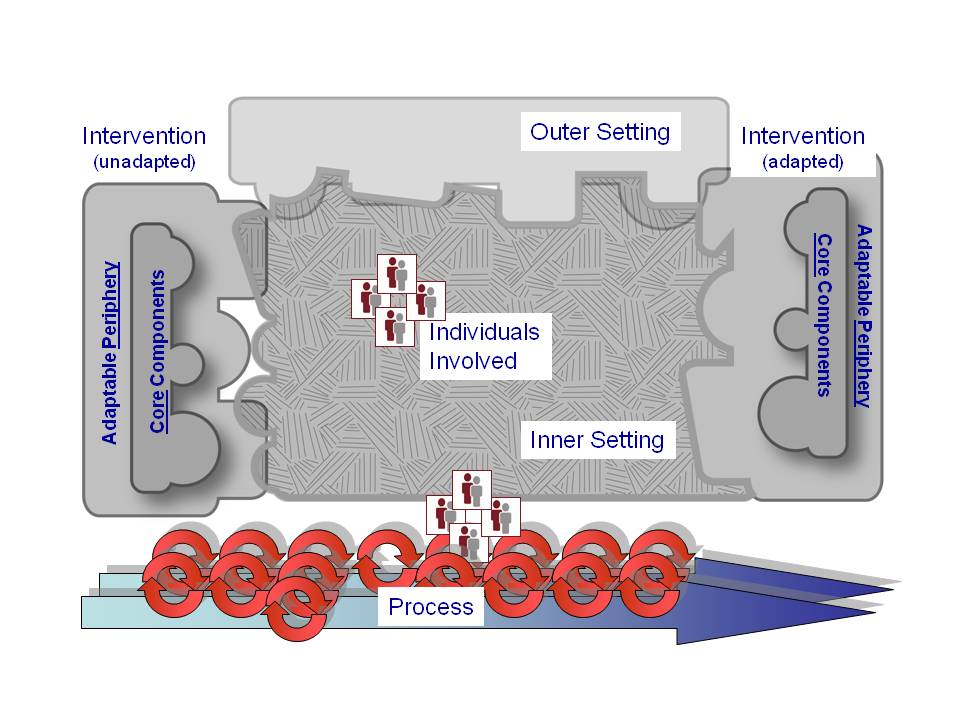
The CFIR identifies 5 major domains: intervention characteristics, outer setting, inner setting, characteristics of the individuals and implementation process. Each domain has further constructs within, which are further defined making 37 constructs in all. Importantly Damschroder pays particular attention to the dynamic and adaptive nature of the contextual setting into which a practice is introduced.

The heuristic representation of the CFIR (Figure 1) indicates the changing relationship between the core domains and of the system and setting into which the practice has been implemented over time. It recognises the contributions of both individual actors and of organisational influences within the system. The model acknowledges the mutually adaptive potential of the organisation and of the intervention over time as it envisages an eventual end state of adaptive stasis between the system and the intervention. One of the attractions of the CFIR is that it recognises that change will continue to take place over time. The influence of the CFIR within implementation science is significant.

Damschroder et al (2016) undertook a systematic review of the use of the CFIR in implementation research since 2009 when the CFIR was first published., Damschroder et al discovered over 400 article citations in their review but found that only 26 studies used the CFIR in a ‘meaningful way’ and achieved inclusion under the reviewers stated methodological criteria. Despite one of the central aims of the CFIR being to create standardised definitions of concepts and therefore to enable broader generalisations of findings to be made, the actual application of the framework has fallen below the original ambitions of the developers. This may also be as a result of the finding that the CFIR was being more commonly applied retrospectively in the post implementation period than at the start of the implementation. The authors reflected that the CFIR will have greater utility as a live implementation tool and in this way it may act as a continuous reference point and a guiding aid to the evolving implementation processes. Nonetheless, Damschroder et al showed some frustration that the use of the CFIR has not allowed for greater advancement of implementation science despite their continued support of it and continued refinement of available technical assistance. An open source research group was established <http://www.cfirguide.org/> (Damschroder et al. 2013) with the high ambition of setting a template for future research and an on-line collaborative system to encourage the widespread use of CFIR and the reporting of results.

**Figure 1**

**Consolidated Framework for Implementation Research (Damschroder et al 2003)**

[](https://www.google.co.uk/url?sa=i&rct=j&q=&esrc=s&source=images&cd=&cad=rja&uact=8&ved=0ahUKEwj6laHYx_rYAhVBthQKHYzNA2cQjRwIBw&url=http://cfirwiki.net/wiki/index.php?title%3DFile:Figure_1_Round3_1_Page_COLOR.jpg&psig=AOvVaw3jj1OFXiGdWCo9OcCY5bBI&ust=1517225531041179)

The first application of the CFIR (Damschroder and Lowery, 2013) researched a weight management programme for military veterans called ‘MOVE’ which was evaluated using the CFIR constructs. A good fit was established for many of the variables examined with the conclusion that

“Of the 31 CFIR constructs assessed, 10 constructs strongly distinguished between facilities with low versus high MOVE implementation effectiveness” (Damschroder and Lowery 2013 p1)

There were mixed results for a further 16 constructs with insufficient data to assess the remainder, with the individual domain not tested in this research.

In parallel with the development of conceptual frameworks there are continuing attempts to develop a general theory of implementation (Grol et al. 2007, Feldstein and Glasgow 2008). Whilst May et al (2009) have taken a grounded theory approach to theory building to expand understanding of the processes by which new ways of working become embedded into practice. This has become known as Normalisation Process Theory. May (2013) has continued to refine his model by integrating additional constructs to create a general implementation theory, which develops and expands the reach of his original work. He has defined four core constructs; capability, capacity, potential and contribution and described their relationships. Within each there are sub themes, which are also defined and characterised. For example within the construct of capability May sets out a definition of workability and of integration. From this he elicits four key propositions that he intends to test in real world settings. For example, capability is tested by his first proposition, that

“The capability of agents to operationalise a complex intervention depends on its workability and integration within a social system” (May 2013 p5)

For May, the important core element is the notion of human agency in shaping and modifying the social system and the social processes that then result. This will be reviewed further in discussion. Moving from the academic and theoretical the next section considers the reality of implementation in practice in a social care setting.

## Social Work and implementation of evidence-based practice

One of the themes of this thesis is the question of why it appears that evidence-based practice elicits such strong supporters and detractors in social care. This is a key area for practice and for the dissemination of evidence based interventions.

However, in considering the use of evidence based interventions in social care, Ghate (2015) found that

“Published surveys or audits of the penetration of evidence-based (or even evidence-informed) interventions are notably lacking, both at local or regional levels and nationally” (Ghate 2015 p814)

Which suggests that this is an under reported phenomena and one which may be difficult to research given a paucity of evidence. How and what is the nature of the resistance from professional groups, especially social workers and how is this articulated? What are the relational, cultural and systemic issues, which need to be addressed for the professional system to learn or accept in order to adapt and embrace change, rather than resist it (McCaughey and Bruning, 2008) As already introduced, there are questions concerning evidence based practice itself in terms of how it is defined and by what criteria or standards are used to judge this (Mazza, et al 2012). A broader question concerns why the development of evidence based practice has, until the advent of the *What Works Centres*, been at the margins of national debate concerning the effectiveness of social care and youth justice policy in the UK (Axford and Morpeth, 2012).

By way of a contrast to social workers, as a similarly registered professional body, Clinical Psychologists are expected to demonstrate the use of evidence-based practice throughout their training and careers. Indeed their professional registration with the British Psychological Society and their statutory registration with the Health and Care Professions Council (HCPC) requires their demonstration of Continuing Professional Development (CPD). Social work, as a profession which is also regulated by statute by the HCPC, has a tradition of ethical underpinning and values based practice (Beckett et al 2017). The revised standards of proficiency for registrant social workers in the UK (HCPC 2017) sets out values for social workers to adhere to in the context of a professional charter as it is in the USA (NASW 2017). However, one suggests that these are far weaker and a less well known set of standards than the obligations encumbering Psychologists. Arguably, the revised charter has not impacted upon the social work profession to any great extent. Nor does there appear to have been a widespread national debate in the profession regarding their creation or adoption. Only one line pertains to evidence based practice

‘12.3 Be able to engage in evidence-informed practice, evaluate practice systematically and participate in audit procedure’ (HCPC 2017)

but without further definition it lacks teeth or credibility. Ghate and Hood (2019) point out the relative structural imbalances between health professionals and social care professionals. In terms of status, political support and training social care is underfunded and enjoys far less political leverage than the medical profession and allied health professionals in the NHS. This suggests a collection of professional disadvantages for social care.

In the recent past social work has appeared collectively resistant to taking evidence based practice further (McDonald 2000) and herein lies a problem for those advocating for the expansion of it in children’s service settings, often from outside of the profession itself although this may now be slowly changing (Ghate and Hood 2019)

The evidence based practice debate was brought to the fore with the question posed by the National social work review, ‘How can evidence-based practice be successfully implemented and sustained in Children’s Services?’ (Munro, 2011) as Professor Eileen Munro articulated a new direction for child protection and early help services. The ambivalence of social work to evidence-based practice and its implementation is a matter of continuing debate as theorists and practitioners seek to develop intellectual, moral and value driven arguments both for (Gibbs and Gambrill 2002, Shlonsky and Stern 2007) and against it (Nevo and Slonim-Nevo 2011).

Historically, social work was founded in the early religious and voluntary groups of the late 19th Century, whilst state management of social problems is identifiable from the 1600s. Early sociological theorists (Saint-Simon 1820, Comte 1865) identified value positions for social work with distinctly positivist explanations of social distress. Defined within social movements, social work grounded itself in the emerging behavioural sciences with calls for the adoption of scientific reasoning as positivist and deterministic thinking led social work away from the aim of religious salvation toward social outcomes and social justice.

“Positivism was also the dominant philosophy of science during the establishment of the British system of social welfare, as exemplified in the work of founders such as Sidney Webb” (Thyer and Myers 2011 p13)

Redefined by the United Nations Convention of Human Rights (1948) social work today is professionally bounded in values and ethics with established codes of practice (General Social Care Council 2006, International Fellowship of Social Workers 2004, 2010, HCPC 2016).

Reisch and Jani (2012) argue that social work has moved away from notions of social justice and consider that social work has lost its way politically. Aiming to deliver change for individuals, communities and society they describe how social work is innately political given the daily impact of structural inequality upon families, stating that social work has become too accepting of existing institutions as fixed and immutable. Challenging the

“Professions uncritical embrace of a positivist epistemology under the label of ‘evidence based practice’ and emphasize relations of intra-organisational power” (Reisch and Jani 2012 p1140)

Thereby positioning social work now as less of an agent capable of delivering sustainable behavioural change in partnership with families, and more as an agent of social control. Is the role of social work to ameliorate the excesses of political power or to emancipate those oppressed by inequality? By understanding social work within an explicitly political context Reisch and Jani conclude that the profession needs to refocus on power relationships first and foremost, criticising notions of ‘effectiveness’ as serving to reinforce the status quo by maintaining social workers as professionals with expert knowledge.

Alongside political perspectives there are other influences upon what social workers think and believe. Rubin (2010) describes how training social workers in research techniques has fallen in and out of social work training. By 1982 social work training in the USA included research design and methodological training. Rubin (2010), suggests that whilst laudable the

“Enthusiasm for the empirical clinical practice model gradually diminished toward the end of the 20th century, as various studies consistently found that even among students who were trained in the model, very few were actually applying the model in their practice after graduating” (Rubin 2010 p66)

Along similar lines and in attempting to establish a university and social work collaboration to try to cover a perceived ‘research to practice gap’ by developing training of evidence-based practices with social work staff. Bellamy et al (2007) encountered

“Barriers related to practitioners’ negative attitudes toward research evidence and lack of understanding or misperceptions about evidence-based practice concepts and process” (Bellamy et al 2007 p13)

The researchers quite realistically considered that this approach would bring benefits in time if they persisted, especially with the newer students who were qualifying in social work as they had less entrenched beliefs but it might still take a long time to develop.

Barth et al (2011) express concern with the observation that social work practice has taken what one might describe as a ‘pick and mix’ approach to the use of theory and scientific models. Their research described how social workers know that theory underpins practice but in unspecified form with social workers commonly describing their practice as ‘theoretically eclectic’ or drawing upon a range of different theoretical positions.

“Yet, many who identify their practice as eclectic cannot identify the theories or methods that they practice”. (Barth et al 2011 p108)

One can only share their anxiety with the incoherent theoretical jigsaw with which they were presented. Many theoretical concepts such as attachment theory and social learning theory are used in everyday social work practice, assessments and Court reports and feature in social work training. However, Barth et al consider that these are rarely described as part of a coherent body of theoretical work which is then consistently applied in practice. This approach of low level theoretical articulation may have hindered the social work profession by compromising its ability to speak with certainty and clarity in regard to the purpose of social work and of the social work task in public discourse. Thereby impacting upon the reputation and understanding of the profession as credible and distinctive when compared to other disciplines. Politically and culturally social work risks becoming the ‘make it up as you go along’ profession lacking internal consistency or a credible sense of itself when faced with external scrutiny or political hostility (Munro 2011).

The appointment of the first Chief Social Worker for England and Wales (2013) shows a determination by Government to support professional social work, after years of media assault and criticism (Warner 2014). As national advocate for the profession, this role is only now beginning to usher in programmes for the long term reform of social work with the establishment of the new regulator, Social Work England (2018) under the chairmanship of Lord Patel succeeding the HCPC as registrant body.

The drive towards evidence-based practice within social work has not been welcomed uncritically (Adams et al 2009). One critique of evidence-based practice is that it may de-skill rather than up-skill practitioners (Timmermans and Mauck 2005). Leading evidence-based programmes such as MST, require continuous assurance of the fidelity of the programme and the manner of delivery in terms of the intervention is highly structured (Hengeller et al 1990). Practitioners are directed by a clinical manual which guides the intervention markers of quality assurance. Ayre and Calder (2010) suggest such interventions deny the centrality of the therapeutic alliance being freely created between the practitioner and the service user, which for many is central to the social work task. Rubin (2011) counters this assertion, pointing out how therapeutic alliance is universally stressed as an important building block and a precondition in evidence-based programme manuals (Alexander, Robbins and Sexton 2000)

Whilst Webb (2001) counsels against the mute acceptance of the epistemological and methodological assumptions which are marshalled under the banner of both evidence and effectiveness. Webb’s position may be summarised as one whereby

“Relying solely on empiricism – that is, the notion that knowledge comes only or primarily from measurable experience – is considered to underestimate the value of other ways of knowing” (Axford and Morpeth 2012 p269)

Webb (2001) sets out five sources, which he believes support the trend toward evidence-based practice: Behavioural social work, medical and health care research, positivistic and empirical science, the increasing influence of evaluative research about practice effectiveness, and government supported managerialism aimed at developing performance culture by controlling quality, optimizing effectiveness and reducing risk in social work departments. Webb’s sources are drivers that could create the preconditions for evidence-based practice to be informing contemporary policy. For evidence-based practice to flourish these trends will need to be in place. Perhaps what is striking is that the rhetoric of strategic intention Webb described in 2001 remains consistent whilst the evidence of change to practice has been much slower to be realised.

Webb argues against a stifling assault on social workers’ autonomy, calling for a return to the rational and dynamic interactions between human agents, which recognises

“Social agency as meaningful, intentional and interconnected” (Webb 2001 p76)

This gives primacy to the central idea of paying attention to relationships first although one might reasonably argue that the social work task should also be seeking purposeful change too. Webb’s assertion may be a rather one-dimensional view of evidence-based practice in which the social worker is perceived as taking a mechanistic ‘painting by numbers’ approach with scant regard to the interaction between the social worker and subject.

Barth, et al. (2011) also challenge the notion of importing evidence based practice into social work practice, suggesting that

“Rather than simply emulating early effort in clinical psychology by embracing manualised treatments wholeheartedly, social work has the opportunity to blaze a new trail toward effective treatment delivery through the adoption of cutting edge clinical practices that reflect the core values of the profession” (Barth et al 2011 p108)

This is a more values driven objection. Barth et al argue that evidence based programmes continually struggle with implementation and that they are neither sufficiently attuned to the differing needs of clients nor are they culturally versatile or flexible enough to recognise diversity. In other words interventions might be good at what they do but their utility is limited outside of the narrow template for which they have been tested, packaged, marketed and licenced. At its’ most extreme this echoes the unbridled contempt with which Pitts (2001) described the interest by the Youth Justice Board with a highly structured programme approach in youth justice. Similar to programmes that were current in the Probation Service at the time, the intervention would have removed discretion from practitioners and replaced traditional case working functions in favour of rigidly delivered group work. For Pitts, the adoption of this approach would lead to the

“Zombification of the youth justice professional” (Pitts 2001 p1)

By which the professional delivers a programme mindlessly. In reality though, professional practice is, in my experience at least, a long way from this caricature. At best, evidence-based practice seeks to enhance skills and ensures that the most effective practice skills that a practitioner can bring to bear are recognisable and utilised more of the time, not less. The major interventions define the operating conditions and the facilitated space into which the practitioner is able to engage families and to then seek to use their skills to create sustainable long term change. This includes the centrality of relationships and engagement between the practitioner and young person and their family. (Alexander, Robbins and Sexton 2000). The use of an evidence-based framework also allows the Supervisor, with oversight of the intervention, to be reasonably confident that the nature and content of the intervention will be delivered as intended.

Webb (2001) describes the social worker as a rational agent making decisions made not only on an assessment of available evidence but on a range of variables including pre-conceptions, beliefs, politics, morality and their world view. Social workers are neither empty vessels nor without experience and should be encouraged to bring their practice skills to the fore. Chaffin and Friedrich (2004) further describe how social workers have sought to combine scientific theory with practice skills, knowledge and values to craft evidence informed or evidence suggested practice interventions. They helpfully contrast this traditional practice with an evidence based approach in table 4 below. This shows the differences in orientation and perspectives. One may infer how this represents the dissonance which may be present between mainstream social work practice and evidence based practice.

Table 4

**Contrasting evidence based practice with traditional practice (Chaffin and Friedrich p1101, 2004)**

|  |  |  |
| --- | --- | --- |
|  | Traditional Practice | Evidence based practice |
| Source of knowledge | Accumulated subjective experience with individual cases. Opinion based. ‘In my experience’ | Well designed, Randomised controlled trials and other controlled clinical research. ‘The data shows that..’ |
| Knowledge location and access | Hierarchical. Knowledge is possessed by opinion leaders. Charismatic expert driven | Democratic. Knowledge available to all. Information technology driven |
| Method of achieving progress | Haphazard, fortuitous, based on changing values, fads, fashions and leaders | Systematic, predictable, based on incremental and cumulative programmes of outcome research |
| Practitioner expertise | Quasi-mystical personal qualities and intuition | Specific, teachable, learnable skills and behaviours |
| View of practice | Art, creative process with fluid boundaries | Craftmanship, creativity within the boundaries of the models and protocols |
| Research to practice link | Indirect. Inferential | Direct, integral and fundamental to practice |
| How research is summarised and applied to practice | Individual, subjective practitioner synthesis of whatever literature is consumed | Best practices, workgroup or collaborative summary based on exhaustive reviews of the outcome research |
| Programme evaluation | Inputs (credentials of practitioners) and outputs (number of clients served, number of units delivered) | Outcomes (measurable ‘bottom line’ client benefits |
| Location of research | Mostly in laboratory settings and divorced from practice | Field clients routinely enrolled in trials to test benefits and refine services |
| Quality control | Focus on how well service rationales are conceptualised and the credentials of who provides them | Focuses on how well services are behaviourally delivered vis a vis a prescriptive protocol |
| Practice visibility | Actual practice is seldom observed by anyone other than the client or practitioner | Direct peer or consultant observation of practice with specific feedback |
| Assumptions about outcomes | Faith. Service programmes in general are seen as good and are assumed to be beneficial | Scepticism. Knowledge that intervention may be harmful. Benefit to be empirically demonstrated and not assumed |

Their main concern with the continued use of the traditional approach of employing evidence informed practice being the risk of inconsistency and variability, echoing earlier concerns.

“The central difficulty with ‘Evidence informed‘ practices or policies is that the bar is set too low; so low in fact that inert or harmful practices can qualify, especially given reasonably articulate proponents and a rationale that resonates with current social values.” (Chaffin and Friedrich, 2004 p1099)

They develop their argument with the finding that many well intentioned, logical and value led approaches are simply ineffective or at worse, harmful unless they generate rigorous outcome evidence. The implication is that social workers may not have the ability to discriminate sufficiently what is good or not good in practice. Nor do social workers possess the requisite skills to set up research trials which might provide evidence. One might add that the organisational support to achieve this may not be forthcoming either. Given Chaffin and Friedrich’s work one can see how social work may be culturally resistant to evidence based practice.

Neither is social work striving towards objectivity in decision making given the subjective nature of how practice is crafted and what skills and experience are valued by the profession, as Chaffin and Friedrich describe. Interestingly, the odds of wholly rational decisions being made in practice are lower than one might expect as McCaughey and Bruning (2010) found in work reviewing decisions made by health managers, even when those managers were themselves highly disposed to evidence based practice.

Unhelpfully, evidence based practice has no standard definition and may also be known as ‘Best Practice’ ‘Evidence Informed Practice’ ‘Evidence Supported Practice’ and ‘Empirically Supported Practice’ (Mazza, et al 2012). The cited reference in the Oxford English Dictionary of ‘best practice’ is from a 1984 accounting journal. Successive Government guidance since the 1990’s uses ‘evidence-based practice’ to describe good ideas worthy of replication. This could be used to describe a project, which has had a user satisfaction survey as the measure of outcomes rather than a fully considered piece of evaluative research. This is of course a long way from the original conception of the term, which was used to describe experimental evidence from rigorous trials providing statistically significant effects of a causal relationship (Flay et al, 2005) From medicine a helpful working definition of evidence based practice is

“The conscientious, explicit and judicious use of current best evidence in making decisions about the care of patients. The practice of evidence-based medicine requires integration of individual clinical expertise and patient preferences with the best available external clinical evidence from systematic research.” (Guyatt and Rennie 2002, p412)

For social work practice this is represented as the three domains of the Venn diagram in Figure 2 below (Ciliska 2006) in which evidence based practice is posited at the intersection of best evidence, client values and practitioner expertise. This places a social work definition of evidence based practice within the context of the practitioners relationship with the person who is receiving the intervention.

Figure 2 Evidence based social work 

(Ciliska 2006)

Teater and Chonody (2017) support this perspective by describing how, in social work practice

“The process of reviewing and applying the best available research evidence while also taking into consideration the practitioner’s experience and wisdom, and the client’s values and wishes is also referred to in the literature as evidence-informed practice (EIP).” (Teater and Chonody 2017 p3)

Teater and Chonody’s (2017) research evaluated how ready the new graduates of social work training in the USA were for evidence based practice. Given recent changes to the curriculum there is cause for optimism. However, they considered that once social workers start their practice they find that the organisation that they join may be unprepared to support their continued learning and development, nor facilitate their attempts to integrate evidence based practices into their work. Pointing out how, as in the UK, social workers become cut off from the resources and opportunities available at university such as library access and journals. Instead social workers become reliant on internal training and second hand knowledge. Certainly there is a weaker tradition of continuing academic relationships for social workers through their careers than for example Psychology.

As in politics, social workers do not have the time or luxury to make decisions following entirely dispassionate and rational assessments of evidence in the knowledge that the desired result will follow. Social workers often face competing demands and have to deal with complexity in human relationships at the worst of times in people’s lives. Considering evidence based policy (Cairney 2016) describes the messy political realities and how far away from an idealised policy cycle political decision making really is. Decisions are made in the worst of circumstances and mix expediency, factionalism and short-termism in full public glare. Tellingly perhaps Webb (2001) cites Nisbett and Ross (1980) whose own arch assessment states that

“People are unmoved by the sorts of dry statistical data that are dear to the hearts of scientists and policy planners…information that the scientist regards as highly pertinent and logically compelling are habitually ignored by people” (Nisbett and Ross 1980 p115)

There are generic lessons regarding implementation for professional service systems in health, social care and in education to learn and adopt (Fixen, et al. 2005). Some of these lessons are wider than the specific implementation requirements of the programme developers themselves (Hengeller et al 1990, Chamberlain, 2001). Commissioners are not simply buying a product off the shelf but a licence to operate. Such licences stipulate a continuing relationship with a owners of the product which usually constitutes a relationship with a programme consultant who assures that the intervention is set up and managed according to the stated implementation process.

Much as one may be persuaded by financial arguments for the use of evidence based practice (Aos et al 2001), a moral assertion can be advanced that

“The advent of evidence based practice has placed an unwritten ethical imperative on human service practitioners to ensure, as far as is possible, that interventions are informed by current best available research evidence about the most effective interventions and outcomes” (Gray et al 2012 p1)

This is not politically neutral and so what new services are commissioned and conversely what might be de-commissioned as a result of looking at services through the lens of evidence-based practice has far reaching consequences for individuals, services and organisations.

Defining what evidence-based practice is, what research evidence is accepted and what standards apply remain matters of considerable controversy. (Lipsey et al 2010, Chaffin and Friedrich 2004). Continued and successive attempts at definition and classification have tended to be based upon a process of external accreditation of evidence-based programmes as seen with the evidence based practice registries and more recently the What Works Centres. Puttick (2018) has reviewed and mapped the 18 different standards and evidential frameworks currently being used in social policy in the UK and the timeline of their adoption. From the GRADE (Grading of Recommendations Assessment, Development and Evaluation) framework used by the National Institute for Care Excellence in 2000 to the CERQual (Confidence in the Evidence from Reviews of Qualitative research) adopted by the What Works Centre for Wellbeing in 2017. Puttick notes the varied uses of scales, standards and methodological position of each and the points of variation. She proposes an independent accreditation system which can build consensus within the sector given that the current.

“Diversity can create confusion. It is alarming to hear that some interventions have been rated a decent two on one scale, but a poor zero by another. That sends a garbled message to our sector”

(Puttick 2018 p 4)

The varied criteria often places RCT research findings at the top of the evidential hierarchy whilst others advocate a more balanced approach where

“Findings obtained by qualitative, mixed methods or case studies are valued as important sources of evidence as well as those arrived at by RCTs” (Nevo and Slonim-Nevo 2011 p1194)

Whilst some will reject all other forms of evidence such as practice based research (Dodd and Epstein, 2012), as an inferior alternative. Not all practice innovations may be appropriate to be tested by an RCT in any case and there are clear ethical considerations to consider in designing research that may deny access to service to a control group (Gambrill 2015) or involve work with vulnerable groups (Dixon et al 2014). RCT research may require expert knowledge, long term organisational support and is often prohibitively expensive to set up whilst results may take years to be produced. Research RCTs conducted by programme developers may have in-built bias towards positive results too (Eisner, 2009), when compared to independent evaluations. This could be because of the close control the developers have of the process or as a result of their expertise and motivation giving greater support than a later less experienced implementer might.

The anticipated economic outcomes and effect size (Aos et al 2001) are calculated to be reduced by 25% when a programme is implemented without the direct involvement of the developer. Whilst inconsistent outcomes for MST in Canada, one of the first conducted outside of the USA, created significant challenges to the programme developers who were perplexed by the lack of discernible effects when the programme was introduced there and was independently evaluated (Leshied and Cunningham 2002). This led to considerable debate between MST Services and the Canadian Justice Department regarding the quality of the research design, local variables and of the interpretations of results. A later MST RCT in Norway piloted four Teams, finding that one site consistently recorded fidelity scores below optimum which resulted in a corresponding poor set of results (Ogden and Halliday-Boykins, 2004). In many ways this helpfully proved the significance of the relationship between fidelity and outcomes. The lessons learned by the Norwegians in this trial were used in the national implementation plan for MST, with close attention paid to fidelity.

**Leadership in organisations**

For this research the relationship between implementation and leadership emerges as a major theme. Accepting Bass’s (1985) concept of leadership as one of the many functions of managers, Yukl’s (2013) well cited definition of the role and function of leadership provides a helpful identification of task and purpose, describing leadership as

“The process of influencing others to understand and agree about what needs to be done and how to do it, and the process of facilitating individual and collective efforts to accomplish shared objectives” (Yukl 2013 p7)

This fits within the sociological perspective in which

“All forms of leadership are subjective, socially and discursively constructed and dynamic” (Schedlitzki and Edwards 2018 p7)

This stresses both the contextual and the relational positions between leadership and those who are followers, as a mutual process. In contrast to the psychological school which is more concerned with the individualistic leader-centric paradigm, competencies of leadership and the attributes or characteristics of individuals in leadership roles. The sociological school, utilising qualitative methods, appears well suited to the theoretical position taken forward in the methodology of this thesis of social constructionism, which seeks to understand the context in which leadership takes place and how meaning is dynamically constructed between actors. Of interest is the process by which leadership create a culture for change, influencing and sustaining the implementation process through active collaboration. This is because the role of implementation leadership may be seen as one of attentive facilitation and collaboration as well as the exercise of power within and involving a network of others.

Clarke (2018) describes how, from a social constructionist position, that leadership is a

“Collective activity, constantly shifting depending upon the particular context and the goals that need to be pursued…Indeed, the demands on organisations to constantly innovate and change, means that leadership needs to be performed by many individuals at differing times”

(Clarke 2018 p 29)

Moving further away from the individual leader Cullen et al (2012) perceive leadership as

“An accomplishment of collectives rather than as the actions of individuals”

Cullen et al 2012 p 428)

As the thesis will explore, leadership through and across the research sites was centrally important to the implementation process and often shared. This next section describes leadership and the Local Authority organisational context in which this takes place. As large public sector institutions Local Authorities are not single homogeneous entities but are complicated, factional, political systems with leadership taking place at micro, meso and macro levels (Leslie and Canwell 2010). Local Authorities are commonly split into departments, services and teams, each with their own leaders and subordinates and a multiplicity of inter and intra relationships. Change and adaptation are now constant motifs of Local Authorities and no more so than in the present climate of austerity with reducing resources and high demands requiring reorganisation, re-prioritisation and transformation. (Local Government Association 2019). Structural change is also a continuous response to budget pressures. (Webb and Bywaters 2018) Change can be internally driven in pursuit of staffing efficiencies or may be required or imposed in response to new responsibilities, national policy and legislative changes, legal precedents and external conditions (Murphy et al 2017).

The pursuit of organisational change is rarely cost neutral and may quickly conflict with vested interests as French, et al (2009) consider,

“It is not surprising that there are reports of problems in the organisational capacity of the public sector to effectively manage best practice innovation, particularly around issues of power and politics between different professional groups” (French et al 2009, p1)

This may be particularly acute when change takes place at the most senior levels. In business and in public sector settings, there is an expectation placed upon the CEO by the board or Councillors to drive strategic change. This may be in the Weberian sense of a charismatic leader whose skills are highly prized as the leader who may be considered

‘To be a visionary, extraordinarily gifted and capable of delivering exceptional performance (who) communicates an appealing vision and is willing to take personal risk while also showing a high level of consideration for his team and a keen sensitivity to their environment’ (Petit 2012 p513)

There are however risks for organisations with charismatic leadership (Roe 2017) whilst Weber (1978) describes how organisations must pass through a process of routinisation in order to transform and make routine into the everyday, what has been driven through by charismatic leadership and as charisma begins to dissipate. (Wilderom, Van Den Berg and Wiersma 2012.) This can be particularly pronounced at the point of transition and succession between leaders.

Given the status and premium afforded to Chief Executive Officer (CEO) positions, the literature from both public management (Boyne et al 2011) and business schools (Frangos 2016) reflect the challenges of succession in describing the search for new CEOs. Should the new leader be an insider or an outsider is a constant dilemma. Schnatterly and Johnson (2008) describe how internal succession planning for replacement leaders in high tech companies has worked effectively, especially in periods of growth and expansion, with insiders holding significant advantages over outsider candidates in terms of knowledge, familiarity and personal investment in the business. They contrast this with the risks of a high-flying outsider who may seek growth and change but whom will take time to learn the fundamentals and intricacies of the business and therefore lose valuable time or the momentum which gives competitive edge in the marketplace.

In a review of succession leadership Hutzschenreuter, Kleindienst, and Greger (2012) describe how the search for an outsider candidate is often driven by an organisational perception that an insider will not grip change sufficiently to deliver fundamental change given their internal interests and personal alliances accrued over time. Henderson, Miller and Hambrick (2006) describe a life cycle theory of the CEO, which suggests that the longer a CEO is in place the less appetite they will have for initiating change. They find a relationship between length of tenure and increasing strategic inertia, although this can be more pronounced in more dynamic and innovating industries such as technology than in more stable ones such as food production for example. Business studies literature is full of examples of successful and unsuccessful case histories where the insider or outsider has been either fantastically successful or devastatingly unsuccessful, leading a company to either riches or ruin. It is interesting to reflect upon how change is delivered in public sector organisations and to use insider and outsider positions to think about leadership here too not least with the persistence of the myth of leader as hero paradigm (Clarke 2017).

Researchers from both the sociological and anthropological, (Merton 1972) (Malinowski 1922) perspectives have considered the insider and outsider position from the standpoint of participant research. Merton (1972) established two opposing views, the insider doctrine and the outsider doctrine, which may be thought of as two ends of a continuum. Merton suggested that the outsider may be wholly objective but can never have the same insights as the insider and vice versa. This sets the scene for the challenges researchers from either position face in gaining access to communities, dealing with sensitive information, making assumptions or simply missing the meanings behind behaviours they are observing. Dwyer and Buckle (2009) developed the idea of the ‘space in between’ rather than a dichotomous relationship between the insider and outsider, which they consider to be otherwise too absolute. Kerstetter (2012) applies this idea in regard to the manner by which a researcher may position themselves in this space, using four categories of position:

“Indigenous-insider, indigenous-outsider, external-insider and external-outsider” (Kerstetter 2012 p101)

Whoever the leader is it is their actions and leadership style which will set the tone for how the organisation and wider system come to manage and achieve the strategic objectives for the organisation. Whether to direct, persuade, empower or command are common leadership dilemmas.

Heifetz et al (2009) argue that command leadership approaches are a natural, if not an inevitable response to the state of permanent crisis in which we perceive that we now live in. Anticipating that in the post economic crisis world a new adaptive leadership would emerge that would encourage participants to embrace changes to the established order more readily as they saw a new imperative to do so. This new integrative style of leadership may be defined as drawing up the leadership tools required to bring

“Diverse groups and organizations together in semi-permanent ways, and typically across sector boundaries, to remedy complex public problems and achieve the common good” (Crosby and Bryson 2010 p211)

However, this cooperative and consensus building leadership does bring its own challenges and risks. Braga et al (2008) describe a wide partnership of statutory and non-statutory bodies which attempted to deliver a youth violence reduction programme in Boston, USA in the 1990’s before closing in 2000, finding that

“Collaborative efforts are expensive, fragile, and unreliable. It is very difficult to implement and sustain initiatives that draw on assets and capabilities distributed across different organizations” (Braga et al 2008 p220)

The risk may well have been weak or confused leadership that had not been well defined between competing interests. If leadership is neither obvious nor present then lack of direction is likely to result. Of course wide and inclusive partnerships can and do exist and can deliver successful projects and services as large as the Olympic Games but usually with clear executive leadership and strong lines of authority. Grint (2010), counsels against seeing distributive leadership as an obvious answer to leadership given that

“The evidence thus far suggests that distributed leadership is anything but a simple solution to a complex problem and the subsequent difficulties of making it work seem to have led many to resort to Command and Control in the face of collective congealment and indecision. (Grint 2010 p311)

This raises issues for both the leadership approach and for the systemic changes it seeks to achieve, not least given the fact that transformative work in one part of the organisation does not mean that surrounding services are in any way static. Organisations will continuously shape and adapt to new circumstances and in response to their own pressures in the constantly shifting organisational space as, for example, both recent NHS reforms and the criminal justice Transforming Rehabilitation programme have demonstrated (Krachler and Greer 2015, Burke and Collett 2016).

The literature on implementation science and the literature on management and leadership help to open up the organisational, political and systemic issues that enable or frustrate leadership in the process of transformation change (Aarons et al 2016). This is useful in considering if there are generic lessons to learn for organisations and how one might acquire the tools for leadership to replicate successful implementation of evidence-based practice.

From a social constructionist position, Grint (2008) categorised problems as ‘Tame, wicked or critical’ and suggests that different approaches are required of leaders to solve them. Whilst tame problems might be highly complex there are known standard operating processes for dealing with them and the management task is to follow a defined process that has worked successfully in the past. Examples of this would include legal proceedings under the Children Act 1989, which are often contentious and complicated, but operate in a well-defined framework with procedural rules and case law guiding the process. The managerial task is therefore one of a rational organisational process and the application of tried and tested approaches to consider how to arrive at determinations and judgments.

Grint states that critical problems require a much more command and control response of leadership, as critical problems are by their very nature a point of acute crisis. Such problems may require decisive actions in short time periods with executive power being ceded, at least on a temporary basis, to a leader who will act for the public good and provide quick answers in high-risk situations, even if this means suspending normal rules or norms for a temporary period. Examples of command leadership include military operations or police responses to civil emergencies such as the London bombings in 2005 or the suspension of flights over London in the immediate aftermath of the 9/11 attacks in 2001. In contrast the wicked problem has no ready template for resolution and so Grint suggests that this requires novel thought. The leader’s role is to

“Ask the right questions rather than provide the right answers because the answers may not be self-evident and will require a collaborative process to make any kind of progress.” (Grint 2008 p8)

Setting out four organisational archetypes that are working models to use to explain organisational cultures. He stresses that these are broad tools to understand different ways of thinking rather than that they are likely to be found quite so starkly in real organisations. The four archetypes are characterised by: Individualism, Fatalism, Egalitarianism and Hierarchy. Each archetype will understand problem solving in a different way given the cultural norms of each. The individualist archetype will see solutions to problems as resting in the unfettered activity of the free market through the loosening and freeing of rules and regulations. This freedom allows space for innovation, which is perceived as being a key to success. The individualist feels naturally resistant to the call to follow others. The fatalist will largely perceive their world as a given and is therefore simply unable to create or contribute to change because the world is a pre-determined place where change is created by others and change is done to one rather than controlled and manipulated by individual agents. The egalitarian model places value on empathy and collective responsibility. It is an anti-egotistical way of thinking. Egalitarian solutions usually take a decentralised approach for the common good. For the hierarchical archetype the creation of order places value on the rule of law and rule enforcement. Therefore, the answer to a problem such as young people and knife crime is the rigid enforcement of the rules. Should young people continue to carry knives and violent knife crime persists then the answer is in even more intrusive enforcement or revision of the rules.

For Grint, each model has an internally consistent means of devising solutions to problems as they occur. He argues that this approach is well suited to both tame and critical problem solving. Such approaches create what Grint describes as ‘elegant’ or uni-linear problem solving. However none of the models is good at solving wicked problems alone. The solving of wicked problems requires the stitching together of elements of the three models (assuming that fatalism rarely has anything creative to add to problem solving) in an ‘inelegant or clumsy way’ in order to create a solution, which is the best possible in the circumstances. This requires the intervention of the leader as a ‘Bricoleur’ or artisan craft worker, able to create a make-do solution in the best way possible but by drawing on the best fit between the three main archetypes. Grint describes the pragmatic utility of seeking clumsy, imperfect solutions as being the core task of leadership. The point of this is that the skills of effective leadership rest in the ability to harness the most salient elements from the available tools.

Grint gives examples of the questioning style of President Kennedy during the Cuban missile crisis in 1962 as effective solution finding to a wicked problem. He contrasts this to the absence of questioning by President George W Bush of his emergency planners, FEMA, immediately before Hurricane Katrina struck New Orleans in 2005, which led to serious loss of life and damage thereby perhaps demonstrating that leaders have to search to find the right questions to ask rather than be relied upon to provide immediate answers.

Turning from how leadership operates within an organisational context it is useful to think about how organisations operate as functioning political systems

Fixen, et al. (2005) states that

“Systems trump services” (Fixen et al 2005 p79)

Which appears to be a realist appraisal of the power that organisational and functional systems may exert, to either accept or reject a service. The systematic review of implementation research, Fixen, et al (2005) described the multi-layered relationships between the different levels of a social welfare system at strategic, operational and cultural levels. Fixen sets out how deficits in any part of the system across these inter-related layers will have the effect of reducing the likelihood of successful implementation of evidence-based practices although he does point out that systems are not static. Like a living cell, systems have a tendency to be integrated and compensatory in that weaknesses tend to be balanced out by strengths to achieve homeostasis.

Palinkas, et al. (2011), have stressed the importance of collaboration across networks as critical to evidence-based practice implementation and this may be vertical or horizonal across an organisation and beyond.

“In some cases, opinion leaders are persons who bridge different social networks, and their position as a bridging tie facilitates their success in bringing new practices from one network to another” (Palinkas et al 2011 p8)

Thinking about the long-term sustainability of evidence-based programmes and adaptability within a system, Wiltsy-Stirman, et al. (2012) suggest that

“The success of some programmes may be less dependent on the implementation of a set of procedures with fidelity than on the flexibility and adaptive capacity of the system or organisation that implements the programme” (Wiltsy-Stirman et al 2012 p10)

The amount of adaptive stretch that an intervention programme may offer is usually relatively limited but is it a key function of the mutual coming together of the system and the intervention as (Damschroder et al 2009) describe with the adaptive periphery and May (2013) extends through normalisation process theory.

From an organisational and cultural perspective, Weiner (2009) describes implementation as a ‘team sport’ although it can be a team with varying degrees of commitment to the goal in hand

“Organisational members can commit to implementing an organisational change because they want to (they value the change), because they have to, (they have little choice), or because they ought to (they feel obliged)” (Weiner 2009 p3)

Weiner places a strong emphasis on how change will be successful if the organisation can articulate the values that underpin the changes. He makes a direct link between organisational readiness, as a measurable variable and as a shared property, which is owned by the team in seeking to understand the preconditions that lead to successful implementation.

In summary, the available research on leadership confirms that many of the organisational challenges that have been encountered in implementation practice are identified and considered in contemporary implementation science. In this context the nature of leadership and organisations becomes easier to understand but not necessarily easier to tame. At the very least, an understanding of the dynamics of how implementation takes place can begin to more than hint at how variables might be controlled and what leadership skills the modern manager might need in order to transform practice. A review of evidence-based practice by Stetler, et al. (2009) suggests that

“Multi-levelled leadership by managers, educators, senior leaders, staff nurses and supervisors, characterises organisations that have successfully implemented evidence into practice” (Stetler et al 2009 p11)

This is a reminder both that leadership is neither a single event or indeed a single person but a collective effort over time throughout an organisation.

**Chapter 3 Methodology**

This chapter outlines the development of the research questions and the choice of methodological design. With reference to the relevant methodological literature, the aims and objectives of the research project and the rational for the methodology selected will be described. The coding and analytic strategy will be discussed and explained. At the end of this chapter is a description of the research journey undertaken and the decisions made in regard to the research design will be further explored.

**Research questions**

The following research questions have been addressed in this thesis;

1. How does leadership shape and drive the implementation of an evidence based practice in a Local Authority setting?
2. What are the conditions in the organisational and environmental context which facilitate or hinder the implementation of evidence based practice?
3. What practice lessons for implementation may be drawn from the relationship between leadership and the organisational and environmental context which may lead to the sustainment of evidence based practice.

The primary research question aims to determine what factors may contribute to the successful or unsuccessful implementation of an evidence based intervention in a Local Authority setting. The question extends beyond the immediacy of the mobilisation and set up phase for the new intervention in the first year of planning, preparation and initial operation. It extends to the point at which the intervention achieves relative stability and integration within the operational system into which is has been placed and, potentially, achieves sustainability. The conversion of a grant funded, time limited or medium term funded project into a sustained intervention is a consistent theme for evidence based practice settings. It is accepted that many more services are initiated than are sustained in the long term and many organisations are littered with programmes which never prospered. (Hodge and Turner 2016, McKay et al 2018)

Local Authorities have invested considerable resources in their commissioning and procurement procedures, pay large sums of money and commit significant human capital to implementation efforts to set up evidence based interventions. It is therefore intriguing to consider whether the quality of the implementation itself, as a distinct process, predicts, if not assures, the sustainability of the intervention which has been established. One might wonder if the foundations laid during the implementation period matter in establishing a programme within the organisation. Conversely, can a programme become stable and secure in the long term following a difficult start or an implementation mobilisation period which was somehow compromised or flawed. If so then what processes might be taking place? How has the intervention managed to connect and sustain itself into the organisational system into which it was placed if the implementation was less than optimal.

What may be more important overall however is the changing and dynamic interplay between the leadership and the organisation’s setting over time. One can consider that this relationship is central to facilitating the operational and strategic space into which it is anticipated that the implemented intervention will both thrive and succeed. Organisations may intend for an intervention to be sustained in the long term but may not have the will or ability to achieve this aim. Organisational setting and leadership represent two of the major core components of what might be termed as the organisational context in implementation science although there are variants and differences between some of the implementation frameworks as to how this is described (Damschroder et al 2009, Kitson et al. 2008)

One might expect that the trajectory of implementation into an organisation would appear as a bell curve graph (as described by Rogers 1995, in regard to diffusion of innovations theory). It may be possible to track the integration of an intervention into a system over time as it moves from being a new project at the boundary or margins of an organisation to that of becoming a mature and an integral part of it. Some interventions though are never wholly integrated and always remain at the margins of an organisation or system throughout their existence. (Greenhalgh et al 2012). This less stable position may expose the intervention to continued risks by remaining peripheral to the system’s core. The way in which an intervention is thought about by the system matters too as Greenhalgh et al (2012) found in their review where commissioners declined to incorporate the new intervention into the existing system, as had been hoped by the funder. A system may perceive an intervention as either an internal, transitionary or as an external object and modify behaviour towards it as a result.

In beginning to think about how organisations achieve integration of interventions, implementation science offers potential in helping to understand how interventions are sustained and what changes take place to enable this through system adaptation. How, and in what circumstances does this occur, are key lines of enquiry. (Scheirer and Dearing 2011,). The suggestion is that in exploring this further that one might find the points or processes at which the implementation phase has come to an end and the intervention has transitioned to become a part of mainstream business. It could be that there is a process of mutual adaptation taking place. Successfully achieving such adaptation may be through a process of leadership driven facilitation of the operational setting. This may entail the active management and leadership of the system coupled with careful attentiveness to the prevailing conditions which constitute the organisational context. (Proctor et al 2015). It appears certain that the process will not happen organically through maturation and the passage of time alone. It is clear too that the natural state for the context of an organisational system is usually one of flux and change with only brief periods of calm. As Greenhalgh et al 2012 discovered in a review of NHS innovation and sustainability,

“For a whole-system change effort taking place at a time of high environmental turbulence, rapidly changing patterns of need, a complex and changing service infrastructure and multiple external policy initiatives, all of which militate against the long-term continuation or relevance of any particular set of activities” (Greenhalgh et al 2012 p 540)

The present context for public services is known to be one of high churn, particularly in leadership positions.

As a thesis for a professional doctorate, there is an imperative to define research questions that take practice and apply it to theory. This in itself is a difficult process (Bryman 2012). Too broad a question and the research will never be completed but too narrow and it will not allow for sufficient exploration of the subject in hand. Punch, (1998) adapted by Silverman (2013), suggests that the research question should be guided by three guiding tests; firstly, answerability, with clear obtainable data requirements. Secondly, interconnectedness, where questions are related to each other in a meaningful way. Third, substantial relevance, with questions that will justify the effort expended in answering them. These tests lead one to reconsider the scale and definition of the research question so that the subsequent research effort is achievable.

In contemplating evidence based interventions, there is no need to answer the first overarching question for the evidence-based movement which may be summarised as ’Do evidence based programmes work?’ as research has demonstrated much of this already, Hengeller et al (1986), Sexton and Alexander (2000), Chamberlain (2003). Clear controversies regarding evidence, evidential standards and efficacy continue but these are beyond the scope of this work. What might be thought of as a follow up question ‘Can this evidence-based programme work in this setting?’ is further along the evidence and implementation continuum and assumes the general validity of the intervention being used in so far as the first question has been answered. This is demonstrated by the number of times which these interventions have been commissioned. This second question is less concerned with the core integrity of the programme itself but much more concerned with the organisational system into which it is implemented and how this develops over time. It asks for the context to be investigated and evaluated as a critically important feature of implementation.

It is known that there are a number of sites which have delivered evidence based interventions such as Multi Systemic Therapy across the world but which no longer do so, including several in England ([www.MSTServices.com](http://www.MSTServices.com)) So this begs a primary question as to why did these services close? Then a secondary question, what lessons there might be for practice from these sites so that a new service might expect to be sustained? Discussion regarding the closure of sites was identified as a gap in the research literature and so appeared to be an interesting avenue for exploration. It was not clear if the reasons for these sites closing were to do with the intervention itself or the fit of the intervention into the chosen setting or system. Perhaps the interventions are too complex or clinically demanding and so closure might relate to a failure to achieve expected standards of model fidelity. Or perhaps those in the system could not manage to facilitate the conditions by which it would work? Other factors might be at play too so it was important to remain open to other possibilities or factors having influence. It might be all of these issues in varying combinations or no theme may be discernable.

After all of the considerable efforts and resources expended to set services up it seemed strange that more was not being asked about why services had not been sustained. The research question therefore formed into one of understanding the organisational and leadership context in which implementation takes place and which factors contribute to how interventions are sustained in the long term. The next step was to design research to find out a means of approaching these questions.

**Research design**

The research takes a qualitative, grounded theory approach (Charmaz 2006, 2014) through which a conceptual analysis was developed. It is centred upon 12 semi-structured interviews with operational managers and strategic leads in three Local Authority children’s services departments in England. All three sites implemented Multi Systemic Therapy (MST) into their local children’s services in 2008. Each site had a different experience of the implementation of this intervention, for young people on the edge of care, with two of the sites closed and one continuing to operate ten years later within an expanded portfolio of evidence based services. By utilising a qualitative methodology, a deep understanding of the experience of those involved in the implementation of MST in the three sites was established. This data underwent an analytical process following the grounded theory approach described by Charmaz (2006, 2014).

Grounded theory was utilised and in doing so inductive reasoning and logic were employed. By closely attending to the data generated through the research interviews a rich story emerged, built from the multiple perspectives of the interviewees. From this interview data, using a process of abstraction and analytic techniques, new theory was developed. This new theory captured the essential elements of the experiences and delivers new conceptual understanding and therefore an original contribution about the implementation of the intervention. Finally, based on new theory, potential applications to practice and for future research are proposed.

At the start of research, the research investigator is encouraged to establish ontological and epistemological positions alongside their developing research questions, Bryman (2012). This is important as these decisions will confirm and direct the basis of the research design. Ontologically, a grounded theory constructivist approach (Charmaz 2014) was taken in order to access the subjective experiences of the chosen participants. This approach is the antithesis of the objectivist ontological position which assumes the existence of an external world which may be observed and recorded by the researcher. The constructivist position essentially

“Shreds notions of a neutral observer and value free expert. Not only does this mean that researchers must examine rather than erase how their privileges and pre-conceptions may shape the analysis but it also means that their values shape the very facts that they can identify” (Charmaz 2014 p13)

At the outset it was clear that the research design must go beyond a simple narrative account of what had happened in the three Local Authorities. This is because a purely naturalistic approach to gain a descriptive account of events and actions would not add sufficient meaning or evidence nor provide any analytical interpretation to the material being generated by the participants. Silverman (2013) describes the shortcomings of a purely naturalistic approach in that it can

‘Overlook how people create meaning in their lives. Respondents are treated as mere sources of data without any interpretive capacity of their own’ (Silverman 2013 p106)

It was assumed that the interview participants would have already established meaning about their experiences at the time and then will have integrated and reflected upon these since. The accounts would always be a form of subjective perspective rather than an objective and absolute truth or fact. Taking a constructionist grounded theory approach to interviews as a choice of research methodology places the experiences of participants as they encounter social situations, centre stage in the research. Charmaz suggests that

“As we learn how our research participants make sense of their experiences, we begin to make analytic sense of their meanings and actions” (Charmaz 2014 p19)

The aim of the research in the design stage was not to seek a means of finding or determining a single objective reality. Following Charmaz’s approach

“Explicitly assumes that any theoretical rendering offers an interpretive portrayal of the studied world, not an exact picture of it” (Charmaz 2006, p10)

Therefore the position adopted considers that multiple and competing realities exist, including that of the researcher whose position is neither neutral nor without bias and preconception. The research task became set as one of seeking to understand the multiple social constructions of meaning and knowledge using participants experiences and reflections to build a rich and detailed picture from which interpretations could be abstracted. This view supports the choice to use interviews as the data source in order to capture and to construct these multiple perspectives. An immediate challenge of this approach is that many interpretations of the results may be possible given that

“Neither observer not observed come to a scene untouched by the world. Researchers and research participants make assumptions about what is real, possess stocks of knowledge, occupy social statuses and pursue purposes that influence their respective views and actions” (Charmaz 2006, p15)

This position accepts that participants construct reality with the researcher whilst acknowledging that the researcher brings values and interpretations too through co-construction. Recognising the importance of pre-existing values and the subjectivity of the perspectives being generated and recorded is key. At an early stage, when setting out the expectations for research interviewees, there was the consideration of using some form of respondent validation in order to return to the participants, after initial analysis of interview data, to seek confirmation that the meanings of their experience have been correctly understood. This would not however have been a straightforward process and one that carried methodological risks. Whilst it has a perhaps noble intention in that

“The goal is to seek confirmation that the researchers findings and impressions are congruent with the views of those on whom the research was conducted”. (Bryman 2012 p391)

There are risks and consequences if there are sharply divergent views of interpretation, not least given the general concern that the participants might react with defensiveness or seek to ask for a less frank or abstracted interpretation than that which had been arrived at by the investigator. As a researcher one might feel immediately impeded or fettered by post interview feedback and therefore less able to be free and critical. As confidence in the adopted position grew, it was realised that the participants cannot validate the researchers findings, as these are in any case based upon the interpretations of the researcher. Therefore it became clear that one had to rely upon one’s own interpretive skills throughout the research process although of course to remain grounded and guided by the data throughout.

The interviews generated considerable material which was rich in meaning and so the deconstruction of the transcripts using discourse or narrative analysis techniques was not necessary. The coding analysis followed Charmaz’s sequential steps of initial coding and focused coding before higher categories could be abstracted (Charmaz 2006, 2014). (See below for a more detailed description of the coding procedure). Nvivo software was used as a coding tool. Nvivo helpfully allows for memos to be written into the system and so ideas and thoughts through the analysis were captured through memo writing. Charmaz views memos as important for developing the analysis and for thinking about early analytic interpretations as the material is coded. Reflections were captured throughout the analytic phase in memos which aided the formation of ideas from the start through to the end of the coding process. Interviews were transcribed shortly after being conducted.

At the original design stage it was intended to use the CFIR framework as an initial coding structure using a codebook approach as described by Guest, MacQueen and Namey (2012). By taking a flexible approach it was considered that additions to the codebook might be made through the refinement and addition of codes as they emerged through the data analysis. There was though a clear methodological risk in this which was noted at the outset in that

“The logic of grounded theory coding differs from quantitative logic that applies preconceived categories or codes to the data” (Charmaz 2006 p46)

Therefore the methodological danger was that the coding would become skewed by the need to fit data to the codes rather than to allow the codes to emerge. This echoes the notion of forcing of preconceived ideas which was anathema to the founding fathers of grounded theory Glaser and Strauss (1967). The decision to use the CFIR code book as a working tool on which to build a coding analysis was quickly abandoned. There is no doubt that early thinking was informed by Damschroder and the five domains of the CFIR upon which the interview questions were broadly related. Whilst this work was a clear influence the departure from the CFIR is marked here.

**Research participants and data collection**

The fieldwork interviews were conducted in three English Local Authority areas. Given the length of time that had elapsed since two of the sites had closed a fixed purposeful sampling method was employed (Bryman 2016). This was not the theoretical sampling approach advocated by Charmaz (2014) where further participants were sought as new theory emerged until the point of theoretical saturation was reached. This choice was made largely on the anticipated limited access to research participants which meant that further interviews beyond the initial selection was unlikely to be possible. Despite exhaustive efforts to secure a second interview in Isolated Coastal the pool of people to draw from was small and four potential participants declined to participate, even when seeking to use the single interviewee to suggest potential candidates to interview in a snowball strategy. One potential participant in Metro City was unable to be interviewed on the day as planned and attempts to reschedule were unsuccessful. Twin concerns were the diversity of site and of job role for the participants with sufficient experience of the implementation process. The twelve participants did provide great depth and variety of experiences.

**Table 5 Research participants**

|  |  |
| --- | --- |
| Participant job role | Number of participants |
| Heads of Service (Local Authority) | Five |
| Senior NHS Clinical Managers | Three |
| Operational Managers (Local Authority) | Two |
| Voluntary Sector Chief Executive | One |
| National Lead NHS England | One |

Further detail regarding the participants is not provided due to the ethical concerns of identification and the consent agreement approved at the ethics committee. Participants were asked to agree a job title at interview

Consideration was given to looking at the implementation of further evidence based programmes other than MST. Using multiple programmes for comparative analysis and understanding different settings might allow for conclusions to be drawn as to the wider generalisability of the findings. However, the unique implementation challenges of different programmes might make it harder to attribute common features and findings across different settings, especially given different contexts. Therefore, given the detailed knowledge already acquired regarding Multi Systemic Therapy it was decided to select from these sites only. There was a need to acknowledge the risks of making biased assumptions regarding the implementation processes of this methodology but on balance it was thought that the common experience of a standard process would reduce distractions. MST has one of the most robust and prescriptive implementation templates in terms of processes required by the developers for new sites, as described by (Löfholm, Eichas and Sundell 2014) therefore as each authority undertook a standard template this was actually a strength. Discounting international examples for reasons of practicality, three UK sites which all had common features were chosen and fortuitously all had started at the same time.

The selection of sites was a process of purposeful selection (Miles and Huberman,1994). Each site being a Unitary Authority where local government services have been amalgamated into a single unified structure. Each a City with high rates of deprivation and all had begun MST at the same time, following the expansion of evidence-based programmes led by the Departments of Health and Education in 2007/8. Two of the chosen sites experienced implementation failure and were no longer operating MST by the time the fieldwork interviews were conducted in 2014/15. One might be described as an early stage failure and another a late stage maturity failure. The third site had successfully sustained the original service and then significantly expanded its’ MST portfolio.

**Methodological alternatives**

Several alternative methodological approaches had been considered including an ethnographic study and a hypothesis-testing approach. An ethnographic study employing embedded participant research was not possible, not least given that two services had closed and the implementation period was long passed. A hypothesis-testing approach was an early possibility but was rejected, not least given the preference for using qualitative methodology to access the participant interviewees accounts and to understand their experiences.

Owuegbuzie and Leech (2005) have described how the research divide between qualitative and quantitative researchers is ultimately an unhelpful barrier and argue for a third, integrated and pragmatic approach to seek the best route to answering the research questions being posed, pointing out the dilemma that

“In qualitative research the most common purposes are those of theory initiation and theory building, whereas in quantitative research the most typical objectives are those of theory testing and theory modification. Clearly, neither tradition is independent of the other, nor can either school encompass the whole research process” Owuegbuzie and Leech (p380 2005)

Ontologically, a mixed methods approach could have been taken in order to access the subjective experience of the chosen participants whilst also theory testing (Dewey 1986, Creswell, 2014). This could have sought to understand the experience of the interviewees whilst also determining the nature and extent of selected concepts proposed in the Damschroder (2009) framework.The methodological attraction being that

“The inclusion of quantitative data can help compensate for the fact that qualitative data typically cannot be generalised. Similarly, the inclusion of qualitative data can help explain relationships discovered by quantitative data” Owuegbuzie and Leech p383, (2005)

From an epistemological position the evidence based practice is rooted in the quantitative, positivist paradigm. This has a clear utility in demonstrating the relationships between variables and in seeking to prove causality beyond correlations alone using statistical analysis. Randomised control trials seek to establish if participation in programme x results in outcome y, a methodology and reasoning of the natural sciences using scientific and statistical tools to confirm knowledge and eventually intervention validity. Therefore quantitative research has a very strong base in implementation science.

However, it was important to develop clear contextual descriptions of the culture, pressures and unique features of the organisations to be studied and participants were invited to reflect on these in the interviews. One of the strengths of a qualitative approach only is the depth of understanding that can be achieved. There is of course danger of falling into the trap of too much contextual description without sufficient analysis being made, what Loftland and Loftland (1995 p164) warn of as ‘descriptive excess.’ As the interviews generated over 120,000 words of transcript from the interviews there was plenty of source material from which to draw upon. It was not necessary to extend or seek further interview participants once the interviews were transcribed as a point of theoretical saturation had been reached. A mixed methods approach was rejected, as the choice for qualitative research methods was adopted so as to fully explore the participant experience with depth.

An alternative qualitative analytic strategy to that proposed by Charmaz is a thematic analysis of interview material. Within the same family group as grounded theory the process of thematic analysis is less prescriptively defined, uses a different language and is a relatively new methodology (Bryman 2016). In regard to the analytic process Rapley (2011) points out the similarities between grounded theory and thematic analysis as both being concerned with

“Close inspection of a sample of data about a specific issue. This close inspection is used to discover, explore and generate an increasingly refined conceptual description of the phenomena” (Rapley 2011 p 276)

However, thematic analysis is applicable to more than one research paradigm and is therefore

“Unusual in the canon of qualitative analytic approaches, because it offers a method – a tool or technique, unbounded by theoretical commitments – rather than a methodology (a theoretically informed, and confined, framework for research). (Braun and Clarke 2017 p297)

It is this flexibility and utility which gives thematic analysis wide appeal in that it can be used for both large and small data sets, use inductive or deductive approaches or even in combination. Braun and Clarke (2006) describe the analytic process stages for thematic analysis and how coding and fragmentation of interview material into a table to be labelled and noted can build the codes, sub themes and themes of the analysis. Although thematic analysis can be conducted as a single researcher (Bryman 2016) the steps described suggest that a second researcher or research team is often necessary to challenge and confirm theme validity (Jenkinson et al 2017). Whilst thematic analysis might have been a tool with which to build an analysis, the rigour and theoretical clarity offered by grounded theory meant that thematic analysis was rejected. Whilst thematic analysis may be thought of as a generic tool the researcher must additionally confirm epistemological and ontological positions.

**Semi-structured interviews**

Damschroder’s framework for implementation (2009) was influential in structuring initial thinking about implementation processes and systems. The five core domains and individual concepts provide an abstract frame for thinking about the relationships between the various themes and moving parts of the operating system at different levels. The framework informed the way in which the interview questions were developed with the intention that this would then lead towards an initial schematic for the organisation and interpretation of data. Conscious not to impose and force ideas too quickly the view of Thornberg describes how

“An informed grounded theorist sees the advantage of using pre-existing theories and research findings in a substantive field in a sensitive, creative and flexible way instead of seeing them as obstacles and threats” (Thornberg 2012 p7)

There was no research plan to replicate nor test for Damschroder’s concepts, not least as a qualitative analysis is not a suitable methodological approach for doing so. The framework did help to lift thinking to a more abstract level at the start of the research design.

Interview questions were kept open and broad with the purpose of the interviews to

“Elicit a range of responses and discourses, including a person’s concerns at the moment, justifications of past actions and measured reflections” (Charmaz 2014 p85)

A semi structured interview format with participants was chosen. This allowed for some flexibility in the conduct of the interview but gave enough structure to cover the intended areas of investigation. Each interview began with an invitation to give an open narrative account of the implementation process from the subject’s perspective from the point at which their involvement started up to the present day. Most participants gave a full account with only minor prompts made. As interviewer an active listening style was used to encourage interviewees to expand and develop their reflections. The narrative start to the interview enabled the participants to tell their own story with their own emphasis on points that appeared relevant to them rather than being driven too quickly or narrowly towards the research concerns. Most participants gave a long and reflective account that took from a third to a half of the interview time.

The interview schedule then moved to questions loosely based upon the five core implementation domains, proposed by Damschroder et al (2009), with an additional question exploring the concept of belief (Furness and Gilligan, 2010) although in the findings this did not appear relevant. Of interest was how interviewees described and reflected upon the issues concerning their implementation experience. How they thought about the impact of their organisational contexts then and now and how they considered the implementation process which at that point was around five years ago. At the end of the interview there was an open question to see whether participants wanted to add another area or concept which they thought was important to bring to attention. The full interview schedule is in appendix 1.

Charmaz’s (2014) approach suggests beginning the early analysis of data during the data collection process so that the interview schedule can change and adapt in response to the early findings. This provides a freedom to the researcher to follow new possibilities should they emerge rather than to rigidly stick to the script of the interview schedule. This is one solution to dealing with new material and leads which were not anticipated at the outset. The interview schedule was adhered to as it was intended. However, it is possible that the focus of interest for the researcher was already shifting towards emergent concepts as the final interviews took place. The process of thinking, recording and reflecting upon interviews began immediately after they had taken place rather than filing them for later analysis. Each interview was transcribed as quickly as possible and memo notes regarding ideas and reflections were recorded contemporaneously.

Interviews are commonly used in qualitative research and a semi structured approach allowed for flexibility with enough structure to make the interview professional and purposeful. In terms of the power dynamic the position adopted as interviewer was one of being known to be knowledgeable of the subject but largely if not completely unknown to the local system in which the interview subject was positioned as expert. Acknowledging how the exercise of power might play out during interviews meant that a balance was struck to achieve, as far as possible, an equalisation between interviewer and interviewee (Vähäsantanen and Saarinen 2013) which enabled co-construction to take place in the interview. The aim, within a constructionist frame, was in

“Eliciting the participant’s definitions of terms, situations, and events and try to tap his or her assumptions, implicit meanings and tacit rules” (Charmaz 2006 p 32)

Whilst the interviews were a co-construction between the interviewer and interviewee, the use of interviews in research is not without its challenges as to the reliability and validity of data generated through these means. As Yeo et al (2014) describe

“If the content of the interview is generated by the actual interaction, what weight can be placed on it? And what meaning can this content hold outside of the interaction of the interview itself ?” (Yeo et al 2014)

The answer to this is a pragmatic one as at the extreme of this argument is the suggestion that no participant can really share their experience meaningfully at all. Certainly the interviews allowed the interviewees to explore meaning and interpretations of events and circumstances as they experienced and made sense of them. In this way the interview should be considered as

“Contextual and negotiated. Whether participants recount their concerns without interruption or researchers request specific information, the result is a construction, or re-construction, of a reality. Interviews stories do nor reproduce prior realities.” (Charmaz 2006 p27)

**Coding strategy**

An initial and focussed coding strategy as described by Charmaz (2014) was followed in which there was

“An initial phase involving naming each word, line or segment of data followed by 2) a focused, selective phase that uses the most significant or frequent initial codes to sort, synthesize, integrate and organise large amounts of data” (Charmaz 2014 p113)

The coding process enables the researcher to build and ground theory from within the data. Charmaz is clear that during the initial coding the aim is to remain open to all options for theoretical possibilities and to then use the second stage of coding to refine and define concepts.

At the first step, initial coding of the interviews used Nvivo software to sort the interview material into 39 initial codes which were assigned as an Nvivo node. The initial codes are listed in appendix 2. The process required careful picking through of the material and fairly high level codes were created for segments of data in paragraphs rather than for words or short phrases. This was not the line by line coding suggested by Charmaz but was used to ensure that the data was not too de-contextualised and meaning was easily retained, as can be the risk with a line by line approach (Bryman, 2012). In fact as long as the unit of analysis is consistent this appears methodologically congruent with Charmaz’s approach of coding incidents or segments (Charmaz 2014, p128) . The sorting of the interview data in this way proved useful in creating large but focussed data sets from which decisions were then made regarding which would be taken forward for further analysis. The data sets which progressed were those which directly pertained to the major themes of the research question: leadership and organisational context.

In regard to what is being discovered in the initial coding phase Charmaz describes how

“We may think our codes capture the empirical reality. Yet it is *our* view: we define what we see as significant in the data and describe what we think is happening” (Charmaz 2014 p 115)

Therefore the act of giving labels to data is the researcher’s prerogative and the researchers own language, views and values which are then used to construct the codes. This began to open up the analytic process as continuous decisions were made in this first coding phase.

Charmaz (2014) following Glaser and Strauss (1967), sets out the analytic task for grounded theory generation of using constant comparison methods. By checking through the data under the initial codes and comparing the segments of the material Charmaz asks the researcher to use intuitions, and to “make sense of the material”. Therefore, before starting on the second phase of focussed coding initial reactions and early analysis of the data was used to form ideas and elicit themes from the data. Memos were used to retain ideas and thoughts. Working through the data, now allocated to codes, it appeared that the implementation experience of the participants was dominated by the material generated under the following five initial codes: leadership, implementation reflections, culture, collaboration and champions. Therefore it was this material which became drawn into the second stage. The forming analysis was picking up the impact of leadership on the operational system and how the management of the process of implementation, as experienced by the interview participants, had impacted upon them, both negatively and positively. The contextual setting or environment to which interview participants were responding was also strongly featured. It was important to note, as Charmaz points out, that

“What you see in your data relies in part upon your prior perspectives. Rather than seeing your perspectives as truth, try to see them as representing one view among many” (Charmaz 2014 p132)

The beginning of the next coding exercise was a form of a repeat of the initial coding stage but this time taking a more detailed line by line approach to the material gathered under the five chosen nodes. From this large subset of the dataset 119 new codes were developed from the five chosen initial codes. (See appendix 3 for the full list.) These detailed and specific codes were significantly related to the data as every interview line under the five nodes were subjected to renewed scrutiny and interpretation.

Moving almost seamlessly into the focused coding stage, each of the 119 codes/concepts were developed into initial categories with supporting material, in the form of notes and quotes placed by the side. The coding of all concepts and how initial categories were developed in set out in appendix 4. Many of the codes were re-labelled whilst some remained named as in vivo quotes. Charmaz describes one of the goals of focussed coding as

“To determine the adequacy and conceptual strength of your initial codes” (Charmaz 2014 p140)

Initial categories were developed and their continued grounding within the data was checked. After this, a process of ordering and grouping took place in order to develop more abstract and representative high level categories. A set of 26 higher categories were created. From these the top ten have been taken into the research findings as these higher categories have the greatest number of underpinning initial codes/categories and so are the most strongly evidenced and representative of the data. Significant factors relating to leadership and to the contextual environment in the process of implementing an evidence-based programme were identified with new dimensions of leadership and of the environment which impact on the implementation process revealed. The top three categories are:

1. The high collaborative environment
2. Leadership for implementation
3. The hostile environment.

The category for a high collaborative environment is strongly related to the success and sustainment of evidence based interventions. This is aligned to a category named leadership for implementation. Also defined is the hostile environment as a category to describe the features of a constantly shifting environmental context. These three are the most compelling of the categories and are fully explored in the findings and conclusion.

Charmaz and Bryant (2011) describe the process of theoretical sampling as a means of continuing to seek data sources until no new helpful data emerges. This is the moment when data saturation has been reached and at which point the researcher need not seek further data for analysis. As the interviews were completed and the analysis was in the final stages there did not appear to be a need to seek further interviewees given the amount of material obtained. It is an arguable point as to whether a second interview in Isolated Coastal would have added greater weight to the thesis but the opportunity for this was not forthcoming despite best efforts. The depth of material which was obtained delivered significant potential for analysis.

Strauss and Corbin (1998) describe a different, more methodologically prescribed pathway for a coding strategy with open coding to develop concepts and categories followed by axial coding whereby new connections between the categories and the data can be found. Their final stage is one of selective coding which draws the analysis together to establish a ‘core category’. Charmaz describes instead a process of initial coding, focused coding and synthesis and it was this approach that was followed for the analysis. Therefore Charmaz offers a more flexible and less structured approach than Strauss and Corbin(1998) which is both more adaptable and one where

“The researcher makes decisions about the categories throughout the process, brings questions to the data and advances personal values, experiences and priorities” (Creswell and Poth p86 2018)

Charmaz states that coding is

“The pivotal link between collecting data and developing an emergent theory to explain these data” (Charmaz 2014 p113)

And so in staying close to the data, moving to and fro between the data in the interviews and the emerging concepts and using constant comparison the concepts were abstracted and new categories were developed. The surprise was in how much one needed to continually return to the data to substantiate the emerging concepts and to find supporting evidence. Although Charmaz clearly sets this out it was only through the experience of doing so and close to the end of the analysis that one might be able to confidently assert that this was a grounded theory study, which had been led by the data and inductive thinking. The coding analysis enabled me to see the data in a new way and began, as Charmaz described,

“Weaving two major threads into the fabric of grounded theory: generalizable theoretical statements that transcend specific times and places and contextual analyses of actions and events” (Charmaz 2014 p113)

**Coding process**

The coding process undertaken is set out in table 3 below. The in vivo node, summary information and material from notes and memos were used to create an initial category. This in turn is related to sub-categories which also support it

**Table 6**

**Coding analysis**

**Key**

|  |  |
| --- | --- |
| Initial Concepts  - *supporting material* (in vivo, summary, notes)   |  | | --- | | Initial Category |       Sub category/theme |

The material identified under the leadership node was the first to be progressed in the second stage of coding analysis. A more detailed, line by line approach to the material was taken. This broke down the leadership material into constituent parts so that initial concepts could be created. Following the approach described by Charmaz (2006) required giving close attention to the material several times. By checking back to the raw data regularly it was possible to continuously test for the relevance of the concepts as they emerged. This re-checking enabled the generation of concepts closely related to the data as each line was subject to detailed scrutiny and interpretation thereby ensuring that findings and interpretations were accurately drawn out of the material. Table 7 shows the hierarchy of code, concepts and categories

**Table 7 The analytic process (Charmaz 2006)**

|  |  |
| --- | --- |
| Stage | Process |
| One | Initial coding (and memo writing) |
| Two | Focused coding (and memo writing) creates initial concepts |
| Three | Tentative categories are created from initial concepts |
| Four | Synthesis to create higher categories from tentative categories |

The coding example one below shows four examples of the secondary coding analysis under the node for leadership. These are all from subject interview ten under the leadership node

**Coding example 1**

**Table 8**

|  |  |
| --- | --- |
| 1.Allocated tasks    *-Things to do*  *- Activity with a purpose in pursuit of the goals*  *- Steps towards achievement*  *- Directions being made*  - *Being given actions to complete*   |  | | --- | | Tasks |   Value  Quantity  Accountability |

In this first example, in table 8 the interviewee describes the way by which tasks were accomplished and how the action of leadership was one of taking oversight of the implementation workstreams. The leadership function is comprised of tasks and processes in service of the implementation effort. The role of leadership here is to make sure that matters were progressed through the implementation which delivered quality, accountability and value. The leader has ownership of the process and allocates tasks to others which are then reported back as completed. The leader is active and consistent in following actions through as they take accountability for the implementation.

**Coding example 2**

**Table 9**

|  |  |
| --- | --- |
| 2. Driving force  *- Momentum and energy*  *- By force of will*  *- Pulling and pushing towards the goal*   |  | | --- | | Leadership |   Pushing and pulling    Taking people with you  Goal Driven |

In this second example in table 9 the interviewee was describing the momentum created by the leadership to achieve the implementation. This was the enactment of both the will and of the writ of the leadership to achieve the implementation task. The energy created by the leadership was perceived of by the interviewee as forceful and powerful as it swept people along to deliver and achieve the desired outcome. There was a palpable sense of the leadership inspiring people to achieve but also of pushing others into line so that the result was going to be reached. The interviewee was not certain that forcing through was necessarily the way to build consensus regarding the legitimacy of the tasks required. But could see that creating the space for the intervention, within the operational setting, required dynamic and concrete actions so as to overcome organisational inertia.

**Coding example 3**

**Table 10**

|  |  |
| --- | --- |
| 3. Well organised    - *Planned*  *- Purposeful*  *- Logistically supported*  *- Thoughtful*     |  | | --- | | Planned |     Factors considered  Anticipated  Ordered |

The interviewee described, in table 10, how the leadership took a strategic and planned approach to change management and how sufficient attention, time and resources had been allocated to the task in hand. The purposeful, intentional approach served the implementation well with milestones described, anticipated and met. By undertaking an ordered and planned approach, the support of the wider organisation was enabled and secured, at least well enough so as to facilitate the initial implementation process.

**Coding example 4**

**Table 11**

|  |  |
| --- | --- |
| 4. More than one person  - *Team effort*  *- Co-ordinated*  *- Engagement of others*  *- Multiple participant*  *- More than the vision of one person*   |  | | --- | | Leadership |     Shared vision and tasks    Distributed leadership  Multiple participants/team |

In this fourth example, in table 11, the interviewee began to describe plurality of leadership across the system in which leadership was shared and distributed. The sharing of vision and then tasks was an important underpinning of the leadership story in Metro City. Leadership was in the hands of multiple participants, who were comfortable working with each other. These leaders were sufficiently coordinated to be able to positively influence and manage across the services which they directly controlled so as to influence the whole system for children’s services.

Knowing the subject interview transcripts well and following the coding under the leadership node it became clear that there was other interview material which was considered to be significant to the research questions and to leadership in particular which wasn’t captured directly under the leadership node. This was often connected to the context in which leadership was operating and in the immediate organisational environment during the implementation process. This material often represented ideas and reflections about the implementation process itself and so to include this additional material in the analysis the choice was made to include the following four stage one nodes:

1. Implementation reflections
2. Culture
3. Collaboration
4. Champions.

Taking these four additional nodes and undertaking a detailed secondary coding analysis of these too provided greater depth of data. The primary reason for taking this approach was to increase confidence that the relevant material to the research questions were drawn out. Additionally, it was important to elicit contributions from all of the interview participants. A couple of interviews had generated little material under the leadership node alone. However it was obvious that there were insights and reflections concerning the implementation experience added considerably to understanding of the experience of the implementation which were important to include. Table 12, from interview one shows this additional material under the implementation reflections node.

**Coding example 5**

**Table 12**

|  |  |
| --- | --- |
| **Implementation reflections node**  1. MST was oversold  *- MST presented as solving all problems*  *- The reality did not match expectations*  *- Alienation of a disbelieving workforce*   |  | | --- | | MST was oversold |     Families continued to require services  The workforce was skeptical and suspicious    Over-hyped and glossy  Not a cure all |

In this example taken from interview one, table 12, the interviewee described how the intervention was presented to staff in an unrealistic manner and how the potential benefits and outcomes for it were over stated. She intimated that the seeds of disaffection were sown for her organisation at this moment as the intervention could never live up to the expectations originally presented. Without a clear connection to the values of the workforce being explicitly made and nurtured, the suspicion and ambivalence towards the intervention went unchecked and never faded.

**Coding example 6**

**Table 13**

|  |  |
| --- | --- |
| 2. Relationships  - *Professional relationships between social care and MST*  *- Referrals a source of conflict and tension*  *- Relationships with young people changed (youth offending)*  *- Created a sense of loss/change/jealousy/disquiet*   |  | | --- | | Relationships |   Competitiveness for referrals    A dogmatic approach created bad feeling  Taking over and excluding from relationships    Pathway for referrals damaged staff relationships  Something valued taken away from staff (youth offending relationship to young person) |

This example, in table 13, from the YOS Psychologist interviewee describes the competitiveness created by the establishment of the service and how tensions began to develop as staff reacted against it. Staff began to complain about what they saw as an unwanted intervention which was impacting upon their work and intruding into relationships which they valued. This was exacerbated when the research phase began in Expanded City.

The inclusion of these additional nodes provided further relevant material concerning the impact of leadership and in regard to the context in which this was taking place. The detailed descriptions given by the interviewees established how the management of the process of implementation had been perceived and experienced by them, both negatively and positively. The full coding analysis sets out from which interview the component parts of each concept were derived from. (See appendix 4.)

**Synthesis**

At the third stage of developing the analysis, a process of synthesis took place to order the initial stage two concepts into higher level categories. This phase enabled a more abstract level of categorisation and labelling to develop. Numerous attempts were made to logically order and group concepts into coherent categories. All of the initial concepts were written on cards and then laid out and ordered into cluster groupings which could become draft categories. Over a series of sessions the cards were successively re-ordered under new categories until a full first draft set was reached. Concepts that could not be easily grouped with others led to temporary sub categories being created before being reviewed further. (See appendix 5)

The most challenging dilemma in the categorisation process concerned the development of the category for the ‘relational aspects of leadership.’ Many of the concepts which comprise this category were initially placed into the ‘high collaborative environment’ and then into ‘leadership for implementation’ before the decision was made to extract them and to make them into a distinct category. This was because of an emerging set of findings concerned with the specific role that effective leaders appeared to play in attending to partnership relationships which then had a facilitating role in enabling the intervention to succeed. Not wanting to lose this point within another category it was created as a category of its own. Not least as there is something distinct about the orientation to work in partnership which pays attention to relational dynamics which appears relevant. This could also be interpreted as a form of emotional intelligence being demonstrated by leadership. In fact the label (emotional intelligence) was used at one point as a transitional category before the title was changed. The analytic compromise was to create a distinct category whilst being open to the notion that the relational aspects of leadership category could still be placed as a sub-category of either ‘the high collaborative environment’ or ‘leadership for implementation’.

A process of checking back to the interview material again was undertaken in order to be certain that the categorisation could be justified by the data and that the process of abstraction was not losing meaning or relevance to the material. Categories were re-ordered three or four times until it was considered that a workable set had been developed. New categories were created and then abandoned in favour of new groupings that were as accurate and true to the data as possible. Several categories were split and renamed only to be later re-grouped again. The end result is a set of high level categories which demonstrate and exemplify the implementation process as it was experienced by the participants and with leadership rising to be the dominant driver.

**Rigour**

There was divergence from the grounded theory process as described (Charmaz 2016) in that second interviews did not take place. These were not possible given time and practical constraints with the geographic dispersal of participants. The interview schedule was unchanged throughout the twelve participant interviews although as analysis had started immediately post the interviews, there were subtle changes of emphasis as ideas were formed and reflections were gathered. It is accepted that this lack of secondary interviews could be seen as a weakness of the research.

Malik et al (2016) describe how their research sought to achieve rigour, following Charmaz, by applying

“Four criteria including credibility (logical and conceptual grounding), originality (significance of the study), resonance (offers meaning and scope for all those for whom it may be relevant) and usefulness (knowledge development and practical application).” (Malik et al 2016 p 886)

It is considered that this thesis meets these four tests given how it was conceived and conducted and so can claim confidence in the findings. The research findings are firmly grounded in the interviews which were subjected to detailed coding using Nvivo software. There is very little published literature which explores the implementation of evidence based interventions in Local Authority settings and whilst the START trial (Fonagy et al 2018) was wholly based on Local Authority settings it’s focus was not on implementation. This supports the resonance test, implying that there should be an audience for research of this type and nature given the increasing adoption of evidence based practice in Local Authorities. The practical application of lessons learned is a an explicit outcome required of a professional doctorate.

In regard to the issue of bias in qualitative research this is a question which stems from concerns from the foundationalist/positivist position in which bias is to be minimised and controlled for, in pursuit of a perceived single objective reality, with the researcher in a neutral position (Lincoln, Lynham, and Guba 2011). Therefore, bias is

“Conceptualised as a “problem”.. inextricably entwined with epistemological questions concerning how knowledge about the social world is produced, what counts as research, and how the quality of research is assessed.” (Roulston and Shelton 2015 p 336)

Roulston and Shelton (2015) argue for a re-conceptualisation of bias for qualitative research and for the open exploration of the researcher’s position, values and motivation in qualitative methodology as intrinsic to the research process. They describe the use of reflexivity in which the self-aware researcher attends to and reflects upon their subjective assumptions employing

“Thoughtful, self-aware analysis of the intersubjective dynamics

between researcher and the researched. Reflexivity requires

critical self-reflection of the ways in which researchers’ social

background, assumptions, positioning and behaviour impact

on the research process”. (Finlay and Gough 2003 p ix)

In this research thesis the researcher position, prior experience and knowledge was an essential part of the interviews and analysis. Reflexivity was expressed by using journal notes, capturing thoughts and reflections post interview and throughout the analytic process.

**Ethical issues**

At the start of the research it was important to consider the ethical issues which were pertinent to the whole of the research design. Research does not take place in a vacuum and principles for ethical research practice are clearly established (Diener and Crandall 1978, Punch 1998) to protect the participants of research. The interview participants were anonymised and referred to by an agreed job role title. A written outline of the research was prepared for each interviewee setting out the aims of the research which is in the appendix 1a. Participants gave their informed consent to participation with a signed form containing clear reference to the uses of the subject matter that they were giving, including storage and methods of identification before any interview commenced, appendix 1b. Trust is important in the interview process and any breach of this trust would be perceived as contrary to the ethical approval for the research. The right of withdrawal was stated at each subject interaction and was recorded on the tape. Interview participants were approached via their organisation by letter and organisational approval was sought. Three potential interviewees who were contacted declined to participate and were not contacted again.

The research sites have been given pseudonyms. There remains a risk that the sites could be identified by someone who had knowledge of the 2008 expansion of MST in the UK. Ethical approval was obtained from Anglia Ruskin Departmental Research Ethics Panel (DREP) in accordance with the code of conduct prior to research beginning. Data was stored securely in compliance with the Data Protection Act on a computer with two phase password protection and integrated security protection.

Considering the context for the research one acknowledges ones’ own position and values and how prior experience of implementation shaped perspectives and understanding. The choice of semi-structured interviews was made in order to elicit the narrative accounts of others. However one must do much more than simply record as a process of reportage alone and declare that the recorded stories are interesting. Whilst interviewing a wholly professional cadre of participants there are clear ethical issues to address, such as the adherence to professional standards by interviewees registered with the HCPC. If it became clear that an interviewee was describing unethical or illegal practices which placed a vulnerable person at risk of harm then exceptions to confidentiality would have been reached and reporting of this risk or incident would have been required.

The research premise often included discussion of the failure to achieve something, in this case to successfully implement an intervention. The research explores failure at an institutional level. Associated with failure is blame and as such there are risks to participants given the potential for individuals to feel blamed or ridiculed. Children’s services managers in particular can be prone to calls for sanctions in the media when serious incidents occur and a blaming culture in public services perpetuates, for example the vilification and sacking of Sharon Shoesmith, publicly insisted upon by the Secretary for Education in 2008 after the Baby P case, (Daily Telegraph 2008). This can lead to careers being blighted. The potential risk of exposure could have led participants to deliver a partial narrative that painted them as either a victim of a process or biased in their recollections to cast themselves in a favourable light. Local Authorities too are keenly aware of the public standing in which they are held both corporately and politically. As it turned out all participants were keen to have their story told and generously described the importance of this work for others to learn from.

**Chapter 4** **The wider context of children’s services and evidence based interventions**

This research is concerned with the implementation of an evidence-based intervention for working with children on the edge of care or custody in children’s services settings in England. The intention being to consider three different implementation sites in detail so that the commonalities and differences between them may be explored. This chapter examines how the initial selection and implementation process took place and how the interviewees experienced this. In beginning to understand the narrative accounts of the participants, a brief description of the contexts of the three Local Authorities who were chosen is necessary. What immediately becomes clear from the participants is how dominant the contextual experience is to the implementation experience. Therefore it is important to give sufficient detail of these issues in order to enable a detailed understanding of the major themes of the research to be drawn to the fore.

**National funding for evidence based interventions**

The proposal for funding for the establishment of the new Multi Systemic Therapy (MST) Teams in England in 2007/8 came from a grant award under the ‘Emerging Personality Disorder’ funding stream set up by the Department of Health. Funding was granted to competitively selected Local Authorities who applied to be a part of the programme via a formal application process and subsequent interview. Funding was granted specifically to establish MST teams only. The funding was geared so that it deliberately tapered down in stages over the three-year life of the programme. This was purposefully designed so that Local Authorities would have to find the local funding to sustain the services, which had been created, in the medium to long term. There was an explicit expectation from the NHS funders, at the application stage, that Local Authorities would be weaned off central funding over time and that the Local Authority contribution would rise to the full cost once the grant was exhausted.

The Department of Health paid for the individual site operating licences with MST Services Inc. in the USA in the initial period. The licences allowed each of the Local Authorities to implement MST and to access the protected intellectual property. Additionally, the Department of Health provided access to funded peer support through what became known as ‘Sector Advisers’. These were professional practitioners drawn from Health and Local Authorities with experience of implementing evidence based services. This was a semi-formal mentoring type of relationship although the Authorities could choose to engage or not with their nominated Adviser.

The Department of Health held an anchor contract with MST Services Inc., to act as the initial implementation advisers and to assist with the set up and implementation of the MST sites established under the funding round. Two experienced USA based MST staff with a remit for development and implementation travelled to the UK periodically to assist in the early set up phase immediately after the grants were awarded.

**Initial implementation and mobilisation plan**

MST Services Inc. have a well-developed implementation process and an organisational template that has been used many times in the implementation of new services and which sets out expectations for new areas to adhere to in order to secure a licence (Hengeller et al 2009). This includes a requirement for the establishment of local inter-agency partnership agreements, initial stakeholder engagement sessions and practical arrangements for the recruitment and initial orientation training of staff. There are human resources components too, which include model job descriptions, person specifications and key competency standards. Interview guides detail model questions and role-plays for potential staff to be asked to perform in order to test their ability to receive coaching and feedback. Operational protocols for agencies to adopt are defined, including referral processes. These were all described in a MST handbook known as the ‘Goals and guidelines’ document, which sets out the standards and processes to follow (<http://www.mstservices.com>) The guidance used for these new services was not specifically tailored to a UK social care setting but had been used in the USA, Norway and elsewhere in the UK before.

The ‘Goals and guidelines’ document required the creation of an MST specific project or steering group to be established for the coordination and management of the partnership of agencies who would be delivering and supporting MST. These were typically Social Care, Youth Offending, Council Finance, Education, Child and Adolescent Mental Health Services (CAMHS) and sometimes other partners too such as the Police and voluntary agencies. The National Lead from the Department of Health personally attended steering group meetings as regularly as possible as both grant funder and supporter of the intervention. In some circumstances a Sector Adviser also attended. One interviewee suggested that the draw of Government money was always a good way to get partners around the table, even if individual agencies were implicitly or even explicitly ambivalent about implementing this new intervention into their local setting.

The implementation process required that each Authority organise an initial stakeholder event at which an official launch would be held. The stated purpose being to set out expectations of the new service for partners, to describe how the new service would work and to celebrate and acknowledge the establishment of a new team into the local children’s service system. These events were organised at the new sites to coincide with the visit of the MST Services staff from the USA. In both Metro City and Expanded City the event was held in one of the major civic buildings in the city centre. In Metro City there were over fifty attendees and there was standing room only for latecomers at the back of the hall. Likewise, in Expanded City the event was well attended and also had good representation in terms of both the number of different partners who attended and in the seniority of those who came. To all concerned the launch at both sites was perceived as an event to put on a show and to make a clear statement of commitment from all of the parties who were involved.

At Isolated Coastal the contrast could not have been stronger to Metro City and Expanded City. The event organised at voluntary organisation who had driven the bid, ‘The Hub’, had more Hub staff than any other partners attending and was an altogether much lower key event with noticeably poor representation from the Local Authority. The Lead for the Department of Health expressed her sense of foreboding afterwards and also experienced more than a little embarrassment at arriving at the event after a long journey with her two MST Service Inc. colleagues from the USA. Indeed she reflected that her MST colleagues were never going to forget the underwhelming and half-hearted reception that they had received there, which remained a portent of things to come.

Recruiting suitably qualified staff was difficult in all sites, not least, as MST was still relatively unknown in the UK at that time and so potential staff had little awareness of the model or clear expectations of the job role. The MST model requires a much more intensive way of working with families than in a traditional social work, family support service or Child and Adolescent Mental Health (CAMHS) setting. This intensity is coupled with a strong and unrelenting focus on clinical accountability for staff for the achievement of outcomes. This attention can contribute to increased personal and professional stresses and may quickly exposure fallibility in professional staff compared to other services where scrutiny is less intensive and so becoming an MST worker is not for the faint hearted. Not only was the methodology new to almost all of new staff but the working hours, expectations and pressures were also different including the professional reputational risks for the new staff themselves in having to achieve quality outcomes and being under almost continual review through the supervision process.

MST Services Inc. attended the interviews for staff as well having providing a manual for their recruitment. All of the sites felt under pressure to get their teams going and to recruit their staff as soon as possible in order to achieve the expected ‘go live’ dates as required by the grant funding. There was an identified risk of recruiting staff who did not make the benchmark standard in the hope and expectation that they would be good enough over time. Authorities often felt internally under pressure to recruit from the first round rather than run a recruitment campaign again, risking delay and uncertainty, if suitable candidates were not immediately available. This particular conundrum appeared to confound the US advisers somewhat, given the greater ability to hire and fire as employers in the USA, often with little or no notice. In the UK, stronger employment protection places a higher burden on the employer too, to support a failing employee to make the grade for much longer than in the USA, before being able to manage them out of the organisation.

**Research participation**

A central condition of the grant funding was the participation in the Systemic Therapy for At Risk Teens (START) research trial (Fonagy et al 2018). The trial was designed as a multi-site evaluation of the MST intervention compared to a control group of treatment as usual. Almost 700 families were to be tracked over two years post treatment. The investigation aimed to examine whether MST could reduce anti-social behaviour, increase well-being and educational outcomes and improve family functioning. The research methodology and protocol required the sites to establish themselves with functioning MST teams and to be taking cases from the local children’s services with a developed referral pipeline. (Fonagy et al 2013) Only then, at the point of the team performing reasonably well were areas to begin to allocate to treatment as usual or MST through randomised assignment. The research team actively supported the process and clear protocols for randomisation were developed that were congruent with the ethical approval given to the research once sites had reached a point of early maturity. (The impact of the randomisation process is described in appendix 5)

**The local context**

The three Local Authorities selected for this research each have their own unique histories and circumstances and have been named as Isolated Coastal, Expanded City and Metro City. It is suggested that the contextual differences in each of them have a high level of relevance to the implementation process. At the outset, all three Local Authorities completed expressions of interest and presented their case for selection to the Department of Health. Grant awards were made on the basis of participation in the research and funding was subject to standard conditions of grant being applied. All sought to participate and so one might draw the initial inference that they all intended to succeed with the implementation. A narrative description of each local authority is provided at appendix 6 whilst a summary of key features is represented in Table 14 below

**Table 14 statistical comparison between research sites**

|  |  |  |  |
| --- | --- | --- | --- |
| Key feature | Isolated Coastal | Expanded City | Metro City |
| Population (2011 census) | 234,982 | 78,777 | 751,485 |
| Ethnic minority population | 7.1% | 17.5% | 18% |
| Population living in 10% most deprived areas (2010) | 12% | 16% | 19.9% |
| Looked After Children (2010/11) | 375 | 310 | 1450 |
| Rate of Looked After Children per 10,000  (2010/11) | 76 | 76 | 95 |
| Ofsted rating of children’s services (safeguarding) | Good (2010) | Inadequate  (2010) | Adequate (2011) |

**MST in Isolated Coastal**

Unusually, the bid for the funding for MST was put forward by a voluntary mental health and youth organisation, known as ‘The Hub’, rather than directly by the Local Authority. This was an unexpected application source, according to the National NHS Programme Lead, but was permitted under the grant criteria. The bid was seen as providing a more mixed economy of applicants. Whilst the expression of interest form for the Department of Health required the sign off of the Local Authority at a senior level and this was indeed given, the application itself was written and led by the Chief Executive of The Hub. She was called to interview and attended with two Local Authority Heads of Service, one from the Youth Offending Service and one from Social Care, to represent Isolated Coastal.

The bid was successful and a grant award offer was duly made. However, it quickly transpired that the Service Director in children’s services with responsibility for this area of work in Isolated Coastal did not personally approve of the bid. Indeed it was later found that the two Heads of Service who attended the interview at the Department of Health had not communicated their involvement to this Director directly about their attendance and participation in the selection process. These points are particularly controversial given that the Local Authority had to have signed the bid paperwork at a strategic management (Director) level and also to have explicitly indicated support for working in partnership with The Hub. The National Lead from the Department of Health confirmed that the Local Authority had given the sign off at the time and so the bid was progressed to the point of a full award.

There was significant political support from the then Government Regional Office to see investment in the region and also to support a Local Authority that was known to have high needs. This support, added to the fact that it was a novel award to a voluntary sector organisation rather than directly to the Local Authority or NHS Trust, led to the commitment being made.

The National NHS Lead reflected on her misgivings at the time, that this was one of the weaker bids that had attended for interview and in a context in which the nearest neighbouring MST team was going to be over three hours’ drive away. She was already aware of the isolation of the Authority and of the potential for it to be a challenging service to support, given the geography. In light of her learning and experience now she reflected that she would have declined the application. She was happy to be supporting a voluntary organisation as a matter of principle. But she described how she would now have asked for more developmental work concerning the potential for both collaboration working and in regard to the strategic fit across the Local Authority to have been demonstrated. She would also have sought reassurances in regard to how the Local Authority intended to work with The Hub as a partner agency. Additionally, she commented that she would also have imposed stronger and more explicit requirements for the nascent service to have been supported much more actively by the emergent MST community in the UK.

In Isolated Coastal the Local Authority established and chaired the steering group for the service. Whilst the perception of the steering group as a functioning partnership meeting was as a reasonably helpful meeting in some circumstances, particularly in establishing the team, the National Lead for Department of Health began to reach the view that over time it felt less like the steering groups that she was attending in other places and was experienced differently,

‘More like a contract monitoring group’ *National NHS Lead*

By this she meant that it didn’t feel like a partnership of equals or a place where problem solving could take place with partners trying to assist with developing solutions to practice issues. Instead it felt like somewhere for The Hub to be held to account. Perhaps reflecting the power imbalance between a Local Authority and the voluntary sector and the way in which the Local Authority considered this as an external project to be performance managed rather than an internal one, to be nurtured and supported.

The MST team was established using the ‘Goals and guidelines’ manual as prescribed. However, the Hub Manager reported that the recruitment process was for her too over engineered and laborious compared to usual recruitment process that she was used to, reporting that frankly it was

‘Too anal, too Americanised’ *Hub Manager*

This stands in contrast to other sites, which found the processes refreshing in their clarity and certainty, with an expectation that if candidates did not attain the benchmark standards that no appointment would be made. In Isolated Coastal, as elsewhere, once the Supervisor was recruited the Therapist staff were then employed with the Supervisor involved in the selection of their own team whilst still working their notice of their old job.

**MST in Expanded City**

Expanded City shares the same NHS Mental Health Trust with a County Council in which an MST service was already well established and had been running for several years. Therefore, MST was reasonably well known as an intervention to several of the key service leads in Expanded City, notably in the youth offending service, who decided to garner interest locally in preparing to bid for the funding. As a mid-sized unitary authority the City had previously considered if it had enough cases to justify the setting up of a service with its own resources. The opportunity to bid for funding was welcomed and was built upon interest already generated. There was a known pressure upon the Youth Offending Service to reduce custodial sentencing, which was at a high rate compared to statistical neighbours. This need was coupled with the demands on Children’s Services, often perceived and indeed graded as a failing service and under pressure too, so the decision to apply was a compelling one. The bid was developed by a partnership between the Youth Offending Service and Children’s Services and was led by a Head of Service and a Clinical Psychologist.

The Expanded City bid was seen as a particularly strong one by the Department of Health who were impressed that the applicants had taken a parent of a young person, known to the Youth Offending Service, with them to advocate for the setup of the service to the interview. Expanded City were judged to have a confident understanding of MST based on their contact with their near County neighbour and NHS colleagues. They also appeared realistic in how they would set about implementing and then delivering a service in their local setting. They also had clear strategic commitment from their Chief Executive who was an enthusiastic supporter of this investment.

Initially, the Council Chief Executive chaired the steering group in Expanded City. This endowed the steering group with significant political support and kudos, which was of benefit to the MST implementers. The steering group was empowered to quickly and effectively overcome or even override organisational barriers to progress. Interview participants recalled it as a dynamic group that created momentum and energy to enable it to quickly get going. There are some non-traditional working practices and processes, that MST requires, which could create friction with the usual practices in children’s social care, such as on-call payments, dedicated administration time, recruitment and selection practice. Some were relatively minor but nonetheless each needed to be overcome in order to make progress and each barrier was overcome. Expanded City recruited the Psychologist who wrote the bid in the second round of recruitment (whilst Isolated Coastal managed to attract a Family Therapist to move there as their Supervisor.)

**MST in Metro City**

The Youth Offending Service Manager described in interview how he had been interested in MST for a while and had been in contact with an existing MST service elsewhere outside of his region to learn more about the intervention before the funding round was announced. The Youth Offending Service, Child and Adolescent Mental Health (CAMHS) and Children’s Social Care jointly led the bid. The Department of Health Lead also saw Metro City as a strong bid from a mature joint partnership. It was also a bid from people with whom the National Lead from the Department of Health had worked with in the past in previous work concerning child and adolescent mental health.

It was reported by interviewees in Metro City that historically the relationship between CAMHS services and Children’s Social Care had been extremely poor. The NHS Director with responsibility for the CAMHS provision and his opposite Assistant Director in Children’s Social Care, both of whom had come into post at a similar time, had worked hard to develop a much more collaborative relationship over the previous five years and so the relationship and partnership working was much improved. The relationship had, according to the CAMHS Director been best described as

‘Difficult, fractious and mutually blaming’ *CAMHS Director*

characterised by very long waiting lists and a sense that CAMHS were generally antagonistic if not simply unhelpful to Social Care. The change process took several forms including the establishment of a joint CAMHS and Social Care prioritisation panel that agreed to take the highest concern cases from Social Care for immediate assessment on the basis that the lower need cases would not be seen quickly and would be placed on a long term waiting list.

This working agreement also prioritised the cases for Court reports where children and young people required expert CAMHS assessment in support of cases progressing through the Family Proceedings Courts. The second innovation was the development of a consultation model, which created case supervision groups for social workers and which were led by CAMHS professionals, acting in a consultative role each month. Complex cases were brought by social workers to a monthly discussion group for review and analysis. A positive consequence of this was that many of the CAMHS professionals started to become professionally known by the social work teams in the City. Despite early nervousness on behalf of Social Care that this was going to be very exposing of their practice and a difficult process that only the most robust of their staff could bear to participate in, it began to become part of the normal practice between the two agencies and built a much better and more trusting relationship across the City. Indeed after a while the CAMHS Director reflected that

‘After a couple of years there wasn’t a social worker we hadn’t met’ *CAMHS Director*

which made relationships much easier and further collaboration possible, based on familiarity and trust. At both an operational and a strategic level in Metro City, therefore

‘When we had the early discussion about MST I was meeting with people I knew, and meeting with people who knew me and meeting with people who had an experience of (Metro City) health and social care working well together’ *CAMHS Director*

The Metro City steering group was created largely as a reconfiguration of the existing joint prioritisation panel membership with new terms of reference to include wider partners than only CAMHS and Social Care, who had been in the predecessor group. An Assistant Director for Social Care chaired the steering group and maintained this position for the long term, even after being promoted to the more senior role of Director. The senior managers who attended had worked together in the past and had good working relationships. Unusually perhaps, these relationships were to last, with few changes to these key personnel in Metro City.

Metro City felt that they were “extremely lucky” to secure an experienced MST Supervisor from overseas who, according to one Manager

‘Outshone everyone by a country mile’ *YOS Manager*

with good interpersonal skills, a confident and charismatic personality and a strong belief in the MST model, about which he could enthuse others. Certainly several of the interviewees credited his leadership and influencing skills as being a significant factor in the successful implementation of the team.

**Professional system during mobilisation**

MST was not universally welcomed by the professional systems into which it was introduced. The reality and experience of the interviewees was very mixed in terms of the reactions that they experienced from their colleagues and from the wider organisations and systems in which they worked. From suspicion and scepticism to outright hostility the challenges reported were many and varied, both implicitly and explicitly expressed. Interviewees remarked that during the initial phases of implementation staff in the professional system were often intrigued as to what was being proposed but also often deeply sceptical of the intervention and of the change processes required to mobilise it.

Many in Children’s Services, across the three sites, considered that the intervention was overhyped and oversold to them. Firstly by the programme developers from the USA and then secondly by their own Authority who were introducing the intervention as if this was a simple answer to complex problems. It is certainly true that MST Services Inc. stated at each launch event that it aimed to end a period of MST intervention with no further services being required by families by way of step down or onward referral. In some cases this was indeed the case. This assertion regarding continuing services not being required reflects the therapeutic intention, which is to help families to sustain their own lives and changes made so was both consistent with the logic of the methodology and an honest intention. It appeared unusual at the time to explicitly seek to reduce dependency on services for challenging families, although this is much more current now as the welfare state is shrinking back. It was also a truth about how services are offered in the USA where MST is commissioned by state government. There are often few if any follow on services as the welfare system is run at a significantly lower value than in the UK, so discharge in the USA really does often mean no more services.

All of these points created, for some, a direct challenge to many of the traditional long-term interventions, which Social Care had at their disposal for high need families. It was still common for a long term cases to remain open to Social Care with periods of high and then low activity but the case rarely being formally closed. The MST developers promise that there would be ‘no further services’ was consistently referred to by interviewees as a problematic statement which came back to haunt the service further down the line and was used to criticise the intervention in later years. It was invoked as a central plank of the argument, levelled at the perceived effectiveness of MST, when families did continue to receive follow up services immediately post treatment. Interview participants described how, for some professionals, the simple binary of receiving further services or not receiving further services became an unwritten measure of effectiveness for MST, regardless of other areas of progress made. It was also noted how the MST intervention, with the focus on delivering interventions directed at creating sustained behavioural change, was seen as a counter to the more process driven case management elements of contemporary social work.

There was undoubtedly some professional jealousy in the system too. MST Supervisors travelled to the USA at public expense for initial training and conferences; something most Local Authorities would rarely countenance in any circumstances and so MST was perceived as seemingly both exotic and extravagant. MST Supervisors and Therapists were paid more than their similarly qualified peers and pay differentials were a source of contention in some areas too. However, MST staff were also providing an on-call rota for which they received an additional enhancement. Therapists were expected to work more unsocial hours, especially into the evening when seeing families at home. They had very small caseloads of four families each whilst Social Care were often carrying caseloads anywhere from the low to high twenties. There was some sympathy of these views of inequality in senior managers too. There was a sense

‘Of MST being a little bit elitist’, *Youth Offending Service Manager*

and of being treated as both ‘other and or different’ from the rest of the Social Care and Youth Offending Services in which they were respectively based.

There was consternation regarding the translation of the model to the UK and a view by some social workers that the needs of families were very different in the UK to the USA, despite

‘All the glitzy evidence’, *Youth Offending Manager* *Expanded City*

being presented at stakeholder events these doubts persisted. Interview participants reported that some of their colleagues objected to the idea of a methodology being bought under an operating licence and saw this in terms of the commercialisation or commoditisation of Social Work. This compounded the view that MST was of dubious ethical standing as if it were a private franchise to be resisted. Although this YOS Manager did later concede that

‘Some of the sceptics were in the end accepting of it as a valid model but some people never came to terms with it’ *YOS Manager Metro City*

The reception by senior managers, steering groups and partners was often more balanced and participants could see benefits to new ways of working

‘It felt like something different was being done, the Americans were impressive. The Chief Executive was pleased’, *MST Supervisor*

Other interviewees were drawn to the model by the robustness of the implementation process and by the requirements to put local protocols and systems in place in order to facilitate the best operating environment for the service to work in. In designing interventions with families it was made explicit what needed to be done in terms of the conception and formulation of problems, tasks, outputs and overarching goals to achieve. MST also required the use of a quality assurance system that supported the demonstration of high accountability for clinical outcomes. These were new innovations that required, for some professionals, a significant shift in orientation towards the model. But some interviewees perceived that these changes were also seen as fundamental challenges to the status quo of social work at the time by others.

**Chapter 5 Findings**

In this chapter the core findings from the subject interviews and coding analysis are presented. Two major themes emerge; leadership and contextual environment. The main constituent categories which comprise these themes are discussed in depth with examples from the interviews. The relationship between leadership and the contextual environment is explored. A number of subsidiary themes and categories were identified through the analysis and these are mentioned but space precludes descriptive detail. At the end of this chapter there is an account of how the two services in Isolated Coastal and Expanded City reached the end of their operational period and closed and an account of how the service in Metro City was sustained.

**Major and minor categories**

The strongest evidence in the data is for the major categories i.e. those supported by the highest number and most compelling of initial concept cards grouped under the category heading. These are ordered hierarchically in table 15 below.

**Table 15**

**Major categories established through the analysis**

|  |  |
| --- | --- |
| **No.** | **Major categories** |
| 1 | The high collaborative environment |
| 2 | Leadership for implementation |
| 3 | The hostile environment |
| 4 | Poor adaptation to the system |
| 5 | Networks of support |
| 6 | Political context |
| 7 | Systemic strengths |
| 8 | Vulnerable leadership and leadership risks |
| 9 | Shared ownership |

A secondary set of categories were developed through the analysis which had a lower number of concepts supporting them. These will be referred to in the conclusion and are not detailed here as they have less evidential strength, so governance was the tenth most supported category in the analysis but is the highest of the minor categories. Table 16 sets out the minor categories for which there were fewer underpinning concepts.

**Table 16**

**Minor categories established through the analysis**

|  |  |
| --- | --- |
| **No.** | **Minor categories** |
| **1** | Governance |
| **2** | Refreshing the system |
| **3** | Relational aspects of leadership |
| **4** | Patronage |
| **5** | Use of evidence |
| **6** | Creating momentum |
| **7** | Budgetary concerns |
| **8** | Vulnerable champions |
| **9** | Vision |
| **10** | Publicity |
| **11** | Implementing an evidence based practice |
| **12** | Doing new things |
| **13** | Academic into practice |
| **14** | National context |
| **15** | Making efforts |
| **16** | Planning |

The major categories created in the coding analysis have been split into the core themes of this thesis; Leadership and Environmental Context. Although there are overlaps, which will be discussed later, the categories may be allocated between the two major themes diagrammatically. Figure 2 describes categories which fit under Leadership. Figure 3 describes those which relate to Environmental Context

**Figure 3**

**Leadership by major category**

**Leadership**

**Leadership for Vulnerable leadership Shared ownership**

**Implementation leadership risks**

**Figure 4**

**Environmental context by major category**

**Environmental context**

**High collaborative Systemic**

**Environment strengths**

**Poor adaptation to**

**the system**

**Networks of support**

**Hostile environment**

**Leadership**

**Leadership for implementation**

The data analysis generated strong evidence for this category with ten underpinning concepts supporting it. There was a strong relationship between committed senior leadership and the effective implementation of the evidence based practice. This was clear from both the presence and from the absence of leadership as demonstrated by the subject interviews across the three authorities. The leadership concepts drawn into this category include: strategic leadership, commitment, systemic leadership and acting as a senior champion. The minor category of the relational aspects of leadership could be added here too as it highlights the value of seeking reciprocity and mutual understanding in the leadership task across agencies. Interviewees described effective leadership for implementation as enabling others, paying attention to the status of the intervention continuously and being consistently attentive to how the intervention was managed in the strategic and operational setting.

“I think that having that very senior manager who reports into the Director of Children is what has, I personally think, made the most difference. So it is not so much ,well there is an element of bottom up, but I think that having that person has been what the implementation has been about” *CAMHS Manager Metro City*

In Metro City, the impact and actions of leadership to achieve the implementation was highlighted as important by interviewees. Furthermore, this was aided by both an operational and a conceptual understanding of what outcomes the intervention could deliver for young people and families by the leadership and so inspiring practitioner confidence.

“Having someone very senior who was very committed to it, who knew about it, who could think about how this would impact in families with very real operational situations…I that that this was very much a driver in making it work” *Operational Manager Metro City*

The vision of the intervention was translated into practice through demonstrable actions to support the implementation. The leaders’ collective will was well known and communicated to others. Leadership for implementation in Metro City was a means of facilitating and opening the operational space for the intervention to seed and then to flourish. There was leadership consistency in Metro City as the Director continued to be actively involved in the steering group through the mobilisation and beyond, rather than to delegate this function.

“There are some strong leaders who understand MST, where is can help the Local Authority with its other objectives and have really championed it really strongly from a senior level” *YOS Operational Manager Metro City*

There was concerted leadership investment in Metro City and the development of a critical mass of enthusiasm for new approaches which would achieve corporately desired outcomes for children, including evidence based interventions. Links to academia were created and a learning culture was established with seminars and masterclasses for Social Workers, supporting the use of evidence authority-wide, at which attendance was expected. Practitioners and leaders were engaged in formal and informal learning events and workshops linked to new values for Children’s Services.

“I remember being at the workshops where (Director) was presenting to our social workers, this is what we are going to do, this is what we have done, we have been listening to these Professors and this is what they have told us and we are going to design our service, what we do, based on this and people were absolutely loved it”.

*Operations Manager Metro City*

The mix of academic knowledge and strategic intention was expressed in the collaboration between leaders too.

“You had (Social Care Director) who in terms of operations was saying yes this is a great idea. You have (CAMHS Director) who is the academic and the clinician saying this is the evidence base, this is what works, the two come together beautifully so I think that mix worked really well” *CAMHS Manager Metro City*

Committed senior leadership from Social Care, Youth Offending and CAMHS in Metro City came to the fore in mobilising for the new Metro City team. The relational leadership style of interaction built partnerships around shared goals, making partners feel included, valued for their contributions. No-one appears to have been coerced or bullied into collaboration. From this platform, the MST Supervisor was able to confidently engage with partners across the system, to muster support and consensus for the operational changes required for implementing MST, utilising the template protocols provided by MST Services and using his previous MST practice experience to bring the potential of the service to life.

“He really believed in MST, you know if you chatted to him he wasn’t evangelical, he could just sell you MST” *CAMHS Manager Metro City*

Reflecting on the referral pipeline one interviewee conceded that even after five years of the service taking referrals, the process continued to take time to get right and that the system required constant refreshing, not least given the consistent churn in social work staffing.

‘Some will never refer; some do at the wrong time. (Metro City) is a big place so has volume. The indication of a good referral is pre-engagement and a clear sense that the family are expecting the knock on the door.’ *Youth Offending Manager*

Achieving continued quality of referrals required vigilance and the attention of senior managers who acted as experienced and knowledgeable gatekeepers. This need for attention on the referral mechanics within the operational system did not seem to diminish over time either in any site. Inevitably, there will be turnover of staff at all levels of the organisation and so whilst not unexpected the need for active promotion of referral processes required conscious, active reinforcement by managers or the referral rate would either drop or attract ineligible cases.

In the implementation stage, the MST Supervisor in Expanded City, who had drafted the application for the pilot, transitioned from her Youth Offending Service role and established the team with assistance and support from her steering group and previous line manager. Informal mentoring support was offered from her neighbouring MST Supervisor. The positive start of the implementation was driven by the emphatic leadership of the Expanded City Chief Executive who empowered others and pushed the implementation forward, directing and requiring compliance in pursuit of the mobilisation of the service and into the first year of operation. The intensity of this leadership support was not however sustained and so once the service had drifted away from the Chief Executive’s orbit of immediate interest the leadership was passed to Strategic Directors, who changed frequently and suddenly. Of note here is how leadership was influencing and creating the environmental context.

Contending with rapid and frequent changes in leadership, the MST Supervisor could not hold all of the moving parts together in the professional system herself neither was the funding secure.

“(It) Was probably a mistake as we didn’t start the sustainability as planned, at the very beginning, by the time that they needed to look for the money all of those set up people were gone and the other people who were running it did not really understand how it was working” *MST Supervisor Expanded City*

She had not been able to refresh the system leadership around her as the absence of distributed leadership diminished the constituency of support that she could draw support from. Planning for her own succession threw this into stark relief and so, painfully aware of how the strategic leadership changes had worn her down, she could see how leadership support had ebbed and flowed away from her.

‘I think that I was starting to get fairly exasperated with the throughput of them. I think that I was probably on my ninth Director by the time that I went.’

*MST Supervisor Expanded City*

Leadership in Isolated Coastal was weaker still, as the provider was the single leader from the outset and despite having natural drive and determination she was in a weak and unsupported position all through her implementation experience.

“It was such a struggle, all the way through. It did feel like you were

banging your head against a brick wall with a lot of people at a local level”

*Hub Manager Isolated Coastal*

Both she, and the Expanded City Supervisor, reflected that they knew that they needed greater leadership and partnership support and that this was identified by them both respectively as the primary reason why each service had ultimately failed. With a perceived lack of strategic fit that left the service at odds with the direction of Isolated Coastals children’s services the service began to be felt like an unwanted imposition

‘I don’t think that the senior managers at the Local Authority had bought into the idea that this was something that was going to help them…seeing it as ‘we have got to do this and we are stuck with it’ which is how they felt’ *Hub Manager Isolated Coastal*

Whilst the steering group meeting was attended, the reflection was that the Local Authority leadership investment was limited

“If they don’t commit the time to it at a senior level, or the will to it and you could tell that there wasn’t the will to it, then that’s the big problem and you are not going to get past that hurdle and we didn’t” *Hub Manager, Isolated Coastal*

Senior Social Care management assistance was not forthcoming and an unsupportive Director in particular made few, if any, concessions to the implementation process. The organisational system offered little to the Hub Manager who looked to her own board for support, whilst the National Lead made efforts to establish regular calls and visits. Undeterred, the Hub Manager dug deep and expressed her considerable determination to mobilise the service in the face of considerable odds.

**Vulnerable Leadership and leadership risks**

Vulnerable leadership describes the risks of a single leader within a system and how the investment by leaders and partners in one person can create insecure dependencies for the system. Leadership risks describe the threats and difficulties which leaders faced in the operating system. Originally positioned as distinct categories they lacked underpinning strength and so have been combined. In Expanded City the rate of turnover of senior leaders in Social Care created vulnerabilities for the Supervisor, whose alliances were short term and temporary.

“We never got anyone who stayed any length of time after (Director A), (Head of Service B) had it for a bit and that ended in tears and she was really good and at that point I could see that they were just going to burn anybody who got in there as the problems were so intransigent. There were difficulties everywhere” *Psychologist Expanded City*

Leaving insecurity throughout, with seemingly nothing permanent in the Authority to give stability.

As in any professional setting, leaders will leave to progress their careers at a time of their choosing and not to suit the organisations’ needs although the culture in Expanded City appeared to be one ready to dispose of ineffective leaders quickly. New leaders who entered the system were sometimes uninterested, if not hostile towards the projects of their predecessors or sought to take a different direction to make their presence felt.

“There was an awful lot of difficulties on the social care front. You know that we never got anyone who stayed any length of time after (X), (Y) had it for a bit and that ended in tears, and she was really good”

*MST Supervisor Expanded City*

This was particularly experienced in Expanded City toward the end of the operational period with two new Directors arriving with views which

“Were actually quite anti-MST…they had kind of worked together elsewhere, they came in as a clique, they knew what they wanted and we were not a part of that. It was very much in or out and we were out.” *Psychologist Expanded City*

Leaders may feel that they are the rock that keeps the service anchored, to prove that they alone are able to do things that others cannot. In spite of her admiration and support of her, the National Lead could see that the MST Supervisor in Expanded City was holding a partnership together by force of personality instead of attending to the empowerment and distribution of power to others.

“I think that certainly the issue about leadership and making sure that it is not the single leadership of one person, definitely, I definitely took that away from Expanded City….too much on one person was definitely a factor” *National MST Lead*

Power may not be easily devolved by those who hold it nor taken up by those to whom it is offered. This is a common dilemma in many organisations and in Expanded City the stakeholders let the MST Supervisor lead for them.

“It wasn’t that (Supervisor) wasn’t conscious of the need to engage stakeholders, she would actually spend time on that but …there is something about that charismatic leadership, high energy leadership, rather than kind of low key leadership, that means that people see this as your baby” *National NHS Lead*

There were high expectations placed upon the MST Supervisors for both clinical excellence and for leadership, with a combination of skills required including effective governance, team and system leadership. Rarely have Supervisors confidently and competently possessed all of these attributes from the start as the National Lead sought to diplomatically state about the Isolated Coastal Supervisor.

“He was more, well his strengths are more in the clinical field than in the stakeholder engagement field I think that it would be fair to say”

*National NHS Lead*

Several mature MST sites have more recently established a functional split between a Supervisor role and a Programme Manager role which may be taken by an experienced ex-Supervisor who can offer both leadership and a clinical perspective to maintain the partnership in supporting the service within the system in which it is placed. This can spread the risk of too much being concentrated into a single leader and is a de-risking strategy.

The absence of succession planning for the Supervisor role was a leadership risk in all three sites and simply hoping that someone would not leave and would remain in post long term was neither a reliable or purposeful strategy. Supervisor turnover was experienced in all of the sites. Whilst in Metro City the expansion of the service enabled more clinical robustness to develop with additional clinical appointments establishing a peer group of clinicians, in Expanded City and Isolated Coastal it signalled the beginning of the end to the service.

Three years after starting, the steering group in Expanded City had become poorly represented with a discernible drop in the seniority of partners who attended, if they attended at all.

“At the beginning the steering group was very well attended. And chaired by, a range of people, I think (Chief Executive) initially but then she only lasted 12 -18 months, you know that is where it kind of starts, you know people leaving and complete churn in the other parts of the organisation, there were whole swathes of people in the organisation leaving.”

*MST Supervisor Expanded City*

The Chief Executive had passed the chair to a Director and then to a Head of Service until eventually the MST Supervisor was left chairing it herself, creating a risk in regard to scrutiny and governance with the meeting becoming an internal working group rather than a strategic meeting of partners. This led to the service becoming remote from senior leaders and partners. Whilst recognised as a weakness at the time by those who were involved, it was only in hindsight, when the service ran into financial pressures, that the implications of this became all too obvious.

‘I think that it was probably too much of me and less of the partners as too many of them had left at that stage.’ *MST Supervisor* *Expanded City*

A recurrent theme in the lifetime of the MST service in Expanded City is that there were times when good connectivity was made both with the Social Care system, which was often supportive and with senior managers who were in favour of the service.

“We made really strong links with the social care managers who absolutely loved us” *MST Supervisor*

Followed by periods of threat and risk as a result of changes in leadership or of other key supporters. Therefore, the leadership risk was in the transfer from one leader to another. The Supervisor explained how one of the service Directors had a personal connection to one of the leading academics that was conducting the research trial. This created a safe, albeit temporary, period of stability in which she was confident that the service would be protected from adversity. Indeed this proved correct as this post holder was replaced with someone less favourably disposed toward the service.

The YOS Manager described how one new Director sought to swiftly make budget cuts to the MST service in the immediate post implementation phase. The new post holder took the view that as the MST team was relatively new and had not yet embedded itself as part of the core offer to families that it could be closed and a saving achieved, despite the fact that it was still at this point over 50% grant funded.

“I had the bizarre situation where we had a change of Director and they were then faced with making lots of cuts and they literally came in and said ‘well MST has just started, the other teams have been around for ages and MST can just go, made that decision fairly quickly and set about implementing it .” *YOS Manager Expanded City*

The YOS Manager described a frenetic process of gaining partnership support, contacting the legal team and reprofiling the budget with colleagues from finance. A business case for the service to continue was prepared and a series of backroom negotiations ensued with partners, out of sight of the Director concerned.

“It was literally going to a meeting in a weeks’ time and that was all going to be confirmed and no-one was allowed to know or was sworn to secrecy”

*YOS Manager Expanded City*

Not least as the YOS Manager had been explicitly instructed not to discuss the threat of closure with anyone because the service was grant aided.

‘It was almost a game of bluff…it went right to the line and it literally was decided on the day to continue and none of this was known by anybody. It was brutal’ *Youth Offending Service Manager*

The leadership risk of new Directors was clear as they looked for ways to respond to short term budget pressures by making quick judgments, unaware of history and context, highlighting the need for active management to head off crisis through immediate responsiveness to the threats posed. As another new Director came into post the Expanded City Supervisor reflected

“They knew what they wanted and we were not part of it. It was very much in or out and we were out”. *Expanded City MST Supervisor*

It exemplifies how the strategic thread in Expanded City was exposed to the risk of adversity and change at any time as strategic functions passed quickly from one Director to another. The continuity of service provision in the Authority was expressed in the published strategic plan but these were not seen as fixed positions and were often subject to immediate revision in the light of budgetary considerations.

For both Isolated Coastal and Expanded City, the resignation of the Supervisor immediately called into question the viability of the service with the urgency of a crisis. Given the small footprint of evidence based services recruiting to Supervisor posts was often difficult. Once recruited they would need to do the intervention training too.

In Isolated Coastal the requirement to make a permanent replacement was experienced as requiring the partners to restate commitment for commissioning of the service beyond that of the initial three year grant funded period. Therefore, according to the National Lead, partners had to consider their funding position much earlier than had been anticipated. Given the fragility of the service in the eyes of the Local Authority, an interim position was established with an acting up arrangement for the role of Supervisor, but it was a clear signal that the long term commitment would not be forthcoming which then hastened the decline and closure with the narrative already moving against a long term replacement.

“Isolated Coastal were already sort of saying that they were not sure if they were going to confirm the funding” *NHS National Lead*

In Expanded City the Supervisor leaving was also a crisis. The gaps in the system which she had held together were exposed and the structure surrounding the service looked weak and ineffective.

“I remember phoning (National Lead) and saying I think that we are in big trouble here. I am not sure that I am going to take the job, because I think that we are going to lose MST here. Because I think that they saw that whilst I was there I could create enough havoc that it wasn’t worth trying to go for it but it had become quite embattled at that point and (Director) seemed to want our money” *MST Supervisor Expanded City*

Whilst a permanent replacement was recruited to do the clinical work, the system leadership, supported by the previous Supervisor was lost and the service never recovered, closing a year later. Had a strong strategic leader and a stronger partnership been in place then the service might have been retained, according to the reflections of the interviewees but Expanded City was still experiencing changes in senior leadership with interim appointments following interims and the new permanent incoming strategic Director made it obvious that she was going to put the service at risk of closure. There was clearly some opportunism in this with the service at this stage looking vulnerable and the NHS, original grant funder not having a prepared response to funding challenges.

“I think back then we were perhaps a bit naive about ..having a plan B if a particular funder drops out or says we have only got this amount of money”

*NHS National Lead*

Both the original Supervisor and the National Lead, reflecting on this, suggested that they had under estimated the impact of leadership that the original MST Supervisor had had on Expanded City. The Supervisor had carried the service. The churn of partners led her to state in exasperation

‘I mean, the amount of champions that we had lost…I was the last man standing’ *MST Supervisor*

which reflects how the partners and supporters had slipped away from her. It is also a comment on the clear absence of any distributed leadership across the system.

In Metro City, progress was made

“Fairly quickly, by Local Authority standards anyway, we got the first team up and running and we were quite excited by how quickly they established themselves and we would put that down to a leader who hit the ground running because the leader was steeped in MST not new to MST” *YOS Manager Metro City*

This enabled a positive start with the initial period of implementation perceived as successful. The promotion of the Assistant Director responsible for MST empowered him to consolidate his leadership and interest in evidence based interventions

“Because it was owned by senior leadership and people like (Assistant Director) in particular and people like that who really wanted it and really wanted to see it expand and do well it sort of put it at the forefront really” *YOS Operational Manager Metro City*

The lead was also able to continue to maintain oversight of the service from a higher strategic position and extend his patronage in two ways, by continuing to chair the steering group and by taking the line management of the Supervision with him into his new role. This was, for the intervention at least, a strengthening of position rather than a weakening of it.

**Shared ownership**

Shared ownership, as it relates to leadership, may be understood as a form of collective responsibility for the delivery of the intervention. It represents joint investment into the system to keep the operating environment vital and refreshed. It is related to governance functions but pertains more to the vertical and horizontal ownership through the partnership agencies and children’s services of the intervention. There was a palpable sense of ownership of MST in Metro City from the interviewees which felt different to elsewhere.

“ There is quite a high belief in evidence based approaches and research.. We have a series of masterclasses that we have all the time and people absolutely love it and they are oversubscribed and you will hear people talking about them” *Head of Service Metro City*

“We have three areas of social work practice and we have three areas of MST teams, so everybody knows, some of them are in the same buildings and there is a strong discourse between them.” *Operational Manager Metro City*

As the interview narratives unfolded the interviewees described how MST was something that Metro City had found, nurtured and developed and which had become a central part of the improvement journey of children’s services. This created a common narrative of why Metro City operated as it did and how it was now internally and externally lauded as a high functioning authority, including at a political level.

“I was at scrutiny board a couple of weeks ago and we were all being criticised for using acronyms and every time somebody said something they were picked up and I happened to say MST and no-one picked me up and I think that was quite interesting because you have a got a massive group of elected members there who were picking up everybody but they understand MST and understand what it is and I think that is quite important as well” *Operational Manager Metro City*

The intervention and implementation effort was described as part of a determined strategy to make the City a place where all children were seen as valued. The strategy building a sense of collective responsibility across children’s services, the wider Authority and beyond.

“I think that the way that it is built into all of our structures.. I think gives it the security that is has got now in terms of the time we have been doing it and the way that it is built into everything that we do. So it is just one of the parts of the continuum now” *Operational Manager Metro City*

Shared ownership in Expanded City was short lived. During the early stages as the Chief Executive embraced the implementation but as her influence reduced the ownership was held by an ever diminishing group of professionals who could not expand shared responsibility any wider than within the immediacy of their own network in the latter period of operation. Ownership and leadership was conferred upon the Supervisor alone as the frequently changing partners deferred to her.

The MST intervention was known to be funded for three years and in Expanded City this led to the sense of impermanence, that the intervention was only temporary and therefore would not be long lasting in the professional system.

“It wasn’t as well embedded within the local landscape as it could have been. Which I think led some people to, just resist it which was not helpful in terms of making it. So, I think that you have to embed it better. So not rushing it, embedding it effectively and making sure that it forms a proper part of the whole landscape, that it is not seen as being something out there, that it is actually in here as part of the armoury that you have got.” *YOS Operational Manager Expanded City*

As an undemanding governance body, the steering group missed the opportunity for the re-positioning of the MST service after the end of the research phase. This could have enabled the service to develop a new purpose, built upon shared ownership and re-aligned within children’s services and with partners, notably CAMH. However, new partners to the steering group were never inducted into their role and were expected to pick up as they went along by experience alone. Awareness of the strengths and weaknesses of the intervention and of the necessary conditions for it to succeed were low in the final period amongst steering group members, nor was there a collective memory to bring to bear.

**Environmental context**

***The high collaborative environment***

In Metro City, there was strong evidence to support the category which is described as the high collaborative environment, as shown in appendix 5. This category is composed of eleven initial categories. The notion of collaboration with others in pursuit of a goal or outcome through co-operative activity and leadership was clearly expressed. This was supported by the environment, professional system and organisation in a way which was enabling and facilitative.

This category was exemplified through what the interview participants saw, reflected upon and experienced across both children’s services and health. There was a deliberate leadership intention to actively collaborate. Leadership collectively harnessed a pre-existing propensity to work together as effective partners. The stage was then set to achieve clearly defined and agreed partnership outcomes, in this case the implementation and delivery of an evidence based intervention.

“I think that it is easy to collaborate around looking at evidence based practice and what it can deliver and looking at the outcomes of what it is delivering” *CAMHS Operational Manager Metro City*

There had been a willingness and a determination to overcome historic organisational inertia, barriers and obstacles to multi-agency working in order to achieve a successful outcomes.

**“**I remember having discussions about feeling confident that we would be selected as a pilot site because we could present the track record of working together and we thought that we were bloody good and that we were bound to get offered the chance to be a pilot site because we had a compelling case”. *CAMHS Director Metro City*

The roots of collaboration, already evident in Metro City through the earlier leadership efforts to develop an improved operational relationship between CAMHS and Social Care, proved an important foundational platform for collaboration to be extended via the introduction of MST. Partners knew each other, they had worked together for some time and had found it to be beneficial to collaborate in delivering services in which they had an invested common cause.

“Ofsted came and commended the close degree of collaboration and so there were lots of brownie points for both services and that was the backdrop that the MST thing came along.” *CAMHS Director Metro City*

Partners had overcome initial fears through planned organisational development and purposeful time spent in a joint consultation processes across the City. The collaboration between partners in Metro City was evident to the National Lead at the application interview when asked specifically about their working relationships

“They all sorted of looked at each other and were like ‘we are working on this, we are working on that’, they gave concrete examples of other things that they were working on collaboratively but also they were like ‘we have known each other a long time”

*National NHS Lead*

This may have been a high-water mark for inter-agency collaboration by the leadership at the time and at the point of the implementation in 2007/8. It was clear from the material that momentum and intensity during the immediate implementation itself was generated by the combined leadership of the partners. Interview participants reflected upon whether a similar constituency of collaborative support and leadership would emerge now, should the opportunity arise again, given how much the context had changed since 2007/8 in public services through the years of austerity.

“Because we are talking about money in a depleted environment so it is very much to (Metro City’s) credit that they have persisted with it and continued to sustain it I think. But at what cost to them I don’t know. I do know that (Director) has remained extremely positive about what MST can deliver” *CAMHS Operational Manager Metro City*

Interview participants suggested that collaboration was a hallmark of how they operated now, as an expected normative condition and that they thought it probably would.

“MST is not a pilot anymore, it is an established part of the landscape”

*YOS Operational Manager Metro City*

However, most participants believed that there was a time of collaborative effort which somehow broke the mould of how agencies had worked together historically which had a unique quality to it at the point of implementation.

‘Everyone got behind it, health, social work, everyone…it was a different time when it came along. If you came and offered us MST today and we didn’t have it I think that we would say ‘love to’ but we can’t afford it. It would be the bottom line.’

*YOS Operational Manager Metro City*

Over time and through the post implementation period, there have been changes to both the context and to the leadership in Metro City where collaborative leadership was at its’ strongest. There remained, by the point of the interviews in 2015, support and examples of continued collaboration which have sustained not only the original MST service but have substantially expanded the reach of it across the Authority. This expansion enabled equity of access with all relevant children and young people eligible for referral. Metro City has now achieved a greater expansion than in any other contemporary service, with further services and new clinical variants established. (Further evidence of this expansion to corroborate this assertion could reveal the site location.)

Many of the leaders who were present at the start remain in Metro City and this stability must play a part, not all are in the same post but one might argue that they remain influential and potential allies of the service within the broad operational system, perhaps to be called upon again if support were required in the future.

‘We have had some key partners who have been with us since the beginning and are still as committed now’ *Social Care Manager Metro City*

It is clear, from the analysis, that the collaborative environment did not appear out of a vacuum or by serendipity, nor was it the product of a single leader’s drive and vision alone. It was an environment created and sustained by the leaders and participants who worked in it and who led the system at different levels of seniority, drawn together by shared beliefs and values.

“Another lesson would be being willing to commit time and effort to consider other people’s perspectives and paradigms and ways of working and remembering that the things that health do seem natural to us but don’t to social services and vice versa.”

*CAMHS Lead Metro City*

The evidence supports the contention that a high collaborative environment is a product of sustained long term and relationally driven leadership. The leaders in turn value partnership working and are attentive to the detail of inter-agency interactions, differences and pressures that partners are under. This leadership sought opportunities to act collectively and enabled systemic re-enforcement of collaborative endeavour. Indeed, the leaders now in place have found others who would work and lead in this way as new entrants join the organisational system as senior leaders turn over. The attraction of Metro City to likeminded leaders makes this a self-replicating system, at least for now.

“I had no intention of ever leaving the job that I had and just by chance became aware of what was happening in (Metro City) and one of the biggest draws for me was around the use of evidence and research because it fits” *Head of Service Metro City*

The collaborative environment was substantially assisted by systemic support mechanisms and contextual circumstances that resulted at least in part from the size, scale and capacity of Metro City. As the larger of the three local authorities under investigation this might be perceived as a counter intuitive assertion, given that bureaucratic size is most commonly negatively associated with the diffusion of innovations. However, size also creates potential for critical mass to develop and once the benefits of the intervention began to be realised the practice appears to have become normative quickly, supporting the fit with the new strategic values created at the same time. With a the explicit support of the Director, political support and a process of organisational reform also being initiated, MST became part of a

“Deliberate approach really, to build it into everyday work, so for our social workers and practitioners, MST is just another one of the interventions now where it works really, really well” *Head of Service Metro City*

Collaborative leaders significant impacted upon the expansion and sustainability of MST in Metro City.

“Some of the people that had championed the programme and been part of the bidding did move on and obviously where you have a smaller authority you are reliant on a smaller number of people so like in Metro City that fact that (Health Commissioner) was a champion and then moved on was probably less of an impact” *NHS National Lead*

Metro City chose to use the existing case prioritisation panel, which had already been established for several years between Social Care and CAMHS. This panel revised its terms of reference to enable it to act as the allocation panel for referrals. The MST ‘Goals and guidelines’ were seen by participants as helpful in setting up the referral process. Whilst the relational aspects of the interagency panel were seen as contributing to the success and a building block to developing effective referral flows, even if they took a bit of time to refine. The CAMHS Director stated that

‘If you have good working relationships, even if the pathways you have got aren’t that good, then good stuff still tends to happen’ *CAMHS Director.*

Therefore the willingness to seek an effective referral flow (or pathway) for the system was substantially aided by the trust and mutual respect which already existed between partners and leaders.

**The hostile environment**

The category of the hostile environment was not constructed as a category by way of being the direct inverse of the category of the high collaborative environment. The hostile environment has distinct features and is named as such from an in vivo quote.

“The context of the hostile environment was very important. Because the authority was under so much pressure, consistently in terms of performance and special measures and we always figured at the top of the tables, the bad tables, for performance and for outcomes for young people and so there was defensiveness from most areas and from most partners” *YOS Manager Expanded City*

In Expanded City and Isolated Coastal a tight group of highly motivated and collaborative leaders and practitioners were striving to sustain their services but faced being overwhelmed by the contextual factors and events taking place around them in the organisation and system.

“The whole thing was quite precarious…you know everyone was just embattled, trying to protect their own, it became more and more difficult, you know we were shoved around.” *MST Supervisor Expanded City*

Holding on to the operational integrity of the service within a hostile environment required considerable professional, if not personal, commitment to ensure the survival of the service and a guarded watchfulness within the contextual setting. MST endured in these two settings because of the determination of the few, working against the prevailing environment.

“When I left there wasn’t a single soul around, I mean (YOS Psychologist) had been part of it and (YOS Operational Manager) and they were busy trying to watch their own ship, thank you very much” *MST Supervisor Expanded City*

The hostile environment describes both contextual conditions and circumstances which do not allow the intervention to flourish in a setting which is changeable and pernicious. A context typified by sudden threats and pressures that emerged seemingly out of nowhere and a low level of trust between staff.

“It was difficult...when people were afraid and defensive as a default position” *Youth Offending Manager Expanded City*

Or one which contains persistent risks that require reactive defensive actions to be initiated and mobilised against the omnipresent dangers of budget cuts, service reviews and organisational changes. The hostile environment is far from a fixed or static condition and one which is liable to sudden change.

“This played out in how we were located in different parts of the building and it felt, as soon as they knew that I was leaving, it was harder and harder then to hold things” *MST Supervisor Expanded City*

Interview participants in all of the three sites described both good times and bad times in the operating environment. This was particularly evident in Expanded City when operating conditions were much more favourable in the early stages when, as described in the earlier findings under leadership, the Chief Executive was supporting the implementation. There were periods of considerable optimism about the long term future being secured. Right up until the decision to close the service in Expanded City there was a sense that the circumstances and environmental conditions might yet just change for the better. Hopes were raised as a new strategic leader came into post. There were hopes too that a reappraisal of the outcome data by the corporate centre or a supportive shift in the priorities of the local authority might change the views of leadership.

In my opinion, this might have been a naïve and hopeful wish for deliverance in the face of overwhelming odds, not least as it appeared that the service had not only run out of supporters but that it had gained some enemies too in the local system by the time that it eventually closed. But it was known that the environment in Expanded City was highly changeable by the participants who worked within it. Change of direction was identified as driven particularly by senior leadership actions and often at a political level too which added to the lack of control and influence that the supporters of the service felt as decisions were taken above their heads.

“I think that there was enough information about the money saved, about the sort of benefits that it provided young people and their families to actually say that this is something worthwhile but the decision was finally made by the Director (who said), nah, this is £300 thousand pounds wasted, we can’t afford it. I was thinking can you really not afford it?” *YOS Operational Manager*

The experience and narrative of Expanded City is one of a relatively successful service trying to maintain itself in an increasingly hostile environment in which the churn of senior and operational leadership created a loss of strategic continuity and therefore service ownership. This coincided with financial pressures, which eventually came to overwhelm it. Although the service had been confidently established, there was immediate hostility towards the introduction of the service, not least from Social Care who

‘Were in almost perpetual special measures for a number of years and were really battered as a service, they had lost quite a few Directors and so morale was at rock bottom.’ *Youth Offending Manager* *Expanded City*

Hostility was expressed in terms of resentment at new investment being made to another service when Social Care was in crisis and under pressure to improve both internally from Councillors and externally from the Ofsted. There was a palpable sense that there was an unspoken criticism of Social Care in the desire of the corporate centre of the Authority, led by the Chief Executive, to support bringing in a new intervention from the outside rather than to invest in enhancing in house services.

“There was quite a lot of jealousy too, we were seen as having quite a lot of funding compared to other people which might have set up some resentments” *MST Supervisor Expanded City*

With pressure on the Local Authority to improve performance in children’s services and poor standing in national tables across a range of indicators and outcomes, an opportunity for innovation and investment in this period was seen as a rare opportunity. The partnership environment in Expanded City at the time was characterised as one of

‘Defensiveness from most areas and most partners, getting cooperation from partners, education and health and to a lesser extent the police, although that was one of the stronger ones, was actually very difficult’ *Youth Offending Service Manager*

Historically, Expanded City had difficult relationship with the CAMHs services, often openly blaming the service for not reaching out and assisting the troubled and poorly rated Social Care service. There were limited examples of good working relationships and a sense of anger at the reluctance of CAMHS to provide more responsive services to a partner in difficulty. At the point of the establishment of the MST steering group the YOS Manager reflected that

‘The money drew a reluctant partner (health) to the table’ *YOS Manager*

However grudging support from CAMHS may initially have been, there was energy and momentum in the early stages of implementation by all partners which was seen as a corporate imperative and actively backed by the personal involvement of the Chief Executive, carrying the partners forward through active and determined strategic leadership, drawing wide praise in terms of the leadership support given from the interviewees. The service enjoyed initial success and positive publicity, winning awards and receiving glowing external media exposure in the absence of any other good news story emanating from the Local Authority Children’s Services at the time.

‘Senior managers loved the accolades… they loved the external stuff.*’ MST Supervisor*

Frailties and systemic weaknesses in both partnership commitment and in the long-term leadership of the service emerged over time and within an ever-changing context of turbulent changes of senior leaders as has been already described.

The experience of interview participants in Expanded City in particular demonstrates how maintaining the system to consistently facilitate the optimum conditions for the intervention to operate effectively required continuous and pro-active attention across the organisation. At a strategic level keeping leaders updated with information regarding the outcomes of the service. This enabled the service to periodically restate and highlight the value of the service to the organisation. As leaders turned over the service sought immediate engagement with new personnel with the aim of drawing committed support to the intervention. Creating a connection to the emerging priorities of the new leader to ensure strategic fit also appears to be an important feature to ensure strategic continuity.

Developing the notion of a hostile environment further is the idea of a ‘toxic trio’ proposed by one of the interview participants. This provides a neat encapsulation of some of the core elements of the hostile environment and shifting context.

‘The three riskiest factors for new evidence based programmes failing is, change of leadership, lack of effective partnership support and dwindling resources and I think that when the three come together it is lethal, I think that it is almost inevitable that you will not be able to survive that’ *YOS Manager Expanded City*

These three factors exemplify hostile events in the context of the delivery of the MST service. For this interviewee, the toxic trio describe three environmental circumstances which are relatively common in children’s services. He proposed that services may be able to cope with one of the three factors if they occur individually or possibly more than one if they occur sequentially over time. However, he proposed that in combination they may prove to be overwhelming, even to the strongest service. The interviewee reflected that strong leadership or a strong partnership might provide a relatively effective counter or defensive bulwark against contextual changes. Therefore, the defence to a weak partnership could be a strong leader and the counter to a weak or absent leader could be a strong partnership.

Senior leadership changed successively in Expanded City. Therefore, new strategic alliances were difficult to forge with each new incumbent bringing their own perspective to the problems facing the Authority. The change in MST Supervisor exposed gaps in knowledge of the service by the remaining steering group partners whose interest had diminished over time. The new Supervisor appeared unaware of the value that the partnership could bring to supporting the sustainment of the service. This could have been out of political naivety although could equally have been due to her attention being focussed upon the demands of clinical supervision and operational activity. One could speculate as to whether partnership support could have been courted by the new Supervisor and if this was resurrected sufficiently might it have made a difference. Almost inevitably the service collapsed when the next round of the corporately proposed funding cuts found neither an effective leader nor an effective partnership to oppose them.

All organisations and systems enter times of transition and change with movement of senior leadership. Understanding the stability of an Authority may become an important feature to assess in considering the viability of establishing an evidence based service within it. The relative stability of senior leadership in Metro City is unusual and it may have been a matter of luck that they did not experience successive churn of leaders. Metro City had the advantages from the outset and this was noticed by the National Lead at the point of application

“They came across very solidly but it was very much kind of this is an authority where people stay around for a long time and we have very well established relationships and that kind of thing” *NHS National Lead*

which may well have enabled a less febrile atmosphere to prevail compared to that of a smaller authority where the impact of change may be felt more quickly due to smaller numbers of senior staff.

**Poor adaptation to the system**

In Damschroder’s (2009) CFIR the heuristic representation describes a closely fitted jigsaw piece for the organisation connected to the adapted periphery of the intervention at the point of maturity. This represents both the extent and the eventual limit of the mutual adaptation to the system by both organisation and intervention, a sort of homeostasis. This is a helpful means of conceptualising the mutual adaptation of the intervention to the operating system and vice versa. Not least as the equilibrium of this position is then maintained.

Conversely, the inability to achieve sufficient adaptation to the system creates an imperfect connection with gaps and overlaps. Interviewees described a range of factors, from cultural fit to the sense that the intervention which was being introduced was “over hyped” and could “never live up to the sales pitch”. In fact, the notion of buying and selling a product which was known to be licenced and promoted by an international, for profit, company was something that always jarred with several interview participants who considered that this was somehow immoral.

“There were certainly challenges around selling it more than anything else and a challenge about the ethics of around it.” *YOS Operational Manager Expanded City*

The assumption by some was that buying a commercially licenced intervention is a step towards privatisation of services and therefore something to be explicitly and implicitly resisted thereby decreasing trust in the intervention and reducing engagement with it. With both jealousy and scorn at the new expensive service.

“(The Supervisor), kept jetting off to America and we would all like to be jetting off to America and the MST workers kept jetting off to America to conferences and this and that” *Head of Service Metro City*

This adds to the sense by which some of the detractors of evidence based interventions were waiting for the intervention to fail or were seeking confirmatory evidence of ineffectiveness. Both the youth offending service and social care in Expanded City were openly sceptical and MST was

“A difficult thing to sell to some of the staff here and certainly in the early days there was a huge amount of suspicion around implementing MST I have to say but in the end I think that as a management group and as a steering group we were confident enough in the process to be able to say, you know ‘you may not actually like what we are suggesting but this will be effective’ and I think that that kind of drove it through” *YOS Operational Manager Expanded City*

Each setting needed to establish a referral pathway and to locally adopt or adapt the process laid out in the implementation manual to their own context and systems. Effective referral flow is an indicative bell weather of the functionality of an operational system. Too many referrals and the service is overwhelmed with pressures it cannot meet whilst not enough referrals and the service suffers from underutilisation. The referral ‘pipeline’ is commonly controlled and managed by administrative and managerial staff within Social Care and conducted at a panel meeting where the threshold for resource allocation is held. Panels assure effective senior management oversight so that resources can be deployed appropriately. Effective panel functioning is dependent upon front line Social Workers and Youth Offending Officers making appropriate referrals.

In Expanded City the early referral flow was volatile and inconsistent from the outset and took a long time to stabilise. Social care were under considerable pressure at the time and some Social Workers saw the development of a new service as the opportunity to refer to MST simply in the hope that it would alleviate the pressure on their own caseload. The YOS Psychologist described how there was an almost thoughtless process of Social Workers seeking services for their cases, which impelled them to

‘Refer on, refer on and refer on’ *YOS Psychologist*

In the hope that the service would take their case on. Another manager suggested that Social Workers chose particularly difficult cases to refer for MST in order to highlight the pressures that they were under to senior managers, more than to seek resolution for the cases that they held. The point was also made by interviewees that the referral of exceptionally difficult cases may have been motivated by a Machiavellian desire to prove that MST could not work and was designed to evidence its ineffectiveness to both the referrer and to the Social Care system more broadly. One view articulated by several interviewees in Expanded City is that there appears to have been a disappointing lack of appreciation of the potential for the service to become a helpful addition to the available options for adolescents and their families within Social Care. It was as if MST was something to be resisted rather than embraced as a useful addition to the system.

Several interviewees in Expanded City considered that cases referred to MST, were ‘taken away’ by the service and removed from the continuing involvement and oversight of other services. The sense that cases being accepted for MST was experienced as disempowering of workers in other teams speaks to wider disengagement with the MST team and a poorly adapted system which provoked a professional backlash against the MST model. One Manager described that professionals were unhappy to step back to let the service work with the family alone. This suggests a struggle in conceptual terms regarding the nature of the intervention with this conceptual dissonance most strongly expressed in Expanded City, although there were echoes of it elsewhere. This impacted upon referral flow as if Social Workers

‘Don’t really believe it or if they don’t really like it or it doesn’t fit with how they like to do things then they are not going to get the buy in. You’re not going to get referrals, you’re not going to get support’ *YOS Psychologist* *Expanded City*

Whilst an advocate of MST herself, the YOS Psychologist had her own reservations based on the perception that young people might lose relationships with trusted professionals such as Youth Offending workers when referred to MST highlighting how if young people had concurrent criminal supervision orders running alongside the MST intervention then their contacts with their Youth Offending worker were reduced significantly. Contacts became a weekly reporting process instead of one in which a fuller relationship might have been developed with their YOS worker. Fears that the child’s voice was unheard if not lost in the MST methodology as MST workers spent their time with parents coaching them on behavioural strategies were also raised by the YOS Psychologist in Expanded City although these reservations were not publicly expressed.

“My only query really is to make sure that that child is given some light as well and not just all the systems. Because you know all the systemic stuff I love it, it’s brilliant and necessary beyond belief, but I think that as long as the child is seen on their own and there is some kind of look to see if there is anything more going on then that would be helpful” *YOS Psychologist Expanded City*

In Isolated Seaside the referral flow was slow to develop and required constant attention and activity by ‘The Hub’ in order to generate sufficient activity. The Hub Manager and the Supervisor began to undertake regular promotional visits to social work team meetings, giving presentations, providing information about the service and how to refer to it. The Hub Manager complained that the lack of referrals was clear evidence of Social Care’s lack of acceptance of the validity of the service offer and of service managers in particular who had

‘Not bought into the concept of it’ *The Hub Manager*

The MST Supervisor in Expanded City reported a clear cultural gap and felt that the MST service sometimes felt like a round peg in a square hole. For example, getting the administrative staff to be located with the Therapist team instead of being sent to the admin pool on another floor was a problem. As the team were often working and seeing families in the early evening and then returning to the office much later in day than other staff the building was sometimes locked up for the night and the team were locked in more than once.

‘It felt like we were doing something different from everyone else, we were trying to work when they were going home’ *Supervisor Expanded City*

The opposite was the case in Metro City where MST had been adopted and adapted by the Authority and was here to stay.

‘There was a kind of thought around the Metro City takes these things on and then Metro City-ises them, if that makes sense’ *YOS Operational Manager*

This is a local claiming of how MST was operating in Metro City with a sense of pride and ownership, even though it was clearly understood that they held no real claim over the intellectual property rights. The YOS Operational Manager stressed that they kept to the core elements of MST and were adherent to standards of fidelity and were not ‘tinkering’ with it. MST was owned and embraced by Metro City and as a result, he and others would defend it. He acknowledged that MST conceptualisations now infused his thinking about cases when understanding barriers to changing behaviours and so his practice had changed. MST had ceased being a pilot project but

‘An established part of the landscape really.’ *YOS Operational Manager*

and so became part and parcel of what Metro City was about.

**Networks of support**

The existence of both formal and informal networks of support were seen as important for the leaders and practitioners with an interest in evidence based interventions as well as for those who were seeking to influence the system. The ease by which the National Lead for MST was able to access the professional network and leaders in Metro City was considerably assisted by a pre-existing network of connections between her and leaders in Metro City. The National Lead was able to trade upon her existing connections and to then be passported into new networks in which she became a ‘vouched for’ person, carried forward by the relationships with other leaders.

“It wasn’t that I knew everyone but I was a known person” *NHS National Lead*

It is easier to work with people with whom one has worked with before and to build a community of support based on potential and previous working endeavours. A shared experience draws people together in ways that can establish trust as well as personal connections which can prove useful in times of trouble. In Isolated Coastal the National Lead was almost the only external network that ‘The Hub’ had to call upon and despite her efforts to connect the Hub to others, to be present and to be helpful, the absence of any other networks for the service to access was a limiting deficit. Metro City supported formal and informal networks across the large neighbouring cities, universities and professional associations that created opportunities for support and innovation.

The National Lead for the Department of Health described how she felt that the service in Isolated Coastal was never really going well, feeling like it had missed an important stage of development from which it could not recover. The Hub Manager saw the National Lead as being a strong champion of the service as she made determined and committed efforts to support the service as demonstrated by her regular attendance at the steering group and her willingness to make the effort to travel half a day to attend a meetings. The lack of Local Authority support had to some extent been countered by her and by the support from the regional Government Office who supported the funding award. But the demise of the regional structure of Government Offices soon after the Coalition Government came into power in 2010 and the lack of any other obvious peer support network for the service made the sense of strategic isolation more acute.

In order to reduce the expense and burden of travelling time and also the loss of productivity for the team, the decision was taken by MST Services to offer the required two day quarterly booster training with the MST Consultant, as a single team rather than to undertake their training with the closest team to them, over 3 hours away. In hindsight the National Lead recognised that this was a missed opportunity to establish peer support and a connection to another service in another relatively small unitary Authority. As a consequence of the intense nature of the work and with small caseloads, there can be a tendency for single MST teams to become self-absorbed in their own functional dynamics. This is particularly shown in the Therapist and Supervisor dyad within which there can be an intense mixture of support and challenges as constructive critical feedback on case interventions is given each week through the supervision and consultation process. Booster training with another service can enable teams to see that relational issues are regularly experienced in supervisory relationships in MST and are not unique to the personal characteristics of individual Therapists and Supervisors. This can help teams to develop perspective on the dynamic of intensive working as well as to provide support and encouragement with common problems and in finding solutions to issues. Without this it is possible for a single MST team to become inward looking or for the relationships to crumble under pressure leading to disputes and dysfunction and therefore become vulnerable.

“When teams booster with each other they see that some of the things that perhaps they are finding challenging are about the model or it makes it easier for them to distinguish what is MST and this is how you work in this way and this is my Supervisor having a go at me. So I think that also when you get a different experience of a different Supervisor who might describe something in a different way so it can help the Supervisor sometimes shift their position” *NHS National Lead*

In contrast, Metro City was part of a vibrant regional cluster grouping of several MST teams, which had a peer support network at its heart. The MST Consultant played on local competitiveness to motivate performance. Not only did the MST teams know each other well but their senior managers also had experience of working across this regional structure.

“There was some positive collaboration but there was also some competition. So the Supervisors were busy collaborating with each other and the leaders were too but you know in a healthy way” *NHS National Lead*

Support was mirrored across different parts of the organisations with boosters moving location each quarter to different sites within easy geographical reach. Expanded City were also in a regional grouping and could also readily seek formal and informal support from their near MST providing neighbouring authority.

The MST Supervisor role not only provides leadership and clinical supervision to the Therapists but also leads relationships within the professional system. This creates and holds the space for the service to operate, developing and managing the system and working with partners to ensure that referral flow is maintained. Additionally, Supervisors are expected to, in the words of the NHS National Lead, to ‘find ways to be useful’ to the system and to offer to do things for the professional system which makes them feel a valued and helpful presence. This could entail contributing to developmental work or offering consultative advice in Children’s Services.

In Expanded City the Supervisor was seen by the system as a capable leader whose force of personality was able to keep the service afloat through her strong will and good connections. Her impending departure placed the service at risk as it was realised what would not be covered when she was not present. Fortuitously a replacement Supervisor, already trained in MST was recruited and began to manage the service. New to the area, the new Supervisor was far less engaged in the externally facing partnership work of her predecessor and did not actively seek to develop a network of support wider than that within the immediacy of that required for clinical cases.

**Political context**

As in national politics, decisions in Local Authorities are often made in a moment of need, crisis and pressure rather than being based upon a dispassionate evaluation of the available evidence. Local government responds to the priorities of local partner agencies too, such as those placed upon Health and the Constabulary and to the writ of national government policy and funding directives. Elected Councillors decide upon policy and are legally responsible for setting a balanced budget. Although rarely interfering in operational or clinical decision making Councillors clearly act in both a governance role through their scrutiny functions and a strategic role in setting policy direction.

“For our politicians we needed to assure them that this wasn’t just a numbers game this was about doing the best thing for children and we would save money because of all the costs. MST is absolutely clearly part of that so it is kind of good practice, it works well for families…..I think that we saved about £6M by reducing the number of external placements” *Operational Manager Metro City*

Local Authorities are politically led institutions, but the political context described in this category is more relevant to the everyday political deals and decisions made by senior officers and strategic leaders than to anything more essentially party political. Internal politics represent the exercise of power and authority at a strategic level and flow through the departmental structures and systems within children’s services and the partners. Without starting a discourse on the political machinations of local government, consideration should be made as to how the political context shapes and influences practice. What is in or out of favour, what compromises need to be struck to balance competing demands and what is or is not a politically palatable course of action to take are part of the daily political decision making. The Chief Executive and their Directors exercise considerable political power and control both directly and through their delegations of power through subordinates. The three sites under examination are all single tier authorities rather than distinct County and District administrations.

There was certainly a view by interviewees that the MST team in Expanded City, once so in favour, was implicitly traded away by the Chief Executive. At a point of desperation to find replacement leadership for Children’s Services she gave an unconditional offer to the incoming leadership as a pre-condition for their acceptance of tenure into a highly challenging post. In effect this meant that no protection was given to any service, with the new incumbent mandated to make their own choices for the struggling department. This could be viewed in terms of a kind of a withdrawal of political patronage by the Chief Executive, which may well have been a highly uncomfortable professional decision to take. Alternatively, it is arguable that the choice made was indeed in the best interests of the authority at the time and that the demise of the MST team was an unfortunate victim, but a logical consequence, of a wider drive to improve the standing of children’s services which required substantial restructuring to meet needs. However, interviewees struggled to rationalise the political shift that had taken place given the support that had been so evident at the start and they felt that the system had treated them harshly and unfairly.

“I certainly tried to make positive noises, not that it made much difference. I think that there was a lot of people trying to work really hard. And then it was a feeling that somehow it would be saved and salvaged. Then it just never was really” *YOS Psychologist Expanded City*

In Isolated Coastal the provider tried hard to negotiate the politics of the Children’s Services and felt successively blocked by the Director. Eventually, supported by the National Lead, she took the approach of organising an event at which a wide group of stakeholders were invited in order to demonstrate the successes of the service to as many people as possible with the aim of working around the Director and garnering broader support. Whilst this was a successful event it was not enough and the service closed shortly afterwards.

In Metro City the MST service rode the wave of innovation and change that was being led by the political and practice improvements being ushered into the authority by the new Director of Children’s Services. With the strategic alignment in place the service continued to expand and develop. The intervention was used as a totem for modernisation and for the adoption of evidence informed service delivery.

Political support may be individually granted through a form of political patronage, which extends a protective wing or cover that may be proffered to a service, leader or Supervisor by a senior leader. There is little doubt that in Metro City there was powerful patronage extended towards the Supervisor by both the Children’s services lead and by the lead for CAMHS who demonstrated continued strong interest.

This created freedoms and protection from adversity and created operational momentum for the service to become established and well regarded. Particularly as line management of the Supervisor was retained when the Assistant Director progressed to a more senior post. The transitory nature of political patronage can be counter-productive and can be exposing once it is removed as a service is opened to the same pressures as others, as happened in Expanded City. The ending of patronage may reveal previously suppressed jealousy by others to be brought into the open or become more explicitly articulated as people are emboldened by changed circumstances to voice dissent without fear of repercussions. In Expanded City there were clear signs that there was some unhappiness in regard to the operational activity of the MST team and this was expressed by several interviewees.

Culturally, as a youth facing organisation, ‘The Hub’ was seen as leading from the young person’s voice and in the promotion of young people’s needs and wants. This created a cultural conflict in working with MST which is more attuned to supporting parents in reasserting control and boundaries than in providing individual advocacy of young people. This required ‘The Hub’ to address cultural differences with their staff and with their Trustees at an early stage but it was not clear if everyone was convinced of the shift in perspective. For the Hub Manager though

‘The political challenge was the biggest challenge.’ *Hub Manager*

and despite many efforts to engage the senior managers at Social Care, to invite them to training and development days, to share the results with them and to utilise evidence of effectiveness the principle block was the Director

‘It is amazing how much just one person can have such an influence, a negative influence’ *Hub Manager*

It probably did not help her own cause that the Hub Manager reflected that she sometimes found it hard to describe MST to others and she wondered if this led to a lack of connection being made by other professionals to it. She was certainly committed to her team and service and in delivering the contract, but her reservations concerning the model remained. These thoughts were not expressed to partners, as the steering group was not a safe enough place for her to reveal her misgivings. It therefore presented something of a double bind in that the Hub Manager could not articulate any doubts for fear of hastening the decline of the standing of the service to which she was committed and indeed was largely its chief supporter. This echoes the sentiments of the YOS Psychologist in Expanded City. Had she been able to discuss her concerns then it is possible that some adaptive solutions could have been managed with partners and this may have allowed the service to find a more comfortable fit in the local system.

For ‘The Hub’, the major political problem continued to be the single Director who was explicitly against the service coupled with an increasing lack of buy in by senior managers in the Local Authority. The diminishing connection to the mainstream Children’s Services strategy and operational activity made the service appear almost counter cultural in what is was trying to achieve in regard to the rest of children’s’ services rather than enhancing and supporting it.

The Hub Manager encountered suspicion of the voluntary sector and became aware of a change in strategy that dictated that the Local Authority were going to restrict funding bids for projects which were not going to secure their own long-term funding. It demonstrated that the Local Authority were retrenching as budget cuts were on the horizon and were only interested in internal commissioning rather than externally commissioning services.

‘It really felt like they did not want anybody else to get the money they thought that they should get. They wanted to be in complete control of it and decide where it went’ *Hub Manager*

There were attempts made by ‘The Hub’ to use their board of Trustees to seek to influence the Local Authority politically but this did not progress too far. The relative imbalance of power and the fact that ‘The Hub’ could not expend limitless political capital fighting this battle and place other relationships at risk made this difficult. Especially in a small population where sustaining relationships was seen as an important part of the political dynamics of the city.

**Systemic strengths**

The category of systemic strengths describes what the system has in place already, or can bring to bear in order to facilitate the successful adoption of the intervention. It includes what might be termed the ‘good will’ of the system and what the system has going for it that will assist the implementation process by way of tangible and intangible assets. Metro City was substantially assisted by the existing expertise in the professional ecology with a three dominant leaders who were determined to enable the intervention to succeed and with one of these leaders holding expert knowledge of evidence based interventions.

The recruitment and importation of an experienced Supervisor into Metro City gave the implementation process a substantial boost as the Supervisor was already both competent and confident in the intervention. Having implemented MST before he knew what to expect and could anticipate problems and offer solutions. There was no doubt in regard to the number of eligible cases for referral in Metro City and so whilst the pipeline did take a little getting used to, through the adaptation of an existing panel, there was never a problem with the volume of cases coming through to secure the viability of the intervention.

The CAMHs Manager in Metro City was active in supporting the innovation. He recalled that some of the CAMHs staff initially felt threatened by the introduction of MST. Some colleagues struggled to articulate why this was other than that they just did not seem to like it. He suggested that this was likely to have been related to the high clinical accountability for outcomes that MST places on all practitioners, with the implied threat that a more accountable structure might at some point end up being imposed on the CAMHs service. For other CAMH colleagues their dislike was more straightforward.

‘There were people who pooh poohed it “*You can’t learn therapy from a manual.”* They misinterpreted what manualised meant and were quite dismissive to be honest.’ *CAMHs Manager*.

As a Family Therapist, he was convinced in the systemic model and personally committed, becoming the backup Supervisor to the service and describing himself as ‘completely sold’ on the model. He *was* taken with how accountability for engagement with families rested with the practitioner and required them to consider the barriers to engagement. He also recognised the importance of the leadership of his own organisation in supporting the development via the CAMH Clinical Director, with sector leading knowledge of evidence-based research, whose drive and energy was vitally important. Together they brought CAMH on board.

In Expanded City the system was considerably strengthened by the connection to the same NHS Trust as a neighbouring authority providing MST. The geographic proximity and shared Trust provided immediate sources of support in the form of logistical and practical support including attendance at interviews, establishing working practice protocols, site visits and confidence building.

“I had also been to several things that (neighbouring authority MST Supervisor) had presented at, large scale events where she had presented results and I talked to her and at Trust events and it came out all the time. It was intriguing and interesting to us because we heard bits of it, which I didn’t understand then but understand now… it was just so ahead of its time, wasn’t it? *MST Supervisor Expanded City*

There was already knowledge of the intervention in agencies which worked across the two authorities such as the Police. The services across the two authorities began to share their three month booster training which offered peer to peer support from administrators through to supervisors.

Isolated Coastal had a strong relationship with the mental health Trust who had embedded a young people’s mental health service at The Hub. Whilst a helpful partnership it was the lack of connection to the Local Authority which proved problematic and in this regard the Trust were unable to assist with facilitating this relationship. The assumption of the usefulness of a strong relationship with the Trust, as a systemic strength, at the point of application by all parties, proved to be illusory.

**Relationship between Leadership and Environmental Context**

Charmaz (2006) recommends continually checking back to the data source so that validity may be asserted for the higher categories. Therefore, having established abstract categories a return was made to the stage one nodes used in the original coding of the interviews in order to explore the relationships between the full set of categories and the four chosen nodes that had a focus on leadership as the dominant theme; Culture, Collaboration, Implementation Reflections and Champions. In this way it was possible to develop linkages between the categories back to the original codes as shown in tables 11 – 15 in the appendix.

There is a strong relationship between the two major themes: Leadership and the Contextual Environment. The dynamic relationship between these two major themes lies at the core of the experience of the three local Authority implementation journeys. Although there are an almost limitless number of societal, political and economic influences within the meta-environment in which Local Authorities find themselves operating in, the more immediate contextual environment in which children’s services departments operate is largely constructed by the participants operating within it. Leaders respond to, create, adapt and manage the environmental conditions in which they find themselves trying to manage their teams, statutory obligations and achieve outcomes for children through the delivery of services.

For the implementation of evidence based interventions, one of the core tasks of leadership is to harness and manage the environmental conditions through the change process so that the context is facilitative of the intervention. The success or failure of the implementation is a product of how leadership can make use of existing strengths in the system, how it can open the space and build capacity for the new intervention and how it can overcome inertia or hostility to create sustainable adaptation of the system. This is substantially easier in an environment in which leadership is confident, enabling and collaborative and the environmental context is adaptable, functional and stable. When leadership is distracted, changing or driven by short termism and the environmental context is febrile, disconnected and hostile the likelihood of failure over success is much higher.

Figure 5 sets out the relationship between leadership and environmental context by major category. The larger double headed arrows for the high collaborative environment, collaborative leadership, networks of support and systemic strengths reach across leadership and contextual environment whilst the shorter arrows have weaker connection between the two major themes.

**Figure 5**

**Leadership and Environmental Context**

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The high collaborative environment has a clear leadership dimension to it and could be placed under the leadership theme rather than in the environmental context. The argument in favour of environmental context is that leaders operated collectively and created a culture for collaboration into which others joined. The culture became re-enforcing in Metro City and so looked set to persist beyond individual leaders who joined or left the Authority. This culture was underpinned by values too which were driven system wide by leadership to all participants in the operational system.

Leadership was consistently confronted by and interacted with the hostile environment in Expanded City, wrestling with the demands and pressures of a struggling Authority whilst seeking to maintain the strategic threads which has led to MST being introduced in the first place. The leadership tasks for leaders in a time of persistent crisis are certainly different to those in a more settled time. The tendency for leadership to express short termism is much stronger in an uncertain environment than the likelihood of taking longer term strategic decisions which might take time to bear results.

**The closure of Isolated Coastal**

Being a single team made the Isolated Coastal service vulnerable to adversity. But it was the turnover of the Supervisor, the key leader for clinical work, which really began to hasten the process of terminal decline. Ironically, the team was performing well at this point. At the suggestion of the MST Consultant, a local conference event had been set up to celebrate and promote the successes of the service as it headed towards the two-year anniversary. Supported by the Department of Health and this time well attended by partner agencies, the service appeared in a good place. According to the Hub Manager the service was reporting the delivery of some favourable outcomes for the families with whom it had worked. However the next step down in the grant funding support from the Department of Health in anticipation of the next financial year heralded a new crisis for the steering group combined with the need to resolve the long term position of MST Supervisor. Despite marshalling the support of partner agencies and of parents who had received the service and significant attempts by the Department of Health to leverage political support the decision was made by the Local Authority of Isolated Coastal to close the project during the currency of the grant period.

“In several meetings and multiple calls I remember going down there multiple times to have meetings with people there, obviously not very effectively and to me it felt not like a total surprise when they said that they would not fund it” *NHS National Lead*

There had been an agreed contingency plan in Isolated Coastal to use a local Psychologist as an interim to cover the gap created with the Supervisor leaving. Recruiting permanently to the post seemed like a significant step and a long-term commitment to a new contract for a senior member of staff. The decision to close was made at that point with the remainder of the grant funding used to pay for the statutory redundancy costs for the staff. If the original MST Supervisor had remained in place might the decision have been quite so pre-emptive or did the turnover simply create an opportunistic moment for the service to be withdrawn. Certainly the Hub Manager reflected that she felt as if the service had been ‘whipped away’ whilst rueing the strategic gap which had never been closed between her organisation and the Local Authority.

Reflecting on the experience some five years after the closure she considered that there was a lack of adaptiveness to her context and setting by the MST model, which could have taken her local circumstances more into account. It was not clear what she meant in regard to how the service might have operated differently. But there was certainly a reaction against the rigidity and inflexibility of some of the core model requirements which she considered had been blocks to the operational delivery which had jarred and made implementation more difficult. This also suggests that the poor adaptive fit with the Local Authority was a feature too.

**The closure of Expanded City**

Attempts to take funding from the service had been headed off in the past when the finance team had wanted to take £150k from the service budget as it effected a standard percentage budget cut against all teams and services in the Authority at the time. As an evidence based model and as a particular feature of MST teams specifically, this would have had the effect of reducing the capacity of the service to take referrals whilst still requiring the relatively expensive infrastructure requirements demanded of the service by way of licence cost, Consultant time and quality assurance systems. In absolute terms it would make a MST case appear much more expensive as a unit cost. The MST Supervisor successfully worked with the finance team to deepen their understanding of how the service operated and why it needed full funding or else risk serious negative consequences on operational capacity.

The Supervisor had laid strong trails of support through to the Social Care Director with whom she had a strong and positive relationship for the continuation of funding and the take up of the funding requirement as the grant taper took effect. However this agreement was not carried on to the next Director when she left. A original steering group member from the finance team was still attending and knew of the grant agreement requirement to find local funding support over the life course of the grant period but by this time the partnership support had waned considerably and so

‘By the time that we really needed to look for the money, all of those people had gone.’ *MST Supervisor*

Several Expanded City interviewees questioned whether or not the Local Authority had ever intended to fund the service once the grant money was exhausted, which led several people to return to the point at which the original decision to initiate the service was made and to re-examine the commitments made and obligations entered into with the Department of Health. There appeared to be an emerging view that

‘The original financial backing at the point of agreement could not be sustained in the long term’. *Youth Offending Operational Manager*

which reflected the funding climate at the time. Related to this were questions about the cost effectiveness of the MST service and so a twin track challenge of budget allocation generally and of effectiveness of the MST service specifically began to play out.

In developing a defensive position, the MST service in Expanded City developed a strategy of drawing evidence and compelling cases together in order to sustain themselves, supported by the Department of Health and outlining a cost benefit case for the service to continue. This was compromised by the reporting delay of the START trial research which had promised this kind of outcome evidence but had yet to publish, having been extended. Secondly, lacking a matched cohort, the service found it hard to explain the rising numbers of Looked After Children when one of the reasons for the service being created had been to reduce the number of children who were taken into public care and were then Looked After by the Local Authority. Therefore, attempting to seek attribution of success to the cases that had experienced MST was proving difficult whilst anticipated savings to the Local Authority in regard to actual cash saved for the placements budget, which had been suggested at the beginning of the MST implementation, failed to materialise. Indeed the children’s services system in Expanded City appeared to recognise the failures more readily than the successes with a

‘Perception that the service was not cost effective, that cases came back, that the service was ineffective.’ *YOS Psychologist*

and so Expanded City seemed to be embarking on a process of seeking confirmatory evidence of ineffectiveness in order to justify the potential to close the team.

The interviewees mentioned the cases, which were referred back to Social Care post MST intervention, with despondency. This was the moment when the sales pitch from MST Services, that cases would not need further intervention once they had completed the intervention came to haunt the service as an empty promise. Proponents from both sides of the argument began to gather their own evidence. As, for example,

‘One of the interim Directors had a negative view of MST and would quote the two studies which confirmed her view that MST was not effective’ *Youth Offending Service Manager*

Partnership support was diminishing too and despite this being an evidenced based intervention

‘CAMHS had kind of lost interest, they didn’t really rave about it.’ *YOS Psychologist*

exemplifying a denuded partnership environment at both the steering group and in the wider context of children’s services as the CAMHS service had their own budget cuts to contend with. An opportunity may have been missed by which the service could have been returning evidence of successful cases back to the Expanded City system, if they had consistent outcome data to hand. Such evidence could have countered the developing narrative of negativity. Although how ready the system was to consider and accept a counter narrative is not clear. This then lies at the heart of the discussion regarding what evidence professionals choose to use, listen to, accept or reject in terms of proof of effectiveness.

It was clear that the financial pressures were biting hard into the Authority with a prevailing view from Councillors that

‘Children’s services were always perceived as over budget rather than as underfunded’ *Expanded City Supervisor*

The service was finally and swiftly closed by the new Executive Director, despite continued efforts from the National Lead and the neighbouring County (which had an existing MST service) to develop a business plan to save it. There was discussion about a new way of commissioning the service using external investment and bringing in other partners so that the service could trade across a wider geographic reach but even as this was being developed the Authority closed the service with the NHS quickly redeploying the seconded staff.

The reasons and explanations for the closure of the service showed interesting variation between interviewees. The YOS Manager thought that he had produced enough evidence for the Chief Executive for her to be a long term and committed supporter, after his departure from the Local Authority but saw that

‘The Chief Executive support for MST seemed to fade in order to keep the Assistant Director on line for other things’ *YOS Manager*

The YOS Psychologist was surprised and disappointed that more people in the professional system had not emerged to offer their support although she conceded that she had at times also felt like a lone voice and advocate for the service. The YOS Operational Manager questioned whether Expanded City had ever intended to fund the service in the long term and expressed astonishment that the Department of Health appeared unable to recover costs from Expanded City, having spent their money and not sustained the service. The MST Supervisor’s summative view was that

‘It could not survive the turbulence that was created by the change and the pressure of the change’ *MST Supervisor.*

**The journey towards sustainability in Metro City**

Metro City had an Ofsted Children’s Services inspection in late 2009, shortly after mobilising their MST team. The new service providing one of the few positive references in an otherwise poor assessment of leadership, outcomes and ambition for Children’s Services. The inspection report set the strategic agenda for Metro City and for the recruitment of a new Director of Children’s Services in 2010 who led several urgent initiatives, including the creation of a new narrative for Children’s Services. Developed in collaboration between the leadership team and leading academics regarding key outcomes for children the vision was promoted across the Authority and included a commitment to evidence based approaches, which then flourished as a result. A striking feature of the Metro City interviews was the connection made by interview participants between the Director’s vision for children and the delivery of MST which heralded a period of rapid cultural change for Metro City and woven into well stated core values. The reflection of one interviewee was that

‘Evidence is now part of the DNA of Metro City’ *YOS Manager*

Inevitably there were tensions and difficulties both at the implementation stage and as the service reached a point of maturity and expanded across the City, but the overriding impression of the Authority was one that was strongly facilitative of innovation and of empowered distributed leadership. Several favourable factors that were helpful in the establishment and implementation phase for MST were evident; Firstly, collaborative work across leadership for CAMHs and Social Care, having overcome previous antipathy between services. Secondly, a single citywide Children’s Commissioner for Health who was particularly sympathetic towards evidence based interventions. Thirdly, the National Lead for the Department of Health having worked with Metro City before and known to key leaders further enabling collaborative potential. For the implementation process then

‘A whole series of things fell into place really’ *CAMHs Manager*

with a strong steering group, well-connected strategic managers working across the system and then later, post-implementation, an emerging and value led strategic vision for evidence based practice.

The YOS Head of Service and YOS Operational Manager were both highly supportive of the intervention and were able to make a clear link to the ambition of Metro City to reduce their Looked After population from historic high levels at around the time of the implementation. They both had considerable experience of managing the relationships between staff teams and in seeking to establish the original team and also the later growth. The expansion to three teams was in part a drive towards equity of the offer of services across the city which Ofsted had questioned. The original team had previously covered one high need division of the City only.

The Head of Service was aware of continuing system issues to address, most recently with differentiation between services for families and adolescents with several services offering intensive family support or support for anti-social adolescents. Growth in this area was a direct result of new expectations on Local Authorities to develop services in relation to the *Troubled Families Programme* (Cameron 2011). This politically driven agenda created expectations on Local Authorities to develop assertive service interventions for families where crime, anti-social behaviour and worklessness were rife under a form of payment by results. (Bewley et al 2016)

Managers in Metro City recognised that there was a continuous requirement for attention to be paid to systems of referral and that services should be coherent and non-competitive with each other whilst acknowledging the clear overlaps between the MST services and the cohort identified as being within the *Troubled Families* criteria. For referring Social Workers to use the services effectively they needed to have a working understanding of the differences between each service offer. But the YOS Head of Service was not fazed by this and saw this as normal operational business and not anything out of the ordinary. His concern was in getting the referral quality to be higher so that correct decisions regarding the allocation of scarce and expensive resources could be made. He was certainly active in this space, as well as trying to manage the occasional service competitiveness that existed and some jealousy between staff regarding the pay and rewards offered to them and that which the MST teams were entitled to.

Unlike Isolated Coastal and Expanded City there was no point of acute financial crisis for MST in Metro City as the grant money began to taper down. The longevity of the collective memory of the steering group, whose participants had been largely stable, meant that the funding commitment made at the outset to the Department of Health held up and was well understood by all so that

‘The decision to continue was not a difficult one’ *CAMHS Director*

That is not to say that it was taken lightly and several interviewees described both nervousness and uncertainty regarding the continuation of funding but expressed relief that it had been maintained in the budget discussions. Several interviewees wondered if the opportunity to establish the service now (early 2017) was presented to Metro City whether it would have been able to make a similar commitment in the current financial climate.

Questions of cost and value have not gone away and there have remained challenges from the finance team as to why the service costs as much as it does and especially in regard to the cost of the licence and the ties to MST Services. The finance team asking if the services could be run without the licence now that the services are well established with competent Supervisors and Managers who understand the methodology well. These have been rebuffed but are seen as a fair challenge by the YOS Managers and others who constantly have to justify all of their budgets and outcomes. Differential pay and rewards for the MST Supervisors and Therapists have been periodically raised too.

In regard to the partnership that underpins the steering group, the CAMHS Operational Manager considered this had weakened over time although remained chaired by a committed Service Director and was regularly attended by partners. He saw that as MST teams were more directed to cases that would commonly be understood as being on the ‘edge of care’ then CAMHS interest might reduce as a consequence. Although no longer attending the steering group, the CAMHS Director remained a benign and powerful advocate behind the scenes and within the professional system. The Director for Social Care’s leadership and determination to maintain both the chair and the management of the original MST Supervisor, once promoted to a more senior role, declared political patronage and was perceived as a system strength.

Metro City survived the challenge of turnover of the Supervisor who returned to work overseas. Liked, competent and well regarded for establishing the services in Metro City the loss of him to the system was indeed feared but the services continued and a new Supervisor was quickly appointed. With services expanding the elevation to Programme Manager of the Supervisor to strategically lead the MST teams enhanced the leadership and profile of MST and was justified as a result of the critical mass of services now in place. One Metro City interviewee arrived after the original MST team had been implemented and was drawn to Metro City because of the evidence-based services and Director of Children’s Services vision. As the professional system replaces and refreshes itself with staff following turnover it may attract further staff with this motivation and become self-perpetuating.

**Chapter 6 Discussion**

In this chapter the three major categories: The high collaborative environment, The hostile environment and Leadership for implementation, are discussed. The definition, conceptualisation and analytic dimensions of each core category are examined in turn. Each category is considered in regard to implementation literature and theory, highlighting where new contributions to knowledge have been made. The three categories are then considered in combination. The categories represent the most significant findings from the coding analysis following the fieldwork research and have been developed through the grounded theory methodology, as described by Charmaz (2014).

The practice application of the categories create opportunities for greater understanding of key variables which interact with the implementation process, providing insights into the management of the environmental and contextual conditions for the implementation of an evidence based intervention, especially in regard to the leadership required to facilitate it. The three categories may be considered as relevant throughout the implementation process rather than at a single point, given that they are dynamic and constantly changing. It is proposed that the categories may be applied at different stages in the implementation process: at the commissioning stage before a service is initiated, at the site assessment stage before implementation takes place and through the implementation mobilisation period and beyond. It is argued that continuous attention to these categories will assist in achieving the twin goals of intervention sustainability and full system adoption. Leadership and the actions of leaders inevitably play a major role in establishing the contextual environment of the settings under examination and so leadership is referenced throughout the chapter before being considered as a category of its own.

**High Collaborative Environment**

The high collaborative environment category is conceptualised in the context of pro-active and reciprocal leadership, enabling networks of support, joint enterprise and the desire to achieve cross agency outcomes. Of note too was the connectivity established to external expertise and the acquisition and adoption of new knowledge, as organisational learning became culturally and operationally supported. The high collaborative environment may be considered as drawing upon both inner setting and outer setting constructs given that collaborative working was evidenced in the findings in chapter 5 both within Children’s Services and across Metro City.

In the existing implementation literature, attributes of the high collaborative environment have been discussed in the context of organisational complexity (May and Finch 2016, Pfadenhauer et al 2017), culture (Glisson et al 2008), climate (Aarons et al 2014, 2015) and leadership (Aarons et al 2016) whilst implementation frameworks (Damschroder et al 2009, Tabak et al 2012, Nilsen 2015) have conceptualised whole system implementation processes which consider the entirety of the setting in which implementation takes place. However, the relevance of joint collaborative working, academic and leadership collaboration and joint operational working, particularly between the disciplines of health and social care has not been discussed in depth in this literature.

The high collaborative environment is a category which is exemplified by the intentional aim of leaders to work collectively with internal and external partners in a way which transcends divisions of team, service and organisational boundaries. The concepts and evidence which support this category include demonstrable evidence of joint working within and outside of the organisational setting, the clear articulation of the benefits of collaboration for self, team and others and the choice to work in collaboration with others. This mattered in Metro City in terms of the success of the implementation process by optimising the facilitated context for change and in opening the potential operating and strategic spaces in Children’s Services for the new intervention to be successfully introduced. Indeed collaborative working was already evidenced at the application stage where it was identified as a key strength by the National Lead for MST.

Following the initial mobilisation period, continued attentiveness to collaborative working, principally at the steering group but elsewhere too, sustained the intervention in the long term and enabled the original MST team to be quickly expanded with new teams commissioned to cover the city. By attending to the space within and between operational services, the environment for the intervention to succeed was created as it found and secured a place in the bandwidth of the service offer. (In Expanded City this space was forcefully pushed open by the Chief Executive, only for it to later close up around the service as leadership interest declined and the context changed). Collaboration in Metro City was forthcoming as it had proved successful in the past, as described in regard to the improved working relationships between social care and child and adolescent mental health teams, which preceded the MST implementation (described earlier in chapter 4.) This provided a platform of trust from which leaders were able to direct participants’ attention and energies toward to the outcomes desired for young people and their families when the MST implementation took place.

The high collaborative environment did not appear by chance and was created and maintained by the leaders and service managers as a style of working to drive operational activity in order to achieve strategic aims. Collaboration at strategic and meso levels created the conditions and supported the constituent constructs, generated from the analysis, for it to become established. Evidence for this category could be traced through the overarching strategic leadership for the Authority. However, there was stronger evidence in the findings of the more organic and operational, though nevertheless intentional and purposeful, development of collaborative working between leaders at a service leadership level where the clear intention to work in collaboration was stated.

The vision of the Director of Children’s Services in Metro City was underpinned by freshly articulated, high level values for Children’s Service, which were part of a strategic response to a poor Ofsted inspection. The Ofsted report had highlighted missed opportunities to manage risk and identified system weaknesses in the operational work to deliver good outcomes for children in need. For those who were Looked After by the City in particular the outcomes and aspirations had been too low. This may have marked the point at which system tension for change (Greenhalgh et al 2004, Damschroder et al 2009) may have been highest, whereby if

‘Staff perceive that the current situation is intolerable, a potential innovation is more likely to be assimilated successfully’ Greenhalgh et al (p607 2004)

One should add the political imperative for change post Ofsted as a driver too, as Councillors committed to support the change agenda. This created and enabled the political context to pursue system reform through the explicit granting of permission to act and by implication to deliver cultural change. The high collaborative environment was further encouraged through the involvement of external experts with the Authority wide change programme which was initiated in Metro City and which called in leadingacademics to assist with the strategic move towards a more research informed policy driven agenda. Taking the form of joint workshops with local Universities providing contemporary evidence of effective practice for senior leaders and managers who then introduced this to social work practice as part of the roll out of organisational development. That is not to say that the external experts were the main driving change agents, as that role was posited in the leadership in Metro City who had invited them in, but their role and cultural influence, according to the interviewees, was impactive and long lasting.

The strategy and vision, underpinned by new evidence and a new narrative, was communicated across the City as increased expectations for continuous professional development engaged the social work teams in operational settings through supported practice learning both in situ and in taught masterclasses. This seeded the emergent environmental conditions and context for change and for the later expansion of evidence based interventions citywide. The service strategy objectives, in pursuit of higher outcomes for children in need in the City, were both simple and widely understood and included the explicit aim of reducing the care population. The central methodology to be used to achieve this aim was intensive family work with the MST service at its core. Indeed the repetition of the organisational objectives by interview participants, who had incorporated these aims into their own practice values, was striking as the journey of change was described in the interviews.

The category of the high collaborative environment resonates with the form of facilitative, system leadership described by Barnsley et al (1999) where

‘System leaders can encourage organisational members to consider and accept change by clearly communicating the collective vision and by seeking ways to enable and reinforce learning activities that support the vision’

Barnsley et al (1999 p15)

It was evident in tangible and concrete ways how the pathway to achieving the outcomes in Metro City were to be achieved for all operational staff.

This research has shown that these varied forms of collaboration played a central part of the implementation process. The findings describe how the steering group was a key part of the implementation architecture and a place for collaboration to be enacted, with partners coming together to problem solve and to steer the implementation. Several partners had worked together previously and trust was extended as a result, both between these parties and to external partners. Over time there was cultural transfer and induction for new operational and strategic leaders via steering group membership. This is in sharp contrast to Expanded City which saw the steering group quickly diminish in status and representation over time whilst in Metro City the steering group was maintained and refreshed as the system matured.

The divide between the professional disciplines of health and social work was discussed in chapter 2, highlighting differences in professional training, attitudes and orientation towards evidence based interventions. Collaborating across these distinct disciplines required mutual respect, professional humility and appreciation of the different perspectives and pressures each organisation faced, coupled with agreement upon commonly desired outcomes. Given the previous enmity between health and social care in the past in Metro City the development of collaborative working had initially required a mechanistic and interventionist approach to de-toxify the relationships. Sustained attention and leadership effort has re-positioned these relationships beyond the point of functionality and eventually into mutually beneficial relationships which were valued by practitioners and leadership alike. Familiarity with each other through regular purposeful contact across health and social care was cited as being instrumental in achieving better relationships.

The establishment of an academic partnership in Metro City created opportunities for the use of research and evidence to inform strategy and practice. This was a cultural shift for Metro City which the findings suggest has been sustained. Such collaborations are reasonably rare in Social Care settings where the tradition of academic involvement is significantly weaker than in health which has had formalised academic and practice relationships for many years. The National Institute of Health Research has funded regional Collaborations for Leadership in Applied Health Research and Care (CHLARC), now becoming Applied Research Collaborations (ARC), which include Local Authorities as partners and has a focus on applied research including a remit for bridging the translational gap of transferring research evidence to practice. However the NIHR has largely prioritised issues related to public health and chronic illness rather than how research evidence and collaborations with health can improve the delivery of outcomes in Children’s Social Care. As described in chapter 2 the What Works Centres may yet fill this gap but must move beyond being repositories of evidence alone if the field is to move forward in adopting and implementing new approaches.

The high collaborative environment category supports the outer setting construct of cosmopolitanism (Damschroder et al 2009) which considers the extent to which an organisation is externally networked and the findings show clear connections across disciplines, geographies and services. The system wide adoption of MST in Metro City was supported by functional professional networks. Leadership and leaders could readily traverse between practice and academia, drawing support too from other large neighbouring authorities. Metro City called upon and made use of both internal and external social capital (Breham and Rahn 1997, Gittell and Vidal 1998). Leadership guided and made use of these opportunities strategically through facilitation and empowerment in which shared ownership was a common feature. Metro City became a well networked authority, outward looking and open (Greenhalgh et al 2004) seeking to deliver the vision of improved outcomes in a contextual setting of high needs and significant economic and social challenges. Greenhalgh et al (2004) describes this function as one of ‘external boundary spanning’.

Within Metro City, the CFIR inner setting construct of networks and communications, that which operates within the organisation, was clearly relevant to the implementation process. This construct describes how organisations are considered as complicated, factional, political systems. Succinctly captured as the ‘complex web of sources of power and covert and overt sources of influence” Feldstein and Glasgow (2008 p 233). Or understood as the enactment of internal politics, personalities and patronage. Both Damschroder et al (2009) and Greenhalgh et al (2006) stress the importance of norms and values in establishing, maintaining and inducting individuals into the culture of an organisation. Culture being recognised by both research groups as a term which is very difficult to define in the literature. In Metro City this cultural change, of working collaboratively in service of the outcomes was harnessed to good effect, benefitting the implementation process rather than impeding it, as occurred in Expanded City.

**The Hostile Environment**

The hostile environment is conceptualised as a category containing internal and external threats, marked by sudden changes of strategy, uncertainty, a loose fit within the operational setting and the continuous cycle of service cuts and financial pressures. The underpinning concepts named in the analysis include organisational churn, deep seated crisis, missed opportunities and a sense of being overwhelmed by context and change. The findings provide rich and detailed descriptions of the interviewee experiences of working in a hostile environment in Expanded City and Isolated Coastal. In the findings, interviewees in Expanded City considered that they had become increasingly isolated and that this then required them to defend the MST service without the senior leadership support which they had previously relied upon. This led the operational service leads to openly question the commitment of the Local Authority to the intervention and to evidence based practice more broadly. Interviewees in Expanded City described how a bigger political process was overtaking and moving support away from them, crowding out the reasons why the service had been commissioned in the first place and ignoring their contribution to the operational system and desired outcomes. Interviewees described a prolonged hiatus with the organisational culture in which values were unclear and strategic direction was increasingly uncertain as a product of transitory leadership. Interviewees described how the MST service became almost counter cultural as the Local Authority appeared to have distanced itself from it as leadership support withdrew. This created a general sense of uncertainty and risk for the MST team and those who continued to seek to sustain it. Interviewees were perplexed and frustrated as to how the service had lost its position and had slipped away from them, hoping that the next change in leadership might yet change the strategy positively in their favour and recognise their potential and contribution.

The category of the hostile environment can describe a context which is insecure right from the start, as in Isolated Coastal, which might be termed an early maturity failure. Having reached the point of successful operational activity, post the initial implementation phase, managing cases and taking referrals, Isolated Coastal closed pre-emptively before the grant funding ran out. Consistently unable to find a strategic fit with the Local Authority the wider system failed to adapt or engage with it. Starved of support and facing an ambivalent Local Authority and geographic isolation led to service collapse.

The category of the hostile environment can also be applied at a later stage as an initially positive context decays and sours over time, as took place in Expanded City. Originally celebrated as a dynamic new service addition Expanded City was widely perceived to be a successful service with good prospects for a long term future although, as the findings suggest, there were hints of flaws in the stability of the supporting partnership from the beginning. Expanded City might be termed a late maturity failure, closing at five years. A successful, adherent team with good fidelity to the MST model, the environmental context became strategically unstable as the churn of senior leadership, operational staff and dwindling support overwhelmed the service. The strategic thread within the Authority and the collective memory which underpinned the rationale for the service and what role it had played in the improvement journey within children’s services was irrecoverably lost.

The effectiveness of the steering group in Expanded City reduced as budget pressures mounted toward a point of crisis. The net effect being a denuding of partnership support which might have been forthcoming had leadership been more attentive and active. Weakened governance left the core tasks of leadership with the MST Supervisor alone and whilst it continued for a short period of time under a new Supervisor after her departure, it collapsed soon after. Without a dedicated champion and political support which valued the potential of the service or was prepared to reposition it in the light of new challenges, MST was disposed of and the team disbanded, as described in chapter 5.

There is a gap in the literature regarding how, why and in what circumstances evidence based services close. As described in chapter 2 implementation failures are more likely than not to be hidden by both the host organisation and by the developer/licence holders. Neither party appears keen to dwell upon the reasons why this might be. It appears that these questions, if they are asked at all, are more often posed in terms of how are evidence based interventions sustained rather than what causes their collapse or discontinuation. On this point, a recent systematic review by Hailemariam et al (2019) found limited evidence of research or conceptual agreement for how sustainment is defined in the literature. In seeking to understand the implementation process and how interventions can achieve acceptance and stability within a setting Greenhalgh et al (2004) were struck by the finding of their review that

‘Empirical studies of implementing and maintaining innovations in service organisations (1) had been undertaken from a pragmatic rather than an academic perspective and been presented as "grey literature" reports (which for practical reasons we did not include in this review); (2) were difficult to disentangle from the literature on change management in general; and (3) were impoverished by lack of process information’

Greenhalgh et al (p620 2004)

This suggests that there is a paucity of literature concerning the experience of implementation, beyond the initial mobilisation period, which might describe the difficulties of leading and managing evidence based interventions in settings such as Local Authorities or which end is closure. As mentioned (chapter 2 page 31) Greenhalgh advocates the further investigation of this area of implementation research. This thesis has sought to contribute to this gap in knowledge by investigating how two services were disbanded by Local Authority’s. The category of the hostile environment makes a contribution to literature by identifying and describing the risks and circumstances which closed down the operating space for the MST intervention in both Expanded City and Isolated Coastal. The identification of a ‘toxic trio’, described in chapter 5 further adds to understanding of what form contextual threats might take and how these may be particularly dangerous if they co-occur.

**Leadership for implementation**

The category of leadership for implementation is conceptualised as a particular form of system leadership which works across the organisation and which leads and supports the implementation process. This is achieved through championing, problem solving, collaborating and sustaining interest through long term engagement with the intervention and with the partners whom support it. The findings suggest that this also includes determining ways of connecting the values of frontline practitioners to the intervention itself and the outcomes which it is designed to deliver.

In Metro City the consistent leadership group attending the steering group may be considered as a form of leadership network. Interviewees described how leaders prioritised attendance at the steering group and that this created a stable platform and a forum for problem solving both inside and outside of the meeting room through trusted relationships. The findings support the notion of perseverant leaders, collectively identifying, responding and smoothing out operational problems and keeping the intervention going whilst maintaining the operating space around it. The appointment of a MST Supervisor with prior experience of implementation of MST in Metro City created additional advantages for the system on joining the leadership network. This allowed the steering group implementation insights in anticipating problems and then applying solutions and adaptations based on the supervisors experience of problem solving in a previous MST setting. Describing how leadership networks can be created Clarke (2018) suggests that it is

“Through the creation of ensembles where individuals and/or work groups come together with a shared interest to problem-solve, that new patterns of behaviour can emerge.”

(Clarke 2018 p 135)

Both shared and distributed leadership were evident in Metro City. The findings are close to those of Aarons (2016) leadership for implementation and stress much more than functional command and control or direction giving leadership as Grint (2008) described in chapter 2. The functions of implementation leadership are closely aligned to the requirements of the implementation effort and the involvement of others is a clear feature of this category through both shared and distributed leadership. Gronn (2002) helpfully draws a distinction between these two forms of leadership, stating that distributed leadership tends to be more in regard to empowering and distributing power to those in subordinate positions. Shared leadership though is considered

“Not fixed within a team and is therefore a fluid and dynamic concept. In this sense shared leadership suggests leadership emerges in the relations between team members and represents a systemic property of the team itself”

(Clarke 2018 p 87)

Which supports the interviewees views of the steering group and the notion of system leadership. Chreim and MacNaughton (2016) develop these ideas further in describing ‘constellations of leadership’ as they sought to define different groups and types of leadership in health care settings, whereby distributed leadership

“Is not an isolated individual forging a path but a network of reciprocal relationships that shapes the leadership constellation via the combined agency of various actors”

(Chreim and MacNaughton 2016)

Again this then shifts leadership away from the attributes of a single leader and the personal traits of leadership, to a broader network of leaders, with a common cause, operating across the system. This is more supportive of leadership for implementation as a group process than the more individual orientation of Aarons et al (2016). However, leaders within the network have to do more than passively give their support by position or name only and must take up the strategic threads themselves as individual leaders when called upon or enabled to do so which stresses the need for leadership activity. It is evident that senior leadership in Metro City was stable and collaborative across the system in the long term and well distributed from senior to middle and operational management. As Cullen et al 2012 suggest one can perceive

“Leadership is an accomplishment of collectives rather than as the actions of individuals”

(Cullen et al 2012 p 428)

The category of leadership for implementation contributes to and extends the notion of implementation leadership as defined by Aarons (2016) by providing examples and conceptual support for the particular forms of leadership which are suited to the implementation task. These include championing of the intervention, continued attentiveness post implementation, partnership with other leaders and the facilitation and support of the strategic and operational system. As Grint (2008) explored, in chapter 2, there is a place in all systems for visionary, charismatic or forceful leadership and contexts which might demand such archetypes, including the leadership required to innovate and disrupt systems (Rogers 1995) or drive the changes needed to implement evidence based interventions (Bono et al 2004, Aarons 2006, Michaelis et al 2009).

In contrast to Metro City, in Expanded City senior leadership was initially underwritten by the City’s most powerful leader, the Chief Executive, but this support was temporary. Leadership eventually rested upon the post of the MST Supervisor alone. Her experience of collaborative support from peers and senior leaders was highly variable within the turbulent environmental context of the Authority, with several long term supporters immediately around her but with strategic leaders in a state of almost constant flux. The findings show that new leaders entered the professional system with increasing frequency and with ever shorter periods of time to make their mark in the Authority. Each new incumbent arriving with a new mandate for change leading to short termism in decision making and volatile shifts in strategy without reference to historical context. In Isolated Coastal leadership within the system was largely left to the voluntary sector agency to provide alone, with wider leadership in the local system uninterested or absent making the contextual setting neither helpful nor facilitative.

Within a contemporary Local Authority context, in the continuing age of austerity, senior social care managers and directors are required to achieve and demonstrate high level leadership competencies in order to meet the challenges of our time (Ofsted 2015). Executives and directors must ensure that they can adapt their leadership to the pressures, political realities and financial constraints being imposed on their departments. As the President of the Association of Directors of Children’s Services reflected on the role of her peers

‘It is not enough to be a system leader, overseeing a single system of services for children and young people, rather we must be involved in shaping the numerous systems that impact on the lives of children and their families across the public sector’

Jones (The Guardian 11th October 2012)

Local Authority leadership must quickly gain traction in the task of achieving corporately desired outcomes during their tenure. The risk is in failing to gain the support of others in the shifting sands of interagency churn and to be able to deliver against their targets (Hulme, McKay and Cracknell 2015). The experience of leadership in Expanded City in particular supports the leadership risks and vulnerabilities identified in the findings in a system in which leadership and therefore power, were uncertain and contingent.

The evidence for the category of leadership for implementation is well supported in the findings and by other research. The role and importance of leadership features consistently in implementation science literature. The work of Aarons and his colleagues in particular (Aarons et al 2011, 2014, 2015) has sought to create definitions and measures for leadership, as it pertains to implementation, through quantitative empirical research and the development of instrumentation for measurement. For example, the Implementation Leadership Scale (ILS), an assessment tool which has been created

‘To assess the extent to which leaders support their staff in implementing Evidence Based Practice’ (Aarons et al 2014 p8)

With the intention that assessments of leadership capacity for implementation can be used to address identified developmental needs both for current and future leaders within the organisational setting. This is proposed as being of benefit both to the individual leader and to the organisation. For Aarons et al, implementation leadership is comprised of four behavioural dimensions:

‘Being *knowledgeable* about the EBP being implemented, being *proactive* and anticipatory in problem solving, *supporting others* in the implementation process, and *persevering* through the ups and downs of the implementation process’

(Aarons et al 2017 p2)

The findings support Aarons et al (2015) in the assertion that the category of leadership for implementation is beyond that described as transactional or transformational leadership alone. There is support from this research for a further form of leadership, implementation leadership, which has distinct attributes. These relate to the functions which are most assistive to the implementation process. There is a good fit between the leadership dimensions outlined by Aarons and the interviewees implementation experiences, (chapter 5 5.2), so extending the concept further by providing greater detail and examples. One strong commonality is the attention given to the continuous leadership effort required to facilitate the implementation process through the actions of both self and others. The findings suggest that leadership for implementation is not a single moment of executive decision making, nor the acts of a single leader in isolation but a process of the determined pursuit of a strategic aim in concert and collaboration with others within the operating system. Unlike Aarons (2015) this suggests that

“The network approach to leadership seems to complement the collective approach and suggests that leadership is not based on the attributes of a leader but on the relationships that connect individuals”

(Schedlitzki and Edwards 2018 p 185)

Therefore the relational awareness of leaders, their ability to look across and beyond the operating system as well as their support of the intervention itself and intention to work in collaboration are core to the category of leadership for implementation.

**Links between categories**

There is a strong linkage between the categories of leadership for implementation and the high collaborative environment. Although each has a different conceptual underpinning, the findings and the contextual setting of Metro City demonstrate that the categories have mutually supporting attributes. This may best be evidenced and reflected in the working of the Metro City steering group where the activity of leadership created the operational and strategic environment to deliver the MST service. The genesis of this was the group of senior leaders from health and social care, who were already orientated to working with each other and had done so in the past to good effect, who started meeting to implement the first MST team. The steering group, constituted just over a year before the Metro City Ofsted inspection, was responsible for the submission of the application and then the mobilisation post grant award. For these leaders, working collaboratively across their respective agencies was an operational and strategic choice in which they could foresee mutual benefits. As the findings describe in chapter 5, this was a much deeper collaboration than simply coming together as respective individual service leads under a flag of convenience to secure inward investment. The outcomes that the MST leadership group in Metro City agreed upon as desirable for children and young people were joint and shared. The steering group used their existing relationships to build momentum and the capacity for change across the operational system. They also formed relationships with new participants who joined them either permanently or temporarily for the implementation process. Greenhalgh et al (2004) note that

‘The adoption of innovations by individuals is more likely if they are homophilous -that is, have similar socioeconomic, educational, professional, and cultural backgrounds’

(Greenhalgh et al 2004 p602)

The steering group took the opportunity of implementing MST to promote new ways of working and, as one of the few positive service developments to be highlighted in the Ofsted report, coupled the potential of the intervention to the new value driven children’s agenda as the environment shifted positively towards it. Heads of service and operational leads enjoyed the permissions created by the corporate and political support of the moment, to which there was growing concordance with the key partner agencies own ambitions. It was the leaders themselves who found the connection to their respective agencies’ strategic agendas. This legitimised their own involvement whilst enabling them to give direction to act to others through shared and distributed leadership. The findings describe tangible intra-organisational and inter-organisational alignment, (chapter 5, 5.3) at least between the senior leader partnership which was setting up the MST team. This created the necessary drive and momentum to implement the service into the organisation successfully.

Post-implementation, at the end of the NHS England taper grant funded period, Metro City became a sustained service as the additional new teams established and embedded themselves in the Children’s Services Department, supported by the child and adolescent mental health service and Youth Offending Service. Funding for the MST teams in the long term was mainstreamed via an almost seamless transition to core rather than end dated project funding allocations in service budgets. There is evidence in the findings of the professional system and of the networks that supported the services, of continuing to refresh leadership representation with new leaders entering Metro City in alignment with the organisational values and strategy. The Authority continued to reap the benefits of learning from the organisational development strategy, which is close to the CFIR Learning Climate sub-construct (Damschroder et al 2009). Barnsley et al 1997 suggest that ‘Organisations that excel at learning have a rich constellation of teams and networks that span operating entities and connect knowledge and perspectives’ (Barnsley et al 1997 p 15) which supports the ambition of the Metro City strategic position in regard to organisational learning and development.

Combining categories is a means of understanding the complexity and relationship between themes in implementation. Aarons et al (2017) combined the leadership scale with an organisational scale to create the Leadership and Organisational Change for Implementation scale (LOCI), now undergoing large scale testing in the field of substance abuse services in the USA. This is built out of the Full Range Leadership model, which itself is underpinned by a validated tool (Multifactor Leadership Questionnaire, Avolio & Bass 1990). The LOCI describes archetypes for leadership including transactional leadership, transformational leadership and implementation leadership, where the latter two are seeking systemic change rather than operating within a fixed and static organisational culture. The findings provide evidence of the attributes of leadership for implementation and of contextual collaboration.

Aarons has further extended his teams’ leadership research to combine the LOCI with an implementation climate scale, describing how

‘Cross level relationships between executive management, mid-management and first level leadership develop and support congruence of EBP support structures and processes in a targeted and concerted strategy’ (Aarons et al, 2017 p2)

which suggests that implementation leadership is interacting with the CFIR inner setting construct of networks and communications too (Damschroder 2009). This again is supported by the findings which provide detailed practice examples of leadership at different points in the hierarchy. Aarons too explicitly refers to leadership taking place at different levels within the operational system rather than at the strategic level alone, also commenting on the risks of potential misalignment between the senior leadership within an organisation and with the operational teams, posing a question for sustainment as to whether

“The congruence or incongruence between leader self-perceptions and supervisee perceptions of the leader’s sustainment leadership could also provide insights into sustainment-related outcomes” (Aaron et al p9 2018)

Suggesting that strategic alignment is highly desirable and that the assessed strength of this may indicate the greater likelihood of sustainment of the implemented intervention, as in Metro City.

In Expanded City there was a discernible disconnect between the senior leadership system and the existing operational services as the leadership group was pre-occupied with both financial pressures and the improvement agenda for children’s services. As the meso level operational leadership continued to support MST delivery, the two systems appear to have operated in different orbits from one another with only occasional moments of alignment. The MST team in Expanded City, in the later stages, continued to operate almost in spite of senior leadership and persisted because of the dogged determination of the few remaining supporters in the operational sub system who kept it going.

As Grint (2008) warns, the risk of single leadership for any organisational system is a high one and it is perhaps only when that leader, on whose shoulders so much rests, is no longer present does the system realise how much was carried and held together by that person alone. Tourish (2013) identifies the risk of creeping narcissism and poor decision making for the transformational leader who may have lost their grounded sense of self-perception. It may be argued that implementation science cannot yet judge if an intervention is fully embedded into a system or if it is in fact held in place by the determined grip of a single leader. Understanding more about this has become an important area for implementation leadership research and leadership networks might well provide some mitigation to this risk. Aarons et al (2016) are developing work to create measures to determine how embedded an innovation into a system has become. There are more obvious risks for single leadership that are easier to identify, such as the absence of distributed leadership and the readiness of others to simply rely upon the single leader to pull the service together without really participating in the support of the intervention actively or directly.

In considering organisational readiness for the adoption of an evidence based intervention in a future setting, leadership risks may be important to assess in more detail at the commissioning and procurement stages before proceeding to implementation. Perhaps investigating a new organisation’s history and stability with evidence of joint working through examples and references. Exploring the political context, strategic vision and evidence of collaborative leadership with the organisations ability to support cross agency working. Issues of cultural, geographical and political isolation may rightly be seen as a red flags of risk by awarding body evaluators, given how these may frustrate leadership of innovation implementation where poor networks are found as the findings showed in Isolated Coastal.

In practical terms, leadership and contextual risks may be hard to assess until one is actively working within the organisational setting although using the pre-assessment tools such as the LOCI may tease out these factors, as later research may yet determine. Connecting leadership behaviours to the context in which a Local Authority finds itself and considering the organisation as an innately political system may also enable leadership risks to be identified and then potentially mitigated through contingency planning and explicit risk management. Even asking the simple question ‘what will happen if this leader leaves?’ might be a way of testing out system strengths, weaknesses and contingencies.

Recognising how important the environmental context and leadership can be for the success or failure of implementation is a key theme in implementation research (Glisson 2002). The successful implementation of an innovation is not guaranteed at the outset and organisations which have not implemented an evidence based intervention will require considerably more support than those who have done so before (Durlak and DuPre 2008). Understanding the impact of the environmental context and mitigating the effects of it may be one of the core contributions that implementation science can offer to practice settings which are seeking to introduce innovation. The categories of the high collaborative environment and the hostile environment deepen knowledge here.

Glisson et al (2010) undertook a research project that combined the implementation of Multi Systemic Therapy with an organisational development programme known as, Availability, Responsiveness and Continuity (ARC) across 14 counties in Tennessee, USA. The two by two research design enabled comparisons to be made between a combined MST and ARC condition, single conditions and a control group. The results at 18 months showed a significant difference for young people in the MST plus ARC condition, with the core outcome measure of being placed in care less frequently when compared to the control group. Of interest is the way in which the ARC model concentrated effort upon staging and preparing the organisational system through assessment of their readiness and adaptivity to an evidence based model using

‘Manual guided activities within 12 intervention components. These components are implemented in three stages to develop the collaboration, participation and innovation within organisation and community social contexts necessary for effective implementation’ (Glisson et al 2010 p538)

This supports the contention that paying attention to the organisational environment per se, aside from the implementation of the programme itself and of the process that the developer requires, in this case MST, may well have additional benefits. This is because the organisation has undergone a process of thinking through the facilitation of the intervention before it arrives. Whilst a recent systematic review, Forman-Hoffman et al (2017) has pointed to methodological weaknesses in this research and to the small sample size, it is suggested that this may prove an important approach to consider further. In regard to practice improvement one should consider that preparing the organisational system may be an important step for the promulgation of evidence based interventions more broadly.

Returning to Rogers (1995) diffusion of innovation theory it is of note that the ‘innovators’ at the start of the very start of the bell curve are the least trusted people in the organisation as they are doing something which is essentially counter cultural, advocating that the organisation take a new direction it has not been in before. Intriguingly the next group, Rogers ‘early adopters’, are the most trusted, both within their organisation and by those outside of it who might seek advice from a trusted source. It may be that preparation of the professional system, as Glisson describes, hastens the journey from the innovator position to that of early adopter and is therefore relevant to the forming attitudes of individuals and assists in achieving faster cultural change. The high collaborative environment may have reduced the innovator barriers by creating a broad alliance for change, underpinned by values. The appointment of a trained MST Supervisor who himself was an early adopter of MST may also have brought gains in greater trust in Metro City. One can sense in the findings the continued mistrust of MST in Isolated Coastal in particular whilst in Expanded City many social workers did not see MST in a positive context following the initial presentation of it and negative attitudes persisted unchallenged.

Cook et al (2018) have continued the original work of Aarons (2004) in applying the Evidence Based Practice Attitudes Scale (EBPAS) as a means of determining attitudes of individuals, in this case in educational settings, towards evidence based interventions based on the hypothesis that

“If employed at the beginning of an EBP adoption process, the EBPAS could help inform efforts to prepare a setting or organisation for initial implementation, as favorable attitudes among professionals is a component of organisational readiness for change” (Cook et al p6 2018)

The implication being that the results of the EBPAS might then indicate what implementation strategy might need to be adopted, particularly in regard to promoting attitudinal change within the professionals in the setting in question. Certainly in the findings, the impact of professionals attitudes towards MST came out strongly in regard to how the intervention was perceived in the long term. In some professionals, these attitudes changed over time, often as a direct result of experience of the intervention, to a more favourable orientation but not always. Some of the initial negative attitudes towards the intervention became fixed quite early on, especially amongst frontline social workers whom may have felt threatened by the challenge of this way of working. Several interviewees considered that this was a result of the way in which the intervention was first presented by the developers at the launch of the service but also pointed out that legitimate concerns were ignored by the Authority.

Williams and Glisson (2014) developed and tested an organisational social context measure to establish how organisational culture and climate can impact upon outcomes in child welfare settings. They suggest that a positive organisational culture is an antecedent to organisational climate, finding a significant relationship between an organisational climate and the outcomes achieved in youth service mental health settings. Metro City engaged the workforce through a similar organisational developmental strategy although concentrated on a values led approach to engage the workforce. Research is continuing to seek to define organisational contexts for implementation and to create measures for implementation climate with Ehrhart et al (2010) developing and testing an Implementation Climate Scale with a particular focus on evidence based practice implementation. The aim being to

‘Support appropriate pre-assessment of organisational context and the development of strategies to accelerate effective implementation’ (Ehrhart et al 2014 p2)

The scale pays attention to how an organisation might orientate itself to prioritise the achievement of an evidence based practice implementation including supporting employees and providing rewards and sanctions to promote desired behaviours that will facilitate the implementation and the intervention being adopted to achieve a cultural fit. This should be welcomed although the experience in Expanded City was of an initially positive fit which then turned as leadership changed. It is possible that the service was not sufficiently anchored in the mobilisation which was forced through by the Chief Executive although the findings suggest that it was the shift in leadership which change the context which was most telling. The hostile environment therefore reflects the changing nature of organisations and of culture which can move in both positive and negative directions.

May, Johnson and Finch (2015) suggest that the strategic and cultural norms now established through the organisational strategy in Metro City would require determination to dismantle at this stage, given the longevity and depth of operational and strategic support that exists for the current MST service configuration. In this setting, and confirmed in the findings, MST has become the way in which services are delivered and so the teams are perceived as a core element of the children services offer, at least as far as might be reasonably predicted. Quite how much of a shift in leadership or what the level and nature of external threat might begin to place the services at risk is not known but the interviewees described a sense of cultural appropriation of MST which felt enduring and contributive to sustainability. May et al (2013) theorised the process by which an evidence based service becomes part of the normative condition of a system and how redundant practices are continued or deleted with Normalisation Process Theory describing how systems change over time.

In trying to understand how implementation efforts will vary between settings and in developing and extending Normalisation Process Theory, May et al (2016) contend that context is best understood as a continuous and dynamic process rather than a fixed condition. Describing how those participants involved in the implementation must negotiate the normative and relational environment of the setting into which the intervention is being introduced and the two environmental categories described certainly bear this out. The consequence of this is a form of system adaptation characterised by two processes: normative and relational restructuring. Normative restructuring

‘Leads to modifications to the conventions, rules and resources that participants experience as providing the scaffolding for everyday behaviour and action’

(May et al 2016 p23)

Whilst relational restructuring

‘Leads to changes in the structure and conduct of the interpersonal interactions and group processes that make collective action possible. As participants enact their contributions to an implementation process, their accountabilities to each other are reworked’ Ibid

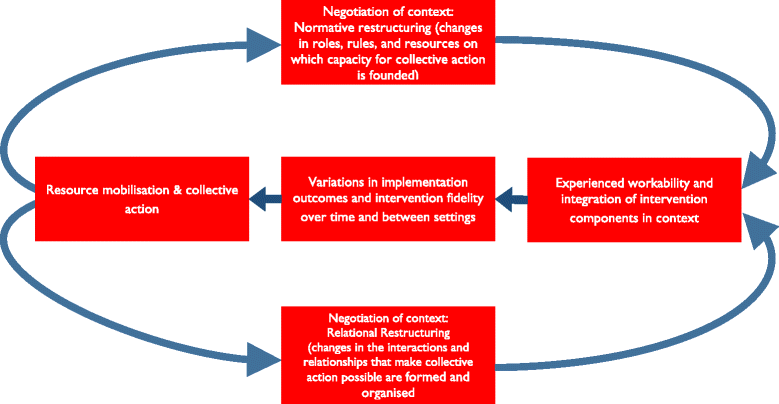
Both restructuring processes interact with the properties or components of the intervention itself and in regard to what May (2016) describes as their plasticity and elasticity. Intervention plasticity relates to how much an intervention can be moulded by participants to their context, which in turn dictates the room for manoeuvre or discretion that can be used in its deployment by individuals. Conversely, elasticity describes how far the context may be stretched to accommodate the intervention components. This is clearly relevant to the high collaborative environment and the MST implementation in Metro City because

‘When intervention components are inflexible and rigidly applied, they require high levels of commitment from their users—and where this cannot be guaranteed, they require specialist practitioners or facilitators—because the turbulent flows and varying magnitude of events that are associated with complex adaptive social systems make them difficult to routinely embed in practice. Inelastic implementation environments are often characterised by rigidly formed group processes and inflexible and impermeable organisational structures.’ Ibid

May’s work on Normalisation Process Theory adds to the understanding of the complexity of context and the theoretical underpinning of it is represented below in figure 6. It provides further depth to the notion of the implementation process described by Damschroder et al (2009)

**Figure 6**

**The continuous feedback loops in the implementation cycle for Normalisation Process Theory, May et al 2016**

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One can see how the MST intervention may have been experienced in a negative way by some practitioners as having perceived low plasticity, for example in Isolated Coastal. The level of elasticity offered by those who implemented MST in Expanded City and in Metro City was high and this has been of benefit to the implementation efforts.

May (2016) describes how organisations, as complex adaptive systems, seek to naturally restore their own order or homeostasis, arguing that through the implementation process the ‘damping down’ of turbulence in the system is a requirement of long term normative adaptation as the intervention becomes part of the operational system. In Metro City there is evidence to suggest in the findings that the system did shift both normatively and relationally and this was encouraged and facilitated by the leadership for implementation within the high collaborative environment. In contrast, the hostile environment in Expanded City meant that the Authority continued to exist in a high state of flux and uncertainty in which the system did not adapt and settle in the long term. Indeed it was the actions of a small and dedicated group in Expanded City who fought for it to survive and who managed to sustain it until they were diminished and overwhelmed. In this setting neither normative nor relational restructuring took place as gains made in this direction in the early years were not consolidated and were eroded as the context changed.

In Expanded City, one can see a relationship between the increasingly desperate efforts to sustain the service and the context in which it was operating, which moved along a continuum from a positive to a negative one. Whilst implementation science has regularly looked at barriers and obstacles to implementation it has looked less at the factors which promote and secure the sustainability of programmes and interventions in the longer term (Cooper, Bumbarger and Moore 2015, Shelton, Cooper and Stirman 2018). Implementation science has also found dealing with environmental context factors, such as those in Expanded City, difficult too, not least given their unique character and almost limitless potential of expression which can make theoretical generalisations difficult to apply as May, Johnson and Finch (2016) acknowledge. The category of the hostile environment may begin to establish understanding about why a service may fail to be sustained.

Chambers et al define sustainability as

‘The process of managing and supporting the evolution of an intervention within a changing context’ (Chambers et al 2013 p8)

This certainly resonates with the lived experience of the interview participants. Chambers (2013) developed the Dynamic Sustainability Framework (DSF) in order to provide an ecologically based model that proposes the dynamic adaptation of systems and of interventions over time that move and shape according to the contextual shifts and changes that will inevitably take place in public services. Chambers is conscious of the challenges of a dynamic process to enable sustainment given the obvious tension to adhere to manualised programme fidelity through quality assurance, naming this the sustainment paradox. This was well described by an interviewee in Metro City when outlining the temptation

“To adapt to a Metro City sort of way and I think that there was a danger early on that we might have risked doing that with MST not being in its’ purest form but as I say, the benefit of having a programme manager who had experience and actually said no you need to stick to the actual model, you can’t do your own thing , sort of contributed to successes” *YOS Operational Manager Metro City*

This Manager further described how one should not ‘tinker with’ or compromise the core integrity of the methodology, echoing Damschroder et al (2009) and Greenhalgh et al (2004) who both describe the soft periphery and hard core of evidence based programme components. For this manager the struggle was to make MST adapt enough to the local setting so that he could make it work in practice without undermining the principles of the model’s fidelity and core components of the intervention. He was professionally committed to doing so as he believed in it and had a values based connection to it. Over time he was able to achieve this balance even it remained a permanent state of dynamic tension. One might consider this tension to be a positive expression of continued leadership attention and activity.

Unlike the drive for continuous quality product improvement in the information technology sector where each upgrade to the system is an improvement to the last. The imperative of most evidence based programme developers is to perceive too much adaptation to a local context or system as a potentially corrupting development with negative outcomes to be avoided (Stirman et al 2012). This broadly remains the case, even in the face of shifts in context that may leave an intervention out of sync with the new landscape. Developers have tended to launch and test new, distinctive clinical adaptations (Tolman et al 2008, Ellis et al 2012), rather than reshape the original product incrementally. Part of this is to protect their original intellectual property of course but also to maintain the line of research outcomes which support the model in original form.

In the UK there has been a subtle shift away from youth justice as the principle referral source and toward young people on the ‘edge of care’ for MST, which has sometimes caused friction with the developers who fear a functional creep toward a population for whom the methodology has less clear evaluative research. (Fox and Ashmore 2015). In the UK the long term reduction in the size of the youth justice population since the mid 2000’s has been matched by a rise in the edge of care population as the balance has shifted from punishment to welfare (Taylor 2016). This is in contrast to the US which retains a strongly interventionist juvenile justice culture and where incarceration is much more common and at an earlier age.

Chambers (2013) describes a missed opportunity for continuous quality improvement which cannot be reconciled with the developers’ desire for control and product fidelity and this tension exists today. Importantly, Chambers (2013) suggests that efforts to begin the process of securing the sustainability of an intervention should begin early during the implementation and that the implementation phase and sustainability phase are not mutually exclusive. As a reflection for wider practice this is a point which appears often to be missed. There is little common agreement in implementation science about when the implementation phase reaches a conclusive end point and this was also evident in the interviews. For some interview participants this point was reached at the moment at which the service began to take on cases, whilst for others the end point of implementation was a much more distant and fuzzy end point. For example, when the steering group becomes absorbed into the general performance management structures of children’s services or when the funding status of the intervention moved from project to core. Sometimes this has been expressed as when a service no longer feels like a project and becomes ‘normal business’.

Drawing together leadership and environmental contextual factors are therefore key from the start of the implementation journey through to the end point of sustainability (Scheirer 2005, Stirman et al 2012) if the evidence based intervention has any chance of long term success. Whilst Ehrhart et al (2018) assert that despite

“Progress in understanding the organisational context for implementation and specifically the role of leadership in implementation, its role in sustainment has received little attention” (Ehrhart et al p2 2018)

Leading to the development of a Sustainability Leadership Scale which aims to expand the leadership dimension within the final stage of the EPIS implementation framework (Aarons et al 2011) and the Implementation Leadership Scale (Aarons et al 2014). Of note is the interest in distilling out whether the leadership functions for initial implementation are similar or different to those required for sustainment. Ehrhart at el (2018) reported that in addition to the four dimensions of the implementation leadership scale: Proactive, Knowledgeable, Supportive, Perseverant, there was a fifth, emergent dimension, of Available leadership, by which they found close and accessible operational first line manager leadership which supported staff delivering the evidence based intervention. This further confirms the category of leadership for implementation in that the continued attention and support of immediate line managers and operational leads is vital to continuing to facilitate the operational space for the evidence based intervention to succeed. This is helped by a stable workforce and also by those staff who have moved from the front line to first tier management and beyond whose continued support has a high value. Ehrhart et al (2018) acknowledge that their research concentrated on operational leadership and that it did not attend to the role and influence of higher strategic managers and leaders however as has been demonstrated, leadership can occur at different levels in complex organisations and can hold interventions in place.

**Frameworks**

At the beginning of the research process and learning about applying implementation science in practice there was much to learn from the research foundations that developed implementation frameworks (Rycroft-Malone and Bucknell 2010, Damschroder et al 2009). This learning enables understanding at a more abstract and conceptual level than the immediate experience of implementation in practice. Nilsen (2015) helpfully differentiates implementation frameworks further and sets out the differences between process models, determinant frameworks, classic theories, implementation theories and evaluation frameworks. In clarifying their respective uses, Nilsen makes the point that

‘A model is descriptive, whereas a theory is explanatory as well as descriptive’

(Nilsen 2015 p5)

Both the Consolidated Framework for Implementation Research (CFIR) and the Promoting Action on Research Implementation in Health Services (PARiHS) are determinant frameworks but were developed in different ways. The PARiHS framework being created following observational work concerning three determinants; evidence, context and facilitation. Whilst the CFIR is a research synthesis of a range of frameworks. Nilsen points out that determinant frameworks

‘Imply a systems approach to implementation because they point to multiple levels of influence and acknowledge that there are relationships within and across the levels and different types of determinants’ (Nilsen 2010 p5)

He suggests that a weakness of implementation research can be to assume a linear relationship between determinants and outcomes when the reality may be more complicated or that two co-occurring barriers may interact to become a significant block. This leads to the view that the context in which implementation takes place is highly important to determinant frameworks even though there is a

‘Lack of consensus regarding how this concept should be interpreted, in what ways the context is manifested and the means by which contextual influences might be captured in research’ (Nilsen 2010 p7)

One might agree with May’s (2014) position that, in common with other frameworks, the CFIR is probably more useful in the early implementation stage than in describing the route to sustainability. The collaborative environment and the hostile environment are categories which extend the conceptual understanding of the processes taking place beyond the immediacy of the initial implementation. These categories may help in answering the question as to why an evidence based innovation is or isn’t sustained in a setting in the longer term. The reasons and factors which either degrade or strengthen the environmental context must be one of the next places for implementation frameworks to extend towards through further research. Likewise the category of leadership for implementation appears to have a considerable bearing on the twin processes of both mobilisation and of intervention sustainability.

**Limitations of this research**

There are several limitations to this research. The sample size of interviewees is small even if the depth and detail of the interviews is significant. Local Authorities are large diverse organisations and many more participants could have been interviewed and their perspectives gained in addition to those obtained. Whilst a representative sample of interviewees was sought, further interviews may have yielded additional views and concerns. The majority of interviews were at a senior operational level (Head of Service or equivalent) rather than at a strategic leadership level (Director or Executive Director) or political level (Elected Councillors).

Five years had elapsed between the implementation period under consideration and the subject interviews taking place. Understanding the complicated contextual environment of each Local Authority and the pressures which participants experienced can be hard to gather via interviews. Indeed, whilst the implementation manual for MST was common, the uniqueness and diversity of each setting makes absolute comparison difficult. As explored in the methodology the position of the researcher, their assumptions, prior ideas and experiences undoubtedly shape and influence the conclusions and emphasise drawn from the research.

Implementation science research tends to take a quantitative or mixed methods methodological approach more frequently than a qualitative one and therefore the findings are being compared against the literature from a different position. A common argument levelled against qualitative research is whether it is generalisable beyond the immediacy of the setting from which it is generated.

**Summary**

In understanding the different narratives, experiences and reflections of the interview participants, the relevance of both leadership and of the environmental context to each setting were strong and salient. This research has sought to understand the very different outcomes for the implementation of MST in the three Local Authority settings and leadership and environmental contextual factors were a significant element of the subject interviews. These two factors weighed heavily on the respective authorities abilities to sustain the services as can be evidence by the divergent strategic paths of Metro City and Expanded City. This resonates with the finding of Atkins et al (2017) who suggests that successful implementation is a product of

‘Characteristics related to the broader community environment, external to the organisation (i.e., “outer” setting or context), and characteristics operating within the organisation or “inner” setting or context, such as organisational leadership, climate and culture, adequate staffing and organisational processes, that help support Evidence Based Treatment implementation such as strategic planning are relevant. In addition, characteristics of individuals charged with implementing the intervention and characteristics of the intervention itself are important.’ (Atkins et al 2017)

In summary, the new categories described in the findings propose a novel contribution to the understanding of the implementation an evidence based intervention. The new categories capture and define the experiences of the subject interviews as they reflected upon their understanding of the implementation process. Collaborative leadership and the ability to share and distribute leadership with others in service of agreed outcomes builds the necessary capacity to facilitate the pre-conditions in which an evidence based intervention may succeed. The environmental context in which leadership takes place is also highly relevant to the manner by which the intervention finds its place to operate. In the best of circumstances leadership is distributed through a network and aligned with high levels of committed inter agency support which knows and understands what the intervention can provide. The environmental context and the setting into which the intervention has been placed require constant attention and leadership to succeed whilst the strategic relevance and evidence of effectiveness must be returned to leadership at all levels for the system to retain confidence in the intervention**.**

**Chapter 7** **Conclusion**

This final chapter summarises key themes before making recommendations both for practice and for future research. A Professional Doctorate differs from a PhD in that it is structured to consider practice, theory and then practice again. In this way integrated and applied research can be developed which brings new theory to practice. This thesis is in service of advancing the field of concern, in this case the implementation of evidence based interventions in children’s services settings. It is with this in mind that this chapter is developed.

As has been explored through the literature review, the policy and practice search for ‘what works’ is a strategy for seeking to improve outcomes for those with high needs who often place a high demand on public funds, in this thesis young people on the edge of care. It is though a form of top down policy in which assumptions about where evidence can be generated from and notions of knowledge and expertise continue to privilege positivist scientific approaches as interventions progress from university and business developer to practice. This perpetuates the mobilisation of evidence *into* practice instead of developing notions of effectiveness and evidence discovery *in* practice (Ghate and Hood 2019).

The implementation struggle is to seek to replicate, in real world settings, the outcomes achieved in intervention efficacy trials in which contextual variables have largely been controlled. This task is compounded by the variability of skills and motivation of both leadership and practitioners to facilitate the optimal contextual conditions for the intervention to succeed within the pressured and turbulent setting of a Children’s Service’s Department facing multiple demands. Practitioners may feel deskilled to the point of resistance when faced with new methods of intervening with families which are outside of their professional training or which cut across their sense of core professional values.

It is not surprising that there needs to be sustained organisational effort to create the conditions in the professional ecology and a reliable pipeline of eligible referrals for an intervention to even begin to achieve the promise of delivering outcomes, let alone flourish. Whilst practitioners may be limited by the requirements of specific intervention fidelity from more creative localised adaptation of the model to their operating context, clients group or to differences in diversity in their particular setting. This can frustrate learning and engagement with the model. Fraser and Davies (2019) are more scathing, viewing the pursuit of the ‘what works’ agenda as being

“To the detriment of wider, interpretive, contextually informed understandings around how and why policies and practices do (and do not) work for some individuals and groups in certain places.

(Fraser and Davies 2019 p 220)

There are counter narratives to improving the ability of social care to be more efficient, informed by research evidence and innovative. An alternative approach is to rethink social work training towards a clearer engagement in applied research and practice skills. As has been discussed in the literature review and following Munro (2011) the challenge for social work has been one of moving from an over bureaucratised and compliance based system to one which focuses on effectively supporting families and keeping children safe. This may mean a fundamental re-orientation to service constructions which are

“Placing less emphasis on innovation (and the introduction of new evidence based programmes) and more on improving basic practice and ‘business as usual’ in the work of social care”

(Ghate and Hood 2019 p 104)

In service of this view work being led by Metz et al (2017) in the USA is seeking to build competencies and practice based support teams to integrate evidence informed approaches within social care teams. Using data and evidence to provide capacity, coupled with implementation science and knowledge transfer skills the aim is to provide generalist support and internal capability to therefore

“Straddle the worlds of research and practice. They offer the promise of being able to help service providers to use evidence on what works by making thoughtful adaptations for context, when necessary, without undermining the basic components of effectiveness”

(Ghate and Hood 2019 100)

As the findings revealed, in Metro City, restated values, concentration on core outcomes for the most vulnerable, the high collaborative environment, confident shared leadership and required professional development of front line staff all contributed to a shift toward the adoption of evidence based practice. But it did require determination and effort to get there. It well may be that the comprehensive nature of this approach made the difference through the implementation and to a point of sustainability compared to Expanded City which saw the organisational churn lead it to be abandoned. Or Isolated Coastal where the intervention never gained traction within the Local Authority.

The research question asked what factors contributed to the successful and unsuccessful implementation of MST in three local government settings. The core findings of the research identified strong evidence for new conceptual understanding of the implementation process in Local Authority settings and as such represent a contribution to new knowledge. Specifically, new categories have been created and defined: The high collaborative environment, leadership for implementation and the hostile environment, from the research material using grounded theory. The reported findings may be placed within the inner and outer setting domains of the CFIR (Damschroder et al 2009) although may also be understood as relating to the general implementation science definitions of leadership and of environmental context. These major factors played a significant role in the implementation of MST in the three Local Authorities and contributed to the eventual sustainment or closure of the services considered.

This thesis demonstrates how introducing an evidence based practice into a children’s services department is a long and difficult task, bringing many challenges in terms of multiple barriers (Rapp et al 2010) and issues of cultural change (Glisson et al 2008). The leadership, technical guidance, political support and operational system adaptation required to achieve a successful implementation demands much from the individuals, teams and partners over both the short and the long term (Aarons and Sommerfeld 2012, Aarons et al 2017). The operational climate and environmental context, during which an intervention is introduced is highly relevant to the success or failure of the intervention and this matters, from the initial implementation stage right through to the sustainability of the intervention (Petersen et al 2014, Atkins et al 2017). As has been shown, even good services will fail if the environmental context turns sour and the context is not actively facilitated through determined leadership. Therefore the long term sustainability of an intervention should never to be taken for granted or assumed as a certainty beyond the initial mobilisation period. The contextual reasons for why a service has closed present clear opportunities for learning about implementation and this formed one aspect of the thesis research design.

The three Local Authority sites under examination ostensibly had exactly the same opportunity to implement MST in 2008. Each having access to the same support from the programme developer and from the NHS Programme Lead, the same intervention model manuals and implementation tools were provided, together with the implementation planning templates and the initial orientation training. Each had the same financial support and conditions of grant from the NHS. All three had self-selected for the programme and had made a commitment to implementing MST into their local system following interview with the NHS National Lead.

Therefore, each setting had a stated organisational orientation which was, on paper, favourable to the implementation of an evidence based practice. This is in line with the CFIR inner setting construct of readiness for change, (Damschroder et al 2009). However, the similarities between the authorities ended very quickly beyond the signing of the grant acceptance letter. Each authority had significantly different contexts for leadership, organisational arrangements, climates and cultures. Each authority was bringing very different things to the party, before it had even started, in terms of capacity, ability and mandates for change within their respective setting including histories of collaborative working. These factors made a difference to the early mobilisation of the intervention and beyond.

The grant application and interview stages had sought to elicit what the pre-conditions and attributes for successful implementation might be for applicants to demonstrate. It is fair to say that this section of the application was relatively unsophisticated at that time but research is now developing instrumental measures for the assessment of key organisational and leadership attributes (Ehrhart et al 2010, Aarons et al 2016). It is suggested that it can be hard to determine and to fully evaluate the intent and willingness of an organisations ability to implement an intervention, particularly one which was still very unknown in the professional economy in the UK. This judgment is even harder when the Authority appears willing and committed, whilst seeking to win a competitive bid and making promises as it seeks external investment coming into their area. What is now known from both practice experience and from development of implementation science (Powell et al 2017, Aarons et al 2015, Weiner et al 2015) is that these pre-conditions are highly relevant to what takes place next during the implementation process, let alone what the authorities then did by way of managing and leading their own implementation journeys.

Only the National Lead for MST, as a result of her unique role, had a clear overview of the leadership and dynamics of the three sites over the course of the implementation and so her views have been very beneficial to this research given her perspective. There was surprising commonality regarding the wider interviewees views on the role of leadership, the nature and impact of the environmental context and the process of implementation itself. Interview participants showed great insight regarding how leadership had shaped their experiences and could reflect upon how, if leadership had been different, the context more enabling, that outcomes might have been different in the two sites which closed. Leadership was universally perceived as the most important implementation driver by interviewees.

The contextual settings in each of the three Local Authorities were very different and were also highly impactive of the services. It is an acknowledged challenge to implementation research to articulate the impact of context, not least given the potentially limitless possibilities and influences beyond the immediate confines of the service in question. May et al (2016) make the point that

‘Intervention and evaluation designs seek to eliminate contextual confounders, when these represent the normal conditions into which interventions must be integrated if they are to be workable in practice.’ (May, Johnson and Finch 2016 p1)

And this creates a dilemma for programme developers and those who seek to implement evidence based interventions as these move into real world settings where contexts cannot be easily controlled. Nonetheless, greater understanding of environmental contextual issues should assist those in practice to anticipate problems.

**New theory and learning**

The grounded theory analytic process of developing concepts and categories enabled theory to emerge from the data (Charmaz 2006). The major categories discovered describe new learning, underpinned by the interview material. These categories may be applied in other settings and used in practice development for new implementation efforts but further research will be required before greater generalisability may be claimed.

The high collaborative environment describes an intentional way of working collectively and collaborating for common goals which support many of the leadership functions that are considered essential in delivering evidence based practice. This represents a key area for concerted attention throughout the implementation process. It is striking how at the starting line, to which all of the sites were marshalled, once the starting gun was fired Metro City were able to call upon already acquired leadership capital with which this investment could be quickly established. Through the subsequent years, Metro City were able to overcome barriers and extend their collaboration as trust, common cause and values continued to be upheld by a consistent core set of leaders.

Expanded City combined their local MST connection to the driven leadership of their Chief Executive to deliver their implementation. But the failure to develop more distributed leadership and wider collaboration with partners led to an unsustainable reliance on single leadership which could not carry the service in the long term. Isolated Coastal remained outsiders with poor support, disconnected to their Authority. Unsurprisingly then, it is clear that relational leadership matters and make a distinct difference to how implementation is achieved.

Forceful leadership can make almost anything happen whilst the focus of power is concentrated upon the issue at hand. Sometimes, as Grint (2008) would support, the exercise of authoritarian power is justifiable in the contextual moment in which it is exercised, in an emergency. A crisis is not the best time for distributed leadership to be trialled and the semi-permanent sense of crisis in Expanded City’s children’s services department engendered short termism in the strategic leaders who came into the Authority. As has been demonstrated, the role of leadership is central to implementation but one that requires a particular kind of relationally aware and pragmatic leadership rather than the drive of a determined CEX alone. There is a clear place for distributed leadership. Succession planning must too be identified as a core part of the development of a plan for sustainability of interventions once it reaches a point of relative maturity. The category of leadership for implementation as a distinct form of leadership extends and deepens the original proposals of Aarons et al (2016).

One significant element which enabled Metro City to develop successfully was as a result of the connection to a reconfigured set of values which extended across the leadership of Children’s Services. What also made a difference was relative system stability in which leaders remained in place and continued to support the innovation. Indeed the replacement of leaders with those who ascribed to the utility and value of evidence based practice enabled Metro City to become a self-reinforcing entity. In contrast, the falling away of the steering group in Expanded City and the lack of distributed leadership produced a withering of potential support in the local economy and was too weak to mount a defence when adversity came along.

The category of the hostile environment not only speaks to the instability of strategic leadership in Expanded City and to the absence of collaborative leadership in Isolated Coastal but to a wider set of circumstances in which repeated episodes of threat and risk occurred throughout the lifespan of these two settings. The notion of a ‘toxic trio’ of threats which include financial pressures, change of leadership and poor partnership support reminds one of how problems can cluster into a perfect storm of threats.

‘Sorrows come not as single spies but in battalions” Claudius, Hamlet Act IV, Scene V. (Shakespeare 1603)

Whilst a single event could end an intervention it is suggested that it is more likely that a combination of co-occurring issues, which might be context specific, will lead to closure. The reduction in referral flow, a change in relationships, the threat of a new service, a run of negative outcomes, a change of leadership. The hostile environment also relates to more subtle differences in leaders and operational staff attitudes towards the intervention which add to the sense of either an uncomfortable fit or a misalignment with the setting into which it has been placed.

The application of Normalisation Process Theory (May et al 2013) is helpful in explaining the adaptive plasticity and elasticity of the intervention and of the setting. The idea of relational restructuring is a tangible concept in that it locates the way in which participants adapt and find ways to make use of innovations. Much like the CFIR adaptive periphery and outer context domain this helps to understand that mutually responsive processes are taking place within the context into which the intervention has been placed and the shifting of an organisational system to find a comfortable fit.

Returning to and reflecting upon the research questionsposed for this thesis there remains confidence in the questions originally asked but new questions emergedthrough the research particularly in regard to notions of what counts as evidence and how one can or cannot claim evidence as objective. The impact of contextual factors was far greater than anticipated and so further questions about cultural adaptation to context remain. There is also more to be considered in regard to diversity and cultural adaptation which has been under explored in this thesis. The research interviews might have better reflected these concerns with direct questions about the participants views on contextual issues.

At the outset the position adopted was one of support for MST and evidence based interventions. Whilst still enthused of their potential one is more circumspect about how such programmes can or cannot adapt to the context in which they are introduced. Greater attention to contextual adaptation and a loosening of the boundaries might enable better outcomes and offer the potential of clinical improvement rather than dwelling only on the fear of the corruption of fidelity, important though this is. Therefore one might begin to think of the Metro City adapted version of MST as a distinct entity instead of thinking that all MST sites are essentially the same.

It will be interesting to learn more from the trial of the LOCI (Aarons et al 2016) to see if instrumental development of this scale and its application in practice will assist with the implementation outcomes in the test sites. It has been instructive to learn more about leadership and the differing forms of leadership. Harnessing values and ideas, inspiring and motivating, acting and modelling behaviours and collaborating in service of outcomes have been shown through the findings and interview narratives. As have the pressured, contingent and reactive forms of management which are often a product of turbulence and organisational challenges when Local Government is operating in a period of diminishing resources. It is within this context that achieving the aim of fundamental reform, of lifting social work practice to confident, research led, respected status and able to deliver outcomes seems almost out of reach unless determined national efforts are made to secure this vision.

**Lessons for practice**

Points of risk and challenges have been identified for practice. These include the retention of senior managers and partners at the steering group, succession planning, churn of senior leaders, induction of new partners and system management. Inertia or strategic uncertainty within a Children’s Services setting when under threat from financial pressures and high demand is a key risk with the possibility that the system will return to stasis instead of treading a path towards transformation (May et al 2016) These ideas have the potential for wider application and across different settings. The process of stepping back and abstracting the reasons why something may not work as intended could bring benefits to an operational team considering the introduction of an innovation.

There was clear disappointment expressed in all three sites at the delay of the publication of the Start Trial (Fonagy et al 2018) upon which many hopes rested for a UK evidence base to be generated with emphatic support for the intervention and outcomes when in fact the research outcomes demonstrated little effects. This may be part of a wider ‘crisis of replication’ (Grant and Hood 2017, Martin and Clarke 2017) across multiple scientific disciplines. The reasons for the poorer than anticipated outcomes will continue to be debated, not least as there are many more nuanced lessons from the START trial data across a variety of variables more than a single binary finding of either works or does not work.

Most services established in 2008 did not track their own local outcomes as this responsibility was given over to the researchers for the trial which had been intended to report years earlier. Crucially, in Expanded City, returning local outcome tracking data back to senior leaders where it could have been supporting a narrative of the effectiveness of outcomes may have been a means of generating long term support for the service. The failure to inform the Expanded City system of the strengths of the outcomes being achieved may have contributed to the system losing faith in the intervention. This may have been compounded by the absence of any accepted standards for ascertaining what evidence of effectiveness might have been recognised at the beginning. Nor were any comparable outcomes being collated by other in house services for comparison. The process of random assignment for research created another obstacle for Expanded City as described in appendix 5 .

At an assessment stage and before an Authority is ready to implement an evidence based intervention it is recommended that a thorough analysis is undertaken to test out whether the Authority is committed to system reform to enable evidence based practice in the long term and crucially who has signed up for this. If it is one person only leading this and pulling others along then this is a clear risk. If the Authority is seeking evidence based interventions as a way of improving their Children’s Services following a poor review by Ofsted then one would also wish to learn more about the willingness of the Authority to see this through rather than to reach for this option as a way of complying with what Ofsted has suggested as a quick fix for practice.

It is suggested that concrete examples of collaborative leadership are evidenced as part of the assessment of a site and to see leaders in the same room describing how they intend to work with each other. It may prove difficult to make a judgment about the long term stability of an organisation given that organisations can have alternating periods of churn and stability but finding out more about how leaders come and go and what the political stability of the system looks like too would be important to find out. Finally one might ask about an Authorities’ orientation towards evidence based practices and what experience they and their organisation has had of these. Bearing in mind the questions posed earlier, ‘does it work?’ ‘does it work in this setting?’ one would wish to find out what question the Authority was seeking to answer.

There could be an assessment of whether an Authority perceives an evidence based intervention as a stepping stone towards wider service transformation or as an end in itself. It is a risk if the Authority sees evidence based intervention as a ‘try out’ for something that they have heard of and want to have a go at with the possibility of retreat to status quo if things don’t immediately work out. Projects can remain projects and never become incorporated into the mainstream, existing in a temporary or transitional space. Anticipating how this is planned for from the beginning seems a sensible step to consider. Not least as one could ask about the sustainability of the intervention at this stage too. It would be prudent to ask about the commitment for funding and the points at which decisions will be taken regarding the mainstream funding of the work, particularly in regard to what evidence of effectiveness or outcome tracking will inform this decision, as it may not be known. This is better to define at the start than to try to collect evidence retrospectively. Further, if a comparison group is to be used to develop a judgment of effectiveness then how this group is to be determined is also important to get right at the beginning.

The role of distributed leadership has proved central to this work and so planning for the succession of key staff and also for members of the steering group of partners should be considered. The leadership risk of hoping that people will not leave for new posts is not a realistic plan and turnover should be anticipated, including staff who may have been trained at some cost to the Authority. As has been demonstrated, the turnover of Supervisor staff can precipitate a crisis for the whole of the intervention so contingency planning would make this less threatening to the viability of the service. To some extent the same may be true in regard to champions and supporters of the intervention. New champions should be cultivated in advance of existing ones turning over. Inducting new champions is a worthwhile investment not only within the Authority but with partners too as a means of mitigating leadership risks. One could include elected Councillors in this too as a potential source of long term support.

The steering group needs to be kept informed of progress and of the outcomes being achieved and therefore should have outcome data readily available to it so that it is aware of the evidence of effectiveness that underpins the service. There may be a problem in providing outcome based research to an Authority which may be largely impervious to research evidence of effectiveness or which lacks the skills to evaluate evidence. However the challenge should be back to the Authority to demonstrate the effectiveness of any of its other services as well as to raise the ability of leaders to discriminate between good and bad standards of evidence and to be able to interpret data. Evidence of effectiveness should not be left to someone else or exported to a third party or a perceived expert. Ideally data needs to be returned to the system regularly in a format which makes sense to those who receive it. Expanded City failed to do this to their cost. Outcomes achieved should clearly link to the values which are being promoted through the adoption of the intervention and to which the Authority has subscribed.

Engaging staff across the organisation and at micro, meso and macro is vital if the service is to flourish and is a task which should take place continuously. Understanding where the traction is between and across these levels as well as where barriers and blockers might lie is important to the implementation effort. One of the strengths of Metro City was how social care staff were invited into research and learning seminars to improve practice skills. Their orientation towards evidence based interventions shifted over time as their professional development was encouraged and celebrated culturally. Metro City would contend that this is a continuous piece of professional development which never ends.

Finally, implementation leadership should undertake planning for the predictable crisis. Leaders must have the evidence of effectiveness to hand and the ability to explain what it says about performance and outcomes. Leaders should seek out and collaborate with like-minded people and find allies who will support them across the system. Leaders need to be aware of who their detractors are and be able to build political support for use when it is required. Leadership requires the active facilitation of the environment to allow the intervention to succeed whilst scanning the horizon for the warning signs of impending adversity. Leaders must continue to maintain the strategic thread both themselves and through others and to pass on the baton to safely when they move on. Leaders should never let their steering group diminish in representation and should cultivate good partnership supporters. If leaders can plan for the long game and manage the context then eventually evidence based interventions will become part of how we do business here.

Therefore, as a reflection for practice one would argue for the system to continuously refresh and re-invigorate the leadership and partnership support around a service so that the support that can be drawn in is knowledgeable, purposeful and active. Partnership support has to be built and nurtured consistently if it is to be called upon in times of uncertainty and change. Partnership support was often expressed by interviewees only in terms of attendance and contribution at the steering group. Partners may withdraw attendance if their role changes or if other priorities come along to detain their time and attention. They may not be replaced with the same seniority or if they are then the new representative may not be as invested in the success of the service. One Manager in Expanded City described his own disengagement from the steering group.

‘I think that it was probably a mistake that I withdrew, fairly early on as I had other responsibilities and at the time was happy to see the team develop under new leadership and of course I did not have the capacity to continue or felt that I didn’t at the time so I let them go off and do their thing.’ *YOS Manager Expanded City*

Rarely was partnership support described as a set of defensive measures to bring to bear as needed or as lines of support to be used at the next point of crisis. Not only is succession planning for the Supervisor important but for the supporting partners too. The wider point for practice being made here is that as far as one might or might not be able to control for the hostility of the environment in an organisation, there are steps which the service might do to seek to sustain the immediate environment around it to create a buffer. One can also argue that understanding an organisation as an explicitly political system is one way to think about alliances, political support and as a way to seek to anticipate whom the service supporters and detractors are. Watching an organisation and a system for signs of change can mean that there is less likelihood that a shift in direction will feel as if it has come out of the blue.

One can argue that there is a direct relationship between how referring staff perceive the effectiveness, utility and usefulness of the service to which they are referring and to the number of referrals which are made. Referrers must have a more than basic understanding of the service which means that the core criteria for appropriate referrals has to be widely communicated. Getting the referral pipeline right, not only at the start of the service but throughout the life course of each of the three settings, was a major pre-occupation of the interviewees and a central element of system adaptation. It was also an issue brought to the steering groups to which practice concerns were often escalated.

Networks can instil confidence and offer reinforcement to beliefs and actions. The Sector Advisers established by the NHS became a nascent professional network and this was an intended outcome following the establishment of the role. Previously there had been a very informal network that existed for MST in the UK which had relied upon good will and generosity of spirit between both Local Authorities and NHS professionals. Since the initial development of the new MST sites the UK MST network and the National Implementation Service have been funded and established as resource centres and access points for support. These have the potential to become a place for the sharing of expertise and learning together with practice support.

**Further research**

Further research regarding leadership for implementation and the definition of this at a conceptual and at a practical level should help to establish the skills and training required for the next set of leaders to innovate and drive implementation. The frameworks for implementation research have often concentrated on the start of the implementation process rather than on questions of sustainability. Indeed how systems reach a point of sustainability following their implementation process and what this looks like are questions for further research. Studies might concentrate more upon mature sites which have retained services through long term sustainment to determine why this is the case. There may be more to learn about the context and the leadership which has facilitated this. Coupled to these ideas is the question of adaptability and the relationship between a sustained service and high fidelity to the model. It would be interesting to find out from these sites to see how they overcame the challenges of changes in both staffing and leadership or coped with adverse events.

Given the attention paid to environmental context in this research it is suggested that this field of enquiry extends the concepts generated and can develop further archetypes of environmental context as they pertain to implementation. It would also be interesting to look at examples of businesses or industries which are able to quickly abandon redundant practices in favour of the new and innovative so as to understand more in regard to how organisations can speed up the adoption of new technologies and innovations.

The attitude of social work as a profession, as already noted, towards evidence based interventions remains ambivalent. It is hoped that social work training will move toward this agenda, supported by national leadership, so that new entrants to the profession will be empowered to develop opportunities for challenging the status quo, using research and introducing innovation in practice.

**Towards a new context**

There is room for optimism in the next phase of expansion of evidence based interventions. Both the Big Lottery Life Chances Fund and the Better Outcomes Fund which preceded it are supporting outcome based commissioning models in Local Authorities by creating enhancements for commissioned contracts which are utilising evidence based interventions. This is supporting a new set of Local Authorities, often working in collaborative consortia, to work with social investors to establish social impact bonds to deliver ‘edge of care’ services. These include the interventions: Multi Systemic Therapy, Functional Family Therapy and Functional Family Therapy Child Welfare. The provider market is evolving too with established children’s services providers such as Family Action and Core Assets competing for work alongside new providers, including one established by myself, Family Psychology Mutual CIC which is a social enterprise, also known as a Public Service Mutual, given its creation as a spin out from the Local Authority. It is hoped that these new services will aim for sustainability at an early stage of their implementation.

The Department for Culture Media and Sport and the Cabinet Office are supporting the development of social impact bonds with a dedicated centre for SIBs and funds to support research. Evaluative capacity at the Go-Lab, established at the Blavatnik School of Government at Oxford University is being developed. Social Investors such as Bridges Fund Management, Triodos Bank and Big Issue invest are raising and investing funds into social impact bonds and therefore creating new opportunities for evidence based interventions, not least given the promise of a return on investment as high fidelity programmes. The new wave of expansion brings with it the promise of a highly disciplined approach to performance management with the investor interest retained for the lifespan of the intervention. This may create a greater stability of the environmental context as the contractual arrangements specify both governance requirements and specify operating conditions to be established.

Whilst for some the introduction of a market investment into public welfare systems is viewed with suspicion, for others it will create opportunities for innovation, investment and a move towards a more accountable system in which cases are routinely tracked and operational teams are responsible for the achievement outcomes. The success of the Essex social impact bond, has given the market confidence and has established proof of concept with high achievement of outcomes and a significant saving for Essex County Council in terms of avoided costs. Further maturity of the outcome data may prove even greater savings once the final tracking period has been completed.

The period of doctoral study has not only provided a means of critically assessing the factors for success in evidence based interventions it has acted as a spur to develop a social enterprise company to move into this market as a specialist provider. Taking the lessons of implementation forward into new service areas has already begun. It will be for others to research whether this new wave of services are able to overcome the barriers and sustain the services in the long term as well as to deliver higher outcomes for vulnerable young people and their families.

**Appendices**

**Appendix 1**

**Interview Schedule**

***Recording on***

**Preamble and consent**

**Part 1**

**Open narrative**

I would like to start by asking you if you could tell me the story of the implementation of MST in your local area right from the start to the present day

Possible prompts

Can you remember what was happening in the organisation at the time?

Was it a time when innovation was being encouraged?

Was the organisation ready to develop new ways of working?

Who was driving the implementation?

Were you feel ready when the first cases were being allocated?

What went well?

Was there consistent support?

**Part 2**

**Semi Structured questions**

1. On reflection what would you do differently if you knew then what you know now?
2. What were the lessons that you learned concerning the implementation of evidence based practice?
3. Was the organisation ready for the challenges of implementing MST (relates to inner setting)
4. Was the culture and leadership of the local authority actively supportive of MST? (relates to inner setting)
5. Was the intervention welcomed and championed or did you encounter resistance? (relates to inner setting)
6. Was MST a good fit with your local system? (relates to inner setting)
7. Who or what was most helpful to you?
8. Thinking about the culture of social work, do you think that social workers are convinced by research evidence of effective interventions?
9. Do you think that social workers and other practitioners need to actively believe in evidence based practice for it to become incorporated into their practice?
10. Do you believe in it Does it fit with your professional values?

**Part 3**

**Closing phase**

That is the end of my questions for you. Thinking back over what you have told me is there anything that you wish to add or clarify?

Is there anything else about the experience of working to implement MST that you think I might like to know or may have missed?

Thank you for participating

***Recording off***

**Appendix 1a Participant Information Sheet**

***PARTICIPANT INFORMATION SHEET***

**Section A: The Research Project**

1. The title of this research project is ‘Factors contributing to successful and unsuccessful implementation of an evidence-based programme; a multi site qualitative analysis using an implementation framework’
2. The purpose of this project is to gain better understanding of how the process of implementation can succeed or fail when introducing evidence-based practices into organisations. If lessons can be learned about how to implement change more successfully then this could lead to the more efficient use of resources, improved methods of working and ultimately better outcomes for children and families.
3. You are being invited to participate in this research project because of your experiences in seeking to implement an evidence-based practice. In this case Multi Systemic Therapy (MST)
4. This research project is being undertaken as part of a Professional Doctorate. This is a supervised higher education qualification and is being taken on a part time basis by the research student.
5. The research will be put forward for an academic award and a copy will be held in the British library and also the Anglia Ruskin library. There may be articles published in professional peer reviewed journals at a later date.
6. The research is conducted as part of a course and so is not externally funded by a research body.
7. The person conducting this research is Tom Jefford who may be contacted at [redacted]

**Section B: Your Participation in the Research Project**

1. You have been invited to take part in this research because you have unique experience of an implementation site. Implementation research is a relatively new area for academic research and so learning more about it is a current area of interest both academically and in public policy.
2. You may decide not to take part at any stage
3. You can withdraw at any time by e-mailing Tom Jefford
4. If you agree to take part you will be asked to sign a written consent form, which will outline what will happen to the research and the storage of materials. You will be invited to participate in a semi-structured interview with the researcher at a mutually convenient time and location. This will be recorded and transcribed. It is possible that further questions may be asked for clarification purposes at a later stage. The interviews and review of documents will form the principle material for analysis.
5. The design of the interview should minimise any participant risks. The material to be discussed is not considered to be of a sensitive nature although it will cover areas of practice where unsuccessful implementation may have occurred. There is a risk in discussing potential professional or organisational failure. However the aim of the research is to learn about lessons for implementation research and practice and is not seeking to apportion blame. Ensuring your wellbeing and safety at all times is a key consideration of the researcher.
6. Your agreement to participate in this research should not compromise your legal rights in any way should something go wrong
7. There are no special precautions you must take before, during or after taking part in the study.
8. Interview transcripts will be held on a secure database and for 24 months after the completion of the research before being deleted.
9. Participation in this research should provide an insight into the implementation process and may also form a debrief of your implementation experience.
10. The interview will be confidential. The reporting of findings in the research will use anonymous quotations attributable to generic job roles. The interviewer will agree on a job title descriptor with you. If a quote from your interview is to be used then your specific consent will be obtained. The local area will not be identified in order to achieve anonymity.

YOU WILL BE GIVEN A COPY OF THIS TO KEEP,

TOGETHER WITH A COPY OF YOUR CONSENT FORM

**Appendix 1b**

**Consent form copy**

**Participant Consent Form**

Th

NAME OF PARTICIPANT:

Research title: Implementation of evidence based practice (doctoral research)

Main investigator and contact details: Tom Jefford

1. I agree to take part in the above research. I have read the Participant Information Sheet which is attached to this form. I understand what my role will be in this research, and all my questions have been answered to my satisfaction.

2. I understand that I am free to withdraw from the research at any time, for any reason and without prejudice.

3. I have been informed that the confidentiality of the information I provide will be safeguarded.

4. I am free to ask any questions at any time before and during the study.

5. I have been provided with a copy of this form and the Participant Information Sheet.

Data Protection: I agree to the processing of such data for any purposes connected with the Research Project as outlined to me

Name of participant (print)………………………….Signed………………..….Date………………

Name of witness (print)……………………………..Signed………………..….Date………………

YOU WILL BE GIVEN A COPY OF THIS FORM TO KEEP

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If you wish to withdraw from the research, please complete the form below and return to the main investigator named above.

Title of Project: Implementation of evidence-based practice (doctoral research, Tom Jefford)

**I WISH TO WITHDRAW FROM THIS STUDY**

(You do not have to give any reason)

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appendix 2**

**Initial codes**

1. Adaptation
2. Anti MST
3. Back up Supervisor
4. Belief
5. Budget issues
6. CAMHS
7. Champions and advocates
8. Child and Family
9. Codes
10. Collaboration
11. Competition with other services
12. Contextual issues
13. Culture
14. Effectiveness
15. Ending
16. Engine or driver for change
17. Established staff team
18. Future commissioning
19. Implementation reflections
20. Initiation
21. Leadership
22. MST is new
23. Organisational learning
24. Professionals perceptions
25. Recruitment
26. Referrals
27. Relationship between Local Authority and Department of Health
28. Research
29. Senior Management
30. Service reputation
31. Social Care
32. Steering group
33. Supervisor
34. Sustainability
35. System and organisational issues
36. Utilisation of the service
37. Values
38. Weak relationship to MST
39. Youth Offending Team

**Appendix 3**

**Coding nodes by selected initial codes**

**Leadership node categories**

1. Tasks

2. Leadership

3. Planned

4. Leadership

5. Demonstrable effort

6. Driving success

7. Responsibility and accountability

8. Collaboration

9. Relationship aspects of leadership

10. Leadership provides access to others

11. Collaborative history

12. Strategic leadership

13. Leadership as patronage

14. Risk of single leadership

15. Being perceived as useful to the system

16. Changes in leadership

17. Risk of single leadership

18. Shared ownership

19. Investment in the system

20. Co-occurring factors or events

21. Steering group support

22. High energy leadership

23. Engaging stakeholders

24. Change in leadership

25. Hostile environment

26. Toxic trio

27. The compelling case for continuation

28. Survival

29. Political

30. The unpalatable decision

31. Positive publicity

32. Trade off

33. The use of evidence

34. Investing in the steering group

35. Vision

36. Patronage

37. Financial pressures

38. Shift in national context

39. Organisational churn

40. Patronage

41. Deep seated crisis

42. Budget cuts

43. Supervisor turnover

44. Interim leadership

45. Single leadership

46. New culture

47. The missed opportunities

48. Overwhelmed by context and change

49. Failure

50. New and innovative

51. Leadership key to implementation

52. Strong leadership

53. Senior leadership support

54. New champions and leaders

55. Collaborative leadership for implementation

56. Senior commitment

57. Ability to demonstrate operational application

58. Continuity

59. Strong governance

60. Replacing leadership and succession

61. Translation of academic into practice

62. Political buy in

63. Clear vision

**Implementation reflections node categories**

64. MST oversold

65. Relationships

66. Implementation reflections

67. Peer support

68. Insecure foundations

69. Systemic change

70. Contingency planning

71. Refreshing the system

72. Never doing well

73. Communication strategy

74. Compelling evidence

75. Keeping an eye on the finances

76. Contextual factors

77. The implementation challenge

78. Adaptation of existing processes

79. Charismatic leadership

80. Relational aspects of implementation

81. Political challenge

82. People with energy and enthusiasm

83. Sustaining commitment

84. Implementation template

85. Systemic leadership

86. Expertise within the system

87. Developing understanding

88. Square peg in a round hole

89. Importing experienced leadership

90. The model enthuses people

91. Multi-agency ownership of implementation

92. Epiphany

**Cultural node categories**

93. Geographic isolation

94. Culture and values

95. Proximity

96. Working together

97. Joint work

98. Low change to system

99. Working within a known network

100. The high collaborative environment

101. Cultural dissonance

102. National context for change

103. Working to a model of implementation

104. Workforce development

105. Deliberate intention to implement an evidence based practice

106. Integration of academic into practice

107. Evidence of collaboration

108. Established relationships

109. Collaboration with outsiders

110. Money enabled collaboration

111. Existing relationships

112. Collaboration created by leadership

113. Benefits of collaboration

114. System promotes collaboration

**Champion node categories**

115. The lonely champion

116. The empowered champion

117. The lost champions

118. The lingering champion

119. The senior champion

**Appendix 4**

**Coding Analysis**

**Key**

|  |  |
| --- | --- |
| Initial Concept - *supporting material* (in vivo, summary, notes)   |  | | --- | | Initial Category |       Sub category/theme |

**Leadership node**

Interview 10

1.Allocated tasks - *Being given actions to complete*

*-Things to do*

*- Activity with a purpose in pursuits of the goals*

*- Steps towards achievement*

*- Directions being made*

|  |
| --- |
| Tasks |

Value

Quantity

Accountability

2. Driving force *- Momentum and energy*

*- By force of will*

*- Pulling and pushing towards the goal*

|  |
| --- |
| Leadership |

Pushing and pulling

Taking people with you

Goal Driven

3. Well organised - *Planned*

*- Purposeful*

*- Logistically supported*

*- Thoughtful*

|  |
| --- |
| Planned |

Factors considered

Anticipated

Ordered

4. More than one person - *Team effort*

*- Co-ordinated*

*- Engagement of others*

*- Multiple participant*

*- More than the vision of one person*

|  |
| --- |
| Leadership |

Shared vision and tasks

Distributed leadership

Multiple participants/team

5. Working hard - *Efforts made to attain the goal*

*- Focus and attention paid*

*- Demonstrable commitment to the implementation*

|  |
| --- |
| Demonstrable effort |

Attention and focus on the implementation

Showing others in the system that efforts are being made

6. Making it successful - *Seeking achievement*

*- Investment of time effort and energy*

*- Focus by participants*

|  |
| --- |
| Driving success |

Being outcome focussed

Leading for success

Assumption that effort will be rewarded

7. Not making excuses - *Containing problems*

*- Owning of problems and adversity*

*- Taking responsibility*

|  |
| --- |
| Responsibility and accountability |

Taking responsibility

Facing reality

Being accountable to self and others

Ownership of problems

8. Collaboration with others - *Previous work together*

*- Known relationships*

*- Being known to others*

*- Being passported into a group*

*- Being vouched for*

*- Insider/outsider positions*

*- We had worked together before*

|  |
| --- |
| Collaboration |

|  |
| --- |
| Relational aspects of leadership |

Access granted to others

Forming effective relationships

Who you know Contingent permissions to join others

9. Being seen in a positive light - *Welcomed*

*- Granted immediate trust*

|  |
| --- |
| Leadership provides access to others |

Enabling

Facilitative

Reducing barriers

The importance of patronage

Granted access

10. Joint work with CAMHS *- Previous work with CAMHs and schools*

*- Someone seen as naturally collaborative*

|  |
| --- |
| Collaborative history |

Helping services achieve coherence

Record of joint endeavours

Is collaboration intrinsically motivating?

11. Poor inspection - *Authorities can begin to meltdown*

*- Causes re-prioritisation*

*- Odd behaviours may result*

*- Focus on the ‘must-do list’*

*- Strategic paralysis and fear*

|  |
| --- |
| Strategic Leadership (post inspection) |

Investing in leaders

Addressing fundamental issues

Seeing beyond the short term

Promoting leaders

Thinking systemically

Considering more than front line services

12. Programme champions *- Patronage*

*- Keeping a close eye on it*

*- Offering protection*

*- Offering support*

*- Keeping the service close*

|  |
| --- |
| Leadership as patronage |

Keeping hold Not letting go

Fending off others

Not passing to another

Maintaining interest

Manipulating/facilitating the system to allow it to flourish

13. Over reliance on a single leader *- People will come and go*

*- People were replaced*

*- Relationships continued after they left*

|  |
| --- |
| The risk of the single leader |

The status quo is never stable

Distributed leadership not achieved

Absence of succession planning

Can single leadership bind a partnership together?

Process of replacing a function rather than a personality

14. Being a useful person - *Contributing to the system*

*- A good object*

*- Professional generosity*

*- Able to achieve things*

|  |
| --- |
| Being perceived as useful to the system |

Change agent

Able

Contributive

Reliable

Valued

15. Changes in leadership *- Change*

*-Uncertainty*

*- New*

*- Discontinuity*

*- Threat*

*- Risk*

|  |
| --- |
| Changes in leadership |

New alliances

System shift

Impact varies according to scale

Change to critical mass of support

Loss of shared experience and history

Changes of supporter

Political uncertainty and new agendas

16. Risk of single leadership - *Taking on too much*

*- Easy trap to fall into*

*-Relied on to get things done*

*- No shared ownership*

*- Single champion*

*- System holder*

*- Management style*

|  |
| --- |
| Risk of single leadership |

All about one person

Force of personality

Over investment in one

Last one standing

What will we do if you leave?

Shrinking partnership support

Exclusivity

Over reliance

17. Shared ownership - *Defence against single leadership*

*- Succession planning*

*- People were replaced*

|  |
| --- |
| Shared ownership |

Inclusive and distributive

Joint ownership

Common cause

18. Investment into the system - *Conscious support of system*

*- Facilitative*

*- Risk sharing*

*- Inclusive*

*- Planned*

*- Strategic reach*

*- Systemic understanding*

*- Paying attention to the operating environment*

|  |
| --- |
| Investment in the system |

Refreshing the system

Taking account of change

Contextual understanding

Taking a step back to consider the system

Deliberate/planned intervention

19. Combinations of factors - *Multiple events*

*- Context*

*- Events and stages*

*- System alignment*

*- Constellations*

|  |
| --- |
| Co-occurring factors or events |

Overwhelming factors

Provoking crisis

Things taking place at the same time

20. Steering group *- Business processes*

*- A place of accountability*

*- Totemic of system support/engagement*

*- Solid, shifting or in decline*

*- A litmus test of partnership support*

|  |
| --- |
| Steering group support |

Attendance rates/continuity

A required meeting

A collective memory

Abandon at peril

Level of representation

Contract meeting or partnership support

21. High energy manager/leader - *Able to get things done*

*- Trusted and empowered to achieve*

*- Irreplaceable*

*- False sense of security*

|  |
| --- |
| High energy leadership |

Proprietorial ownership

System disrupter

Risk of charismatic leadership

Compelling

Seductive

22. Engaging stakeholders *- Keeping partners involved*

*- Building relationships*

*- Shared vision*

|  |
| --- |
| Engaging stakeholders |

Relationship management

Key supporters Network

Joint enterprise

Who you know

Interview 11

23. Change in Leadership - *Sudden change*

*- Successive change*

*- Short termism*

|  |
| --- |
| Change in leadership |

Loss of strategic thread

Discontinuity

Multiple changes

Different personalities and styles

24. Hostile environment - *Under constant pressure*

*- Poor performance*

*- Context for decision making*

*- Embattled*

*- Despairing*

|  |
| --- |
| Hostile environment |

Adversarial

Pressured

Short term

Contextually specific

Fast moving

Mono ambitious leadership goals

Systemic defensiveness

Threat of external intervention

25. The toxic trio - *Change of leadership*

*- Lack of partnership support*

*- Dwindling resources/financial crisis*

|  |
| --- |
| Toxic trio |

Lethal combination

Overwhelming

Context specific

Co-occurring

A strong partnership could defend against the other two

Strong leadership could defend against the other two

26. Convincing new leadership - *The most crucial of the toxic trio*

*- How to make the compelling case*

|  |
| --- |
| The compelling case for continuation |

Value based arguments

The politics of change

Winning hearts and minds

Evidence of effectiveness

27. Survival - *Keeping the service alive*

*- Protective measures*

*- Keeping going if not thriving*

*- Living through difficult times*

|  |
| --- |
| Survival |

What is lethal to it

What will kill it

A matter of life and death

28. Political - *Moving into or taking a position*

*- Setting a context*

*- Unsettling to create opportunity*

*- Manoeuvring*

|  |
| --- |
| Political |

Providing a rationale for decisions

Laying out the groundwork

Getting a deal done

Gathering support for a viewpoint

Managing expectations

Understanding contextual factors

29. Decision making - *Making a commitment*

*- Signalling change*

*- Confirming direction*

|  |
| --- |
| The unpalatable decision |

Being clear

The end of uncertainty

Taking responsibility

Grasping the nettle

30. Singing the praises - *Realising the benefits*

*- Positive promotion*

*- Celebrating success*

*- Pride at achievement*

|  |
| --- |
| Positive publicity |

A positive story

Something good to say

Demonstrating to the system

Rewarding innovation and effort

31. Trade off - *A political deal*

*- A bargain*

*- Give and take*

|  |
| --- |
| Trade off |

Sacrificed for the bigger picture

A shift in patronage

Managing the political environment

A calculation of competing demands

32. The use of evidence *- Re-evaluated and reviewed*

*- Were key outcomes met?*

*- Contribution to the compelling case*

|  |
| --- |
| The use of evidence |

The compelling case

Comparative data

Local data

Who used it, how, and was it understood?

33. Active support of the steering group - *Finding and replacing champions*

*- Developing and maintaining partner interest*

|  |
| --- |
| Investing in the steering group |

Keeping engaged

Support for another day

Replacing and refreshing

Building relationships

Interview 12

34. Vision - *Seeing the future*

*- Playing for the long game*

*- Strategic awareness*

*- Calculation of factors*

*- The art of the possible*

|  |
| --- |
| Vision |

Bringing people with you

Leadership

Mission and goals

Understanding the aspiration

35. Patronage - *Not worrying about the budget*

*- Taking on battles for the service*

*- Covering*

|  |
| --- |
| Patronage |

Providing political cover

Supporting and enabling

Facilitating within the system

Protecting

Explicit and implicit support

36. Budget planning - *Were the savings going to be realised?*

*- Could the service show this?*

*- The overwhelming context of rising need*

*- Running on the ‘never, never’*

*- Parallel worlds of finance and practice*

|  |
| --- |
| Financial pressures |

Inflationary costs

Austerity

Eyes on the money

Short and long-term pressures

Buying more care placements

37. Baby P case - *System shock*

*- Risk aversion*

*- Crisis and scandal*

*- Corporate anxiety*

|  |
| --- |
| Shift in the national context |

Professional defensiveness

Moral panic

System in crisis

Resources re-allocated

Increase in care placements

Retrenchment

38. The churn *- Rapid change*

*- High staff turnover*

*- Short termism*

*- Instability in organisation*

*- Loss of strategic thread*

|  |
| --- |
| Organisational churn |

Successive change

System in flux

Clinging to the wreckage

Loss of collective memory

Not experienced before

Unstable

Last man standing

Changes in behaviour of leadership

39. Personal connections - *Support based on personal interest*

*- Personal relationships*

|  |
| --- |
| Patronage (2) |

Counter-cultural, against the tide

Protective

Inter-agency alliances forged by personal connection

Strategic safety provided by personal connection to senior leader

40. Social care was in a mess - *Strategic challenges*

*- Chief Executive under pressure*

*- Risk of organisational collapse*

|  |
| --- |
| Deep seated crisis |

Poor showing in performance tables

Pressure from inspectorates

New leaders burned and spat out

Practice not safe

Intransigence of the core problems

Serious financial challenges

41. Budget cuts - *Taking money out of the system*

*- Destabilising social care*

|  |
| --- |
| Budget cuts |

Invidious choices

Threats to progress made

Nowhere else to take money from

Social care seen as overspending not underfunded

Increased demand for high cost placements

42. Staff turnover (supervisor) - *Immediate change*

*- Loss of patronage*

*- Service left unprotected*

|  |
| --- |
| Supervisor turnover |

Known difficulties in replacing

System shock

System manager/holder

Re-consideration of service viability

Difficult post to recruit to

43. Interim leadership - *Short term*

*- Not really fighting our corner*

*- Single agenda*

*- Short time to produce results*

|  |
| --- |
| Interim leadership |

Values not known

Mono-ambitious

Contingent support

Reporting directly to CEX

44. Single leadership *- Too much of me*

*- Too many partners had left*

*- Last man standing*

|  |
| --- |
| Single leadership |

No succession plans

No-one to pass baton to

Personality held network

Hanging on

System left unrefreshed

Sole person left

45. New leadership culture - *Cliques*

*- No longer a part of*

*- New set of relationships*

*- Cultural change*

|  |
| --- |
| New culture |

New alliances

New ways of working

Insider and outsider positions

Different agenda

46. If only… - *Key supporters had remained*

*- It could have been different*

*- The context might not have been so negative*

|  |
| --- |
| The missed opportunities |

If evidence had been understood

If the national context had not changed

If the research had not taken cases away

If distributed leadership had been achieved

If staff had stayed

47. Overwhelming turnover of leaders - *Ninth director*

*- Churn impossible to live with*

*- Exhaustion of successive change*

*- Loss of strategic threads*

|  |
| --- |
| Overwhelmed by context and change |

Change exhaustion/fatigue

Constellation of contextual changes

Too many fronts

Battle weary

48. Failure *- Fear of failure*

*- Fear of association with failure*

*- Tainted*

*- Falling out of favour*

|  |
| --- |
| Failure |

Attribution to individual

Attribution to service

Blaming

Scapegoating

Perception of failure

49. New kids on the block - *Flavour of the month*

*- Celebrated and lauded*

*- Positive publicity*

*- Corporate interest*

|  |
| --- |
| New and innovative |

Internal and external PR

Creating resentment elsewhere

Professional jealousy

New ideas and concepts

Positive for the authority

Interview 5

50. Leadership is key - *Identification of leadership role and value*

*- Relationship to the implementation*

*- Implementation could fail if leadership poor*

*- Leadership essential to implementation*

|  |
| --- |
| Leadership is key to implementation |

Skills required for successful implementation

Appointment of a new leader

Success is not guaranteed

Leadership is essential

Interview 6

51. Strong leadership *- Clear demonstrable support*

*- Right behind it*

*- Not only social care but finance too*

|  |
| --- |
| Strong leadership |

Health a strong supporter

They were right behind it

Corporate and financial support too

Evident, obvious support

Interview 7

52. Senior leadership support - *They wanted it to succeed*

*- They really wanted the service to do well*

|  |
| --- |
| Senior leadership support |

Protected against adversity

Clear about how it supported the authority achieve

Ownership by senior leaders

53. Changes to champions *- Leadership has changed over time*

*- Leadership has been refreshed*

*- New champions have emerged*

*- Champions have been replaced*

|  |
| --- |
| New champions and leaders |

Always someone to take up the reins

Only a small number of people but powerful

Continuation of champions

54. Collaborative leadership for

implementation - *Steering group wanted it to succeed*

*- Don’t tinker with it*

*- No difficult personalities involved*

*- Drive to implement effectively*

*-Desire to get it up and running quickly*

|  |
| --- |
| Collaborative leadership for implementation |

The desire for effective mobilisation

Kept true to the model

Committed partners

Expressed via steering group

The will to succeed

No contrary voices

Interview 8/9

55. Senior commitment - *Chief Officer support*

*- Unequivocal support*

*- Drivers for change*

*- Operationally aware*

|  |
| --- |
| Senior Commitment |

Vision into reality

Operational vision

Tangible, not abstract

Able to apply with examples

Able to take staff with them

|  |
| --- |
| Ability to demonstrate operational application |

Motivating

Explains how it all works

Vision into operational reality

A leader who ‘gets it’

56. Continuity - *Constant interest and commitment*

*- Consistent chair of steering group*

*- Continuous drive*

|  |
| --- |
| Continuity |

No drop in seniority

Consistent

Promotes stability

57. Strong governance - *Steering group*

*- Combines with effective and stable leadership*

|  |
| --- |
| Strong governance |

Firm foundation

Confidence inspiring

Safety and security

Certainty

58. Replacing leadership - *Supervisor was strong*

*- Successor was strong*

|  |
| --- |
| Replacing leadership/succession |

Certainty that the strategy would continue

Impact embedded

Sought new strong leaders to replace

59. Use of academic research - Learning culture

- Academic into practice

- Deliberate policy agenda

- Led by Director

|  |
| --- |
| Translation of academic into practice |

Academic brought in

Underpinned by values and vision

Leadership led

Culturally and systemically supported and enabled

60. Political buy in - *Councillor support*

*- Awareness of the service by Councillors*

*- Understanding of methodology and aims*

|  |
| --- |
| Political buy in |

Alliance

Cultivated understanding

Defence against adversity

Political cover

Civic pride

Patronage

Strong relationship between Directors and Councillors

61. Coherent narrative and vision - *One story*

*- Value infused*

*- Replayed by all*

*- Highly consistent*

*- Fit of MST to value set*

|  |
| --- |
| Clear vision |

Value led

Part of 5-year strategy

Rationale for investment and actions

Known and well-articulated by leaders

**Implementation reflections node**

Interview 1

1. MST was oversold *- MST presented as solving all problems*

*- The reality did not match expectations*

*- Alienation of a disbelieving workforce*

|  |
| --- |
| MST was oversold |

Families continued to require services

The workforce was sceptical and suspicious

Over-hyped and glossy

Not a cure all

2. Relationships - *Professional relationships between social care and MST*

*- Referrals a source of conflict and tension*

*- Relationships with young people changed (youth offending)*

*- Created a sense of loss/change/jealousy/disquiet*

|  |
| --- |
| Relationships |

Competitiveness for referrals

A dogmatic approach created bad feeling

Taking over and excluding from relationships

Pathway for referrals damaged staff relationships

Something valued taken away from staff (youth offending relationship to young person)

3. If I could do it all again - *Learning from experience*

*- Could problem solve earlier*

*- Put strategies in place*

*- Understanding of model strengths and weaknesses*

|  |
| --- |
| Implementation reflections |

Greater system preparedness

Could foresee problems and rubs

Anticipation of difficulties

Hadn’t done anything like this before

This is a large undertaking (scale, magnitude, system change)

Interview 10

4. Peer support - *Absence of peers a key risk*

*- No informal network to access*

*- Soft intelligence unavailable*

|  |
| --- |
| Peer support |

Defence against isolation

Access to problem solving

Opportunity to find out how to get things done

A supportive and helpful network and a shared experience

5. Insecure foundations - *Always playing catch up*

*- Missed a stage of development*

*- Could not recover lost ground*

*- Should have declined application*

*- Efforts to support did not show improvement*

|  |
| --- |
| Insecure foundations |

Weak from the outset

Did not recover

Identified deficits

Significant recovery efforts made

Should have stopped until more support was forthcoming

6. Systems change - *The system must adapt*

*- The manuals are intended to support this*

*- Under estimated system changes needed*

*- Should have been more assertively pushed*

|  |
| --- |
| Systemic change |

Requires assertive leadership

Better understood now as a process

Required for service to flourish

Amount of adaptation required underestimated

Greater awareness of stakeholder issues now

7. Contingent planning - *Need to have a better plan B*

*- Initially naïve about sustainability*

*- Ask the difficult questions earlier*

*- Consider the potential of partnership failure*

|  |
| --- |
| Contingency planning |

Anticipation of system change

Thinking through the end game plan

Not relying upon a single leader

Consider different scenarios such as a stakeholder leaving

Planning for contingencies immediately after implementation

8. Refreshing the system - Re-purposing and refreshing

- Ensuring service relevance

- Maintaining stakeholder engagement

|  |
| --- |
| Refreshing the system |

Maintaining fitness for purpose

Replacing stakeholders

Keeping the system going

Moving towards business as usual (from pilot to project to mainstream)

9. The problem child - *Never flourished or thrived*

*- Consistently worried about*

*- Troubled*

*- Gut feeling, never felt right*

|  |
| --- |
| Never doing well |

Never felt right

Constant battle

Uncertain how best to support

Higher risk profile

No confidence that they would become more stable

Interview 11

10. Communication strategy - *Communicating outcomes*

*- User stories*

*- Research findings (local)*

*- Comparative data*

*- Compelling evidence*

|  |
| --- |
| Communication strategy |

Re- telling of service user stories

Demystifying the methodology

A unifying process for the system

Letting the system know what you are doing

Keeping people informed

|  |
| --- |
| Compelling evidence |

Overwhelming case history

Comparative data to business as usual

Local evidence of outcomes

Research from the USA

Interview 12

11. Attend to the money - *Pay attention to the funding from the start*

*- Make sure that this is understood*

*- Relationship building with finance team*

*- Implicit support garnered from finance team*

|  |
| --- |
| Keeping an eye on the finance |

Keep finance team engaged

Make this a priority from the start

12 Contextual factors - *Could not have seen austerity coming*

*- De-stabilising effect*

*- Rapidity of change*

*- Senior leadership turn over*

*- Stakeholders moved.*

|  |
| --- |
| Contextual factors |

Overwhelming scale and magnitude

Some factors could have been predicted

The turbulence and pressure of change

Some factors could not have been predicted

The requirement to provide services in the face of ever increasing needs

Interview 2

13. A daunting challenge - *Process changes*

*- Adaptation of the system*

*- System preparation*

*- The volume of training and development*

|  |
| --- |
| The implementation challenge |

A large volume of tasks

Complexity and inter relationships

Managing implementation alongside other demands

Interview 3

14. Use of existing infrastructure - *Existing inter agency panel meeting*

*- Amendment and adaptation of process*

|  |
| --- |
| Adaptation of existing process |

Incorporation into existing panel

Low change

Set within existing collaboration

15. Charismatic leadership - *Charismatic supervisor*

*- Knowledgeable and helpful*

*- Draws people in*

|  |
| --- |
| Charismatic leadership |

Able

Gets things done

Brings people along by force of personality

16. Relational aspects of implementation - *Appreciating other agency perspectives*

*- Different ways of working*

*- Not making assumptions of others*

*- Respecting difference*

*- People who get on with each other*

*- Joint oversight and monitoring*

|  |
| --- |
| Relational aspects of implementation |

Multiple perspectives respected

Respectful of agency differences

Good working relationships

Interview 4

17. Political challenge - *Impossible to bring one person on board*

*- Limitation of influencing role within a partnership*

*- Significant blocks could not be overcome*

*- Dominant narrative of implementation*

|  |
| --- |
| Political challenge |

Unable to progress

Tried to work around using the system

Politics a significant barrier

The influence of one senior leader could not be overcome

Interview 5

18. Find people with drive - *Commitment and passion*

*- High value for implementation effort*

*- Risk of failure if absent*

|  |
| --- |
| People with energy and enthusiasm |

Create drive and momentum

Willing the service to succeed

Intrinsically motivated and committed

19. Sustaining commitment - *Stronger at the start*

*- The agenda moves on*

*- Collaboration can wane*

|  |
| --- |
| Sustaining commitment |

Holding people together

The shifting agenda can dis-engage partners

How can collaborative effort be maintained?

20. The implementation template and manual - *Gave clarity of role and purpose*

*- Awareness of system adaptations*

*- Concentrated in right areas*

*- Brought people together*

*- Referral pathway a key theme*

|  |
| --- |
| Implementation template |

Engaged staff and stakeholders

Recognised system adaptation requirements

A helpful process

Paid attention to core processes such as referral pathway

Clear and definitive

21. The value of systemic leadership - Engaging of people

- Does not bulldoze people

- Selling the vision effectively

- Achieving buy in

- Gaining strategic alignment

|  |
| --- |
| Systemic leadership |

Builds support

Engages strategic leaders

Engages practitioners

Turning the vision into practice

21. Knowledge within the system - *Strong knowledge leader*

*- Respected expert knowledge*

*- Listened to*

*- Valued*

*- Able to lead collaboration*

|  |
| --- |
| Expertise within the system |

Immediate credibility

Internal resource

Contribution to system leadership

Interview 7

22. Developing understanding - Should have paid more attention to practitioners

- They didn’t understand what we were trying to do

|  |
| --- |
| Developing understanding |

Engaging the workforce

Explanatory approach

Enabling the system to function

23. An awkward fit with Court Orders - Not as clean a fit as anticipated

- Took time to refine

- Should have allowed more development time

- Knowledge gap of service lead

|  |
| --- |
| A square peg in a round hole |

Needed to work on the fit

Practical application needed adaptation

Required time and trial and error

24. Bringing in an experienced supervisor - *Pre-existing knowledge and skills*

*- Helpful to setting*

*- Obvious advantages*

*- Immediate knowledge gain*

|  |
| --- |
| Importing experienced leadership |

Confidence building

Significant advantages

Load the dice for success

Benefit of experience

Confident interpretation of what could and could not be adapted

25. The model enthuses people - *Creates energy and interest*

*- Is this the model?*

*- Is this because it is a US import?*

|  |
| --- |
| The model enthuses people |

Momentum created

Builds support

Self-generative

26. Multi-agency ownership - *Clear stakeholder support and engagement*

*- Joined up approach*

*- Didn’t feel like it was one service implementing*

*- Implemented for the City*

|  |
| --- |
| Multi-agency ownership of implementation |

Greater than the sum of the parts

No conflicts

All stakeholders participated

Solution focussed approach

For the City

Supported by and exemplified by the steering group

27. The light bulb moment - *Truly understanding the model*

*- Making sense of the core components*

|  |
| --- |
| Epiphany |

From awareness to understanding

Appreciating the evidence

Learning from experience

**Culture Node**

Interview 10

1. Geographical isolation *- Did not undertake booster training jointly*

*- Logistical barriers in the way*

*- Felt like a potential death knell*

|  |
| --- |
| Geographical isolation |

Remote

No network

No balancing perspective

Easy to become self-absorbed in own dynamics

2. Culture and values - *MST fit within a system*

*- How to connect to people’s values*

*- Developing a connection*

|  |
| --- |
| Culture and values |

Connectivity to system

Think as partners do

Motivation

System leadership

3. Proximity *- Being an outsider*

*- Developing a cluster of services*

*- Overcome an insular culture*

|  |
| --- |
| Proximity |

Geographically and philosophically close

Antithesis of isolation

Ideas spread

Strength in numbers

Networked

Interview 3

4. Working together - *Signposting*

*- Joint expertise and experience*

*- Process of actually meeting was important*

*- Building trust*

|  |
| --- |
| Working together |

Shared experience/journey

Generative of good will

Collaboration

The starting point for deeper relationship building

5. Joint work (social care and CAMHs) - *Monthly consultation*

*- Fun, participative*

*- Overcame initial reservations*

|  |
| --- |
| Joint work (social care and CAMHs) |

Clear leadership behind it

Participative

Cultural differences acknowledged

System led

Culture changing

6. Low change - *Use of existing infrastructure*

*- Didn’t have to change a thing*

|  |
| --- |
| Low change to system |

Adaptation of existing referral panel

Changes easer to implement?

7. Working with known professionals - *People I knew*

*- We had worked together before*

*- Experience of joint work already*

|  |
| --- |
| Working within a known network |

Known relationships

Confidence in network

Mutual appreciation

Existing trust

Positive experience of multi-agency working

Inclination to collaborate

Custom and practice

8. Collaboration - *Commit time and effort to understand others*

*- Pushing in the same direction*

*- Promoted this way of working*

*- Mutual respect for skills of others*

|  |
| --- |
| The high collaborative environment |

Normative

The way we work

Relational

People who can get on

Led to work this way

The background that frames the work

Interview 4

9. Cultural dissonance - *Used to doing what young people wanted*

*- Focus of MST on parents*

*- Opposite to the organisation*

|  |
| --- |
| Cultural dissonance |

MST about parental empowerment

Organisational values based on youth advocacy

Clash of values

10. National support for cultural change - *Mixed policy messages*

*- Scepticism of evidence based interventions*

*- Changing policy not seen in commissioning*

|  |
| --- |
| National context for change |

Ambivalent

Sceptical

Yet to translate into commissioning

Interview 5

11. Working to a model - *Brings clarity and logic*

*- Impacts upon staff used to doing their own thing*

*- Is an imposition but that is a good thing for outcomes*

|  |
| --- |
| Working to a model of intervention |

This is the model

Clear expectations

High accountability

No wandering off into other practices

Interview 6

12. Workforce development - Practice values and culture

- Included in recruitment

- Some dissent but mainly positive

|  |
| --- |
| Workforce development |

Continuous effort by Authority

Included existing staff

Practice development in house

Interview 8/9

13. Deliberate intentional approach - Intention to develop MST

- Planned for

- Commitment across the organisation

- Get on with it

|  |
| --- |
| Deliberate intention to introduce an evidence based practice |

System commitment

Making it happen

Effort and attention

Action orientation

14. Academia and practice - Collaboration

- Steeped in academia

- Research focussed

- Continuous development

|  |
| --- |
| Integration of academic into practice |

Masterclasses

Draws staff to Authority

Cultural fit

Inviting academics in to develop policy with Directors

Supported and celebrated by system

**Collaboration node**

Interview 10

1. Testing for collaboration - *Stakeholder engagement*

*- Local partnerships*

*- Single person’s idea or wider?*

*- History of working together*

|  |
| --- |
| Evidence of collaboration |

Partnership assessment

Stakeholder engagement

Track record

2. Established relationships - *People used to working together*

*- People who stay in post for a long time*

*- Appeared to be a strong partnership*

|  |
| --- |
| Established relationships |

Stable partnerships

Platform of relationships

History of collaboration

Permeable boundary between agencies

Concrete examples of collaboration

3. Collaboration with outsiders - *Previous work experiences*

*- Readiness to embrace*

*- Already known to key staff*

|  |
| --- |
| Collaboration with outsiders |

Acceptance into setting

Culturally accepted

Using a pre-existing relationship to build wider collaboration

Interview 11

4. Money on the table *- Drew partners together*

*- Otherwise reluctant partners*

|  |
| --- |
| Money enabled collaboration |

Elicited the interest of partners

A flag of convenience

Brought them to the table

Mercenary

Interview 3

5. Good existing relationships - *Group of three or four colleagues*

*- Thought it would interest all of us*

*- Easy to see benefits*

*- Yes, let’s do it*

*- We were already collaborating*

|  |
| --- |
| Existing relationships |

An existing constituency of interest

Multiple collaborative pieces of work

6. Good collaboration is created *- Previous poor relationships*

*- Determined leadership to improve*

*- Intentional act of leadership*

*- Consultation model promoted collaboration*

*- Improved relationships*

*- Not a social worker we hadn’t met*

|  |
| --- |
| Collaboration is created by leadership |

Strategic agreement to improve

Practice changes

Intentional act

Promoted cultural change (over years)

From mechanistic to natural

Poor collaboration untenable

Cultural respect

7. Benefits of collaboration - *Inspection feedback*

*- Greater than the sum of the parts*

*- Spin off benefits in improved relations*

*- Easier to pick up the phone and have a call*

|  |
| --- |
| Benefits of collaboration |

Genuine partnerships emerge

Inter-agency confidence

Mutual appreciation

Personal interactions

Good working relationships overcame shortfalls in policies and pathways

Interview 6

8. The system values collaboration - *Evidence of leaders working together*

*- Collegial working expected*

*- Evidenced in problem solving operationally*

|  |
| --- |
| System promotes collaboration |

Explicitly valued

Culturally supported

Expected leadership behaviour

**Champion and advocate node**

Interview 1

1. The lonely champion - *CAMHS lost interest*

*- Surprised and disappointed not more champions - Lone voice*

|  |
| --- |
| The lonely champion |

Unable to garner support

Unsupported

Disappointed Lonely

2. The empowered champion - *Promoted*

*- Consolidated power base*

*- Consistently offering support*

*- Offers patronage*

|  |
| --- |
| Empowered champion |

Advocate

System leader

Continued interest

Builds capacity

Interview 12

3. Lost champions - The amount of champions we had lost

|  |
| --- |
| Lost champions |

No bridges of support

Loss of patronage

Loss to system

Energy required to find new ones

Interview 5

4. The champion hanging on - Fearful of non-replacement

- Personal and not system commitment

- Fearful of system collapse if not present

|  |
| --- |
| The lingering champion |

Personally committed

No confidence in succession

Fragility of the system

5. The senior champion - Right behind it

- Maintained interest

- Plans for succession

- Recruits fellow travellers

|  |
| --- |
| Senior champion |

Keeps system going

Replaces with like-minded people

Critically important

**Appendix 5**

**Randomisation of referrals for research**

Only once the new MST services had reached a point of early stability was the process of randomisation for the research trial initiated and this introduced a new set of issues. The reason for including this in this section is because the two Authorities reacted differently to it and there is more than a hint of a potentially corrupting effect in Expanded City which the randomisation may have created, therefore deepening the rifts already opening within the operational system.

Expanded City were one of the first to start the randomisation of cases for allocation and were the first to achieve the numbers required of them in the research cohort. However, as a small authority the service struggled to attract the double number of referrals required so that half of the cases could be allocated to treatment as usual to form the matched control group. Several interviewees recorded their continuing discomfort with the process of randomisation, which, whilst regularly used and familiar in medicine and health, is relatively uncommon in Social Care settings and was certainly novel to most in Expanded City. Certainly it was experienced as damaging to the credibility of the service in the eyes of Social Care by interviewees.

Ethical concerns were raised regarding the legitimacy of randomising cases that involved children and young people. It does not appear that these ethical concerns were addressed head on across the Social Care system in Expanded City other than being raised at the steering group and in dialogue with the research team. One wonders if these concerns had been more actively managed that the service may have restored its reputation or at least enabled objectors to have had their voice heard. Another issue of note is the lack of research methodology training that social workers take during professional training and so unfamiliarity with research ethics is perhaps understandable but it was certainly a block for many.

The MST Supervisor was described as driving the referral process through the force of her personality alone and she could be seen stalking through the Social Care office to

‘Literally harangue people for a referral’ *YOS Psychologist*

in order to get social workers to make enough referrals to the service. Whilst this may have driven the numbers up for the research cohort it may not have built either relationships or consensus. Whilst the Supervisor had some strong supporters who admired her drive and passion she equally had detractors who saw her determination as naked personal ambition or arrogance.

There were several interviewees in Expanded City who said that they felt that the randomisation process (conducted through blind assignment) took some of the most suitable cases away from them and delivered slightly less suitable cases which were not as entrenched in regard to their levels of need. This anecdote appeared particularly in reference to a series of appropriate Youth Offending cases that were all allocated to treatment as usual instead of MST. Of course randomisation is just that and the process utilised was without question blind.

“I think that the pressure that this brought sometimes meant that we were not actually taking the right referrals for the service and then when you did get referrals which were absolutely perfect then you could guarantee that they would go into the control group and not into the MST group and the number of times that we made referrals in and thought that’s a perfect family they will do really well and then (MST Supervisor) would put it into this system to you know get the answer back and ‘it was computer says no’”

*YOS Operational Manager Expanded City*

The myth of randomisation working against the wider interest of the service persisted. It arose again in having compromised the services’ later attempts to develop their own evaluations of cost effectiveness which became an issue when the service was under threat. There was also the view that Social Care were passing cases through for allocation which were much more about neglect than either anti-social behaviour or criminal offending behaviour which was indicative again of the pressures social care were experiencing with cases on the edge of care placement rather than those with a more anti-social or offending presentation.

As randomisation began in Metro City, cases that were referred were clearly marked on the file notes as to what the treatment as usual service route would be if an MST case allocation was not made. This measure may have helpfully reduced the anxieties of the referring Social Worker who would have known that two options, which were both going to offer immediate assistance to the case, were being considered.

“If the family consented and it was randomised then we knew already what the alternative treatment was so there was no delay and that made participation in a randomised control trial easier because again an RCT and randomisation were an alien concept to social care but they were reassured that there would not be delays in the system because they themselves were helping.” *CAMH Director Metro City*

Here the randomising process was not perceived as being controversial. In fact it was seen as beneficial as the Local Authority was taking active steps to align itself more closely with academia and research evidence more widely therefore linking closely with the cultural changes being promoted in the city by the Director of Children’s Services. It is probable, although not known, if the strong involvement of CAMHS may have also brought more managers with knowledge of research to the steering group.

At a point of service maturity, and post randomisation, Metro City interviewees appeared happy with the nature and throughput of referrals. By the time random assignment had been completed Metro City had already committed to the expansion of the MST service as well as to the clinical trial of a new variant of MST for a different referral population (child neglect).

**Appendix 6**

**Narrative descriptions of the Local Authorities**

Isolated Coastal is geographically remote to the rest of the UK and is in one of the poorer areas of the UK in terms of indices of multiple deprivation. It may be perceived as insular in outlook and with few near neighbours. Isolated Coastal serves a quarter of a million residents who are largely settled and immobile. The ethnic composition of the city is predominately white 96.2% (2011 census). The city is based around a historic naval base and a commercial civilian port, which, together with the fishing industry, have been in significant economic decline for many years. There is little by way of new inward investment with the exception of an expanding university campus. Aside from that, the city has not yet found a way to re-invent itself with new industry and opportunities for the local population are limited. Few of the professionals who work in the city live there, with most preferring the large and more affluent County which surrounds it and of which Isolated Coastal was previously an administrative part.

Expanded City is a growing city with a population now exceeding 200,000. Expanded significantly in the post-war era, the City has recently experienced a new period of high growth due in part to inward migration of East European and Commonwealth heritage migrants since the early 2000s. The population is 70.9% White British and 10.6% White European with the BME community representing 18.5% (2011 census). Economic growth has been seen in manufacturing, which has moved out of London, and in new logistics and financial services sectors. This has created both opportunities and pressures for the City on the infrastructure and for the provision of services, not least given the increasing diversity of the population it now serves. Good rail transport links to London make it a sizable commuter city too. Like Isolated Coastal, it was once part of a whole County administration, before determining to split into a new single administration following Local Government Review in 1998.

Metro City is one of the largest metropolitan authorities in England and it serves an urban population of over three quarters of a million. It is a major UK city with two universities and is a well-connected, cosmopolitan city with a clear sense of itself and of its relationship to both the regional and to the national political agenda. Metro City has a history of trade, commerce and heavy industry. There is a large working class population, which includes a sizable, diverse and well-established BME community of almost 15% of the population (2011 census). There are communities with significant need within the city too and intergenerational worklessness and crime have been significant preoccupations for the Local Authority over time. However, the city continues to thrive despite these sizable challenges. Transport infrastructure is good with a mobile population able to easily reach large neighbouring cities and the sizable County it is encompassed by.

**Appendix 7**

**Category synthesis**

8. Collaboration

11. Collaborative history

19. Investment in the system

55. Collaborative leadership for implementation

96. Working together High collaborative environment

97. Joint work

100. The high collaborative environment

107. Evidence of collaboration

109. Collaboration with outsiders

113. Benefits of collaboration

114. System promotes collaboration

2. Leadership

4. Leadership

12. Strategic leadership

51. Leadership is key to implementation

52. Strong leadership Leadership for implementation

53. Senior leadership support

56. Senior commitment

85. Systemic leadership

116. Empowered champion

119. Senior champion

20. Co-occurring factors or events

25. The hostile environment

26. The toxic trio

28. Survival The hostile environment

39. Organisational churn

41. Deep seated crisis

47. Missed opportunities

48. Overwhelmed by context and change

76. Contextual factors

49. Failure

64. MST oversold

68. Insecure foundations Poor adaption to system

72. Never doing well

88. Square peg in a round hole

93. Geographic isolation

101. Cultural dissonance

65. Relationships

67. Peer support Networks of support

95. Proximity

99. Working within a known network

108. Established relationships

111. Existing relationships

29. Political

30. The unpalatable decision Political context

32. Trade off

62. Political buy in

81. Political challenge

110. Money enabled collaboration

15. Being perceived as useful to the system

69. Systemic change

78. Adaptation of existing processes Systemic strengths

86. Expertise within the system

89. Importing experienced leadership

98. Low change to system

14. Risk of single leadership

17. Risk of single leadership

22. High energy leadership Vulnerable leadership

44. Interim leadership

45. Single leadership

79. Charismatic leadership

16. Changes in leadership

24. Changes in leadership Leadership risks

43. Supervisor turnover

60. Replacing leadership and succession

18. Shared ownership

23. Engaging stakeholders Shared ownership

62. Political buy in

91. Multi-agency ownership of implementation

7. Responsibility and accountability

21. Steering group support Governance

34. Investing in the steering group

59. Strong governance

54. New champions and leaders

58. Continuity Refreshing the system

71. Refreshing the system

83. Sustaining commitment

9. Relational aspects of leadership

10. Leadership provides access to others Relational aspects of leadership

80. Relational aspects of implementation

112. Collaboration created by leadership

13. Leadership as patronage

36. Patronage Patronage

40. Patronage (2)

27. The compelling case for continuation

33. The use of evidence The use of evidence

74. Compelling evidence

6. Driving success

82. People with energy and enthusiasm Creating momentum

90. Model enthuses people

33. Financial pressures

42. Budget cuts Budgetary concerns

75. Keeping an eye on the finances

115. Lonely champions

117. Lost champions Vulnerable champions

118. Lingering champion

35. Vision Vision

63. Clear vision

31. Positive publicity Publicity

73. Communication strategy

84. Implementation template Implementing an EBP

103. Working to a model of intervention

46. New culture Doing new things

50. New and innovative

61. Translation of academic into practice Academic into practice

106. Integration of academic into practice

38. Shift in context National context

102. National context for change

5. Demonstrable effort Making efforts

57. Ability to demonstrate application

3. Planned Planning

70. Contingency planning

**Appendix 8**

**Unclustered categories (unused)**

1. Tasks

66. Implementation reflections

77. The implementation challenge

87. Developing understanding

92. Epiphany

94. Culture and values

104. Workforce development

105. Deliberate intention to implement an evidence based practice

**Appendix 9**

**Higher/abstracted categories**

1. The high collaborative environment

2. Leadership for implementation

3. The hostile environment

4. Poor adaptation to the system

5. Networks of support **Major categories**

6. Political context

7. Systemic strengths

8. Vulnerable leadership

9. Leadership risks

10. Shared ownership

11. Governance

12. Refreshing the system

13. Relational aspects of leadership

14. Patronage

15. Use of evidence

16. Creating momentum

17. Budgetary concerns

18. Vulnerable champions

19. Vision

20. Publicity

21. Implementing and evidence based practice

22. Doing new things

23. Academic into practice

24. National context

25. Making efforts

26. Planning

**Appendix 10**

**Coding category analysis by node**

**Leadership node categories**

1. Tasks

2. Leaders

3. Planned

4. Leadership

5. Demonstrable effort

6. Driving success

7. Responsibility and accountability

8. Collaboration

9. Relationship aspects of leadership

10. Leadership provides access to others

11. Collaborative history

12. Strategic leadership

13. Leadership as patronage

14. Risk of single leadership

15. Being perceived as useful to the system

16. Changes in leadership

17. Risk of single leadership

18. Shared ownership

19. Investment in the system

20. Co-occurring factors or events

21. Steering group support

22. High energy leadership

23. Engaging stakeholders

24. Change in leadership

25. Hostile environment

26. Toxic trio

27. The compelling case for continuation

28. Survival

29. Political

30. The unpalatable decision

31. Positive publicity

32. Trade off

33. The use of evidence

34. Investing in the steering group

35. Vision

36. Patronage

37. Financial pressures

38. Shift in national context

39. Organisational churn

40. Patronage

41. Deep seated crisis

42. Budget cuts

43. Supervisor turnover

44. Interim leadership

45. Single leadership

46. New culture

47. The missed opportunities

48. Overwhelmed by context and change

49. Failure

50. New and innovative

51. Leadership key to implementation

52. Strong leadership

53. Senior leadership support

54. New champions and leaders

55. Collaborative leadership for implementation

56. Senior commitment

57. Ability to demonstrate operational application

58. Continuity

59. Strong governance

60. Replacing leadership and succession

61. Translation of academic into practice

62. Political buy in

63. Clear vision

**Implementation reflections node categories**

64. MST oversold

65. Relationships

66. Implementation reflections

67. Peer support

68. Insecure foundations

69. Systemic change

70. Contingency planning

71. Refreshing the system

72. Never doing well

73. Communication strategy

74. Compelling evidence

75. Keeping an eye on the finances

76. Contextual factors

77. The implementation challenge

78. Adaptation of existing processes

79. Charismatic leadership

80. Relational aspects of implementation

81. Political challenge

82. People with energy and enthusiasm

83. Sustaining commitment

84. Implementation template

85. Systemic leadership

86. Expertise within the system

87. Developing understanding

88. Square peg in a round hole

89. Importing experienced leadership

90. The model enthuses people

91. Multi-agency ownership of implementation

92. Epiphany

**Cultural node categories**

93. Geographic isolation

94. Culture and values

95. Proximity

96. Working together

97. Joint work

98. Low change to system

99. Working within a known network

100. The high collaborative environment

101. Cultural dissonance

102. National context for change

103. Working to a model of implementation

104. Workforce development

105. Deliberate intention to implement an evidence based practice

106. Integration of academic into practice

107. Evidence of collaboration

108. Established relationships

109. Collaboration with outsiders

110. Money enabled collaboration

111. Existing relationships

112. Collaboration created by leadership

113. Benefits of collaboration

114. System promotes collaboration

**Champion node categories**

115. The lonely champion

116. The empowered champion

117. The lost champions

118. The lingering champion

119. The senior champion

**Appendix 11 Relationships between key nodes**

**Table 17**

**Relationship between Leadership and Culture by common category**

|  |  |
| --- | --- |
| **Stage one nodes** | **Common categories** |
| Leadership  Culture | Political context  Relational aspects of leadership  Patronage  Use of evidence  Hostile environment  Governance  Refreshing the system |

**Table 18**

**Relationship between Leadership and Collaboration by common category**

|  |  |
| --- | --- |
| **Stage one nodes** | **Common categories** |
| Leadership  Collaboration | High collaborative environment  Shared ownership  Networks of support  Systemic strengths |

**Table 19**

**Relationship between Leadership and Implementation Reflections by common category**

|  |  |
| --- | --- |
| **Stage one nodes** | **Common categories** |
| Leadership  Implementation reflections | Poor adaptation  Budgetary concerns  Creating momentum  Vision  Vulnerable leadership  Leadership risks |

**Table 20**

**Relationship between Leadership and Champions by common category**

|  |  |
| --- | --- |
| **Stage one nodes** | **Common categories** |
| Leadership  Champions | Vulnerable champions  System strengths  Leadership for implementation Patronage  Political context |

**Table 21**

**Relationship to Leadership by category and selected nodes**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Category | Culture Node | Collaboration  Node | Implementation  Reflections Node | Champion  Node | Not relevant to leadership |
| 1 | High collaborative  environment |  | Checkmark |  |  |  |
| 2 | Leadership for implementation |  |  |  | Checkmark |  |
| 3 | Hostile environment | Checkmark |  |  |  |  |
| 4 | Poor adaptation to the system |  |  | Checkmark |  |  |
| 5 | Networks of support |  | Checkmark |  |  |  |
| 6 | Political context | Checkmark |  |  | Checkmark |  |
| 7 | Systemic strengths |  | Checkmark |  |  |  |
| 8 | Vulnerable leadership |  |  | Checkmark |  |  |
| 9 | Leadership risks |  |  | Checkmark |  |  |
| 10 | Shared ownership |  | Checkmark |  |  |  |
| 11 | Governance | Checkmark |  |  |  |  |
| 12 | Refreshing the system | Checkmark |  |  |  |  |
| 13 | Relational aspects of leadership | Checkmark |  |  |  |  |
| 14 | Patronage | Checkmark |  |  |  |  |
| 15 | Use of evidence | Checkmark |  |  |  |  |
| 16 | Momentum for change |  |  | Checkmark |  |  |
| 17 | Budgetary concerns |  |  | Checkmark |  |  |
| 18 | Vulnerable champions |  |  |  | Checkmark |  |
| 19 | Vision |  |  | Checkmark |  |  |
| 20 | Publicity |  |  |  |  | Checkmark |
| 21 | Implementing an evidence based practice |  |  |  |  | Checkmark |
| 22 | Doing new things |  |  |  |  | Checkmark |
| 23 | Academic into practice |  |  |  |  | Checkmark |
| 24 | National context |  |  |  |  | Checkmark |
| 25 | Making efforts |  |  |  |  | Checkmark |
| 26 | Planning |  |  |  |  | Checkmark |

**Appendix 12**

**Reflections on findings and Consolidated Framework for Implementation Research**

|  |  |  |
| --- | --- | --- |
| Construct | Commentary | Relevance |
| **Intervention Characteristics**  ***1A Intervention source*** | As I see it, there are three main barriers that MST has faced in the expansion in the UK. Firstly it is an externally developed and indeed by a non-UK source so it has not been locally created or engineered by local practitioners to solve local problems. Unusually it has been promoted and implemented via two routes, a practice based, or bottom up route, as interested practitioners have sought to implement it and then also via a top down route which has been led by the Department of Health. Secondly it is a licensed programme, which requires a contractual arrangement in order to be able to use it as it has protected intellectual property. Third it is a business, which for some people in the social care sector is pretty much anathema, regardless of the efficacy of it. The driver for the adoption of MST was not led by the social care sector, whose interest has been slow to develop, and not by the Department for Education who have the national policy portfolio for children’s services but by the Department of Health. Interestingly though both Expanded City and Metro City had been aware of MST and had both reached outside of their borders to find out about it before the launch of the funding round.  There were examples of senior leadership implementation support in Expanded City and in Metro City. The critical question suggested by Damschroder is if this was implementation by direct imposition after (Klein, Conn, Sorra 2001, Helfrich et al 2007) given that  “If the decision to adopt and implement is made by leaders higher in the hierarchy who edict change with little user input in the decision to implement and intervention, implementation is less likely to be effective”  Damschroder et al additional file 4 p3 | High |
| ***1B Evidence strength and quality*** | The process of reviewing research evidence of effectiveness was not common in Local Authorities at the time and formal and informal links to academic research have been fairly limited. Since 2007/8 the Allen Review (2011a, 2011b) has led to the creation of the Early Intervention Foundation (2013) as one of the What Works Centres (2013) led by Sir David Halpern. One might argue that even if it was generally available Local Authorities didn’t pick it up that readily. Unlike the NHS where joint academic and clinical appointments are common these bridges have not been made elsewhere. However Expanded City used connections to their neighbouring authority, which had an established MST service. Metro City had also had contact with the MST service connected to Expanded City. They had wanted to learn about the experience and the outcomes rather than to find out about the research underpinning MST. However Metro City also used their connection to the National NHS Lead who was known and trusted as well as the CAMHS Director who did had expert knowledge of evidence-based practice and research. In this way both Expanded City and Metro City were able to use both proxies and connections to others to develop their confidence in the evidence. This appears to be strongly related to the development of the idea that MST was a credible and evidence based intervention. It is not clear if The Hub had had any external experience of MST prior to the bidding round and it may be that as a voluntary organisation they were looking at grant applications rather than for something specifically related to MST. | Medium |
| ***1C Relative advantage*** | There is almost always an advantage in positioning an organisation to receive grant aid. The award of funding created both tangible and non-tangible rewards for the three sites even if this was not always sustained. For Local Authorities the award of competitively secured funding gives political prestige and allows Council Officers to enhance their standing. This may have been short lived though as seen in Expanded City where after the first flush of success the agenda moved on and the attention of senior leaders moved elsewhere.  There was a process of benefit articulation and benefit realisation set out by both the Department of Health and also initially by MST services in regard to how the services would create advantages for families and for the Local Authorities. This was key in generating momentum for the implementation effort. However, some of the promised benefits were not fully realised or acknowledged by the organisations and indeed by the families to whom these accrued. The monetisation of benefits was developed at a later stage and was implicit in the questions related to sustainability later in the journey. For Metro City there was a good sense of how the services had delivered tangible benefits and lasting change. | Medium |
| ***1 D Adaptability*** | The CFIR describes interventions as having a ‘hard core and a soft periphery’. The schematic of the CFIR shows interlocking jigsaw pieces ready to connect to the organisational system, which allows the soft periphery to connect and dock to the system without the hard core being corrupted. This neatly describes the connectivity that an intervention must achieve with the system into which it is placed without compromising the key elements that are central to the fidelity of the intervention.  There is something of an adaptation paradox if it is the case that the more an intervention is adapted and adopted the better it works but the closer to intruding into the hard core elements it gets the more likely it becomes that the service is something other than what was intended. This creates a key risk for the intervention developers for whom the quality assurance processes are designed to be the keepers of the model fidelity. The risk is that the version of the intervention that is procured is the one that has been through the standardisation, research and manual creation process. It could almost be date stamped or given a version control number as the approved version to be used for particular settings. An evidence-based intervention like MST may well be amenable to clinical adaptation and clinical improvement but the parameters for permitted modification are quite narrow and permissions to be creative are largely refused by the model developers. Introducing new elements or restricting others risks creating a localised version which might be more successful and tailored to the context but which may have also unwittingly moved away from the core original model. I think that Metro City understood this well and I was struck by the way in which they described the idea of making it their own, the notion of proprietorial ownership, to take it in oneself, this is how we do business around here, without seeking to change the core requirements.  Several interviewees described a lack of adaptability and modification as a block for them in the evidence based practice environment and it was not clear if they wanted permission to try new things but could not or if they felt that the intervention could be more successful if they were only granted permission to be allowed to make changes. Clearly many senior and experienced managers and clinicians will have experience of developing and improving services and the lack of ability to do so for the whole of the intervention was experienced by some as an explainable and logical frustration although most seemed accepting of the logic of not being allowed to do so.  It may be that in Expanded City there was a failure to adapt the service offer once the research randomisation came to an end. Having experienced the frustrations of cases not being allocated to access the service when randomly assigned it isn’t clear how the service restated itself and the purpose it now had so that it could take the higher need referrals from the social care system and from the youth offending service post the research phase. There were several interviewees who said that the referrals dipped in need and the MST team started taking less serious cases, sometimes from schools directly rather than from social care. | High |
| ***1E Trialability*** | The MST research project that underpinned the MST grant funding was called the START (Systemic Therapy for At Risk Teens) Trial. The name suggests the trial or piloting of an intervention perhaps unwittingly describing something, which is temporary or short lived, rather than something that will become mainstream business. At the very least a pilot can be reversed or stopped if it proves to be ineffective. Was it a trial, a pilot, a project or a new way of doing business for the long term? I think that whilst the intention of the Department of Health was that this would become long term and sustained I think that for the interviewees the status was far less clear and probably shifted as time progressed. I suspect that for some in Expanded City and certainly in Isolated Coastal the professional systems could put up with a project that felt temporary and restrict the amount of long-term support through temporary accommodation of it rather than seeking long-term adaptation for an MST service. It appears to me that there were clear and distinct phases for the implementation journey; pre-implementation, mobilisation, operational start, randomisation/research phase, post research period and sustainability. Isolated Coastal reached the end of operational start and Expanded City reached the post research period. | Medium |
| ***1 F Complexity*** | The concept of complexity is a combination of factors drawn from other frameworks, which describe radicalness, technical challenges, scale and magnitude. Damschroder draws on the work of (Edmondson et al 2001) to distinguish between what might be described as a ‘plug in’ technology, which requires little adaptation of systems, and what might be a larger scale and more fundamental set of change processes. Edmondson et al found that those who regarded the change as simply a ‘plug in’ did not create successful implementation compared to those who took a broader and more system wide approach.  In Metro City the implementation and adoption of MST was part of a system wide and value led change process. The system clearly adapted so that it could facilitate the most favourable conditions for MST to flourish. In Isolated Coastal the team was seen more as a ‘plug in’ insofar as it was left trying to connect itself into the Local Authority that didn’t really want it and largely refused to adapt to allow it to work. I think that there is a clear risk here in how organisations in the current commissioning climate think that buying a better ‘product’ and assuming that it can be introduced and work well and deliver desired outcomes, particularly for outcome based contracts, may take a ‘plug in’ approach and disregard the system adaptations required to facilitate the effective functioning of it. The great risk being that by poorly implementing a recognised programme it is the programme and not the implementing system, which will be traduced if the programme is not successful.  There is also something about the scale of the challenge of implementation of MST in that it required a fairly small team of people to work in very different ways and under an operating model, which made a large difference to them. Unlike a new computer system for an organisation that everyone has to learn to use or an office move to a new location, the amount of impact on most of the staff in all of the sites was reasonably limited. However the changes that the system needed to make to adapt and to maintain the vitality and functioning of the service made a lot of difference to the team. Whilst the leadership could hold these pathways and doors open for the teams to operate then all was well but if the system was allowed to interrupt or close these openings then the teams were in trouble quite quickly.  In Expanded City the succession of senior managers and interim Directors may not have grasped the complexity of the operating systems in which MST was delivering and the interdependencies, nor their role in it to facilitate the operating conditions which it needed to have in place. However, one should not underestimate the challenges that these roles faced across a whole system and the multiplicity of issues to deal with over short time spans. | High |
| ***1 G Design quality and packaging*** | The way in which MST was presented as a package of tools is impressive. There is a comprehensive clinical manual, job templates and competency standards are set together with the ‘’Goals and guidelines’. The orientation training is delivered on site and the quality assurance processes are robust and long lasting. There were some interviewees who were put off by the way in which MST was packaged and then sold. This may be as much a cultural issue as one of style or values. However interviewees continued to remark on the transactional nature of MST as something that was for sale in the marketplace. | High |
| ***1 H Cost*** | Determining the cost of an MST team is quite easy if one can determine the team costs and the licence costs. The ability to make good quality evaluations of comparative costs in a Local Authority setting can be difficult due to the way in which service budgets are constructed and the manner by which corporate overheads are met. This can make the apportionment of costs for different services harder to evaluate with certainty. Because of the explicit nature of the licence agreement with each service, which sat on top of the MST Team, the services inevitably stood out as being expensive when compared to a family support team or a social work intervention. So it is little wonder why successive service Directors in Expanded City would look at the service and assume that it was expensive.  Over the last 20 years there has been increasing interest in cost benefit analysis of services (Aos et al 2001), which attempt to take an economic appraisal of inputs, outputs and outcomes for services. These can ascribe values to services in terms of costs avoided compared to the costs committed to running services and can be extremely helpful in developing both financial arguments and notions of the effectiveness of services. Sometimes though the sophistication of the methodology and the assumptions made in an economic analysis are reduced to a single ratio of £1 to benefit that risks being decontextualised and used inappropriately. | Medium |
| **Outer Setting**  ***2 A Patient needs and resources*** | The majority of interviewees viewed MST as highly engaging of families and clinically strong in how interventions were delivered. In ‘The Hub’ there was consternation that MST ran across the values of the organisation as being based upon advocacy of the young person and elsewhere there were questions raised in regard to the level of direct engagement with young people. The MST methodology is centrally focussed on parenting capacity and can operate with partial or highly limited interventions with the young person themselves. For some this was initially counter intuitive and certainly very different to the individualised approach most services took with young people such as the Youth Offending Service where a Court order is made against a young person and not for the whole family (although it is possible to make a parenting order to support mandating an intervention with parents). For Damschroder, this concept describes ‘patient-centeredness’ and places it as highly related to successful implementation and adoption of an intervention. | Medium |
| ***2 B Cosmopolitanism*** | This concept describes how well an organisation is networked with an external network of organisations. This is also described as the amount of social capital available through a number of different dimensions.  ‘Each individual’s relationships with other individuals both within and outside of the organisation represent that individual’s social capital. In turn, the collective networks of relationships of the individuals in an organisation represent the social capital of the organisation’ Damschroder Additional file 4 p6  It appears that in Isolated Coastal the available social capital was extremely limited. The opportunity to develop a network of support within the MST community was frustrated by geography. There were few, if any supporters of ‘The Hub’, which could have assisted in developing better relationships with Isolated Coastal despite the efforts of the National Lead to provide a supportive voice. The contrast with Metro City is in stark contrast with a highly networked and cosmopolitan outlook and well connected Local Authority reaching out to academic institutions, regional networks, national bodies and central government whilst internally holding strong relationships with Health in particular.  In Expanded City there were some obvious strengths here and the Supervisor in particular was able and confident in her networks of support with her own national profile and published work. The difference in Expanded City being that she lacked critical mass within her own peer group and network. Her own internal network was weakened by the successive loss of key supporters and rapid turnover of those senior managers whom she had sought to cultivate and find common cause with moving on and not allowing stability to be achieved.  The relational aspects of the implementation process start to become clearer through the application of this concept to the research material gathered. | High |
| ***2 C Peer pressure*** | This concept describes the pressure to adopt an intervention where there may be a market position or competitive reason to do so. Certainly Metro City was on a journey towards improvement of its services and in Expanded City the adoption of MST was in contrast to an otherwise moribund children’s services department. Both areas had sought opportunities to learn more about MST and had made contact, sought information from or visited one of the three existing MST sites in the UK at the time before the funding round was announced. For ‘The Hub’ there was strategic interest by the Manager in developing a broader portfolio of services with a more mixed economy and less reliance on a handful of large contracts so the pressure was less peer led but about organisational stability. | Low |
| ***2 D External policies and incentives*** | The availability of grant funding and also support being offered from the Department of Health was a significant inducement to Local Authorities to embrace the opportunity to implement MST. It was not a government mandate to do so but was certainly positioned by the Department of Health as a leading practice that forward thinking Local Authorities might aspire to be delivering. | Low |
| **Inner Setting**  ***3 A Structural characteristics*** | Damschroder builds this concept using Damanpour’s (Damanpour 1991) research into organisational innovation. It appears that in Metro City the critical mass that emerged as the service expanded into three MST teams and then to five, including the two new variants, significantly bolstered and secured the future of the service. Moving beyond implementation phase only Metro City moved to create a Programme Manager role as a senior management position, elevating a supervisor (clinical psychologist) to hold an overarching management function for the services across the City. | Low |
| ***3 B Networks and communications*** | This concept seeks to describe the formal and informal communication within and organisation. The scope is very wide in that is encompasses the complexities of large multi-layered organisations not only in terms of communication but also in terms of overt and covert power and authority, formal and informal networks and inter relationships between individuals, teams, departments and services. It is neither intended nor possible to entirely deconstruct an organisation of the size of a Local Authority but it is recognised that a number of systems will interconnect, formally and informally, functionally and dysfunctionally. From the way in which decisions are made through the democratic and political processes led by Councillors to the way in which department priorities are set and delivered by Council Officers and strategic managers to the individual interactions between team members.  In Metro City there was a definite sense of a clear line of strategic vision, underpinned by an agreed set of values was being delivered more or less successfully. At least every interviewee in Metro City was able to cite the vision and various measures and steps being taken by the Local Authority towards achieving this. There was a confidence in the relationships between the interview participants in which trust and common purpose could be detected. In Expanded City there was no clear strategic view other than to seek to survive the operational churn and to arrive at a period of stability and certainty. In Isolated Coastal it appeared that the Local Authority was retrenching in the early response to the austerity agenda and was closing itself off to participation with partners to concentrate on statutory work only. There was evidence of poor internal communication at the time of the MST service closing cited by The Hub Manager. | High |
| ***3 C Culture*** | Damschroder acknowledges that culture is hard to define and measure or evaluate but is convinced of its relevance to implementation and innovation. The culture in Metro City appeared to be positively orientated towards achieving good quality of services and to base this within a context of effectiveness of interventions with good use of outcome data. One interviewee was attracted to work for Metro City explicitly because of the culture that existed there. Another interviewee described a Metro City way of doing things, which perhaps demonstrates a pervasive culture that he and others would be able to recognise locally as being distinct from elsewhere. The CAMHS Director in Metro City described how determined efforts by him and the Social Care Director had changed a negative culture into a positive one between CAMHS and Social Care, reminding me that culture is not set but malleable and liable to manipulation and change.    The culture in Expanded City may best be understood in the context of rapid change of leadership and a consistently poor performing social care department which appeared impervious to change and was culturally perceived of as either ineffective or teetering on the edge of going into special measures. Throughout, a powerful Chief Executive appeared as a dominant figure in the Authority. | High |
| ***3 D Implementation Climate*** | Damschroder seeks to develop the concept of implementation climate across 6 sub-categories as a way of acknowledging the wide definitions used in the literature building on previous definitions and descriptions (Klein and Sorra 1996, Greenhalgh 2004) | Low |
| ***3 D 1 Tension for change*** | Both Metro City and Expanded City reported a tension for change within their Authority. For Expanded City this was driven by the perceived long-term failures of the children’s services department. In Metro City this was in an acceleration of an initial foray into evidence-based practice following a poor inspection and a new value driven approach through new strategic leadership. In Isolated Seaside there did not appear to be a strong tension for change other than an external desire to innovate into a system, which was widely perceived of as struggling with the levels of demand and deprivation. | Low |
| ***3 D 2 Compatibility*** | Damschroder describes this as  ‘Degree of tangible fit between meaning and values attached to the intervention by involved individuals’ Ibid  This can certainly be determined from the participants whom were interviewed both as they described their own values and also the values of others, both positively and also negatively when this was absent. This does appear to have been a motivating factor for those who wanted to implement MST. | Low |
| ***3 D 3 Relative priority*** | In Expanded City there was a palpable sense of the priority afforded to the initial implementation effort with the Chief Executive driving this forwards and also facilitating the environment to enable the service to quickly reach a point of functioning. This support diminished over time but for a brief period was clearly in place. In Metro City there too was agreement that this implementation effort was very much ‘the day job’ and not a distraction from it. In Isolated Seaside it was a priority only for the delivery agency and not for the Local Authority. | Medium |
| ***3 D 4 Organisational incentives and rewards*** | There was some association with organisational incentives and rewards to achieve the implementation although most of the rewards came in the form of more intangible benefits such as positive internal and external media rather than direct financial rewards which are less common in the UK than in the US. Some staff were able to travel to conferences and trips with would not normally have been funded. There was some push back against the seemingly elite status and salary payments being made to the teams in both Expanded City and Metro City. | Low |
| ***3 D 5 Goals and feedback*** | This took several forms in regard to the MST Teams and each of these related to each other. Firstly there was internal feedback from the Local Authorities concerning the way in which the services were developing, taking referrals and being seen as useful or not by the professional system. Secondly there was the external validation, feedback and performance monitoring which the MST Consultant provided as part of the MST quality assurance process. Third was the role of the National Lead who held the contract with MST Services and whom saw all of the performance data. Fourth there was the steering group of partners who had oversight of the local implementation. At times there were tensions between these four overlapping systems, often regarding the interpretation and meaning of the data being generated. | Low |
| ***3 D 6 Learning climate*** | It appears that only Metro City has developed a strategy that embraced and sought to promote a learning climate. The introduction of organisational learning events, practice leads in Social Work Teams and the drawing in of academics to work directly with strategic managers to develop a common set of values and policy was a strong step in this direction. It was described how over time the venues, which were hired for the learning events and master classes, had to increase in capacity to cope with the rising attendance. Indeed the learning climate of Metro City became a draw for prospective members of staff. | Medium |
| ***3 E 1 Leadership engagement*** | In undertaking the fieldwork I have found leadership to be highly relevant to the implementation experience and not only at a strategic level but also at a middle management level too. This will be expanded upon later. | Highly |
| ***3 E 2 Available resources*** | The availability of resources, financial, physical, time and attention have all played a part in the implementation journeys in the fieldwork. Whilst highly important, money was not the only factor in this to secure the sustainability or otherwise of the services, as was shown in Isolated Coastal, when they collapsed the service before the grant was exhausted. | Medium |
| ***3 E 3 Access to knowledge and information*** | The ‘Goals and Guidelines’ required all areas to hold a launch event and to pay attention to stakeholder learning in order to secure their engagement and understanding of the model. There was a sense that this was a large undertaking for each area and one that was not a single event but a continuous process of reinforcement and repeat, given the turnover of staff and also the need to keep the knowledge of the model high in order to secure referrals. All areas recognised that they needed to achieve a good general awareness of the model in their area with a sharper focus and specific and detailed awareness by those who were making referrals or acting as decision makers or gatekeepers. | High |
| **Characteristics of Individuals**  ***4 A Knowledge and beliefs about the intervention*** | Damschroder describes the ‘skilled and enthusiastic use of the intervention’ as key to the implementation. However she acknowledges that how much this of itself can carry a wider team, service or organisation is harder to define. Certainly all of the interview participants described the MST Supervisors and Therapists as being committed to the model and to being strong advocates of it throughout. Indeed it would be hard to carry on for long as a Supervisor or Therapist if one had substantial doubts about its efficacy or sought to put up resistance to the operating methodology if the quality assurance process was operating effectively. The interview process is designed to select out those who are not likely to achieve good compliance.  I am interested in how motivating belief is and specifically asked about as an interview question so report further on this in the findings. | High |
| **4 B Self efficacy** | Further to belief, self-efficacy is a descriptor of the willingness to use the intervention as it is described, with confidence and ability, even in the face of obstacles. I think that in the great majority of circumstances the MST Teams throughout demonstrated this although I did not get into the case details, which may have revealed more about this construct. I have a reasonable confidence that the MST intervention is supportive of Therapists to achieve a good level of self –efficacy. | Low |
| ***4 C Individual stage of change*** | This construct is a measure of individual progress towards self-efficacy and competence and confidence in an intervention methodology. I have nothing from the interviews that describes this. | Low |
| ***4 D Individual identification with the organisation*** | This relates to how individuals identify with the organisation. There are strong hints in the interviews about the MST teams being internally bonded and self-supporting but often feeling counter-cultural within their own broader organisational setting. In Isolated Coastal this was clear from the start, even to some extent within ‘The Hub’. In Expanded City this was the case once the strategic agenda had moved away from the team. In Metro City their were efforts made for evidence based interventions to be one of the defining characteristics of Children’s services although even here there was a sense of the ‘otherness’ of the MST teams compared to the mainstream social work offer. | Medium |
| ***4 E Other personal attributes*** | This is not well defined but relates to any other personal attributes, which may have been contributive to the implementation effort. I think that I might add in loyalty, personal sense of mission, a desire to innovate, determination and the desire to act collaboratively as additional features here. | Low |
| **Process**  ***5 A Planning*** | There is little doubt that the MST roll out was highly planned and structured with a clear template, tools, support advisers, finance and a contract with MST Services. The process had been tried internationally and in different settings in the UK with, at this point three services, up and running successfully already. There was an expectation that it would be hard work to set the 10 new sites up but it wasn’t anticipated that any of the sites who had willingly applied to take part in the pilot might not succeed in sustaining the intervention in the long term. It is hard to judge retrospectively if more planning might have reduced the likelihood of failure. Certainly at this point the experience of the 10 site roll out has developed a far more sophisticated understanding of some of the causes of the failures and these learning points can build a more experienced planning instrument. I will argue that these are more relational in their form than a series of points on an implementation plan or Gantt chart. | Medium |
| ***5 B 1 Opinion Leaders*** | The sites all had strong opinion leaders and the greatest constellation of these was in Metro City. The negative opinions of the Director in Isolated Coastal were also relevant to the experience there. This construct largely seeks to find positive opinion leaders who can inform and influence beliefs and attitudes towards the intervention. The battle for ideas has been an important theme of the findings | High |
| ***5 B 2 Formally appointed internal implementation leaders*** | The formally appointed internal implementation leaders all strove to implement the services. | Low |
| ***5 B 3 Champions*** | The emergence of champions in Metro City took place through the hierarchy but was formally led by the system leaders. The support of operational managers who were clearly motivated by the intervention was key to achieving operational stability and acceptance of the intervention. The transitory nature of the champion Chief Executive in Expanded City is an interesting dynamic. The lack of champions internally in Isolated Coastal was a striking weakness | High |
| ***5 B 4 External change agents*** | The Department of Health lead, the MST Services staff, Sector Advisers and Government Office all acted in this capacity but the most impactive was without doubt the Department of Health Lead | Medium |
| ***5 C Executing*** | The execution of the implementation template established by MST Services was generally well supported and managed to get all services to the point of operation. It challenged all sites to a greater of lesser extent but was a system strength. | High |
| ***5 D Reflecting and evaluating*** | Attempts by Isolated Coastal and Expanded City to use evidence to inform their setting about the outcomes being achieved were made but not successfully so. This was frustrated by the lack of opportunity to do so as much as by the readiness of the systems to listen to and reflect upon the evidence which was presented. Metro City undertook large scale professional development to seek to encourage the system to be more influenced by research evidence and feedback. Significant further work is probably required in social care settings to advance this aim more broadly. | Medium |

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