

Exploring the tension between adherence and cultural fit
when delivering Multisystemic Therapy in England

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Abstract

Multisystemic Therapy (MST) provides intensive short-term interventions for young people with antisocial behaviour and the systems that surround them. A wealth of research over the past 30 years has demonstrated the efficacy of MST. Its success has led to it being transported to many countries and this prompted investigations into the need for cultural adaptation. Despite these investigations highlighting the importance of tailoring MST to new countries, when MST was transported to England in 2001, it did not undergo a formal process of cultural tailoring.

This study employed a qualitative approach using a Grounded Theory methodology to explore the assumption that all transported programmes require a level of adaptation and aimed to identify the processes and rationale behind informal 'cultural tailoring' undertaken by therapists. It aimed to explore areas in MST that might benefit from 'cultural tailoring' to improve the effectiveness of its implementation in England. Eight MST therapists from across three MST teams in England participated in semi-structured interviews.

Analysis of the data generated a theoretical model of adherence: the Post Implementation Model of Adherence (PIMA). The PIMA model seeks to explain how therapists in England experience and manage adhering to MST. It proposes that MST therapists strive to adhere to all aspects of the MST model whilst ensuring that it is acceptable and workable for the families and systems they work with. The PIMA model comprised four theoretical codes: Facilitators to therapists staying faithful to the MST model; barriers to therapists implementing MST, overcoming barriers to implementing MST; and the therapist holding the tension.

The findings highlight important cultural adjustments to improve MST's 'fit' in England. Findings also extend Schoenwald's (2008) recommendations for successful transportation of MST, by drawing attention to how a lack of cultural tailoring can be overcome or experienced as stressful by therapists.

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Chapter 1: Introduction

1.1 BACKGROUND

There is a move towards evidence-based practice in the UK, driven by the belief that it will deliver on outcomes and be cost-effective (Cabinet Office, 2001). However, the effectiveness of these interventions can often be compromised when they are disseminated under less controlled conditions in the community (Durlak & DuPre, 2008). Implementation factors are likely to have even more impact when evidence-based programmes are transported out of their country of origin (Tobler & Stratton, 1997). To preserve the effectiveness of evidence-based interventions, protocols have been developed that attempt to balance adhering to the core principles of the programme (to keep the parts that have been shown to work) with making adaptations to ensure fit with the specific needs of the new country or context (Backer, 2002; Kumpfer, Pinyuchon, de Melo, & Whiteside, 2008). There is considerable variation in the extent that adherence or adaptation is prioritised when interventions are transported. Where there is a focus on adherence, it is not known how differences in the new country that do not fit with the model are managed.

1.1.1 Multisystemic Therapy (MST)

MST was developed by Scott Henggeler and his colleagues in the United States in the late 1970s (Ashmore & Fox, 2011). It is an intensive, community-based treatment for adolescents, addressing family conflict, antisocial and criminal behavior by working with the parents and young person. It is designed to specifically support young people at risk of 'out of home' placement as this was deemed by Henggeler as a need inadequately met by traditional services (Ashmore & Fox, 2011). The consistently positive results obtained by randomized control trials (RCTs) of MST in the United States sparked interest internationally and between 2002 and 2009 MST was transported and RCTs were completed in Canada, Norway and Sweden (Leschied & Cunnigham, 2002; Ogden & Halliday-Boykins, 2004; Sundell, Hansson, Lofholm, Olsson, Gustle, & Kadesjo, 2008). MST currently has sites in Australia, Belgium, Canada, Chile, Denmark, Iceland, Northern Ireland, Netherlands, New Zealand, Norway, Sweden, Switzerland, Scotland and England (MST Services, 2010a). MST was introduced in Cambridge, England in 2001 (Butler, Baruch, Hickey, & Fonagy, 2011). Whilst adaptations have been made in the other countries that have implemented MST, there has been no formal adaptation process in England (S, Butler, personal communication, September 4, 2012). All the countries that undertook an adaptation process identified a range of cultural differences requiring consideration to ensure a good 'fit' between the programme and the new country (Schoenwald et al., 2008). This prevalence of country-specific adaptations suggests that similar questions around fit are likely to apply in England.

1.1.2 Aims of this study

This study aims to identify the areas in MST that may need adapting or have been informally adapted for England. It also aims to develop an understanding of the processes that MST therapists use to inform whether and how to adapt the programme. The following section provides an overview of the adherence and adaptation literature, followed by a review of the research into adherence in MST. A review follows of the evidence for considering culturally adapting MST for England, ending with an introduction to the aims and objectives of and rationale for, the current study.

1.2 ADHERENCE AND ADAPTATION

1.2.1 Adherence

Backer (2002) defines programme adherence as “the degree of fit between the developer-defined components of a ... program and its actual implementation in a given organizational or community setting” (p13). Whilst there are a number of words used to describe this process, including fidelity and integrity, this paper will refer to the concept as ‘adherence’. Adherence promotion has developed to combat implementation factors that reduce effectiveness, particularly when models are transported to new countries (Tobler & Stratton, 1997). Programme developers have devised strategies for maximising adherence. This is based on the assumption that practitioners should be aiming for 100% adherence to the model and intervention (Hutchings, Gardner, & Lane, 2004). This is the perspective of the developers and transporters of MST (Henggeler, 2011).

It is rare, if not impossible, to achieve full adherence to the model. In a review of 500 studies outlining the implementation of promotion and prevention programmes, there

was not a single example of a programme that was able to achieve 100% adherence (Durlak & DuPre, 2008). This indicates that some degree of deviation from the model may be inevitable. A further problem in using adherence to combat implementation factors is that it does not account for different populations having differing needs. Therefore, an over-emphasis on adherence may lead to local resistance or reduced effectiveness (Backer, 2002).

1.2.2 Adherence versus adaptation

Backer (2002) defines programme adaptation (or 'fit') as a modification to the programme. It can be deliberate or unintended and includes additions, cutting or changing components, changes to how the programme is administered and cultural modifications. Historically the literature has pitched adherence and adaptation at opposite ends of a continuum (Schoenwald & Henggeler, 2000; Clarke, 1995). More recently a more complicated picture has emerged, with conflicting evidence that positive outcomes can correlate with adaptations (Ferrer-Wreder, Sundell, & Mansoor, 2012) but also that high adherence can correlate with positive outcomes (Henggeler, 2011). Indeed even within the same interventions, the combination of high adherence and high adaptation have been linked to positive outcomes (Durlak & DuPre, 2008).

1.2.3 Balancing adherence and adaptation

Rather than adherence and adaptation being opposite ends of a continuum, Durlak and DuPre (2008) argue that an effective intervention should have an optimal adherence-adaptation balance. Backer (2002) describes the adherence-adaptation balance as "a dynamic process, often evolving over time, by which those involved with implementing a science-based ... program address both the need for fidelity to the original program and

the need for local adaptation” (p14). Despite acknowledging that a consideration of both adherence and adaptation can improve outcomes, Castro, Barrera and Martinez (2004) argue that when a model is transported, there is an inherent tension between the desire for model fidelity and the desire to adapt the programme to ensure cultural fit. Kumpfer and colleagues (2008) argue that, researchers should identify examples where evidence-based programmes have been adapted and the process and rationale behind these adaptations. There should then be a cyclical process of evaluation and adaptation so that the programme continues to evolve to meet the needs of the host community. These adaptations should not include the core principles of the model.

1.2.4 Maximising programme effectiveness

To maximise a programme’s effectiveness, it can be argued that it is necessary to develop a model to achieve the optimal adaptation-fidelity mix (Kumpfer et al.,2008). Protocols have been devised to identify necessary adaptations that will not compromise adherence to a programme’s core principles (Backer, 2002; Ferrer-Wreder et al., 2012; Kirton & Thomas, 2011; Kumpfer, Pinyuchon, de Melo, & Whiteside, 2008; Lee, Altschul, & Mowbray, 2008). Of the various protocols proposed, the Strengthening Families Program Adaptation Model is described in more detail as it applies to international transportation rather than adapting for different cultural groups locally; it continues to adapt and review at points post-implementation where other protocols focus more on considering adaptation before a programme has been implemented; and it incorporates working closely with clinicians to evaluate and improve outcomes (Kumpfer et al., 2008). These were considered important factors, as the current study considers the international transportation of MST to England and whether MST should be adapted at a

point after it has been implemented in the host country, based on clinician's experience and feedback.

1.2.5 The Strengthening Families Program Adaptation model

The Strengthening Families Program Adaptation Model is a nine-step protocol. The first step involves conducting a needs analysis of the proposed population relating to problem behaviours and risk. This 'needs analysis' informs the selection of the most appropriate evidence-based intervention from a range of potential interventions. Once an intervention is chosen, minor changes are made to program materials focussing primarily on translating language and using culturally appropriate examples. The emphasis is to implement the programme "*as written*" without significant cultural tailoring (Kumpfer et al., 2008, p.231). At this stage the program should be piloted with a sufficient level of support to ensure implementation is delivered with high adherence and to a high standard. The program, its support structures and strategies for engaging client families are continuously reviewed and adapted throughout the piloting process based on feedback from client families and team leaders. Throughout the process an external agency evaluates the implementation process using the 'empowerment evaluation framework' (Fetterman, Kaftarian, & Wandersman, 1995). The evaluators collaborate with clinicians; clients and other stakeholders to further adapt and improve programme implementation. The final step involves disseminating a report of the effectiveness of the culturally adapted version of the program. This contributes to an evidence base of the impact of different cultural adaptations, whilst providing a more comprehensive picture for the evidence base for the Strengthening Families Program (Kumpfer et al., 2008).

1.2.6 MST's implementation in England

MST is an example of an intervention that has been transported from the US to England. It has not undergone an adaptation process to ensure cultural fit and has a strong emphasis on adherence. It also emphasises that therapists are responsible for engaging families and “overcoming barriers to successful outcomes” (Schoenwald & Henggeler, 2000, p85.). This implies an element of cultural adaptation to engage families might be appropriate at the therapist level. This study aims to understand how MST therapists in England have managed the tension of prioritising adherence, with achieving the flexibility required to meet the, possibly different, needs and expectations of families and systems in England. It also forms part of the continuous process of evaluation recommended by Kumpfer and colleagues (2008).

1.3 MULTISYSTEMIC THERAPY

In addition to the following description of MST, a glossary of key terms can be found in Appendix A. MST (Henggeler & Borduin, 1990) takes a socio-ecological perspective in supporting young people with serious antisocial behaviour. MST offers intensive short-term intervention for young people exhibiting serious antisocial behaviour and the systems that surround them. This is primarily their family but also other relevant services or individuals such as their school or peers. MST aims to improve the young person's behaviour and prevent further offending (Tighe, Pistrang, Casdagli, Baruch, & Butler, 2012).

1.3.1 Theoretical rationale

MST is founded on the principles of social ecology, which understands human behavior as being determined and influenced by the various systems and contexts within which

each individual operates (Bronfenbrenner, 1979). MST suggests that a young person's antisocial behavior is linked to their own characteristics and their family, peers, school and community contexts (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009). Therefore, MST interventions aim to reduce antisocial behavior by working with families to build strengths across these contexts using an individualised and comprehensive format. The majority of the therapy is carried out with the client family in the community in order to overcome the barriers to accessing services that are often experienced by families, who may be more likely to experience social exclusion (Henggeler et al., 2009). The caregivers are assumed to be the key to long-term positive outcomes for the young person and MST focuses on building strengths and skills within the families to ensure the benefits can be generalised and sustained once the intervention has finished.

1.3.2 The MST principles

The development and implementation of MST is underpinned by a set of nine treatment principles. Table 1 briefly describes each principle. The principles are designed to be able to be universally applied to families and aim to support therapists in conceptualizing a client's situation and difficulties, selecting the most appropriate intervention and also in deciding how best to prioritise work with the client family (Henggeler et al., 2008).

Table 1

The nine treatment principles of MST (Henggeler et al., 2008. p.23)

1. The primary purpose of assessment is to understand the fit between the identified problems and their broader systemic context.
2. Therapeutic contacts emphasize the positive and use systemic strengths as levers for change.
3. Interventions are designed to promote responsible behavior and decrease irresponsible behavior among family members.
4. Interventions are present focused and action oriented, targeting specific and well-defined problems.
5. Interventions target sequences of behavior within and between multiple systems that maintain the identified problems.
6. Interventions are developmentally appropriate and fit the developmental needs of the youth.
7. Interventions are designed to require daily or weekly effort by family members.
8. Intervention effectiveness is evaluated continuously from multiple perspectives with providers assuming accountability for overcoming barriers to successful outcomes.
9. Interventions are designed to promote treatment generalization and long-term maintenance of therapeutic change by empowering caregivers to address family members' needs across multiple systemic contexts.

1.3.3 The analytical process

The analytical process (see Figure 1 below) is designed to support therapists in formulating a client family's problems, including what may have caused them and what might be maintaining them. The process also guides the development, review and refinement of strategies for overcoming the problems through the use of intermediary and overarching goals, arrived at collaboratively with the client family (Henggeler et al., 1998). The analytical process is known informally within MST as the 'do-loop' (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009).

The analytical process draws from a number of other processes specified by the MST model. The 'fit' forms part of the analytical process and also is drawn from the first of the MST nine principles (Henggeler et al., 2009). Therapists and families collaborate to develop a shared understanding of each of the problem behaviours. This is known as a 'fit'. Each fit is drawn from a brainstorming session between therapists and families where hypotheses about what might be 'driving' or causing behaviours are generated. The 'drivers' identified are then prioritized and addressed and the 'fits' are reviewed and modified and new 'fits' generated as work with the family progresses (Henggeler et al., 2009).

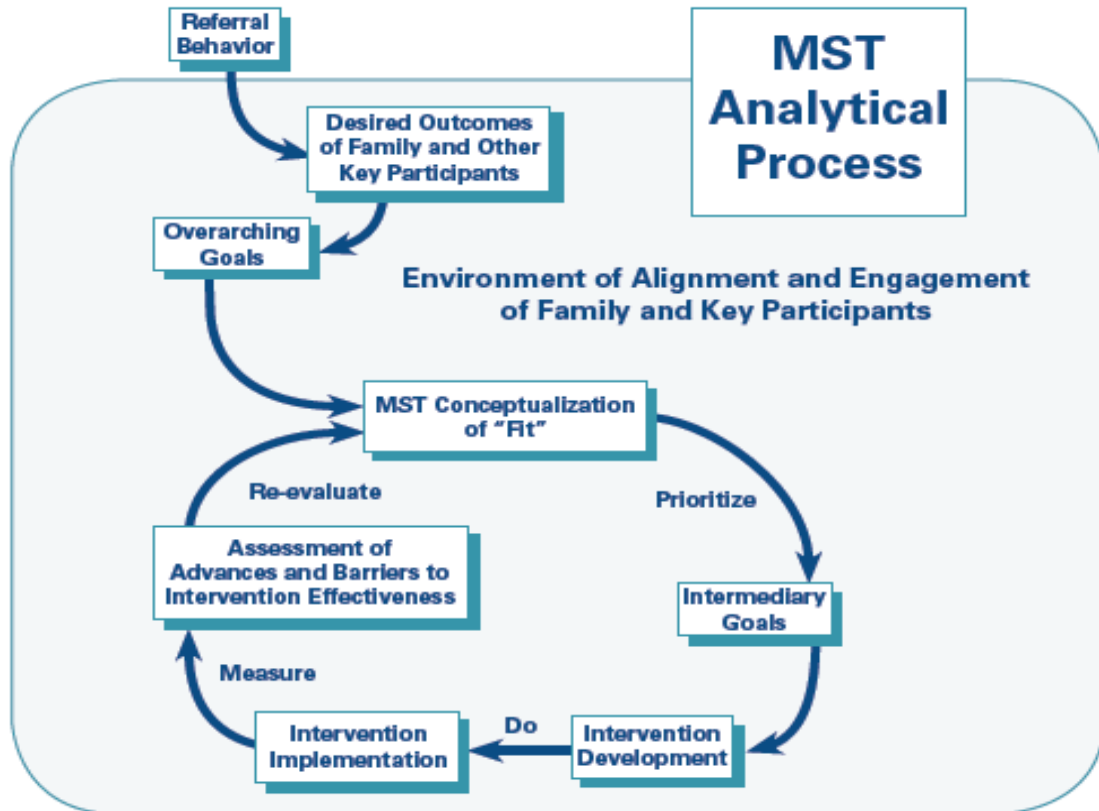


Figure 1 *The MST Analytical Process or 'do-loop'* (Henggeler et al., 1998, p.47)

1.3.4 MST evidence base

A wealth of research over the past 30 years has demonstrated the efficacy of MST. This has included University-based and community-based randomised control trials (RCTs) in the US that have consistently found that MST led to reduced recidivism and conduct problems (e.g. Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Henggeler, Melton, & Smith, 1992). MST's success has led to it being implemented internationally (Schoenwald, Heiblum, Saldana, & Henggeler, 2008). A RCT was conducted in Norway to test whether MST was still effective when transported. It found that the families that received MST had fewer negative behaviours, fewer out-of-home placements, increased

social competence and were more satisfied with treatment than those in the control group who received treatment from the Child Welfare Services (Ogden & Halliday-Boykins, 2004). In the first RCT for testing MST outcomes in the UK, families that received MST had better outcomes than families receiving Young Offender Treatment programmes in terms of reduced recidivism and reduced family ratings of psychopathy in the young person (Butler et al., 2011). However, a Swedish RCT did not find significant differences between the outcomes of families who had received MST and the families who had received treatment as usual (Sundell, Hansson, Lofholm, Olsson, Gustle, & Kadesjo, 2008). Although this suggests that MST was not effective in this instance, one alternative interpretation posited by the study's authors was that the lack of difference between the groups could be attributed to the treatment-as-usual group having more positive outcomes rather than the MST families doing less well (Sundell et al., 2008).

Another example of MST having less success upon being transported internationally was in Canada (Leschied & Cunningham, 2002). The Canadian RCT did not find a significant difference in outcomes for families who had received MST and those in the treatment-as-usual group. A case was again made for treatment-as-usual being of a higher quality in Canada than in the USA. Other possible considerations for why MST in the Canada trial may have had poorer outcomes included the high rates of therapist attrition and the study including client families with less severe problems (Cunningham, 2002). Another possibility is that the Canadian trial did not implement the MST model as faithfully as more successful transportations. The average percentage of TAM scores that exceeded the MST recommended cut-off was 49% (Cunningham, 2002). This was less than in more successful US trials (Ogden & Hagen, 2006). This argument would be more persuasive if a correlation had been found between TAM scores and outcomes in

the Canadian RCT, however a relationship between TAM scores and client outcomes was not found (Cunningham, 2002).

1.3.5 The impact of MST on therapists

The RCT evaluating the transportation of MST to Canada noted high rates of therapist burnout and attrition (Cunningham, 2002). Leschied and Cunningham (2002) do not explicitly ask therapists about their reasons for leaving the job but hypothesise a range of potential reasons. These reasons include the long hours working and being on-call, the large amount of paperwork, the isolation of primarily working within the community without peer support and the constant scrutiny of therapists' work. It is interesting to note given the conceptualisation of adherence and adaptation as being held in 'tension' in the literature that this may have also been experienced as an area of stress for therapists. Although, not a stated research aim, the proposed study will be mindful of whether therapists experience balancing adherence and adaptation as 'stressful'.

1.4 MULTISYSTEMIC THERAPY AND ADHERENCE

Henggeler (2011) argues effective transportation of MST to new countries is dependent on the promotion and monitoring of adherence to the model. To achieve this, the MST Institute (2006) has developed a *quality improvement system*. The MST model identifies the nine treatment principles as being the mechanisms within the MST model for effecting change within client families. The *quality improvement system* aims to ensure that these treatment principles are adhered to (Henggeler, 2011).

1.4.1 Promoting adherence in MST

Therapists undertake a five-day initial training programme prior to practising as an MST therapist, and every three months they attend a booster-training session with their team (MST Institute, 2006). Therapists receive weekly supervision and consultation as a team with a specialist MST consultant. The focus of supervision and consultation is promoting adherence to the core MST principles (MST Services, 2006). Adherence is further facilitated by supervisors reviewing audio-taped treatment sessions (MST Services, 2006). These systems and processes strongly emphasise to MST therapists and teams that adhering to the MST model should be a priority in their work.

The MST developer organisation 'MST Services' has designed a *quality assurance and improvement system* to monitor, improve and evidence outcomes by recording and encouraging adherence to the MST model. MST services monitor adherence at the therapist level (the Therapist Adherence Measure or 'TAM'), supervisor level (the Supervisor Adherence Measure or 'SAM') and specialist consultant level (the Consultant Adherence Measure or 'CAM'). The TAM is completed by client families, the SAM is completed by therapists and the CAM by supervisors and therapists. These adherence scores are reviewed and there is an expectation that low scores will be addressed, as they are indicators of poor adherence to the model (MST Institute, 2006). Therapist adherence is reviewed regularly in individual supervision and areas of need are built into clinician development plans.

1.4.2 The assumptions underpinning MST effectiveness

MST's focus on adherence in England is based on the following assumptions: The MST model reliably achieves its outcome aims in its country of origin, the US (discussed

above); effectiveness in new countries can be achieved by ensuring that the model is adhered to; the MST adherence measures are able to accurately measure how well therapists are adhering to the model; and therapists adherence ratings will correlate with outcomes (Henggeler, 2011).

1.4.3 MST adherence outcomes

There has been some inconsistency in the findings of studies examining the link between therapist adherence to the model and client outcomes. There are a number of studies that indicate that client family ratings of therapist adherence to the model are able to predict intervention outcomes, however this has not been tested in England (Henggeler et al., 1997; Huey, Henggeler, Brondino, & Pickrel, 2000; Schoenwald & Henggeler, 2000). A Swedish RCT and the transportability studies (Sundell al., 2008; Schoenwald et al., 2008) found positive relationships between therapist adherence (as measured by the TAM) improved family functioning and decreased delinquent behaviour. This relationship was found again in a recent follow up study looking at the relationship between adherence and treatment outcome in Sweden (Lofholm, Eichas, & Sundell, 2014).

Although overall research is supportive of the link between adherence and outcomes, a study conducted by Schoenwald, Henggeler, Brondino and Rowland (2000) reported different findings. They compared therapist scores on the Therapist Adherence Measure (TAM), with three measures of outcome (family functioning, parent monitoring, and youth peer relations) (Schoenwald et al., 2000). Although in general, the TAM is completed by client families, in this study the therapist *and* client families rated adherence over 16 weeks to provide a fuller picture of perceptions of therapist adherence within the

intervention. There was not a significant correlation between overall adherence and overall outcome but there was a modest correlation between specific aspects of adherence and specific outcome measures. The Canadian MST RCT was another example of ratings on the TAM not correlating with conviction rates (Leschied & Cunningham 2002). It was not known whether this lack of correlation was indicative of the TAM being a poor measure of adherence or the lack of relationship to adhering the MST model and conviction rates for young people after having received an MST intervention. Given the body of evidence supporting the effectiveness of MST, it could be argued that the lack of correlation between these scores should not be seen as negating the importance of adhering to the MST principles but rather, questions the validity of the TAM in reflecting the MST core principles. Others have raised the question of how accurately the TAM measures MST principles, with Littell (2006) arguing that the TAM measures core therapeutic skills rather than principles unique to MST. Furthermore, Schoenwald and colleagues (2000) did not find a significant correlation between therapist's and client families' ratings of therapist adherence, raising questions about the construct validity of the TAM.

1.4.4 The adherence studies in context

The outcome studies for MST have been primarily conducted by the programme developers. Whilst there are no indicators of bias, it is worth considering 'allegiance effects', whereby researchers who are affiliated to a model are more likely to find positive outcomes when researching that model (Littell, Popa, & Forsythe, 2005). The evidence is supportive of promoting adherence in MST but it also suggests that adherence ratings are not sufficient to predict change in all outcome areas. By looking beyond adherence, the proposed study aims to gain a richer understanding of instances

where adaptations to improve cultural fit might be required and adherence might be a barrier as much as a facilitator to achieving positive outcomes.

1.5 ADAPTING MULTISYSTEMIC THERAPY

A strength of the MST model is its nine principles that operationalise the change mechanisms of the model. Having clearly defined principles has helped the transportation process and on-going adherence monitoring. Whilst the MST model implicitly incorporates flexibility, much could be gained from operationalising the process of adaptation in MST, particularly in circumstances when adaptation *and* adherence are indicated and yet contradictory. RCTs and outcome studies have acknowledged differences and adaptations, but these studies do not explicitly state the adaptations made or the processes informing how they have occurred. It is the purpose of this study to explicate these areas for MST in England.

1.5.1 MST transportation and adaptation

Schoenwald and colleagues (2008) reviewed the cultural adaptation process for the transportation of MST into eight countries (Australia, Canada, Denmark, Ireland, the Netherlands, New Zealand, Norway and Sweden). This review provides a useful template for how MST programmes can balance adherence to core principles whilst making cultural adaptations to facilitate the transportation process. Pre-implementation, MST programme developers collaborated with local stakeholders to adapt the programme to the structure, procedures and culture of the host country. Schoenwald and colleague's review does not state how cultural and social characteristics were investigated and the extent to which this process varied across countries (Schoenwald et al., 2008). 'Stakeholders' include commissioning and service delivery organisations and

other relevant groups, for example, Aboriginal groups were consulted when implementing MST in Australia to facilitate delivering a culturally responsive treatment (Schoenwald et al., 2008). The review also highlights the need to consider legal differences pre-implementation. Countries have different consequences for offending behaviour and different treatment pathways for the young people concerned. This leads to adaptations to referral pathways and whether a family's participation is voluntary or compulsory (Schoenwald et al., 2008).

1.5.2 Adapting training and therapeutic interventions

Schoenwald and her colleagues (2008) also considered adaptations to training and therapeutic interventions. Adaptations were made to ensure concepts were understandable, culturally relevant and appropriate. Schoenwald and colleagues' review (2008) gave the example of the different norms around 'praise' in America and Scandinavia, with culturally appropriate levels of praise in an American family seeming over-the-top or inappropriate to a Scandinavian family. The review (Schoenwald et al., 2008) described taking into account the standard working practices of the host country. Local norms led to adjustments to the training format, the size of therapists' caseload and how the extended hours of the programme were understood and implemented. The review stated that changes in training format led to increased trainee satisfaction and engagement with the model but did not describe how this was measured. It was also unclear how 'cultural norms' were identified. It was difficult to establish the impact that these adjustments had and the extent that 'local norms' were valued and shared by MST trainees, therapists and supervisors. Different expectations about the therapeutic relationship were found to impact on what was deemed an appropriate length and intensity of treatment. For example, in New Zealand a longer time to build engagement

was added following feedback that the therapist asking personal questions was not well received in early sessions (Schoenwald et al., 2008).

1.5.3 Pre-implementation in England

There are no published reports of the pre-implementation process in England. It was however, mentioned in the evaluation for the UK MST RCT pilot (Fonagy et al., 2013). This pilot study indicated that the programme implementers gave consideration to local legal and policy guidelines and to identifying desirable characteristics of therapists (Fonagy et al., 2013). For each MST team, local steering groups made up of different stakeholders met throughout the implementation process and continue to meet monthly. Stakeholders included the MST supervisor from the team and services that were regularly involved in client referrals or part of MST interventions, such as representatives from social care services, youth offending, and child and adolescent mental health services. These meetings focussed on reviewing referral pathways and considering funding opportunities and the financial viability of the service (S. Fox, personal communication, 23rd February 2014). It was unclear, however, to what extent efforts were made to consider and respond to other aspects of cultural fit as identified by Schoenwald and colleagues (2008).

Stephen Butler, the research lead for the trial UK RCT into MST (Butler, Baruch, Hickey, & Fonagy, 2011) stated that no adaptations were made to the MST model to ensure cultural fit with England (S, Butler, personal communication, September 4, 2012). His rationale was that there are insufficient cultural differences to warrant adaptation. As a key stakeholder during the implementation of MST in England, it is likely that he would know of any formal adaptations to the MST programme. The MST international

implementation review (Schoenwald et al., 2008) described above, provided evidence of necessary cultural adaptations for the countries reviewed that have adopted MST, including English speaking countries, such as Australia and New Zealand but did not consider whether cultural adaptation was necessary for England.

1.5.4 Adapting programmes from the US for England

The view that the US and England have insufficient cultural difference to consider adaptations in not supported by a review of the transfer of a similar youth support programme (the Multidimensional Treatment Foster Care for Adolescents, MTFC) transported from the US to England (Kirton & Thomas, 2011). The MTFC, similarly to MST, aims to reduce the number of young people taken into custody through working with the systems around that young person. One key difference between MTFC and MST is that with MTFC the young person is placed with a foster carer rather than staying in the home. Both models include reinforcing pro-social behaviours, skills training and avoiding deviant peers (Kirton & Thomas, 2011).

Introduced to the England early in 2003, MTFC was initially piloted with adolescents, then extended to include younger children. In a qualitative study exploring professionals experience and perceptions of MTFC, Kirton and Thomas (2011) interviewed 31 MTFC professionals including foster carers, social workers, therapists, skills workers, programme supervisors and members of the management board. The authors acknowledged that due to their sample size, it was not possible to assume that expressed views were representative of all involved in the implementation of MTFC. Interviewing birth families and young people could also have provided a more comprehensive picture (Kirton & Thomas, 2011). The study did not include information

about the method used for analysing interview data. Therefore, whilst direct quotes were included in the text, it was difficult to establish the extent that themes and observations were idiosyncratic. Kirton and Thomas (2011) argued that despite an intention to have 100% adherence to the model, the specificities of England made this impossible. For example, similar legal differences were found to the Schoenwald study in terms of referral pathways (Schoenwald et al., 2008).

Participants generally valued adhering to the model, considering it desirable and necessary (Kirton & Thomas, 2011). The study identified two reasons why participants compromised adherence, cultural difference or clinical judgement. Interestingly, the study identified poor cultural fit as being one of three main perceived limitations of the programme (Kirton & Thomas, 2011). The study also reported the tension that was experienced between the strict emphasis on adherence and the desire for 'cross-cultural translation'. It did not state where in the systems these tensions were experienced. Areas of difference included differences in the end goal of the intervention, cultural definitions of specific behaviours or constructs such as 'mean talk' and 'self-harm' and cultural norms of positive focus versus negative focus. The study identified some ad-hoc adaptations, mainly focused on increasing the engagement and motivation of the young people but found that these adaptations had not impacted on the core elements of the model or negatively impacted on its effectiveness (Kirton & Thomas, 2011).

1.5.5 Conclusions from transporting US models to other countries

The findings from the international implementation of MST study (Schoenwald et al., 2008) and the qualitative exploration reviewing the transportation of MTFM from the US to England (Kirton & Thomas, 2011) suggest a gap in the literature. They provide a

strong case for exploring how therapists in England experience managing the tension between adhering to the MST model and achieving a person-centred approach in a host country. The current study aims to fill this gap in the literature by exploring therapists' accounts of balancing adherence with cultural fit when delivering MST interventions.

1.6 RESEARCH AIMS AND QUESTIONS

The studies discussed above on the transportation of MST and MTFC outline the challenges of transportation and review adaptations to improve cultural fit. To build on these findings, the present study interviewed MST therapists about their experience, applying a more rigorous methodology than the MTFC study and with a more specific focus than the MST study. Studies have rarely looked at whether adaptation has occurred in the absence of a formal adaptation process. This study aims to gain insight into the processes involved in managing cultural fit in England, within the adherence-focused MST programme.

This study aims to gain therapists' perspectives on whether they experience the balance between adherence and cultural fit as a tension as predicted by Castro, Barrera and Martinez (2004). As well as providing potential ways of 'culturally tailoring' the implementation of MST in England and considering the extent that cultural difference is conceptualized in ways already identified in the current literature (Schoenwald et al., 2008; Kirton & Thomas, 2011) this study aims to develop a better understanding of the processes applied by therapists to decide when and how to culturally tailor their interventions.

The research questions for this study are as follows:

- To what extent do therapists in England experience a tension between model fidelity and cultural fit when implementing MST?
- How do therapists in England manage any tension between model fidelity and cultural fit when implementing MST?
- Does the MST model need to be adapted for England? If so, how?

The research questions are addressed using a qualitative research design. A purposive sample of eight MST therapists from three sites in England was interviewed at their workplace. The scope of the project was restricted to the standard MST teams as opposed to those adapted for problem sexual behaviours, substance misuse or child abuse and neglect. The MST teams included were restricted to England rather than the UK due to the potential for different legal processes in other parts of the UK. A qualitative approach allowed an exploration of the processes used by therapists and the systems with which they work and was preferable in this instance as it more fully captures participants' experience and reduces the impact of the preconceptions of the researcher (Lyons & Coyle, 2007). The data from the semi-structured interviews was analysed using a Grounded Theory methodology (Glaser, & Strauss, 1967; Charmaz, 2006). To enhance the validity of the research design, quality standards as outlined by Elliott, Fischer and Rennie (1999) were adhered to.

This study explored the assumption that all transported programmes require a level of adaptation and looked at the processes and rationale behind informal 'cultural tailoring' undertaken by individual therapists. It generated recommendations for considering and implementing cultural tailoring to the MST model for England. As more MST sites are

introduced across the UK (Butler et al., 2011) it is imperative that attention is paid to ensuring a good fit with the specific systems and families in England. Improving understanding of how MST therapists manage adherence and cultural fit in England will not only provide a building block for MST implementers to enable more culturally tailored interventions but may also help to reduce therapist stress and rates of attrition.

Chapter 2. Method

2.1 CHAPTER OVERVIEW

Chapter two outlines the rationale for using a qualitative research methodology. It considers how the Grounded Theory approach is the most appropriate qualitative methodology to answer the research questions and explains the rationale for adopting Charmaz's social constructionist approach to Grounded Theory (Glaser & Strauss; 1967; Charmaz, 2006). The second half of this chapter describes the method, outlining the process of data collection and analysis.

2.2 CHOICE OF METHODOLOGY

To select the most appropriate research methodology for this study, consideration was given to the type of questions being asked and the epistemological assumptions implicit in the research questions.

2.2.1 Qualitative or quantitative methodology?

Quantitative research is better able to answer questions relating to measurement and calculating how one factor influences another or how measurements change over time (Wilson & MacLean, 2011). *Qualitative research* offers explanations for how phenomena are experienced and identifies the processes involved (Harper, 2008). This study aims to understand the experience of therapists in England adhering to and potentially adapting Multisystemic Therapy (MST) and to explore the processes used by therapists and the systems they work with to adapt either themselves or the MST intervention to create a good 'fit' between the MST model, the therapist, client families

and other systems. This focus on experiences and processes indicate that a qualitative methodology would be appropriate for this study.

2.2.2 The case against taking a quantitative approach

The epistemological assumptions of quantitative research are that objectivity and neutrality in scientific research are possible. Furthermore, that quantifying constructs and controlling and manipulating variables, minimises bias and reveals psychological 'truths' (Wilson & MacLean, 2011). Two criticisms of these assumptions are that it is not possible to observe separately from one's own preconceptions and so, eradicating bias and interpretation is unrealistic. Secondly, 'truths' are argued to be constructs, which are adopted and eventually discarded for a newer more meaningful understanding or 'truth' (Wilson & MacLean, 2011).

2.2.3 The case for taking a qualitative approach

The epistemological assumptions of qualitative research align with the perspective that 'truths' are constructs and that an unbiased observation is unrealistic. Therefore, quality standards are applied, which aim to provide transparency around the analytic process and reflections and assumptions are documented and shared during the research process (Henwood & Pidgeon, 1992). The qualitative methodology fitted with the researcher's own epistemological assumptions regarding the nature of 'truths' and the impact of the researcher on the research process.

Qualitative research is particularly useful for exploring topics where there has been little previous research (Wilson & MacLean, 2011). This is because it is able to generate data based on participants' experiences and reduces the impact of the preconceptions of the researcher (Forrester, 2010). Research into the transportation of evidence based

treatments has highlighted the inevitability of interventions requiring adaptation to improve cultural fit when implemented in a new setting (e.g. Schoenwald et al., 2008) but there has not been an investigation into the processes used by therapists and MST teams in situations where there is a poor fit between the MST model or protocols and families and systems in England. Therefore a qualitative approach helps to avoid imposing preconceived ideas about how therapists might experience this process.

2.3 WHICH QUALITATIVE METHOD?

A number of qualitative methods were considered before Grounded Theory was selected as the most suitable approach for this study. Methodologies were evaluated according to the extent they were able to address the research questions and the epistemological implications of the methodologies on the research.

The three methodologies that were considered to most closely fit with the aims of the study were Grounded Theory, Discourse Analysis and Interpretative Phenomenological Analysis (IPA).

2.3.1 Grounded theory

Grounded Theory (Glaser & Strauss, 1967) is a method of qualitative analysis devised to create theories of social processes through rigorous and systematic analysis of qualitative data (Payne, 2007). By following a set of clearly defined principles, the methodology leads to the development of a theoretical model grounded in the data and guided by what participants identify as important to them rather than the preconceived notions of the researcher (Henwood & Pidgeon, 1992). These principles include conducting data collection and analysis simultaneously, generating codes and categories from the data rather than using preconceived ideas, conducting the literature

review towards the end of the analytic process, using each stage of the process to develop and refine a theory and sampling being guided by theory development rather than representativeness (Charmaz, 2006). As analyses progress, grounded theorists traditionally aim for 'theoretical saturation' (Charmaz, 2006). This is seen as being when gathering further data no longer reveals new information or theoretical insights. The concept has been criticised for cutting off further analytic possibilities by preventing researchers from noticing new information and leads. As an alternative to theoretical saturation, Dey (1999) suggests grounded theorists should aim for 'theoretical sufficiency', emphasising continued openness to analytic possibilities through constructing categories sufficiently indicated rather than saturated, by the data. Historically a 'ground-breaking theory' was generated first and then hypotheses were devised and tested afterwards. In contrast, the Grounded Theory method develops 'middle-range' theories that are founded upon systematically analysed data (Charmaz, 2006, p.7).

The Grounded Theory approach is well suited to the research aims of this study to develop a model of flexibly adhering to MST in England. Grounded theory was considered an appropriate method of analysis, as the research questions required an understanding of the processes and interpretations underlying the behaviours of therapists. Through therapists sharing their experience of adhering to MST in England these processes and interpretations emerged and generated categories and a model of how therapists experience and manage adherence and cultural fit when implementing MST in England. Grounded Theory provides a framework for generating a theory that emerges from the data (Glaser & Strauss, 1967). It is recommended in areas such as this, where there has been limited previous research (Charmaz, 2006).

2.3.2 Discourse analysis

Discourse analysis takes a social constructivist epistemological perspective and focuses on how language creates and defines social reality. In this way, language is not seen as describing a phenomenon but rather as having a social objective that it is trying to achieve based on the social context within which it lies. Discourse analysis was considered potentially useful in achieving the research aims of this study, in that it emphasises deconstructing the implicit assumptions and providing a rich analysis of therapists' experience. However, the lack of explanatory focus limits the usefulness in terms of drawing clinical recommendations from the data and improving understanding of the processes of how tensions between adherence and adaptation could be understood and managed (Wilson & Maclean, 2011).

2.3.3 Interpretative phenomenological analysis

Interpretative Phenomenological Analysis involves interpreting data to develop hypotheses about the meaning that participants ascribe to their experiences (Smith, 2010). It could usefully provide insight into therapists' experience of adhering to MST but would not offer the scope to understand the processes of how adherence and cultural fit are navigated within MST delivery in England. IPA requires the researcher to make sense of participants' understanding of their own experience. It therefore relies on a level of interpretation on the part of the researcher that was felt to fit less well with the research aims, which seek to demonstrate how the themes are close to the data (Smith, 2010). Furthermore, it would not allow for generating a theory and was therefore rejected as a methodology (Wilson & MacLean, 2011).

2.4 WHICH GROUNDED THEORY?

The methodological and epistemological approach of Grounded Theory has been debated since it was first defined by Glaser and Strauss in 1967. Since 1967, Glaser and Strauss have developed the theory in differing directions. Glaser emphasised an empirical epistemology based on rigorous coding and prescriptive techniques. His 'classical' Grounded Theory combined the quantitative epistemological assumption of positivism whilst maintaining the advantage of qualitative research of approaching subjects with neutrality and without imposing pre-conceived ideas on to the data (Glaser, 1998). Glaser provided structured techniques for coding including defining coding families to facilitate generating more meaningful interpretations (Glaser, 1998). The criticism of 'family coding' was that its prescriptiveness could restrict analysis and be argued to be the researcher imposing their own assumptions (More, 2009).

Strauss focused more on the processes and actions that could be revealed through the analysis of data. The theoretical perspective of symbolic interactionism influenced Strauss, in that he assumed that reality and social experience were constructed through language. Strauss and Corbin (1998) developed a modified version of Grounded Theory focusing on how interactions are perceived and interpreted. This was accompanied by a specific process of relating categories and properties to each other, known as 'axial coding' (Strauss & Corbin, 1998; Corbin & Strauss, 2008).

Despite these diverging methods, Glaser, Strauss and Corbin all upheld the underlying assumption that the researcher is able to remain neutral in their analysis, thus ensuring the emergent theory accurately reflects the data. More recent developments within the Grounded Theory community posit that neutral observation is unrealistic within the research process (e.g. Bryant, 2002; Charmaz, 2006).

2.4.1 Charmaz's Constructivist Grounded Theory

Charmaz (2006) argues that it is not possible to ignore the pre-existing experiences, assumptions and beliefs that researchers bring to their research. Charmaz (2006) takes a constructivist epistemological perspective to the Grounded Theory approach, stating that 'we construct our grounded theories through our past and present involvements and interactions with people' (Charmaz, 2006, p.10). This was a move away from the positivist epistemology of previous ground theory approaches (eg Glaser & Strauss, 1967) towards seeing data and analysis as evolving from experiences shared by the researcher and participant (Charmaz, 2006). Charmaz's constructivist perspective fitted with the researcher's own epistemological assumptions.

Charmaz (2006) states that interpretations a researcher arrives at are influenced by factors such as their age, gender, ethnicity and professional background. These factors may influence different aspects of the research process including sample access and selection, questions and comments during the interview, the responses of participants and the coding and interpretation of the data (Charmaz, 2006). By adopting a social constructivist and relativist perspective, this research does not claim a 'neutral' position but instead names and accounts for inherent biases brought by the researcher's own experiences. This allows the research findings to be more fully informed by the data (Wilson & MacLean, 2011). Charmaz encourages the researcher to consider their professional and personal positions and reflect on the role these might play in the construction of the resulting theory.

2.5 DATA COLLECTION

2.5.1 Sampling

The study required a sample of MST therapists with sufficient knowledge of MST and England to comment on the 'fit' of the model when applied in England.

2.5.2 Inclusion criteria

Therapists were deemed eligible to participate in this study if they:

- A) Were MST therapists currently working in an MST team in England:** to ensure they had current, relevant knowledge of how MST is delivered in England;
- B) Had worked as an MST therapist for more than one year:** to ensure a range of MST experience;
- C) Had lived in England for more than three years:** to ensure an understanding of British cultural norms and expectations;
- D) Were working in a standard MST team that had not been adapted** (i.e. for problem sexual behaviours, substance misuse or child abuse and neglect): to focus interviews on the processes involved in delivering standard MST in a new setting and to avoid confounding the findings with the potential challenges of teams that had been formally adapted for different client groups;
- E) Had experience of consultation with an American consultant:** The teams where MST was first implemented in England all had American consultants and this was deemed a useful way of uncovering potential cultural difference between implementing MST elsewhere and in England.

2.5.3 Exclusion criteria

Therapists were deemed unsuitable for the study if they did not have experience of working in a MST team that had been established prior to 2011. This was to reduce the likelihood of approaching therapists who did not meet the inclusion criteria. The newer teams were less likely to use American consultants and less likely to include therapists who had been working for more than a year.

2.6 ETHICAL CONSIDERATION

2.6.1 Ethical approval

NHS ethical approval was not required for this study as participants were drawn from NHS staff or staff from non-NHS sites (NHS Health Research Authority, n.d.). This study was granted ethical approval from Royal Holloway University of London Ethics Committee (2013/030) in April 2013 (see Appendix B). Research and Development (R&D) approval was subsequently gained from two sites and written approval to interview therapists based at sites not within the NHS were granted at two further sites. The specific sites are not listed in order to protect participant anonymity (see Appendix C). Consideration was given to possible ethical implications of the research for participants. Full details of how ethical considerations were addressed in this study are included within the Participant Information Sheet (Appendix D). Ethical considerations pertaining to consent, confidentiality and anonymity were addressed as follows:

2.6.2 Consent

Participants were provided with a written outline of the purpose of the study and what would be involved in taking part prior to their interview. Their consent to take part in the project was sought verbally prior to the interview and they were asked to complete a

written consent prior to the point of interview (see Appendix E). The information sheet and consent form stated that participants were able to withdraw their consent at any point in the process and if they chose, their data would also be withdrawn. In one instance, after the interview, a participant expressed concern about sensitive information discussed in the interview entering the public domain. It was agreed that there would be no mention or quote from this part of the interview and that any coding pertaining to this extract would not mention the specific incident concerned.

2.6.3 Confidentiality and anonymity

In order to protect the anonymity of families and therapists, information that could identify a client or service was removed from the final report. Anonymity was further protected by using pseudonyms for identification and storing data separately from participants' names. Participants were also asked to consent to anonymised quotes from their interview being used in publications as part of their consent form.

It was explained to participants that information shared in the interview would remain confidential and anonymous unless there was a disclosure of risk of harm to the participant or another person. All interviews were audio recorded, and observations about the setting and the interview itself were recorded in a reflective journal at the end of each interview to enrich the data set (Pidgeon & Henwood, 1997).

2.7 RECRUITMENT

2.7.1 Selecting the participating teams

At the end of 2012, when sampling was initially considered, there were 30 MST teams across England. These sites include standard sites and sites adapted for different client groups (MST Services, n.d.). The locations of the sites are listed in Table 2 below.

Thirteen of these teams had been recently commissioned and therefore fell within the exclusion criteria (MST Services, n.d.). Of the remaining 17 teams, four had been adapted and therefore did not meet inclusion criteria (MST Services, n.d.). The remaining 13 teams worked from within 11 sites (MST Services, n.d.). Each team had three or four therapists (MST Services, n.d.). Permission was sought from seven MST team supervisors to invite therapists from within their team to participate in the study. One of these teams closed down during the recruitment process. In order to preserve participant anonymity the sites approached and recruited from will not be named.

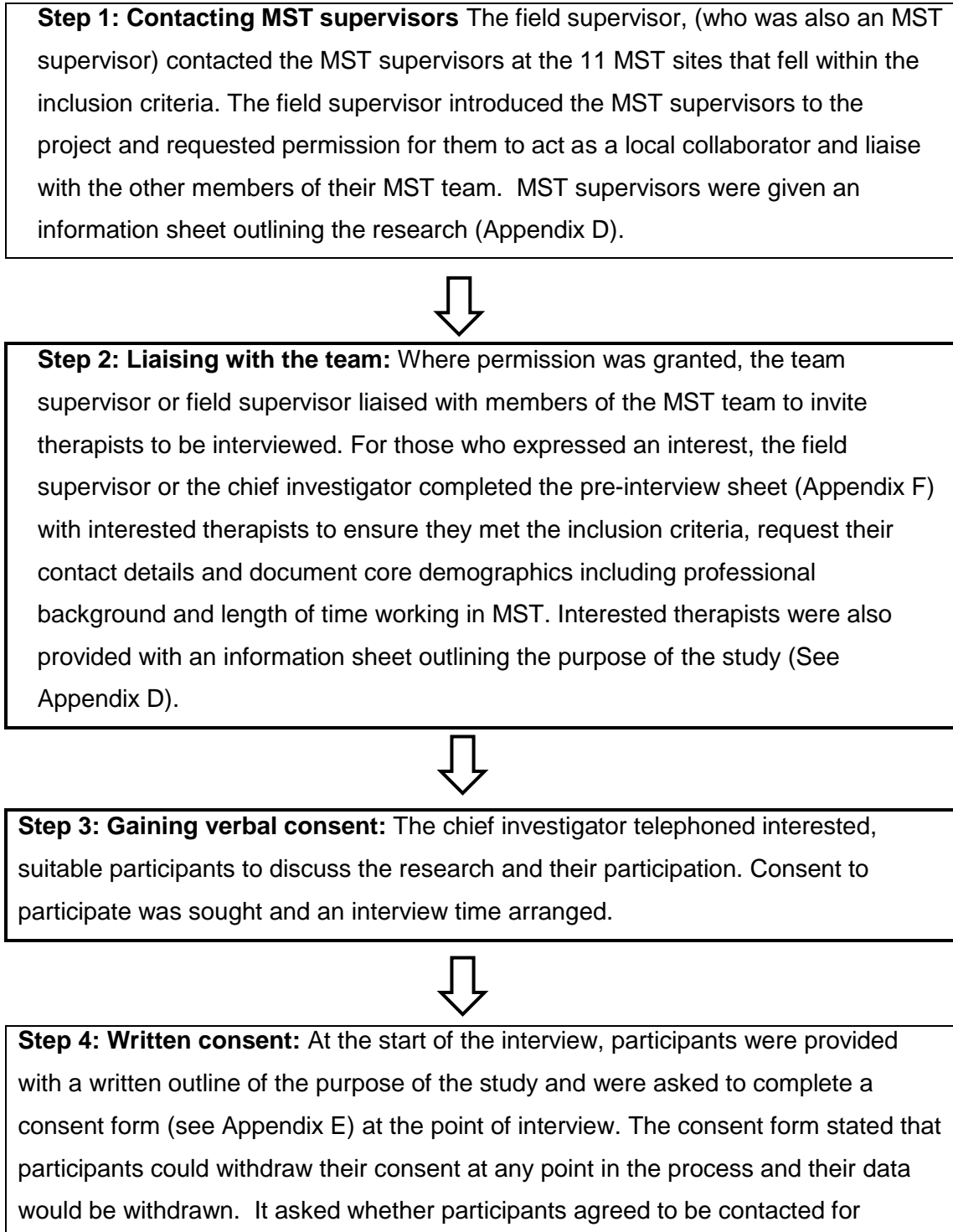
Table 2

Existing and new MST sites in England at the initial recruitment stage in 2012 (MST Services, n.d.)

<u>Existing MST Sites</u>	<u>New MST Sites</u>
Barnsley	Bristol
Brandon Centre London X 2	Cheshire partnership
Birmingham	Coventry
Cambridgeshire X 2	Derby City
Greenwich	Derbyshire
Hackney / NELP	Essex
Leeds X 3	Haringey and Waltham Forest
Merton, Sutton and Kingston	Leicester
Peterborough	Merton Sutton and Kingston
Reading	Newcastle
Sheffield	Northamptonshire
Trafford	Portsmouth
Wirral	Tameside and Oldham

2.7.2 The six step recruitment process

Figure 2 outlines the process for participation in the study.



additional comments after the completion of the interview.



Step 5: Debrief: Following the interview participants were given a debrief form (see Appendix G) outlining the purpose and potential implications of the project and giving contact details for the chief investigator and research supervisor should they require further information.



Step 6: Presenting to an MST team: The chief investigator presented the core findings to a team of five MST therapists and two MST supervisors and sought feedback on how well they fitted with the team's experiences.

Figure 2 *The six-step recruitment process*

2.7.3 Participant characteristics

In line with Harper's recommendations (Harper, 2007) demographic information is grouped rather than broken down by participant. This aims to protect the anonymity of participants in qualitative studies where there is a danger that participants may be able to identify themselves or be identified by another reader. This was deemed particularly important in this study where, within England, there is a relatively small MST community who are well known to each other. Demographic information about participants is described to situate the sample and provide a context for the research but care has been taken to provide only a level of detail that is unlikely to identify the participant (Elliot, Fischer, & Rennie, 1999). As can be seen in Table 3, of the eight therapists interviewed all participants were women, 50% were in their thirties and 50% came from a social work background. Also, 25% of participants had worked as MST therapists for less than 18 months and 50% of participants had worked as MST therapists for between 3.5 and 4.5 years. Two participants declined to disclose how long they had been working as MST therapists.

Table 3

Demographic summary of the sample

	Demographic information	Number of participants (N=8)
Gender	Male	0
	Female	8
Age	20s	1
	30s	4
	40s	2
	60s	1
Nationality	British	4
	Australian	1
	American	2
	Irish	1
Professional background	Social worker	4
	Mental Health Nurse	1
	Psychologist	1
	Family psychotherapist	1
	Occupational therapist	1
Time working as MST therapist (minimum 1 year)	1 year to 1.5 years	2
	3.5 years to 4 years	2
	4.5 years	2
	Not known	2

2.8 SERVICE SETTING

Interviews for this study were carried out face-to-face at the MST offices where the therapists were based between July 2013 and February 2014. Eight participants were

interviewed from within three teams. Two of the teams were in London (n=6) and one in another large urban city in England (n=2). The MST teams recruited from in this study offered community-based MST to young people at risk of 'out-of-home' placement and their families to support them in modifying the young person's conduct or emotional problems and improving their long-term prospects. They support families where young people are aged between 11 and 17, resident in the local area and are at risk of entering care or custody due to severe behavioural problems (MST-UK, n.d.). Two of the teams were commissioned and employed by NHS Trusts and one by the local authority.

2.9 INTERVIEWS

2.9.1 The interview guide

A draft interview guide was developed at the outset of the research in collaboration with the research and field supervisors (Appendix H). In line with Grounded Theory methodology, the interview guide aimed to be relatively open-ended to allow participants' own experiences to emerge (Charmaz, 2006). Questions relevant to the core research areas were drawn from the existing literature on MST and broader literature on adherence and adaptation. The interview guide followed the structure of:

- i) Initial closed questions to build rapport.
- ii) Questions relating to adherence
- iii) Questions relating to adaptation.
- iv) Questions around perceived cultural idiosyncrasies in delivering MST in England.
- v) Questions designed to elicit anything that the participant might have felt was relevant but not yet discussed.

2.9.2 Adapting the interview guide

A feedback process was carried out to seek views on the interview guide before data collection began. A group of three MST professionals (the field supervisor, who was also an MST supervisor, another MST supervisor and an MST therapist) were recruited from an MST team in London. Unfortunately time constraints and the MST professionals' limited availability meant the chief investigator was unable to attend the feedback process. The MST professionals were consulted for their views on the draft interview guide in a group context, led by the field supervisor. The chief investigator provided the field supervisor with a series of prompts regarding the clarity of the questions, how well the interview questions mapped on to the research questions and the language of the questions. Feedback was then provided via email and further deconstructed in a telephone conversation with the field supervisor. Feedback on the interview guide from the MST professionals was largely positive, and conveyed a sense that the questions were clear, relevant and appropriate. Some minor edits were proposed regarding the use of the language, such as changing references to 'adaptations to MST', to 'cultural tailoring'. The term 'adaptation' is used very specifically within an MST context to refer to formal adaptations to the MST model for use with different cohorts (e.g. families where there are concerns around abuse and neglect, young people with problem sexual behaviour or young people with substance misuse problems). The amended interview guide can be seen in Appendix I.

There was a second review process for the interview guide following the transcription, coding and initial analysis of the first interview. The interview had been fairly fluid and the initial themes generated seemed possible to explore further whilst keeping the same structure for the guide. At this point, it was felt that the initial rapport building questions

could be removed, as there was enough opportunity for rapport building in gaining consent and setting up the interview.

After the first four interviews, the interview guide was reviewed again based on a preliminary analysis of these interviews. This is in line with Charmaz's guidelines for achieving theoretical sampling (Charmaz, 2006). Constructivist Grounded Theory posits that as categories begin to emerge from data, these categories should be used to inform further data collection. That is, future interviews should be used to elaborate and refine early codes and categories (Charmaz, 2006). In this study, the interview guide was felt to be broad enough to continue to develop emerging categories.

2.9.3 Conducting the interviews

When arranging and preparing for the interviews, the researcher adhered to guidelines recommended by Berg (2007). These included building initial rapport with participants during arranging the time and place of the interview and prior to the start, keeping focused on the general purpose of the interview, using the interview guide flexibly in order to maintain flow and engagement with the participant, probing respectfully where answers were partial or monosyllabic and being cordial and appreciative of the interviewees contribution and participation (Berg, 2007). All eight interviews were carried out by the same researcher in private consultation rooms at the MST therapist's place of work. Interviews lasted between 48 and 93 minutes.

The interviews were carried out in a flexible way, with general topics covered across the interviews but specific questions asked depending on individual participants' responses. The researcher asked prompt questions throughout to encourage participants to expand on their answer and prompt further discussion of key topics. Summaries of respondents'

statements were provided at regular intervals to ensure that responses had been properly understood and interpreted (Forrester, 2010). All participants were given a debrief form after the interview.

2.10 DATA ANALYSIS

2.10.1 Transcription

Interviews were transcribed verbatim and guidelines were followed to ensure a systematic procedure was applied to all transcripts (McLellan, MacQueen, & Neidig, 2003). This involved including nonverbal sounds, such as laughter, in parentheses, transcribing mispronounced words as the individual said them, standardising common enunciated reductions, such as, 'cos' and 'dunno', including filler words such as 'mm', inserting a hyphen if a word was cut-off or truncated and typing the phrase 'inaudible segment' in square brackets where the transcriber was unable to identify what was said (McLellan et al., 2003). The researcher transcribed all interviews, as this process has been found to help familiarise the researcher with the data and further their understanding (Charmaz, 2006).

2.10.2 Coding

Data coding is the first step in analysis and provides the building blocks for constructing grounded theories. Coding involves summarising actions and processes, where possible using gerunds (Tweed & Charmaz, 2011). A gerund is a means of turning a noun into a verb by adding '-ing' to the end. It is useful in ensuring codes are more dynamic and less static as this is thought to better capture processes (Charmaz, 2006). Charmaz (2006) suggests that Grounded Theory analysis should consist of three distinct stages of coding: initial coding, focused coding and theoretical coding and diagramming. The

Grounded Theory approach suggests a constant comparative process whereby comparisons occur back and forth across all three stages and are supported by on-going memo-writing. The phases of analysis are outlined in a linear way for the purposes of clarity, however, this is not indicative of the more fluid constant comparisons that took place during the analysis stage.

2.10.3 First stage: Initial coding

Following transcription of the first interview, data analysis started with initial coding. Charmaz (2006) suggests that initially the researcher must decide their unit of analysis, either coding line-by-line, sentence-by-sentence or incident-by-incident. The present study felt sentence by sentence coding enabled the research to code in sufficient detail without becoming too focused on individual words. Gerunds and in-vivo codes were used to summarise and categorise each data segment (Charmaz, 2006). In-vivo codes capture the exact wording of participants and are useful in instances where a participant's precise language is felt to represent an important concept. In-vivo codes also serve to ensure that codes remain grounded in the data (Charmaz, 2006). Initial coding is thought to prevent the researcher from coding the data in accordance with pre-conceived categories or theories in mind (Charmaz, 2006). An example of an initial code that includes a gerund is "finding TAM useful when started" (Deborah) and an example of an in-vivo initial code is "they say that in the MST-land burnout's two years" (Amy).

2.10.4 Second stage: Focused coding

The second stage of focused coding involved developing codes to describe larger sections of the data, which were more abstract and conceptual (Charmaz, 2006). The most significant and frequently occurring codes from the initial coding stage formed the

basis of the focused codes. The process of constant comparison of the data ensured that focused codes were grounded in the data. They encapsulated initial codes, but also made analytic sense in contributing to categories and a theory that were comprehensive and coherent (Charmaz, 2006). An example of a focused code was “conflicting messages in the MST model”.

2.10.5 Third stage: Theoretical coding and diagramming

The purpose of this final stage of coding was to raise the focused codes to the level of categories. The categories should encapsulate the focus codes whilst relating to each other in a way that is integrated into a theory (Charmaz, 2006). The emergent theory was made up of four theoretical codes, with focused codes used to explain different aspects and initial codes and quotations representing their properties. A diagram was used to assist this process and help explain some of the categories, their properties and the relationships between them (Charmaz, 2006). At this point the emergent theory was compared to existing research and literature.

2.10.6 Analytic memo-writing

The process of initial coding and constant comparison elicited conceptual themes and ideas, which were recorded in the form of memos. Memos are a means of capturing the researcher’s tentative ideas about the processes and constructs emerging from the data (Birks & Mills, 2011). The memos were reviewed between interviews and preliminary analytic concepts were pursued with subsequent interviewees. Memos were central to the process of theoretical coding and diagramming, as they were employed to establish theoretical links and relationships between the codes (Charmaz, 2006). These memos were further developed throughout the data collection and analysis process and were

ultimately developed into the Grounded Theory of the post-implementation model of adherence (see Appendix J for an example memo and Appendix K for examples of how the Grounded Theory developed).

2.11 REVIEWING THE LITERATURE

Grounded Theory recommends that a literature review be undertaken after the data analysis stage to minimise the impact of existing research on the data collection and analysis (Glaser & Strauss, 1967). In this study delaying the literature review was constrained by the requirements of the Doctorate in Clinical Psychology, which requires the submission of a brief literature review. Charmaz (2006) acknowledges the benefits of some preliminary literature review in order to check the novelty of the subject area being explored. Charmaz (2006) recommends not revisiting the literature until after the researcher's independent analysis. The aim of this strategy is to avoid imposing pre-existing theories on the data. However the degree that it is possible for researchers to suspend their knowledge and awareness of pre-existing theories has been argued to be unrealistic (Heath & Cowley, 2004; Robson, 2002). However Corbin and Strauss (2008) offer an alternative perspective in suggesting that previous knowledge and experience can actually enhance sensitivity to the data and enable a researcher to better understand the meaning and significance of what participants are expressing in their language.

2.12 ADHERING TO QUALITY STANDARDS

To enhance the validity of the research design, quality standards as outlined by Elliott, Fischer and Rennie (1999) were adhered to. The first of the seven guidelines pertains to owning one's own perspective. As the researcher is seen as influencing and a part of

what is being looked at rather than separate from it, quality standards emphasise the importance of taking a reflexive stance (Charmaz, 2006; Elliot et al., 1999).

With regard to my position as a researcher, I am a white British, female, trainee psychologist. My therapeutic role as a trainee psychologist meant I was experienced in building rapport, checking my understanding of what was being said and encouraging others to expand on their topic without being leading. However, I was aware of the need to ensure I remained in the role of researcher during interviews, rather than revert to a more clinical role. Prior to the first interview, I considered the ways that the research interview would differ from a clinical interview: as a clinician, I might support clients to make sense of, or process, their experiences and invite them to consider alternative perspectives, whereas as a researcher my focus should be on gaining the most accurate and thorough understanding of the interviewee's experience. As a clinician, I would be sensitive to letting clients set the pace for what was disclosed and the level of detail, whereas as a researcher it would be appropriate to remain more actively curious and probing whilst remaining respectful of what the participant felt comfortable discussing (Charmaz, 2006).

To foster my ability to remain in the researcher rather than the clinician role, I completed an entry in a reflective journal after each interview (Kazdin, 2003). I reviewed these entries prior to later interviews to ensure I remained mindful of ways that I might inadvertently take a more therapeutic position. I have not worked within an MST team, however, this research was supervised by two clinical psychologist who were also MST team supervisors. I interviewed therapists from within the same team and was mindful that this might impact on how open and honest they felt able to be. I managed this by being transparent about my supervisors' involvement and explaining that they would

have access to codes and selected quotes from the interviews but would not see the transcripts or listen to recordings from members of their own team. There was a third supervisor (from Royal Holloway, University of London) unconnected to MST who reviewed extracts from these transcripts.

Prior to interviewing participants I noticed that I anticipated that therapists would have found instances where they have needed to informally adapt the MST model to fit in England. I also reflected that I assumed they would have experienced frustration with rigidly adhering to the model. I endeavoured to counter these potential biases by including questions about the usefulness of adhering to a model and the times that flexibility may not be helpful.

I hold the belief that the US and British culture are different and therapists would experience that difference in the therapeutic setting. I was mindful of not leading participants into statements that confirmed this belief by checking my questions and comments in the interview transcripts, between interviews. Peer supervision with fellow trainees undertaking Grounded Theory studies also provided invaluable opportunities to discuss methodological and analytical queries. This provided further opportunities to check for potential biases during the analysis process to ensure the interpretation of the data was not unduly influenced by prior assumptions or 'common sense theorising' (Schutz, 1967).

Owning one's own perspective is the first of the recommended quality standards, the second method for ensuring quality standards is situating the sample. Situating the sample is discussed Chapter 2, Section 2.5.3 *Participant characteristics*. Guideline three suggests grounding themes in examples. This report incorporates examples of themes

and categories generated during the analysis process for readers to observe the analytic process, assess the applicability of themes and gain insight into the development of understanding from this process. Quotes from the data have also been used throughout the reporting process to illustrate the developing codes and memos and allow the reader to assess the 'fit' between the data and the researcher's interpretations (Elliot et al., 1999).

Guideline four indicates the importance of providing credibility checks for the categories and model (Elliot et al., 1999). A group of five MST therapists and two MST supervisors attended a feedback session to check the validity of the categories and PIMA model.

Their comments can be found in Chapter 3, Section 3.8 *Feedback from the MST Team*.

Guideline five, states that the results should be coherently presented in a way that integrates the data whilst preserving its nuances. In order to provide a coherent narrative, the model is depicted diagrammatically (see, p90) as well as a comprehensive description of how the themes relate and are linked. Guideline six advises that the generalisability of the research task is made explicit, noting the parameters and contexts within which the findings seek to understand. The parameters of the findings and model are discussed in Chapter 4, Section 4.7 and Section 4.8.2. Guideline seven indicates that the material should resonate with readers. In this study jargon has been avoided where possible and attention was paid to ensuring that the language used matched the language of the therapists being interviewed. Where therapists used the language or technical jargon of MST it has been explained (see Chapter 1, Section 1.3 *Multisystemic Therapy*, which describes the process of MST and Appendix A, which provides a glossary of key MST terms).

To enhance the credibility of the study, validation methods were used to verify the categories and the emerging theory. This involved checking the coding of the first interview transcript and resulting themes with other researchers familiar with Grounded Theory techniques, including the research supervisor and another trainee clinical psychologist conducting research using Grounded Theory (Madill, Jordan, & Shirley, 2000). In addition to the group feedback session the field supervisor, research supervisor and MST expert also verified the resulting themes. This ensured that the researcher did not miss any important themes, that data were considered from multiple perspectives and that the labels and interpretations fitted the data well (Mays & Pope, 2000). It also helped ensure coherence of the results and that the findings were presented in a way that was accessible and resonated with those within the MST community.

An annotated section of a transcript is included in Appendix L to provide transparency through illustrating the interview process, raw data from the study and the initial and focused coding stages.

CHAPTER 3: RESULTS

3.1 CHAPTER OVERVIEW

The analysis of the data is described below. The final stage of analysis produced four *theoretical* codes, which are presented in Table 4. These four codes in turn, encompass a number of *focused codes* developed during the focused coding stage of the analysis. The specific properties of the focused codes incorporate codes developed during the *initial* stage of coding. The *theoretical* and *focused* codes will be described individually in further detail, with participant quotations to further illustrate them. Towards the end of the chapter the Post-Implementation Model of Adherence (PIMA) is shown diagrammatically followed by a description of the model that explains the relationship between the theoretical codes and the process of therapists working towards achieving adherence and cultural fit with implementing MST in England. The chapter ends with a summary of the feedback provided by the MST international expert and from a reviewing MST team regarding the theoretical and focused codes and the PIMA model.

3.2 SUMMARY OF THE FINDINGS

The theoretical codes explain the processes that emerged when therapists described *needing to adhere*, whilst experiencing *barriers to implementing* MST. The first category; **Facilitators to therapists staying faithful to the MST model** identifies processes and procedures that help therapists to adhere to MST when implementing it in England. The second category; **Barriers to therapists implementing MST** identifies processes and procedures that make it harder for therapists to implement and adhere. The third category; **Strategies for overcoming barriers to implementing MST**; identifies the strategies therapists use to overcome the barriers to implementing MST in England. The

fourth and final category; **The therapist holding the tension** identifies the emotional consequences when therapists feel it is outside of their control to overcome the barriers to implementation. Each theoretical code is broken down into its relevant focused codes and initial codes in Table 4.

Table 4

Theoretical codes, sub-codes and properties of the codes for MST therapists

Theoretical Codes	Sub-codes (focused coding)	Properties of the codes (initial coding)
Facilitators to therapists staying faithful to the MST model	Using the outputs from the TAM	(i) TAM evidencing the therapist adhering (ii) Identifying areas for development
	Following MST principles and the analytic process	(i) Being strengths focused (ii) Holding responsibility for the family
	Doing 'whatever it takes'	(i) Doing whatever it takes (ii) Working imaginatively and creatively. (ii) Being asked what else you could be doing when things are difficult
	Following direction from the Consultant and Supervisor	(i) Supervisor and Consultant helping therapist to adhere
	MST tailoring the model	(i) US Consultants learning British differences (ii) 'This team' doing it differently
	Therapist feeling supported and contained	(i) Feeling contained by the process (ii) MST team being supportive (iii) Supervisor supporting therapist
	Barriers to therapists implementing MST	MST not fitting for families

MST not fitting for systems	(i) Therapists in England having less power (ii) Different perceptions of desirable work ethic between US and England (iii) School leaving age in England
Conflicting messages in the MST model	(i) TAM scores not reflecting therapist behaviour (ii) Balancing support with independence (iii) Engaging and aligning contradicting the linking and labeling required to get high TAM scores
MST not acknowledging cultural difference	(i) Not feeling consultant understands England specific challenges (ii) MST feeling that therapists should push their limit but therapist's feeling it is an externally imposed limit (iii) Feeling consultant minimises cultural barrier
Strategies for overcoming barriers to implementing MST	Evidencing it not fitting (i) Putting the cultural barrier through the analytic process (ii) Evidencing it not working by trying it first
	Suggesting creative solutions (i) Working with families to adapt culturally unsuitable ideas into ones that fit (ii) Using 'boosters' to generate creative solutions to shared problem (iii) Teams adapting how the on-call system works
Privileging different parts of the model	(i) Choosing engagement over high TAM scores. (ii) Citing good outcomes to justify different ways of working

		(iii) Identifying an aspect of the intervention that was going well to justify extending
The therapist holding the tension	Feeling under pressure	(i) Being an intense job (ii) Managing multiple obligations and service restrictions (iii) Feeling the pressure to achieve goals
	Feeling disempowered	(i) Poor outcomes leading to therapist losing faith in herself or the model
	Feeling burnt out	(i) Having a three year burnout rate (ii) Therapist feeling burnt out by additional stressors (iii) Therapist feeling unsupported

3.3 FACILITATING THERAPISTS TO STAY FAITHFUL TO THE MST MODEL

3.3.1 Therapists' perception of 'adherence'

Within the interviews, 'Adherence' was the term often used to describe faithfully following the MST model. Adherence did not refer to a single process but meant many different things for participants. Adhering typically meant getting high **Therapist Adherence Measure (TAM) scores** from families, adhering to the therapist's understanding of **the model's principles, protocols and analytic process** or **following direction from the supervisor or consultant**.

The range of responses to the questions 'what does adherence mean to you?' included:

"I guess following the analytic loop and doing what MST expects you to do, in terms of the initial paperwork and erm the fits, which inform intentions. So, it means following the process I suppose." (Beth).

"Knowing what the model actually is and sticking to it as closely as possible" (Ellen).

"What adherence means to me? 'Cos you realise, ok, cos we do get TAM scores. Like we do get therapist adherence measures scores" (Catherine).

"Adherence is, in this case sticking to the ethos and theory of the model when working with the family" (Deborah).

"Clinically, it's just about trying to stay on track on the clinical goals. But sometimes it just feels a bit more like constant checking boxes and ticking and that sort of thing. I understand why there's so much scrutiny on it. It's about staying on track clinically. I think more than anything, that we don't stray away from the model" (Gemma).

"It means being adherent to the model of the MST model and working as close to the model as I can so that we have better outcomes for our families" (Fiona).

Therapists generally felt it important to adhere to the model and to adhere to MST services more generally. Therapists talked about believing adhering led to better outcomes and described the importance of 'evidencing that they're adhering' by having adherence monitored through their TAM scores, having sessions recorded and through supervision and consultation.

"I suppose the things that make it [adherence] easy, are that we have supervision and then we have consult. So we're constantly having someone. There's like a triple check system in place. " (Gemma).

3.3.2 Using the outcomes from the TAM

Therapists considered the TAM to be a useful means of identifying areas of development and valued the **TAM evidencing the therapist adhering** and performing well. High TAM scores increased therapists' confidence and positively impacted on their mood.

"I remember going for my initial interview and I think my interviewers were thinking that that's a negative, that people will be checking up that you're doing what you say you do and all that and like how do you feel about that? And I'm really pleased about that, because one, I'd like to be doing what I'm supposed to be doing and two, I'd like you to know that I'm doing what I'm supposed to be doing." (Ellen).

"Oftentimes it can be helpful, if then scores are low, then or in a particular area then obviously that gets flagged up" (Amy).

"It's all part of therapists' personal development" (Beth).

“I had a long period of you know good TAM scores, certainly above adherence and above that and feeling quite confident and happy about that” (Ellen).

3.3.3 Following MST principles and the analytic process

Participants also felt that following the principles and protocols of MST were key aspects of adhering to the model.

The principles that were discussed more frequently in interviews were MST teams **assuming accountability** for the success of interventions of families and **being strengths focused**. The former was often interpreted as responsibility being held by the therapist. This sense of responsibility spanned a range of situations including the therapist being responsible for keeping families safe, the therapist needing to overcome barriers and the therapist holding responsibility for families aligning with the MST agenda. There was an overriding feeling that the therapist held responsibility for the case. Most participants experienced this level of responsibility as stressful.

“I think that’s the difficulty when you’re having a family that’s particularly difficult to engage, you have to take ownership of it, so you have to say ‘it’s my fault that they’re not engaging’. That’s how you present it to the family or you present it to the network. Which obviously, although your team knows that’s not the case, if that’s how you’re presenting it, it does put an added stress on your shoulders.” (Helen).

This was not consistent across all participants or at all points of the interview. At times, therapists described sharing responsibility with supervisors and the team. Feelings of shared responsibility generally arose in situations where there were shared understandings of the problem and alignment between therapists, supervisors and consultants around what strategies could be useful for overcoming problems.

“The good thing with MST is that it’s not just you on your own. It’s weekly supervision with the whole team so you do feel as though we’re all sort of in it together and it’s not just me on my own struggling with this family” (Fiona).

Therapists described valuing the principle of finding a ‘fit’ and also of following the ‘do-loop’. They talked of feeling contained by having the process to fall back on, particularly for families with complex needs, chaotic lives and during times when therapists were feeling stuck.

3.3.4 Doing ‘whatever it takes’

The expectation that therapists would do **‘whatever it takes’** appeared as a deeply held but elusive value of MST. At times, the data suggested that this value fostered a culture of **working creatively and imaginatively** so therapists felt encouraged to be flexible in how they engaged families, met goals and problem solved.

“Certain cultures don’t like community to know that they’ve got services coming to the family and that’s really really huge. But I think it again goes back to that ‘whatever it takes’ and we try and be flexible and creative. But it’s being clear from the beginning ‘look this family only want us there in the evening, or no one in the community to know that we’re coming, or want us to come when they’ve had prayers’. Things like that where you’ve got to be sensitive and creative” (Amy).

Some therapists perceived doing ‘whatever it takes’ as a pressure that made it hard to separate poor outcomes from personal failure. It was also interpreted as the need to be persistent and not give up or not take ‘no’ for an answer. Some participants understood ‘doing whatever it takes’ as meaning anything is possible, with the implicit message that it is within therapists’ power to overcome obstacles and always meet goals.

“That’s when like MST throws like ‘whatever it takes’ at you? And like ‘whatever it takes’. Like do you have to write letters? Do you have to persistently call? Do you have to do other stuff? Because whatever it takes: If you need to put in a new intervention for that barrier or come at it from a different way. Or if your parent is really resistant how are you going to adjust that? So it is very, I would say, harsh on the therapist... So I feel a lot of pressure.” (Catherine).

“The ethos is ‘whatever it takes’. That’s, they’re kind of like, ‘whatever it takes, therapists will do it’. You can always hear it from them. And ‘nothing is impossible’” (Amy).

3.3.5 Following direction from the consultant and supervisor

Participants varied in their experiences of following direction from the consultant. There was some commonality between participants from the same team who shared consultants. Consultants were seen as checking that the model was adhered to. To a greater or lesser extent for different participants, therapists were expected to follow direction provided by the consultant irrespective of whether the therapist was in agreement.

“I think in terms of the consultant it is difficult because they are the experts. If they want to make sure you’re sticking to the MST model it’s very much, kind of, it feels like it’s very much by the book ... Their agenda is to make sure you’re sticking to the model because the evidence shows that if you stick to the model then you get results” (Helen).

One team regarded their supervisor as an advocate to negotiate and resolve differences with the consultant.

“My current supervisor is strong enough in so many ways, that if somebody went ‘Oh, I don’t know if you’re supposed to’, ‘I think you’ll find we will be doing this because it’s necessary” (Ellen).

Some therapists described their consultant as having a good understanding of the British culture and cultural barriers and another consultant was perceived as receptive to and understanding of cultural difference.

“[The consultant] was great at understanding the culture and that’s because [they] had been a consultant in the UK already. And [they] asked a lot of questions.” (Fiona).

3.3.6 MST tailoring the model

Therapist’s described how MST informally tailored the model to fit in England at the systemic, consultant, supervisor and therapist level. ‘On-call’ was often cited as an example of a protocol that had been adapted at the early stages of MST being implemented in England. This was in response to safe-working policies within the NHS and professional norms around expectations of therapists conducting home visits outside of office hours.

“You’ve got the on-call system, and it looks like we do it differently to some teams. So we don’t go out, I’m clear with my families, it’s on the phone support” (Amy).

“Normally in consult, if it’s something that’s a barrier because of culture, we would say, actually in this country we can’t do that or we won’t do that or it wouldn’t work. They would say ‘Oh, ok’ or ‘how about this?’ It’s not been a huge issue” (Beth).

3.3.7 Therapists feeling supported and contained

Therapists described **feeling contained by having the MST process** to inform their work. This was deemed particularly helpful when working with families who were chaotic, with a large amount of unpredictability. Having the MST's detailed structure enabled therapists to prioritise effectively and not get diverted from the work by getting drawn in to day-to-day crisis management.

"[The do-loop] is really good because you know exactly what you're doing on the model. I need it; it stops me from drifting with families, especially chaotic families. They need to know what we're doing and where we're going, without getting lost in it" (Fiona).

Regular supervision and consultation was also identified as facilitating progress with families, as it required work to be regularly reviewed and the approach to be adjusted where necessary.

"For me the containment is having the weekly group supervision and the consult and I know we all moan about doing it but the weekly paperwork is so focused that for me that's your chance to process where you're at and then focus for next week." (Deborah).

Therapists also found their teams to be a source of emotional support.

"That's quite nice, feeling that there are people that are looking after each other. Making sure you're OK. Because we're a small team, we know each other quite well and you develop relationships in the team, so you're looking after each other emotionally. Because supervision and consult doesn't deal with your emotional needs and how a family are affecting you emotionally. But I think that because you're talking in your small team, that actually you meet each other's needs in that way" (Fiona).

There were examples shared of therapists feeling supported by their supervisor in terms of mediating with the consultant to explain cultural barriers or increase job flexibility.

“Our American consultant was very much like ‘well no, that goes against everything we believe. MST is so intense that there shouldn’t be space for a therapist to be able to [have job flexibility]’. And [the supervisor] had to fight very hard. Well, she had the final say. She agreed, so it’s fine” (Beth).

3.4 BARRIERS TO THERAPISTS IMPLEMENTING MST

A barrier to therapists faithfully implementing MST in England was that at times therapists felt that aspects of **MST did not fit for the families nor the systems** they were working with. Another finding that emerged from the data was that therapists received **conflicting messages within MST**. This was stressful and a barrier to therapists ‘adhering’. Some therapists found that times when aspects of the model did not fit were made harder by instances of **MST Services not acknowledging differences in England** or other obstacles to implementation.

3.4.1 MST not fitting for families in England

For most participants MST was seen as a universal model that could be applied to different cultures with successful outcomes. Participants identified some instances when they had found it harder to fit MST to the needs and wants of families.

The idea of **engaging by persisting** was seen by some therapists as quite counter to British culture:

“I think maybe it’s something to do with the polite British culture. I think it’s something to do with me. I think it’s something to do with the family... and I think it’s a cultural thing in

terms of services. You know, in CAMHS you get two DNAs or cancellations and you get discharged and have to be re-referred. In probation, two fail appointments and you get sent back to court for breach. It is that kind of culture whereby families don't have to engage. They know that if they don't, someone will leave them alone" (Beth).

"[The consultant] will suggest things like 'well can't you go round and do this? Can't you just turn up?' And it feels very uncomfortable to do this. Especially when a lot of the families are very kind of, like to keep themselves to themselves. Just turning up at their house or inviting yourself in, I think that feels quite alien to them. And again, that persistent approach may be quite – well I find it quite challenging anyway. And I know other therapists find it quite challenging as well" (Helen).

Another aspect of the model that participants felt fitted less well was the value MST placed on client families accessing support from their community, through family, friends, neighbours, religion or public servants. Participants described the culture in England as not having this sense of community.

"One of our things is high social support, and I feel like in England there's not a lot of community. People will not ask their neighbour for help. They will not tell their neighbour they're having problems with their kid. I think people are much more isolated in _____. Like people don't know their neighbours. They don't necessarily live by their family" (Catherine).

This was perceived as a barrier by therapists, as they described examples where consultants would make recommendations about accessing local support that did not seem culturally appropriate:

“You wouldn't ask the road sweeper to take a child to school or as extra support. Whereas [the consultant] would say 'well you know, that's the neighbourhood, he's a cleaner, he's up early, get him knock on your door, take your son to school'. We're like 'you can't do that here, they're not CRB checked'...” (Amy).

Another cultural factor that two participants observed was **British families struggling with the strengths-based approach.**

“The whole strengths-based thing is very hard for British people. They're really like 'you're annoyingly positive'... There are generations of families who've lived on the same estate, and generations of people who have never worked, and they don't want better for their child. They just want them to get pregnant and get the flat next door... American's have much more 'pull yourself up from the boot-straps and it'll be OK' and they just sometimes think that's annoying and a lot of crap” (Ellen).

These participants linked being strengths based in terms of feeling confident and optimistic about the possibility of future positive outcomes. Other participants described the strengths focus in terms of identifying strengths within family systems that could be built on and were universal in the ways they could be meaningfully applied to families:

“One family from the outside looks like they've similar issues and then actually when you get in there, what's worked for one family doesn't work for another. But MST accounts for that with the analytical process. You need to be flexible to the family and work to their specific strengths” (Fiona).

3.4.2 MST not fitting with systems in England

Participants described **therapists in England as having less power** and status than their US counterparts and having to be realistic about what could be achieved. This was particularly apparent in terms of systems and agencies such as education, youth offending services, social care and the police. Participants spoke of therapists in England having less authority, making it harder to take the role of lead professional, or make decisions about whether a child was placed in care or not excluded from school.

“Although we take the lead role, we don’t always have that power to take important decisions about young people and their education. There are a lot of people on these panels that have a louder voice” (Fiona).

Catherine described a family that she was working with where the father was physically abusing the mother. She explained how MST therapists in England are restricted in the amount of power they have in deciding whether a child is safe to stay within the home or not.

“We could work forever on the parent relationship, we don’t have the authority to say ‘this needs to stop, these kids can’t live in this home any more’ and doing all the CBT work with mum on making a decision to leave was not successful whatsoever” (Catherine).

Another systemic difference was perceived differences between MST teams’ working practices. Participants described **differences between the MST’s ‘dedicated’ work ethic and the ‘sustainable’ work ethic in England**. There was a feeling that the working norms in the US led to MST services and consultants questioning whether therapists in England were ‘doing whatever it takes’ when they were working within the

norms and parameters of English working practices. Differences in 'work ethic' included the US having a lower annual leave allowance and a feeling that the US had a stronger work ethic and fewer legislative restrictions, such as lone working policies and off-setting working additional hours by taking time of in lieu. This not only varied between the US and England but also between English MST teams.

"[Other teams] were like: 'oh no, we work seven days a week' we're like 'we don't, we work five days a week, we're very strict on that because you build up so much TOIL'. I mean, you know, within four days you can accumulate another six hours. So it's not that we're not doing whatever it takes for the family..." (Amy).

"I think that their work ethic is probably different. I think they do longer hours actually. And they certainly don't have the holidays we have. So I think probably, it's longer hours 'cos they can't understand why we haven't got all our goals and you're like 'well, I did 60 hours this week' and so I do think that maybe the work ethic is a little bit different in the States." (Fiona).

Participants reflected on how having a **lower legal school leaving age** in England, made it harder to achieve MST's education goals with a 16 or 17 year old.

"Our kids right now can leave school at 16. They don't wanna go to school. So we have a huge problem with trying to talk 16 year olds to get into education, employment and training where in the US, I think, if you let US children leave at 16, I think lots of them would but they have to stay until they're 18" (Catherine).

3.4.3 Conflicting messages in the MST model.

Therapists generally strived to adhere and talked about breaking from adherence being

a problem.

“If you aren’t adherent, then it’s a problem and they’ll pressure you about ‘why aren’t you following this, here’s where you need to be” (Catherine).

Tensions arose from situations where interpretation or aspects of the model were contradictory. Deborah gave the following example:

“I’ve been in consult where mum has told me about five times ‘I don’t want MST, you’re pressuring me, it’s too much’ and the consultant’s kind of sent me back in. You know ‘don’t tell her you’re going, if she cancels turn up anyway’ you know and it’s kind of like as a clinician, you kind of get - specially in five years in MST - you get to know which ones are worth pursuing and which ones aren’t. It felt very disrespectful. And this mum completely disengaged... And that is frustrating, because it is about persisting, whatever it takes, once someone’s started you can’t lose them. It’s supposed to be voluntary. If it’s voluntary then let this poor women go.” (Deborah).

In this example, the therapist cites the MST guidelines that the intervention should be voluntary but this seems at odds with the MST philosophy that therapists should ‘do whatever it takes’ to engage families. The consultant is privileging the philosophy of doing whatever it takes, whilst the therapist wishes to privilege the mother’s choice over treatment. Both courses of action could be argued to be adhering to MST.

A number of themes emerged from the data about therapists not believing the TAM scores were a valid measure of adherence. This presented the following challenges for therapists: Firstly, participants described MST assuming that if you adhere, your TAM scores will be high. Therefore, when therapists believed their **TAM score did not reflect their behaviour** they found it harder to know the best strategy for improving their score.

“The times that my scores are low and I don’t know why, what do I do with that?”

Because that can be quite – I don’t know what the word is – disheartening. Quite sort of like ‘what am I doing wrong? I’m doing the same thing as I did 6 months ago when my scores are high now I’m still doing that I think and my scores are low. So what?’” (Ellen).

A number of participants described a trajectory whereby, in the early stages of becoming a MST therapist, TAMs were seen as useful for identifying where to focus personal development and gain a greater understanding of the MST model. As therapists became more experienced, a number of factors other than adherence were identified as being more likely to account for low TAM scores. So if, after a period of scoring high on the TAM, a therapist’s score dropped, it could be attributable to the family’s feelings towards completing the TAM, the family’s feeling towards the therapist or the family not making the link between what the therapist was doing and the wording of the TAM.

The second obstacle for therapists trying to adhere and maintain high TAM scores was where therapists perceived families to be failing to make links between the therapist’s actions and the wording of the TAM. In this instance they were encouraged to become skilled in what one participant described as ‘linking and labeling’ to be more explicit with families about the links. This felt at odds with the strategy of using a shared language with clients to build engagement and alignment.

“We talk a lot about ‘linking and labeling’ so it’s the actual words that you’re using with your families so that they get a clear ‘ohhhh’ when ____ the admin person rings them up and says ‘does she do this?’ that I’ve only just two days before seen them in a session and I’ve actually mentioned those specific words.” (Ellen).

“I just think if I were them, to use that language would feel quite, I dunno, you’re differentiating yourself aren’t you? And I just think it’s different with MST, cos you’re in there all the time and you need to, they need to feel that you’re on the same level I think to an extent. Or that you don’t think you’re above them or something? Do you know what I’m trying to say? But for me that’s important because I think that’s when you really get good results.” (Deborah).

One participant also felt that conversations around feedback in supervision or consultation did not always fit with MST’s strengths-based approach, as it was more concerned with identifying areas for development:

“I feel you’re only as good as your last case. That’s how it’s measured. So you could have 12 great outcomes, one bad one and then that’s, I feel, where the emphasis is, almost. Which, I think goes against the model because it’s very much about strengths focused, but I don’t feel that when it comes to the therapists then it always is strengths focused” (Deborah).

Participants also described the dilemma of balancing the support of the on-call system with the MST principle of increasing responsibility and independence for family members:

“To let families ... who want everything, all given to them – to give them the on-call and say ‘yeah, we’re gonna come there at 11 at night, 12 at night, you know on the weekends, sort it out’ probably will abuse it to the point that it would be at their detriment when we finish. Because they would’ve relied on it for such a long period of time, of four months, that for me, I would see that my outcomes would then drop. ‘Cos they do follow-

ups for these families, I'd see a lot of mine would go back to those old behaviours, because the parent hasn't been able to implement stuff by themselves" (Amy).

3.4.4 MST not acknowledging cultural differences

As participants talked about challenges they faced implementing MST, it became clear it was harder when challenges were not acknowledged by the consultant or the MST model. Participants described experiencing additional pressure from consultants not acknowledging or understanding cultural barriers to implementing MST with families and broader systems. Some therapists spoke of consultants' believing therapists could overcome barriers when the therapist felt it was not within their control. Others described feeling ignored when they said no more could be done within the model for a family.

"A consultant might suggest 'can mum get to know her neighbours, make some brownies, do this?' and that's just not what people do here. They keep to themselves. And I think, for me, that's frustrating to get suggestions like that, because I know if I suggest them to a family; 'I'm not gonna do that'. And I don't think that people from the States – it's almost like they won't accept it's a different culture. It's like 'well it works here so it should work. People are people.' But people are people from where they are. And I think that can be quite hard, expecting what works in the States in terms of relationships and how people interact with one another, that it would be the same as over here." (Gemma).

"I said [to the consultant] 'are we going to talk about this cultural differences between the US and the UK in terms of the support of therapists? 'Cos that seems to be something that's an issue that needs to be addressed. And I don't know the answer but can we?'

and [the consultant] went ‘no, we’re not going to do that Ellen, no, no we’re not’. And [the consultant] floated off. And I was like ‘what?’. So to me, that was someone in a position that could do something, made the decision that we’re not going to look at that” (Ellen).

“I think it just makes it difficult in terms of the consultant because she doesn’t really understand the NHS model. And the barriers that present with that. And our workload increase” (Helen).

3.5 STRATEGIES FOR OVERCOMING BARRIERS TO FAITHFULLY IMPLEMENTING MST

In some instances participants were able to describe strategies for overcoming the barriers they had identified. It became apparent that there were three key strategies for overcoming barriers to MST implementation. These were **evidencing how something did not fit, suggesting creative solutions** to the problem and **privileging a different part of the model**.

3.5.1 Evidencing how something did not fit

The MST model emphasises the value of decisions being informed by evidence. Therapists applied this strategy when they felt an aspect of the MST protocol or suggestion from the consultant was unlikely to work. This was fed through the analytic process, tried out and then brought back to supervision or consult to demonstrate how it had not worked. Alternatively, therapists offered a description of the cultural difference to explain why something would not work.

“If you’ve been asked to implement something and you’ve tried it. You kind of knew it wasn’t going to happen but you’ve still tried it. Then you need to evidence it in your

paperwork that you've tried and this is the reason it's not been successful. Than just say 'it's not gonna work' or 'couldn't do it'. You have to be really clear on what was the reason why it wasn't sustainable” (Amy).

“I was very conscious how I was going to present this, so I'd already planned... I guess we are quite mindful if there are things that go against a purest MST that we are often thinking, how should we present this now? Maybe not formally but in your own thinking 'this is what I'm going to say'” (Deborah).

3.5.2 Suggesting creative solutions

Therapists gave various examples of how creative solutions could overcome potential barriers. These included collaborating with families to shape culturally unsuitable ideas into ones that fitted and using boosters and the team to generate creative solutions to shared problems.

“I would share that anyway. I would say to the family 'Look, this is what's discussed. I'm not sure if it's feasible for you but can we think of how it would work?’” (Beth).

Helen explained how the Youth Offending Service's lack of knowledge and different agenda were barriers to MST therapists' taking the role of lead professional. By taking it to a booster workshop and analysing the problem, the team was able to generate creative solutions to the problem.

“In a booster we were discussing, I think it was multi-agency working and I think one of the drivers was that we had poor communication and links with YOS and that's why our team have decided to really work on that... We've started to do a process where our updates that we give are more in terms of how they write their paperwork. So that it's in

their format, so that it's helpful for them and kind of engages them ...[and] we had a session where we went round before Christmas with mince pies and just did a question and answer half an hour and they asked questions about MST.” (Helen)

3.5.3 Privileging different parts of the MST model

Participants suggested that following a course of action was ‘adhering’ as long as one aspect of MST was being adhered to, even though, another aspect of MST might have discouraged the same course of action. Examples included choosing engagement over high TAM scores, citing good outcomes to justify different ways of working and identifying an aspect of an intervention that was going well to justify extending beyond the recommended timeframe in the MST guidelines.

“I don't call between session tasks ‘homework’ whereas the TAM will ask the family ‘did the therapist pick up on the homework from the previous session’ ... For some, homework is not, especially the clients we tend to work with where they haven't been in school for months or years, to then say homework, for me it's not comfortable.”

(Deborah).

In the following example, Amy justifies her team's adaptation of the on-call process.

“So it's not that we're not giving them the service, erm, and to me that's really important. I think it's different if it wasn't working and we were getting really low outcomes then you would say ‘ok then what are you not doing with the model? What are you not implementing?’ and then I could understand. But we are implementing everything...[and] we've got great outcomes” (Amy).

The extract below illustrates how Catherine's team decided to extend an intervention beyond the recommended guidelines.

Researcher: *"how was the decision made to extend it beyond the five month mark?"*

Catherine: *"Because, what had happened was that she was at grandparents and she was doing well and we were meeting regularly with grandparents, and helping them to manage her behaviour... So if she was there, it was like, ok this we can do. There's a good reason and engagement on the MST work."*

3.6 THE THERAPIST HOLDING THE TENSION

Therapists described **feeling under pressure, disempowered** and there were frequent comments about **therapist burnout**.

For the therapist there's a lot [of tension]. And because we're trying to meet the needs of the model and what the consultant wants us to do.... Because they'll want us to do something with the family and as much as we keep explaining 'mum feels really uncomfortable knocking on the neighbours saying hi I'm so-and-so'. Or the expectation that mum invite her neighbour over to tea" (Gemma).

The reasons therapists gave for feeling under pressure included being in an intense job, managing multiple requirements with service restrictions and needing to achieve goals. There was additional pressure for interventions to work because MST was perceived as the last option for many families and there was no 'safety net' if MST did not work. Whilst therapists did not always make explicit links between cultural differences and feeling burnt out, disempowered and under pressure, these feelings were contributed to by unacknowledged cultural differences. For example, therapists described feeling stressed

by instances where they felt responsible for achieving high adherence scores and progressing with families (see Sections 3.3.3 *Following MST principles and the analytic process* and 3.3.4 *Doing “whatever it takes”*) and where there was not an acknowledgement of cultural differences or flexibility to tailor the intervention to overcome cultural barriers (see Section 3.4 *Barriers to therapists implementing MST*).

In instances where therapists did not feel it was within their control to overcome barriers they were left holding the tension of not achieving adherence or progressing with families.

3.6.1 Feeling under pressure

Most of the participants described the job of an MST therapist as being stressful with a lot of pressure to perform well and achieve therapeutic goals. The extent that cultural barriers were identified as contributing to this pressure varied according to the extent that therapists felt their consultant and team acknowledged and were accommodating of cultural differences. Therapists experienced times when cultural differences were acknowledged and accommodated as not contributing to pressure. Examples can be found within Section 3.3.6 *MST tailoring the model*. Teams varied according to their level of stress and whether it was attributable to cultural factors (as can be seen in Gemma’s quote above) or other factors, such as witnessing child abuse.

“They will give you these ideas and sometimes it feels when we’re like errr [indicating hesitancy] that’s not really going to work, and they think that we are not adhering, at that particular point ‘cos we’re saying ‘it’s not going to happen’ so they see it as a barrier to the intervention. And it’s not actually a barrier to the intervention, it’s purely because we’re in a different country, so we have no power, you know, there’s many places we

can go but MST, they're 'MST who?'. You can't go to the courts and overturn what they... So that's been really tricky" (Amy).

"You feel like you're not meeting any of your intermediary weekly goals. And so then you get a bit stressed [laughing] and think 'why am I not getting this? This is the priority' and everybody's kind of pressuring you like 'you need to get this done'. So sometimes you feel a lot of pressure to move." (Catherine).

"I think it just makes it difficult in terms of the consultant because she doesn't really understand the NHS model. And the barriers that present with that. And our workload increase" (Helen).

"That's the difficulty, this model doesn't look at the effects of holding, one being responsible for everybody's treatment. And I'm not saying that's right, because as a therapist you are responsible for someone's treatment but not to this degree. Like, you are responsible for selling the model to them. Making sure they are aligned with you. Getting it done in three to five months. And sometimes it can take two months to get people aligned. And so I think just looking at the effects of all that pressure on therapists is what MST's really missing" (Gemma).

3.6.2 Feeling disempowered

Therapists considered the adherence measure as *"a way for the MST land to monitor other people's adherence"* (Amy). This was in contrast to other jobs therapists had done where they did not feel the same level of observation, accountability, and transparency in their work. Therapists described how being monitored impacted on them. Low TAM scores contributed to job stress, anxiety and could undermine therapist confidence.

“it could be quite embarrassing ... focusing on you as a poor therapist” (Amy)

“the TAMs make you feel very responsible like it’s your fault; you’re a useless therapist” (Beth).

“my mood in relation to my work dropped a bit, dipped a bit as you think ‘Ah, you can’t do anything right” (Ellen).

3.6.3 Feeling burnt out

Therapists described there being a three-year burnout rate caused by the number of stressors. Therapists managed this through dealing with stress outside of work or one therapist described often feeling tearful and having a colleague who had nightmares about work. All participants talked about feeling that the MST model did not incorporate processes for supporting therapists emotionally and this made it harder to manage workplace stress and emotional responses to the work.

“I’ve got outside sources to deal with stress” (Gemma).

“You can’t do MST for more than three years. I mean some people obviously do but a lot of people don’t because after three years there is quite a high burnout rate, from my understanding. And I can see why. I’m kind of reaching that myself.” (Gemma).

“[It’s] really stressful on the therapist, in terms of trying to negotiate / meet everybody’s needs” (Amy).

“The only thing I would change about the model is finding a way that you can take care of your therapists, who are under a lot of pressure and stress” (Gemma)

Some of the cultural differences described by participants were experienced as unhealthy and potentially contributing to burnout.

“the consultant I had, seemed to work about 20 hours a day, sleep about 4 ... that was her expectation, that everyone works 24 or 20 hours a day and doesn't have any holidays, or works through their holidays and doesn't have sick leave and stuff. I'm not sure that that's one realistic and two actually healthy” (Ellen).

3.7 THE POST-IMPLEMENTATION MODEL OF ADHERENCE (PIMA)

The relationship between the four categories described above can be seen in the Post-Implementation Model of Adherence (PIMA) illustrated in Figure 3. The PIMA explains how therapists in England experience and manage adhering to MST in a country where MST has been implemented without a formal process of ‘cultural tailoring’. The PIMA proposes that MST therapists strive to adhere to all aspects of the MST model whilst ensuring that it is acceptable and workable for the families and systems they work with. A number of ‘facilitators’ were identified as helping therapists move towards achieving adherence and fit, including using the outputs from the TAM; following the MST principles and analytic process; living the MST philosophy of doing ‘whatever it takes’; following direction from the MST consultant and supervisor and the MST system and the consultant and supervisor informally tailoring the model. To further enable therapists to achieve adherence and cultural fit when implementing MST in England, therapists must feel supported and contained by the MST team and model.

The post-implementation model of adherence identifies three types of barrier to achieving adherence and cultural fit when implementing MST in England. The first barrier is MST not fitting for families or systems. Therapists identified a number of ways

that MST might not fit for families or systems. There was variability according to the context and the therapist as to whether the therapists perceived it was in her control to overcome the barrier. The second barrier for therapists was when they received conflicting messages about what MST advised or what 'adhering to MST' meant. The third barrier for therapists was when MST did not acknowledge that the therapist was facing a cultural difference. Each of these barriers could be experienced on their own or could be combined to form a larger barrier to the therapist achieving both adherence and fit for the family or system.

When faced with a barrier to achieving adherence and fit, the extent that therapists implement a strategy depends on whether they feel it is within their control to overcome the barrier. If a therapist's perceived control to overcome a barrier is high, they may adopt one or a combination of the following strategies: Evidencing how the model or suggested course of action does not fit for the family or system, suggesting a creative solution to resolving the barrier or privileging a specific part of the MST model to inform their course of action. Where therapists feel overcoming a barrier to achieving adherence and fit is outside of their control, they are left 'holding the tension' of feeling unable to achieve adherence and fit. This situation is compounded by other stressful aspects of the work, contributing to therapists feeling under pressure, disempowered to make positive changes and burnt out within their role.

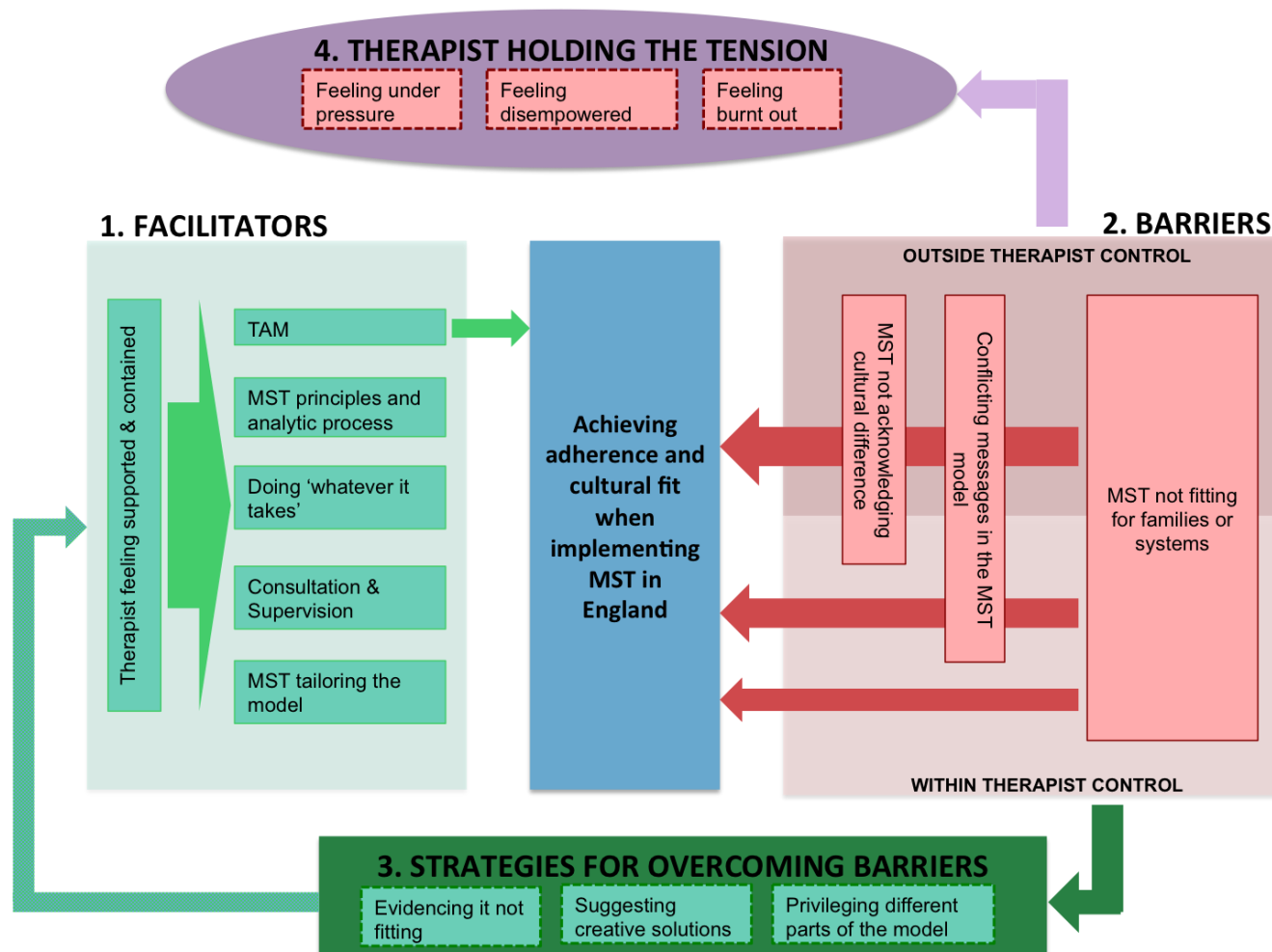


Figure 3. Post-Implementation Model of Adherence (PIMA): *How adhering to MST is experienced and managed by therapists in England*

3.8 FEEDBACK FROM MS LORI MOORE; MST INTERNATIONAL EXPERT.

After the analysis was complete, the theoretical codes, sub-codes and properties of the codes for MST Therapists outlined in Table 4 (p.61) and the resulting Post Implementation Model of Adherence were reviewed by MST international expert Ms Lori Moore. Ms Moore became an MST therapist in Pennsylvania, USA in 1999. She went on to work as an MST supervisor and consultant before becoming an 'MST Expert' in 2008, where she played a key role in transporting and implementing MST to sites in the United Kingdom, Iceland, Boston, and Florida. Ms Moore reviewed a written copy of the codes generated, before providing verbal feedback via a Skype video-call with the chief investigator.

This enabled a further quality control check as to whether the themes and model resonated with her experience and also provided new information regarding the extent Ms Moore felt the cultural barriers were specific to England. Ms Moore felt that engaging by persisting was easier for therapists in the US as she deemed the culture to be more assertive. In considering therapists' reports of families in England having fewer social networks and being resistant to developing them, Ms Moore felt this was a challenge experienced by therapists across the world, as a common feature of families accessing MST is not having high levels of support and engagement in the community. She also stated that in her experience a desire for privacy and reluctance to engage with one's neighbours was not a uniquely British experience as she had also noticed it when implementing MST in Iceland. Ms Moore felt that the emphasis on evaluation and accountability for therapists was fairly specific to MST and stated that in her experience, therapists from different countries have often not experienced this level of scrutiny and accountability before and struggle with the accompanying pressure. Ms Moore believed that a lower school leaving age was a challenge for

MST throughout Europe and disclosed that MST Services have acknowledged it as an area requiring further consideration.

Ms Moore described how the implementers of MST in England had been on a 'learning curve' regarding how MST was perceived by other systems and services within England. She recognised there were barriers to MST therapists becoming the lead clinician. In light of this, protocols have shifted away a little from recommending MST therapists be the lead, with clinical decision making powers and a desire for families to have no further service involvement after being discharged from the MST intervention. Ms Moore reflected on whether issues around MST being less well known and having less credibility with services may also be related to the length of time MST has been practised in the location. She felt that these issues might be temporary, rather than culturally specific, requiring teams in England to overcome barriers in a way similar to how MST teams in the US had to 20 years ago. Working practice differences such as the annual leave allowance were perceived to be a European-wide difference and Ms Moore perceived that this was different to the USA. In terms of the perceived contradictions to adhering to MST, although MST recommends adhering to the nine MST principles, Ms Moore described how these have been operationalized and translated into a range of protocols and guidelines. In her view, whilst the principles are deemed to be universal, the protocols and guidelines need to be adapted to fit the implementing country. This has been a constant comparative process for MST, where there may have been an assumption early on by consultants and supervisors that the protocols and guidelines were non-negotiable and needed to be rigidly adhered to but Ms Moore believed that there should be more flexibility regarding this more recently.

The notion of therapists being under pressure and holding responsibility for adherence scores and outcomes resonated with Ms Moore. She wondered whether

the context of therapists working within a randomised control trial might have provided additional pressure and an increased sense that 'failing is not an option'. She reflected that this might be felt a further pressure given the current economic climate in England leading to the cutting back and stripping away of services and contributing to many services feeling more vulnerable about their own future. The funding of MST teams are justified by their evidence base, meaning there is a constant need to evidence positive outcomes for families. In this way therapists may feel they must prove themselves every day. In addition to Ms Moore's useful perspectives on the culturally specific aspects of the analysis, she also spoke positively about the model and categories stating that they resonated and fitted with her experience of working with therapists in England.

3.9 FEEDBACK FROM A MST TEAM

A group of five MST therapists and two MST supervisors attended a feedback session to check the validity of the categories and PIMA model. They reported that the categories and model fitted with their experience. They provided examples of how, despite the role of MST therapist being a demanding position, this is partially offset by its flexibility regarding working hours and other benefits to the role. They reinforced the perspective that MST lacked a formal support system. Despite their team having built this into their practices informally, they felt the impact of it not being sanctioned at a more global level was that it risked feeling ad-hoc or not being privileged during times of competing pressures. When thinking about the findings relating to the TAM, there was a feeling that it could benefit from being validated for England. Also that it would benefit from having the language culturally tailored as it could feel 'disengaging' for families. There was a sense that work pressures could be quite team specific, with different services experiencing different types of pressure.

Chapter 4. Discussion

4.1 CHAPTER OVERVIEW

Chapter four begins by outlining the study's purpose and aims. Next the analysis is summarised and each of the research questions is addressed. Consideration is given to the theoretical implications of the findings and the research methodology is evaluated, plus suggestions are made for potential areas for future research. The researcher offers personal reflections of the research process before providing a summary and conclusion.

4.2 RECAPITULATING THE PURPOSE AND AIMS

This study explored therapists' experience of delivering Multisystemic Therapy (MST) in England as it was developed in the US and not specifically tailored to 'fit' England. It explored therapists' experience of adhering to the MST model and any ways that this felt helpful or challenging. It also looked at whether therapists had felt they deviated from the model to help meet the specific needs of the people or organisations they worked with. Eight MST therapists were interviewed from three teams in England. The interviews were transcribed and analysed using a Grounded Theory approach (Charmaz, 2006) and aimed to answer the following questions:

- To what extent do therapists in England experience a tension between model fidelity and cultural fit when implementing MST?
- How do therapists in England manage any tension between model fidelity and cultural fit when implementing MST?
- Does the MST model need to be adapted for England? If so, how?

4.3 SUMMARY OF THE ANALYSIS

Four overarching themes emerged from the analysis, which were mapped on to a model outlining how adhering to MST is experienced and managed by therapists in England.

- i) Facilitators to therapists staying faithful to the MST model
- ii) Barriers to therapists implementing MST
- iii) Strategies for overcoming barriers to implementing MST
- iv) The therapist holding the tension

The factors that facilitated therapists staying faithful to the MST model were largely in line with those defined by MST to promote adherence (Henggeler et al., 1998).

Therefore the discussion will focus more on the barriers to implementing MST, the strategies currently used by therapists to overcome the barriers and the consequences for therapists of holding the tension when they felt it was not within their control to overcome the barriers.

4.4 ANSWERING THE RESEARCH QUESTIONS: *THE TENSION BETWEEN MODEL FIDELITY AND CULTURAL FIT*

On one level, participants did not report experiencing tension between model fidelity and cultural fit as the question implied there was a degree of choice about whether or not to adhere, which did not generally fit with therapists' experience. Therapists generally reported that they felt they must adhere to the model at all times irrespective of whether it fitted culturally. Therefore, whilst it could be frustrating, they did not describe it as a tension as that implied a level of choice that did not fit with their experience.

Therapists described cultural barriers to implementing the model with high adherence. In this sense, what may have been conceptualised as ‘tension’ by other models may be conceptualised better as ‘cultural barriers to faithful implementation’ by participants in the current study (Castro et al., 2004). Therefore, the specific cultural barriers to faithful implementation are compared with existing literature.

4.4.1 Cultural barriers to therapists implementing MST

In line with research into therapists in England’s experience of implementing Multidimensional Treatment Foster Care (MTFC) therapists’ in the current study, described clinical and cultural barriers to implementing the model (Kirton & Thomas, 2011). Given the focus of this study, the cultural barriers are explored in detail, as they are deemed more likely to be specific to implementing MST in England.

4.4.2 ‘Persistence’ as a cultural factor

The idea of engaging by persisting was seen by some therapists as counter to English culture. This need to be persistent was reinforced for some participants who interpreted the MST value: doing ‘whatever it takes’ as valuing persistence. The persistent approach was deemed to undermine the client family’s choice of whether or not to engage with MST treatment. It is possible that this was influenced by MST teams being partially funded by, or being positioned within, the National Health Service (NHS). The NHS has a long history of valuing patient choice and in 2012 the Department of Health (DOH) published a policy document titled ‘Liberating the NHS: No decision about me, without me’ which highlighted the importance of patients having opportunities to make informed choices regarding their care and treatment (DOH, 2012). MST therapists drawn from mental health professions may also have previously worked within the NHS and been encouraged to value patient choice regarding their treatment in previous roles.

Taking a persistent approach with families may be an example of where it is useful to take a 'counter-cultural' approach. Despite the current political and legislative emphasis on patient choice, when parents and young people who had received MST in England were asked about their experience, they reported valuing the persistent approach (Tighe et al., 2012). They described persistence as necessary to overcome their initial reluctance to trying therapy due to feelings of hopelessness around change and frustration with previous professional involvement (Tighe et al., 2012).

4.4.3 Families accessing support as a cultural factor

Another aspect of the model that participants felt fitted less well in England was the value MST placed on client families accessing support from their community, through family, friends, neighbours, religion or public servants. Participants described the culture in England as not having this sense of community. MST services' rationale for promoting families accessing informal support from their community is that higher levels of social support have been demonstrated to positively correlate with higher family functioning and parents' ability to promote pro-social behaviour (e.g. Harrison, Wilson, Pine, Chan, & Buriel, 1990; Reiss & Price, 1996).

Participants' sense that MST assumed a greater level of community spirit may have partly come from observing training materials and examples from MST literature suggesting therapists encourage families to access support from the church (Henggeler et al., 1998). This recommendation felt less applicable in England. This may be due to MST being developed in South Carolina (MST Services, 2010b) where a high proportion of the population identify as Christian and 41% of the population attend a religious service at least once a week (The Pew Research Center, 2013). In contrast, despite 53% of the population in England and Wales identifying as Christian in the 2011 census, a recent YouGov poll, exploring religious

beliefs in more detail, found that only 9% of those identifying as Christian had attended a religious service in the past week, indicating that this might be a less appropriate source of support in England (British Humanist Association, 2014).

The MST expert's opinion was that lacking social support was a common feature for many families accessing MST, irrespective of culture (L. Moore, Personal Communication, 22/04/14). This perspective is reinforced by a study looking at the role of social integration on mental health and likelihood of offending, which reported that urban areas with less social cohesion and stability had higher rates of crime and youth offending (Hartwell & Benson, 2007). Turner and Turner (2000) noted two key aspects of social integration; *perceived* social support and *received* social support and found it was the *perception* of available social support that had the largest impact on health and well-being. Given that families accessing MST might be more likely to have lower perceived and received social support (Henggeler et al., 1998) it may be beneficial for MST to provide more guidance in increasing families *perception* of opportunities for social support as well as focussing on increasing the support available.

4.4.4 The strengths-based approach as a cultural factor

Therapists differed in their perceptions of how the strengths based approach was received by families in England. This was partly due to participants having different interpretations of what 'being strengths-focused' meant. Those who felt it was a poor fit for families perceived the strengths-focus in terms of conveying confidence and optimism about the possibility of future positive outcomes. Those who described the strengths-focus approach as fitting well with families described the strengths-focus in terms of identifying strengths within family systems that could be built on. A review of research into the strength-based approach (Saleebey, 1996) found that it was

beneficial in providing an alternative narrative and focus for families whose general experience of services had been more problem-saturated in focus. Criticisms of the approach were that it was equivalent to 'positive thinking' and also, that it risked invalidating the client's experience or ignoring their problems and concerns (Saleebey, 1996). Saleebey argues that where strengths-based practitioners focus on the resilience of clients in terms of utilising their knowledge, skills and motivation, it is able to offer something very different from positive thinking and can validate clients' experiences of their problems but challenge their beliefs regarding the inevitable consequences of their problems (Saleebey, 1996). This appears to apply to MST in England as a study exploring families experiences of receiving MST in the UK, found that families valued therapists focussing on their resilience and strengths (Tighe et al., 2012). Given that America has a long tradition of promoting the power of positive thinking (Saleebey, 1996) it is possible that it is this aspect of being strengths-focussed that therapists felt was counter-cultural in England. Whilst this may be promoted by American consultants 'positive thinking' is not part of the MST model or held within MST's description of being strengths focussed (Henggeler et al., 1998).

4.4.5 Cultural barriers to therapists being the 'lead clinician'

A systemic difference of implementing MST in England that emerged from the data was MST therapists becoming the lead clinician where other services were involved. The expectation that therapists should become the 'lead' is in current recommendations for MST best practice which states that "With the buy-in of other organizations and agencies, MST is able to "take the lead" for clinical decision-making on each case...The assumption is that most MST cases should need minimal 'formal' after-care services." (MST Services, 2008, p.1). Many of the therapists interviewed spoke of this expectation that they should take the role of 'lead

professional' when working with families and consider the reduction of support from agencies as a goal of treatment for families. Taking the lead and reducing ongoing support felt contradictory to the aims and objectives of other services and in some instances felt inappropriate to the MST therapists themselves. It is possible the reluctance to define the MST therapist as lead professional was, in part, due to the shift in working practices in response to the Victoria Climbié enquiry (Department for Education and Skills, 2003). In looking at lessons to be learned from the case of a young girl who had been neglected and abused to the extent that she died from her maltreatment, an inquiry identified areas for improvement and culminated in the 'Every Child Matters' green paper (Department for Education and Skills, 2003). The green paper emphasised the importance of health and social care professionals working collaboratively and sharing information, particularly around risk to children and young people. There may have been a sense for organisations working jointly with MST and families, that 'taking the lead' would involve MST therapists holding information that should be shared or making decisions that should have been taken collaboratively.

A serious case review of a young person who died whilst receiving MST was critical of the amount of risk held by the MST therapist and the amount of risk information known to the MST therapist and not shared with child protection services and other professionals working with the family (Harrington, n.d.). The serious case review highlighted that there can be confusion for MST therapists around the extent that risk management should be shared with other professionals (Harrington, n.d.). This suggests that MST services could be more explicit about how risk management should be shared with the appropriate services and also provides a potential reason as to why other services may have been reluctant for MST to take the lead role. When this was discussed with the MST expert (L. Moore, Personal Communication,

22/04/14) she revealed that MST services have been giving this protocol further consideration at a senior level and that going forward consultants will be less likely to push 'taking the lead role' as an objective for therapists in England.

Furthermore, issues around MST being less well known and having less credibility with services may also be related to the amount of time since initial implementation. It may be that these issues, rather than being culturally specific are temporally specific, requiring services to problem-solve in a way similar to how MST services in the USA did 20 years ago. Plans to move towards Network Partnerships where MST consultants are from England rather than America, should help address the working practice differences, which were expressed by therapists who were interviewed (L. More, Personal Communication, 22/04/14).

4.4.6 School leaving age as a cultural factor

Another cultural barrier to implementing MST faithfully was differences in the age young people must remain in full time education. One of the intervention goals for families receiving an MST intervention was that the young person would be in education or training (Henggeler et al., 1998). Up until last year, legislation in England stated that parents were responsible for ensuring their child received full-time education up until June in the school year that they turned 16. However, this requirement changed in September 2013. Currently 16 year olds are required to stay in education or training until they turn 17 and this will increase to age 18 from September 2015 (Department for Education, 2013). The recent and planned changes in statutory education requirements will enable MST therapists to use the statutory requirements and accompanying penalties to bolster their efforts to re-engage young people in education or training. In this way, the legislative changes may reduce this cultural barrier going forward.

4.4.7 Language as a cultural factor

In a MST setting, the use of language that was in line with MST terminology was deemed important to ensure high scores on the therapeutic adherence measure (TAM). Also, therapist sensitivity to language was deemed important to engaging and aligning client families. Using MST terminology and engaging families were identified as potentially contradictory goals. As part of the process for maintaining methodological quality standards, the main findings and analysis were shared with a team of MST therapists. One of the recommendations that came out of this discussion was that MST interventions in England would benefit from having the terminology adjusted to make it more accessible to families and other systems. It was felt that this would make the two goals of high adherence ratings and engagement and alignment with families and other systems more compatible. This finding was similar to findings from the MTFC study, which described professionals as having a desire for a shift in terminology of some of the terms used within the model to create a better fit in the UK (Kirton & Thomas, 2011). The case for validating and adjusting the TAM is given further credence by the mixed findings regarding the relationship between TAM scores and outcomes for families, with one study finding no correlation between TAM score and outcome (Schoenwald & Henggeler, 2000). Furthermore, Littel (2006) argued that the TAM measures core therapeutic skills. This fits with therapist's doubt over their validity.

4.5 ANSWERING THE RESEARCH QUESTIONS: *MANAGING THE TENSION BETWEEN MODEL FIDELITY AND CULTURAL FIT*

The level of tension or stress experienced by therapists in the face of cultural obstacles to adhering depended on how supported they felt by their supervisor, consultant and team and whether they felt it was within their control to overcome the

barrier. This partly depended on the extent that MST services were able to flexibly incorporate cultural differences at the team, consultant and supervisor level.

Therapists described experiencing a high degree of pressure, some disempowerment and a propensity to become burnt out. Participants described a range of contributors to this, much of it relating to the inevitably stressful aspects of working in the community with high-risk, potentially aggressive, families, intensively, who might be ambivalent about the involvement of professionals. Some of these feelings however, were due to perceived cultural differences that were not acknowledged by MST services.

4.5.1 Strategies for overcoming cultural barriers to implementation

In general, where therapists experienced cultural barriers to implementing MST faithfully as being within their control, they employed the following three strategies; Evidencing it not fitting, suggesting creative solutions and privileging different parts of the model. Where therapists experienced cultural barriers to implementing MST faithfully as being outside of their control they held this tension and felt under pressure, disempowered and burnt out.

By developing nine principles that were designed to be universal and able to be applied flexibly, MST developers have devised an evidence-based programme that can to some extent accommodate cultural barriers whilst maintaining adherence to the core principles (Henggeler et al., 1998). Within the flexibility of the model, therapists described being able to overcome cultural barriers by generating creative solutions. Another strategy was to evidence how a proposed course of action was not helping a family to meet their goals in order to justify a change of approach. The versatility of the core MST processes that therapists use to formulate and review

problems, such as ‘the analytic process’*, ‘fits’ and ‘sequences’ ensure they have structures and strategies available to tackle unforeseen challenges in unpredictable situations, irrespective of whether these are country-specific, family-specific or system-specific (Henggeler et al., 1998).

4.5.2 Mapping therapists’ experience on to the job control, demand, support model

The following sections consider how therapists’ experience of managing the tension between adherence and cultural fit could be conceptualised using the job demand, control and support model (Karasek, 1979). After outlining the model, each of the three key factors (job demand, control and support) is applied to the findings from this study. The concept of ‘support’ is considered further in the context of models of supervision, before considering how Karasek’s model might understand the emergent theme of burnout and staff turnover.

Karasek’s job demand, control, support model (1979) posits that there are three key factors that impact on employees’ psychological wellbeing in the workplace. These are workplace demands placed on the employee, the extent that employees have control over their work and the amount of support available to them. High demands, low control and low support were the conditions that had the most negative impact on employee psychological wellbeing (Van der Doef & Maes, 1999). If employees had more control over their work, as long as it directly linked to the demands, and higher levels of support, these factors could mitigate the impact of high demands placed on them in the workplace (Van der Doef & Maes, 1999). Schaubroeck and Merritt (1997) argue that rather than an objective measure of ‘control over work demands’ it

* See Appendix A for a glossary of MST terms.

is the employee's sense of self-efficacy about meeting demands that moderates the effects of job demand. That is, where employees feel they have the capability, motivation and resources to overcome workplace demands they perceive themselves to have control and are likely to experience higher psychological wellbeing and lower workplace strain (Schaubroeck & Merritt, 1997).

Participants' experiences of feeling under pressure and burnt out may be understood within Johnson and Hall's model (1979) as being in response to experiencing high work demands, having low control in meeting the demands and feeling they lack sufficient support from their supervisor or consultant.

4.5.3 Therapists' perceptions of job-demands

The participants in the current study described how working as an MST therapist was a job that placed high demands on them. They talked about the significant demands of supporting families in their homes and in the community with complex needs, with young people often with a history of aggressive behavior and sessions often taking place within chaotic environments. This work context was perceived as placing a strong emotional demand on therapists. Another source of 'workplace demand' was the perception among participants that they held the responsibility for engaging client families, adhering to the model and achieving positive outcomes for families. The level of scrutiny through the TAM, supervision and consultation increased the sense that therapists were expected to perform at a very high level at all times.

Additional workplace demands were also experienced through the cultural barriers to therapists implementing MST, which were specific to implementing MST in England. For example, times when MST was experienced as not fitting for families or systems represented additional pressures for therapists. Also, where therapists described receiving conflicting messages about the MST model, it appeared harder for them to

have a sense of what was expected of them and hence they may have been experiencing ambiguity around their role. Role ambiguity is also identified as a 'workplace demand' (Schaubroeck & Merritt, 1997).

4.5.4 Therapists' perceptions of control

The flexibility within MST provides many opportunities for therapists to have control over their actions and the approach they take with families. However, there were times therapists felt they did not have the control to meet workplace demands and were restricted by external services and systems or MST principles and protocols. An example of this was the perceived cultural barriers to taking the role of lead professional for their client families. There were also instances of consultants making suggestions that therapists felt were culturally not appropriate, where therapists perceived it outside of their control to challenge the consultant. Furthermore, some therapists talked of disparities between what they felt was within their control and what the consultant felt was within their control, for example, the outcome of a court hearing being perceived as outside their control by the therapist but within their control by the consultant.

One way that therapists interpreted doing 'whatever it takes' was as a pressure to achieve good results at all costs, making it difficult to separate poor outcomes from personal failure. This contributed to participants' sense that they held responsibility for outcomes that they perceived were sometimes outside of their control. Feeling that scores on the TAM were outside of therapists control was another example of therapists experiencing low self efficacy which could potentially interact with the high work demands to create workplace stress and burnout.

4.5.5 Therapists' perceptions of support

One of the themes that emerged from the therapist 'holding the tension' category was

therapists' feeling unsupported. Viswesvaran, Sanchez and Fisher (1999) describe social support as "*the availability of helping relationships and the quality of those relationships*" (p314). In a meta-analysis of studies looking at the relationship between social support and the impact of emotional demands Viswesvaran and colleagues (1999) found that social support served to buffer the impact of emotional demands so they were less likely to contribute to 'strains', such as burnout, reduced job satisfaction, poorer health and intent to leave. They also found that lack of social support was perceived as a stressor in its own right (Viswesvaran et al., 1999).

The job demand, control, support model conceptualizes a person's job as having a fixed amount of demand, control and support, which impact on the level of strain experienced by the employee. The pattern that emerged from the data within this study, was suggestive of therapists having aspects of their work where they felt they had less control and support and that this contributed to workplace stress and feelings of burnout but also times when they felt they had more control and were more supported, when they were able to manage the high job demands without it having a negative impact on them. In addition to variations within participants' accounts, there was also variation between participants, so that the specific characteristics of each therapist, supervisor and consultant also contributed to their experience of job demand, control and support.

4.5.6 Considering support in supervision and consultation

Little attention is given to the relationship between therapist, supervisor and consultant in MST, with supervision and consultation being primarily task and adherence focused. Models of clinical supervision emphasise the importance of attending to a range of factors within supervision and it is possible that were MST Services able to broaden the scope of supervision and consultation this could

improve therapist well-being, performance and reduce the impact of working in a demanding role (Milne, 2009).

4.5.7 Models of supervision

Hawkins and Shohet's seven-eyed model of supervision (Hawkins & Shohet, 2007) identified that supervision should incorporate focusing on the content of therapy sessions; strategies the therapist has applied in sessions, the relationship between the client and therapist, the therapist's processes (such as countertransference), the relationship between therapist and supervisor, the supervisor's own process (such as feelings about the supervisee) and the wider organizational and cultural context in which the work takes place. It is clear that currently MST is not incorporating all these aspects within supervision or consultation (Henggeler et al., 1998).

Holloway's system's approach to supervision (1997) considers the function of the different aspects of supervision. In addition to the functions prioritised by MST of monitoring, evaluating and advising, she also identifies the importance of supporting supervisees (Holloway, 1997). These supervisory processes and functions are seen as key elements in supporting therapists in their primary aim of providing safe and ethical interventions (Milne, 2009). A criticism of the seven-eyed model of supervision and the system's approach to supervision is that they lack a theoretical basis or clear guidelines for implementation (Milne, 2009). Consideration is therefore given to the therapy-based models of supervision, which draw from strongly evidence base of the theory (Milne, 2009) and considers the overlap between the therapeutic model and the supervision process. This is clearly evident in MST, as many of the tools and techniques used with families are also used within supervision. The Cognitive Behavioural Therapy (CBT) model of supervision is considered, as CBT is an approach often used with families within MST (Henggler et al., 1998).

In addition to providing feedback, guidance and evaluation, CBT based supervision emphasises the importance of supporting the therapist through being empathic and warm (Beck, Rush, Shaw, & Emery, 1979) and giving consideration to the relationship between therapist and supervisor (Padesky, 1996). Therefore, the range of models for supervision present a compelling picture for giving consideration to supporting therapists and considering process issues as part of supervision. This is reinforced by current local guidelines (Care Quality Commission, 2013). A report written in response to the Winterbourne View Serious Case Review, the Care Quality Commission (CQC) provided information and guidance for supporting effective clinical supervision (CQC, 2013). This report described the purpose of clinical supervision as *“to provide a confidential environment for staff to reflect on and discuss their work and their personal and professional responses to their work”* (CQC, 2013, p.4). The CQC also states that clinical supervision supports staff to manage the demands of their work and supports them in exploring their emotional reactions to the work, particularly in the case of complex clients. Furthermore, supervision that includes social and emotional support has been found to be associated with higher job satisfaction and higher staff retention (Barak, Travis, Pyun & Xie, 2009; Carpenter, Webb, Bostock, & Coomber, 2012). These findings further highlight the importance of providing emotional and psychological support for MST therapists (Barak et al., 2012).

4.5.8 Therapist burnout and turnover

The Canadian MST transportability study reported high rates of staff turnover and anecdotally recorded this as being common in other countries implementing MST (Cunningham, 2002). Whilst there may be aspects of the MST therapist’s role that are inevitably stressful and high in personal responsibility, if there are areas where this could be better managed, this may be able to reduce staff turnover. This is

important as high turnover is accompanied by high costs of recruitment, selection and training, plus the disruption for families of working with multiple or novice therapists (Sheidow, Schoenwald, Wagner, Allred, & Burns, 2007). Furthermore, turnover culminating from burnout may also impact on team morale and therapist performance (Sheidow et al., 2007).

A study looking at the predictors of MST therapist and supervisor turnover found that perceived high emotional demands were associated with significantly higher odds of leaving (Sheidow et al., 2007). The data for turnover rates among MST therapists in England is not currently available so it is not possible to ascertain the accuracy of participants' in this study's perception of the 'three-year burnout rate', however a presentation at the recent MST European Conference highlighted retaining MST staff as a key risk factor for reducing the sustainability of an MST team (Jefford, James, & Moore, 2014). This indicates that staff retention is deemed worthy of consideration for MST services going forward. It is interesting to note that at least 50% of participants in the current study had worked in MST for more than three years. This suggests that despite the rhetoric and concerns around burnout, these therapists have found ways of remaining in role beyond the perceived 'three-year burnout' mark.

One recommendation of Sheidow and colleagues was to work with clinicians to identify factors that contribute to emotional demands and also interventions to reduce these demands (Sheidow et al., 2007). The cultural barriers to implementing MST identified in the current study offer suggestions based on therapists' experience of aspects of the MST therapists' role that are emotionally demanding. The recommendations described below offer some strategies for managing these emotional demands.

4.6 ANSWERING THE RESEARCH QUESTIONS: *ADAPTING THE MST MODEL FOR ENGLAND*

4.6.1 Tailoring rather than adapting

MST recommends adhering to the nine MST principles, which are argued to be the key elements of the evidence-based model (Henggeler et al., 1998). The evidence base for the effectiveness of MST is strong and it is important that these core elements are adhered to faithfully (e.g. Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Henggeler, Melton, & Smith, 1992). The principles have been operationalized and translated into a range of protocols and guidelines (Henggeler et al., 1998). Whilst the principles are deemed to be universal, the protocols and guidelines need to be adapted or tailored to fit the implementing country. Whilst this tailoring process has been undertaken in other countries that have imported MST, it has not been the case in England. In the view of the MST expert (L. Moore, Personal Communication, 22/04/14) there may have been an assumption early on that the protocols and guidelines developed in the US could be applied in England and were non-negotiable and needed to be rigidly adhered to. Therefore, in line with previous research, 'adaptations' should more take the form of culturally tailoring protocols rather than adapting any of the core principles (Ferrer-Wreder et al., 2012).

Schoenwald's strategies for successful and faithful MST transportation and implementation consider the flexibility inherent in the model but also emphasises the importance of cultural tailoring (Schoenwald, 2008). The following section outlines ways that MST facilitates flexible adherence and recommendations for how it could be usefully 'culturally tailored' to England.

4.6.2 Facilitators to therapists staying faithful to the MST model

MST has taken steps to facilitate the model being implemented faithfully when transported. Henggeler (2001) suggested that the TAM, consultant, supervisor and booster training are all designed to help therapists adhere to the nine principles that have been identified as the mechanisms for change in MST (Henggeler et al., 1998). This suggests that MST's overarching perspective is that therapists should be guided by adhering to the principles if there is a perceived contradiction.

This fitted with the experience of therapists, who identified facilitators in line with the *MST quality assurance system*. The facilitators to therapists staying faithful to the MST model included the TAM, the MST principles and analytic process, consultation and supervision. These were consistent with the '*quality assurance and improvement system*' designed by MST services to ensure the model is adhered to wherever it is implemented (Henggeler, 2011). One of the strengths of the MST model is that therapists must follow the nine principles but within the principles there is scope for flexibility and interpretation to ensure interventions fit for families (Henggeler, 2011). It therefore makes sense that when therapists felt the MST model was able to accommodate cultural 'tweaking' they were better able to achieve high adherence and a good fit. Times when therapists felt supported and contained by the MST process, strengthened the facilitators previously discussed, to achieving high adherence and a good fit for families and systems.

4.6.3 Identifying areas for 'cultural tailoring'

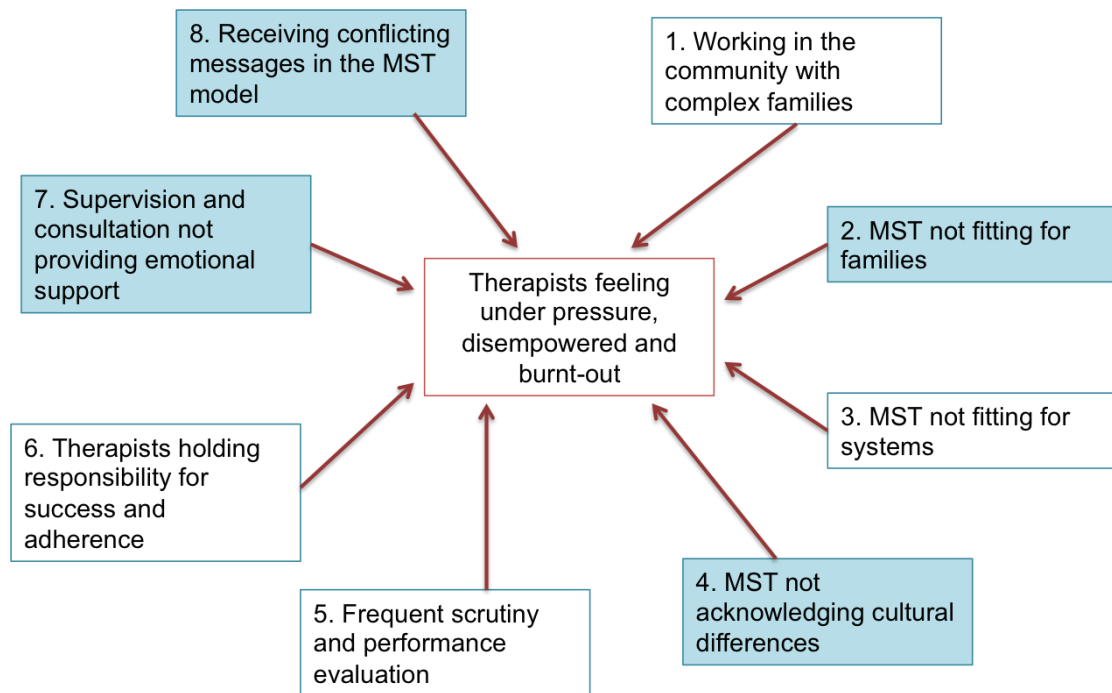


Figure 4: A 'fit' for therapists feeling under pressure, disempowered and burnt out.

The findings from this study highlight a number of clinical implications, which may be relevant for therapists and MST services when considering how MST is implemented in England. The post implementation model of adherence (which can be seen in Figure 3) indicated a number of adaptive ways that therapists could overcome barriers to implementing the model faithfully. The area in which the recommendations focus therefore is in the less adaptive experiences of therapists; feeling under pressure, disempowered and burnt-out. Figure 4 uses the MST technique of applying a 'fit' to the problem (Henggeler et al., 1998). The central box depicts the problem and the boxes around the outside represent the 'drivers' or factors that maintain or contribute to the problem. The boxes highlighted in blue represent the factors (or

'prioritised drivers') where change is more achievable and therefore are the focus of the recommendations.

4.6.4 Improving the fit between MST and families in England

Individual therapists or teams have generated ideas about creative ways to tackle the perceived lack of community in England. However, if it is a barrier experienced throughout England it may be beneficial to more systematically share learning and ideas of ways that families can form links in a manner that feels culturally appropriate and sustainable. Given that families have reported valuing therapist's persistence, it may be that therapists are already finding culturally appropriate version of 'persistence' in England. It may be that the challenge is supporting therapists to feel more comfortable about being persistent. When this cultural barrier was shared with the team of MST therapists as part of adhering to quality standards, they reported that the persistence dilemma is partially around how long to persist with a family before respecting their wishes to not engage. Further guidelines from MST about when 'enough is enough' may therefore be useful. Also, giving consideration to how the 'strength-based approach' is explained to families, with a focus on noticing and building on their strengths and less on taking an optimistic stance may increase the likelihood of it being well-received by families.

4.6.5 Acknowledging specific barriers to implementation in England.

It may be useful for MST services to consider ways of acknowledging the power difference between MST in the US and England. This could usefully include considering the viability and appropriateness of being the lead professional, having the power to make decisions, and believing therapists have more power to influence services than therapists believe to be the case. Consideration could also be given to the challenge of implementing goals around education, employment and training for

16-18 year olds with different statutory requirements. It may also be useful to acknowledge and validate the different work ethic in England although this may become less pertinent as fewer American consultants remain in post.

There is scope for MST therapists to feedback via the supervisor adherence measure and the consultant adherence measure and the program implementation review, however these have a restricted remit in terms of the topics they cover (L. Moore, Personal Communication, 22/04/14). Questions are restricted to how closely supervisors and consultants are adhering to the model and the extent that MST is being implemented in line with the program protocols. These protocols are intended to map on to the principles but are potentially less universal. There does not appear to be scope for therapists to feedback aspects of their work that are challenging or stressful or that do not fall within the pre-defined areas MST have outlined for review. This appears to be the case in the highly structured training, supervision, consultation and to a somewhat lesser extent the booster sessions. Therefore, it may be useful for MST to implement more open feedback opportunities for members of the team.

4.6.6 Support for therapists

Therapists receive weekly supervision and consultation as a team with a specialist MST consultant. The focus of supervision and consultation is promoting adherence to the core MST principles with no formal requirement to consider emotional support or reflective practice (MST Services, 2006).

This study showed that MST therapists may experience stress, burnout and feel disempowered as therapists as a result of the many demands placed on them within their role. As discussed, the job-demand, support and control model (Johnson & Hall, 1988) indicates that additional support from within supervision and consultation could provide a buffer between the high demands of the job, reducing the amount of stress

and burnout experienced by therapists. This would also be more in line with recommendations from models of supervision (e.g. Hawkins & Shohet, 2007; Holloway, 1997; Padesky, 1996).

Therapists currently receive weekly supervision and consultation as a team with a specialist MST consultant (MST Services, 2006). The focus of supervision and consultation is promoting adherence to the core MST principles with no formal requirement to consider emotional support or reflective practice (MST Services, 2006). Therapists meet for one-to-one supervision on an occasional basis to plan therapist's development (MST Services, 2006). MST might benefit from broadening the remit of supervision to include more of the elements outlined by the seven-eyed model (Hawkins & Shohet, 2007). This could usefully include therapists and supervisors reflecting on process issues and therapists considering and being supported on how their work has impacted on them. Given the greater level of emotional disclosure that this might require, MST protocols should give consideration to whether these aims could be better met in a one-to-one rather than group setting.

4.6.7 Ensuring the TAM is culturally appropriate for England.

Testing the validity of the TAM in England could be useful in highlighting any terminology or concepts that would benefit from being culturally tailored. It is anticipated that cultural translation could reduce some of the perceived contradiction in the MST model. This recommendation is further reinforced by the Canadian RCT, which found that TAM scores did not correlate with outcomes for families. It also reported low rates of adherence and outcomes for families who received MST were not significantly better than for families receiving treatment-as-usual. It is possible that a Therapist Adherence Measure that has not been culturally adapted may

negatively impact on how faithfully the model is implemented as well as negatively impacting on outcomes.

4.7 THEORETICAL IMPLICATIONS

The post implementation model of adherence (PIMA) fits well with Schoenwald's (2008) discussion of the factors that challenged MST international implementation and the modifications used to address the challenges and facilitate international implementation. Table 5 outlines the modifications Schoenwald identified at the pre-implementation and post-implementation stages (Schoenwald, 2008). In line with the Strengthening Families Program Adaptation Model (Kumpfer et al., 2008) the PIMA model (Figure 3) considers the impact of cultural different *after* the MST programme has been implemented based on feedback from clinicians. The PIMA model is able to extend Schoenwald's recommendations by providing an explanation of what happens when cultural tailoring has not taken place and how that is overcome or 'held' by therapists. The PIMA model highlights the importance of increasing therapist control as well as providing culturally tailored interventions to meet the needs of families and systems in England with the potential to reduce additional pressure, feelings of disempowerment and burnout for therapists.

Table 5

Strategies for achieving fidelity and cultural fit when transporting MST (Schoenwald, 2008).

PRE-IMPLEMENTATION OF MST	Mutual assessment process with stakeholders	Working with the host country's government and service systems
		Identifying and collaborating with local stakeholders
		Understanding and adjusting to legal and social standards
		Identifying desirable characteristics of therapists, supervisors and consultants
POST-IMPLEMENTATION OF MST	Training and treatment materials and processes	Translating training and treatment materials
		Tweaking therapeutic interventions
		Integrating culturally appropriate protocols
	Service delivery	Adapting the duration and intensity of treatment
		Adapting to local working practices and caseload standards
		Adapting the on-call systems
		Consulting with cultural advisors

4.8 EVALUATION OF THE RESEARCH

4.8.1 Strengths

One of the main strengths of this study was gaining perspectives on how cultural barriers to adhering are managed when there has not been a formal process of cultural tailoring. Whilst the barriers to implementation that emerged through the data fit with Schoenwald's findings regarding areas for considering cultural difference, this study is able to offer further insight into the process by revealing how therapists manage and experience these barriers where they have not formally 'tailored' (Shoenwald, 2008).

Using a qualitative methodology allowed for the perspectives of MST therapists to emerge, which contrasts with the general experience of MST therapists whose feedback is generally sought through adherence measures and formal questionnaires. The use of a qualitative approach also meant that findings were not limited by preconceived ideas or constructs.

A further strength of this study was the incorporation of quality checks as recommended in the quality control guidelines for qualitative research (Elliot et al., 1999). These included enhancing the credibility of the study by the supervisor and a peer familiar with the Grounded Theory approach and checking the coding of the transcript and resulting themes (Madill, Jordan & Shirley, 2000). The resulting themes and model were also verified with an MST expert and a group of MST therapists and supervisors, to check whether the themes and model resonated with their experience (Elliott et al., 1999). Furthermore, the recommendations were framed using the MST technique of a 'fit', improving its accessibility by matching the terminology used within MST and mirroring how MST conceptualises problems and problem solving (Elliot et al., 1999).

4.8.2 Limitations

This study may have been compromised by the completion of a literature review for course and ethics committee requirements prior to the collection and analysis of data (Charmaz, 2006). To counter this limitation, the author attempted to consider this prior knowledge and attend to any instances where questions may have been leading. The researcher also focused on what was emerging from the data by incorporating direct quotes from participants and making continuous comparisons across the data to ensure the emergent theory was grounded in the data (Charmaz, 2006).

The participants for this study were recruited from three MST teams across two densely populated urban cities, potentially limiting the external validity and generalisability of the findings to other sites across England. However, the majority of the 30 MST teams currently operating in England are in densely populated urban cities (MST Services, 2010). Furthermore, given that a limited number of categories related to the demographic of the client group it is possible that the majority of the categories would have applied in other parts of England. The category that might relate specifically to densely populated urban areas was the sense that families accessing MST in England were often isolated and that there was lack of a sense of community.

A further challenge of this study was establishing which barriers to implementation may be culturally specific and which might typically occur in the implementation of evidence-based practice. Most participants had only practiced MST in England and so were unable to make comparisons and were only able to speculate regarding the extent that barriers were culturally specific. To provide further insight into this, themes and model were discussed with an MST international expert who had played

a key role in transporting and implementing MST to a variety of sites across America and Europe. This enabled a further check as to the extent the themes and model resonated with her experience and also the extent she felt the cultural barriers were specific to England.

Grounded Theory suggests that sampling should be theoretically driven and should explore new areas of interest as they emerge from the data (Charmaz, 2006). From this perspective, it may have been beneficial to sample increasingly theoretically as this study progressed, such as focusing recruitment on therapists who had left MST services to further explore issues relating to burnout and perceived pressure. By interviewing therapists who had worked within MST for more than a year it is possible that the therapists interviewed were a sample that were able to withstand the pressures of MST or possibly an unrepresentative group of therapists 'approaching burnout'.

It is also unlikely that all categories in this study reached saturation, due to the relatively small sample size however hopefully this may have been mitigated by the level of reflection and articulation that participants were able to express in relation to their experience of adhering to MST in England (Charmaz, 2006). It also seems that the study has achieved Dey's alternative aim of 'theoretical sufficiency' (Dey, 1999).

4.9 SUGGESTIONS FOR FUTURE RESEARCH

There are a number of possibilities for future research arising from this study. One of the gaps in research identified by Schoenwald (2008) was a comparison between sites where MST had been implemented but not culturally tailored and sites where MST had been culturally tailored prior to implementation. In order to further understand the impact of cultural tailoring this comparison could be undertaken in England. The Strengthening Families Program Adaptation Model (Kumpfer et al.,

2008) highlights the importance of reviewing the effectiveness of the culturally adapted version of a model. If MST improved the 'fit' for MST in England, the impact of cultural tailoring could be measured by comparing outcomes, TAM scores, ratings of therapist job strain and therapist turnover, prior to 'cultural tailoring' with scores post 'cultural tailoring'.

Gaining therapists' perspectives of cultural fit, whilst providing a useful perspective, does not provide the full picture. Exploring the experiences of supervisors, consultants, client families and other stakeholders could build a fuller picture of how well MST 'fits' in England, plus potentially providing more cultural tailoring recommendations. Finally, the Post-Implementation Model of Adherence provides constructs defined by MST therapists that could form the basis of a questionnaire-based quantitative study. This could clarify the extent that the model can be generalized to MST therapists in England and whether it could be useful in understanding more broadly how barriers to transporting and implementing evidence-based treatments are experienced and managed by therapists.

4.10 REFLECTIONS ON THE RESEARCH

Whilst conducting this research I have reflected on my own social, cultural and professional background and also my personal values and beliefs and considered how these may have impacted my objectivity. As a white British therapist in my thirties, I share characteristics with many of the participants. The benefits of sharing similarities with participants are that it can foster acceptance by participants and they may feel able to be more open and discuss topics in more depth (Dwyer & Buckle, 2009). The risk of having shared characteristics are that participants may assume a shared understanding and not describe in as much detail as if the researcher was perceived as 'more different'. Alternatively, the similarity of the researcher's

experience and perspective might make it more difficult to identify themes that are different to the views or experience of the researcher (Watson, 1999).

I reflected on my dual role of being a researcher and clinician. My researcher role required me to take a more probing stance with participants that I was used to in order to gain a fuller understanding of participant's experience. Whereas, as a therapist I might be more led by the pace and level of detail a client wishes to disclose. In considering my own values and preferences, I was aware that my preferred working style is one with a degree of autonomy and flexibility and I am not particularly attracted to working to pre-defined guidelines. I was aware that this may have predisposed me to viewing the structured and monitored nature of MST negatively and I made an effort that my interview style and data analysis was not influenced by my own preferences. As participants began to talk about ways they felt that the MST model did not fit with English culture I noticed that I felt aligned with the British values they talked about, particularly around the importance of patient choice and respecting a person's personal space. I used supervision with peers and thesis supervisors to help me reflect on how these experiences may have influenced the data collection and analysis. Credibility checks such as validation and independent checking of themes by multiple MST therapists also helped to reduce the influence of my own assumptions on the data.

Having previously worked within occupational psychology was valuable when considering how the themes and model could be understood in the context of previous research as it allowed me to take a broader perspective across the clinical psychology and occupational psychology literature. This was particularly helpful in considering processes at the therapist, team and organizational level. Taking an inter-disciplinary approach to developing understanding of evidence-based practice is

critical in order to understand complex client needs and complicated health and social systems (Newhouse & Spring, 2010).

4.11 SUMMARY AND CONCLUSIONS

This study aimed to explore the extent that therapists experienced a tension between adhering to MST and fitting it to families and systems in England. It aimed to extend existing literature on transporting evidence-based treatments to new locations by considering how therapists managed a treatment programme that had not been culturally tailored to the country it was transported to. The results provide important insight into the robust nature of the MST model in providing opportunities for MST teams at the therapist, supervisor, consultant and team level to adhere creatively to the model in a way that enabled them to meet the need of families and systems in England. The results also highlighted barriers to adhering that therapists did not feel as able to overcome, either due to the barrier not being acknowledged by the broader MST service or due to receiving conflicting messages around adherence. Where therapists described overcoming barriers to achieving adherence and cultural fit as outside of their control, they held this tension and it contributed to them feeling under pressure, disempowered and burnt out. By making cultural adjustments to improve the fit for MST in England, acknowledging the barriers to implementing MST in England and formalising support for therapists within the supervision process, MST can potentially reduce the demands on and strain experienced by therapists. The PIMA model developed in this study provides an extension to Schoenwald's recommendations for successful transportation of MST by drawing attention to what happens when cultural tailoring has not taken place and how that is overcome or experienced as stressful by therapists.

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Appendix A

Glossary of MST Terms

Analytical Process	<i>A process for supporting therapists to formulate a problem, including what may have caused it and what might be maintaining it. The process also guides the development, review and refinement of strategies for overcoming the problem through the use of intermediary and overarching goals, arrived at collaboratively with the client family.</i>
Behaviour Plan	<i>Plans for the young person that are monitored and reviewed weekly to encourage responsible behaviour.</i>
Boosters	<i>Therapists receive quarterly sessions of additional training called 'boosters' within their local offices.</i>
Consult	<i>An MST expert provides weekly consultation for each MST team via a team telephone meeting.</i>
Consultant Adherence Measures (CAM)	<i>A 23-item measure that evaluates the MST Consultant's adherence to the MST model of consultation as reported by MST therapists and supervisors. The measure is based on the principles of MST.</i>
Do-loop	<i>An informal term for the analytical process.</i>
Drivers	<i>Factors that cause, maintain or contribute to the problem.</i>
Fit	<i>The 'fit' is the understanding that therapists and families come to collaboratively to understand each of the problem behaviours. Each fit is drawn from a brainstorming session between therapists and families where hypotheses about what might be 'driving' or causing behaviours are generated.</i>
Homework	<i>Therapists develop and design 'homework' tasks for family members to complete outside of treatment sessions.</i>

Intermediary Goals	<i>Intermediary goals are the incremental steps needed to reach the overarching goal.</i>
On-Call	<i>The ‘on call’ service is a resource for families to use for the duration of their MST intervention. An MST therapist is available 24 hours a day, seven days a week to provide support when needed and to respond to crises.</i>
Overarching Goals	<i>As part of the initial assessment process, the MST therapist helps the family to establish ‘overarching goal’s of treatment. Identification of overarching goals guide all MST interventions and are based on presenting problems and desired outcomes as indicated by family members and other key stakeholders.</i>
Sequences	<i>Interventions target patterns of behaviour within and between multiples systems that maintain the identified problems.</i>
Supervisor Adherence Measure (SAM)	<i>The ‘Supervisor Adherence Measure’ (SAM) is a 36-item measure that evaluates the MST Supervisor’s adherence to the MST model of supervision as reported by MST therapists. The measure is based on the principles of MST.</i>
Therapist Adherence Measure (TAM)	<i>The Therapist Adherence Measure-Revised (TAM-R) is completed by caregivers of the referred youth and assesses the therapist’s fidelity to the MST treatment principles.</i>
‘Whatever it takes’	<i>‘Whatever it takes’ is the MST philosophy. MST encourages therapists to ‘do what it takes to obtain positive outcomes for families’.</i>

Appendix B

Ethical Approval from RHUL Ethics Committee

Ref: 2013/030 Ethics Form Approved

Psychology-Webmaster@rhul.ac.uk **Sent:** Wednesday, April 17, 2013 7:57 PM **To:** nvjt114@rhul.ac.uk; Ellett, Lyn **Cc:** PSY-EthicsAdmin@rhul.ac.uk; Leman, Patrick

Application Details: Applicant Name:

Application title: Comments:

Caitlin Kiddy

Interviewing therapists to explore the tension between adherence and adaptation when delivering multisystemic therapy in Englandv2

Approved.

Below are reviewer comments for information.

Best, Patrick

Reviewer 1. Section 1 states that recommendations may be made to all teams based on adaptations made by individual therapists or teams. What criteria will be used for determining whether an adaptation has been successful and warrants recommending to other teams? One thing I wasn't quite clear about is the extent to which potential adaptations made by participants would be considered 'wrong' in terms of their original MST training (given the strong focus on adherence). This might influence how willing participants would be to take part in the study or to truthfully disclose adaptations they have made. Could it be worth adding to the information sheet something about how studies have shown that adherence is never 100% and that there are thought to be good reasons for this? Information sheet: the phrase 'authorised people' in the Confidentiality section is a little vague. Can you be more specific about who these people would be?

Reviewer 2. It would be good to have plans in place for the eventual destruction of the audio recordings and to communicate these plans to the participants before they give consent.

Appendix C

Research and Development Approval 1/3

Caitlin Kiddy
Royal Holloway
University of London
Department of Psychology
Egham
Surrey
TW20 0EX

2nd May 2013

Letter of NHS Permission for Research

Study title: Aherence and adaption when delivering MST in England v1

CSP/IRAS ref: 123250/443569/6/639/200325/270711

Dear Caitlin Kiddy

I am pleased to inform you that the above research study has been granted NHS Permission to be undertaken at [REDACTED], effective from the date of this letter. Please note that:

1. NHS permission has been granted following a review of the information provided in the following documents:

- NHS SSI Form 123250/443569/6/639/200325/270711
- NHS R&D Form 123250/443851/14/831
- REC Approval not required as study involves NHS staff only

2. Permission is granted only for those activities for which a favourable opinion has been given by the Research Ethics Committee and (if applicable) the Medicines and Healthcare products Regulatory Agency, and on the understanding that the study is conducted in accordance with the Research Governance Framework and (if applicable) ICH Good Clinical Practice, and the Trust's policies and procedures.

3. The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any immediate hazard to their health or safety. The R&D office should be notified that such measures have been taken. The notification should also include the reasons why the measures were taken and the plan for further action. The R&D Office should be notified within the same time frame of notifying the REC and any other regulatory bodies. Any amendments (including

changes to the local research team) need to be submitted in accordance with IRAS guidance and the R&D Office informed.

4. Principal Investigators must inform the R&D Office of the total number of recruits recruited to this study on a monthly basis and, for NIHR portfolio studies only, also ensure that this information is recorded correctly on the national accrual database.

5. The Trust is required to monitor all research activities to ensure compliance with the Research Governance Framework and other legal and regulatory requirements. This is achieved by random audit, and all required documents must be made available upon request to facilitate this process.

Finally, I wish you every success with your study. Please don't hesitate to contact me should you require any further assistance.

Yours sincerely

Anthony Davis

Research and knowledge manager

Research and Development Approval 2/3



Research and Development

Ms Caitlin Kiddy
Trainee Clinical Psychologist
Department of Psychology
Royal Holloway, University of London
Egham
Surrey TW20 0EX



15 May 2013

Dear Caitlin,

Research Title: Interviewing therapists to explore the tension between adherence and adaptation when delivering multisystemic therapy in England
Principal Investigator: Ms Caitlin Kiddy
Project reference: PF557
Sponsor: Royal Holloway, University of London

Following various discussions your study has now been awarded research approval. Please remember to quote the above project reference number on any future correspondence relating to this study.

Please note that, in addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, host site approval is subject to the following conditions:

In addition to ensuring that the dignity, safety and well-being of participants are given priority at all times by the research team, you need to ensure the following:

- The Principal Investigator (PI) must ensure compliance with the research protocol and advise the host of any change(s) (eg. patient recruitment or funding) by following the agreed procedures for notification of amendments. Failure to comply may result in immediate withdrawal of host site approval.
- Under the terms of the Research Governance Framework, the PI is obliged to report any adverse events to the Research Office, as well as the REC, in line with the protocol

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and sponsor requirements. Adverse events must also be reported in accordance with the Trust Accident/Incident Reporting Procedures.

- The PI must ensure appropriate procedures are in place to action urgent safety measures.
- The PI must ensure the maintenance of a Trial Master File (TMF).
- The PI must ensure that all named staff are compliant with the Data Protection Act, Human Tissue Act 2005, Mental Capacity Act 2005 and all other statutory guidance and legislation (where applicable).
- The PI must comply with the Trust's research auditing and monitoring processes. All investigators involved in ongoing research may be subject to a Trust audit and may be sent an interim project review form to facilitate monitoring of research activity.
- The PI must report any cases of suspected research misconduct and fraud to the Research Office.
- The PI must provide an annual report to the Research Office for all research involving NHS patients, Trust and resources. The PI must also notify the Research Office of any presentations of such research at scientific or professional meetings, or on the event of papers being published and any direct or indirect impacts on patient care. This is vital to ensure the quality and output of the research for your project and the Trust as a whole.
- Patient contact: Only trained or supervised researchers holding a Trust/NHS contract (honorary or substantive) will be allowed to make contact with patients.
- Informed consent: is obtained by the lead or trained researcher according to the requirements of the Research Ethics Committee. The original signed consent form should be kept on file. Informed consent will be monitored by the Trust at intervals and you will be required to provide relevant information.
- Closure Form: On completion of your project a closure form will be sent to you (according to the end date specified on the R & D database), which needs to be returned to the Research Office.
- All research carried out within [REDACTED] Trust must be in accordance with the principles set out in the Department of Health's Research Governance Framework for Health and Social Care 2005 (2nd edition).

Failure to comply with the conditions and regulations outlined above constitutes research misconduct and the Research Office will take appropriate action immediately.

Please note, however, that this list is by no means exhaustive and remains subject to change in response to new relevant statutory policy and guidance. If you have any queries regarding the above points please contact me on [REDACTED]

Yours sincerely,

A handwritten signature in black ink, appearing to be 'E. Eboda', written over a horizontal line.

Ms Enitan Eboda
Research & Development Co-ordinator
On behalf of the Research & Development Committee.

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Research and Development Approval 3/3

Emailed approval from non-NHS site:

Sent: 07 October 2013 2:33 PM
To: Kiddy, Caitlin (2010)
Subject: RE: Interviewing MST therapists.

Hi Caitlin,

We are happy for you to contact MST therapists who have been in post for 6+ months regarding your study. The next step is for you to send us something about your study that you would like us to send out, and one of our MST Coordinators, [REDACTED] or [REDACTED], can send this out to therapists (I have copied in our [REDACTED] email which they both check). It will be down to therapists to respond and arrange to meet with you for interviews. I am happy to answer any further questions you have and act as a liaison if any issues arise during the process. I hope that's helpful. Let me know if you need anything else.

Best wishes,

Appendix D

Participant Information Sheet

Adherence and Adaptation when Delivering MST in England

I would like to invite you to take part in a research project. Before you decide if you want to take part, I would like to explain why the research is being done and what it would involve for you. Please ask me if there is anything that you do not understand.

Purpose

The purpose of this research is to find out about the experiences of MST therapists in England. Particularly to understand how therapists have experienced adhering to the MST model and any ways that this has felt helpful or challenging.

I am also interested in understanding whether therapists have adapted the model to help it meet the specific needs of the people or organisations they are working with. I wish to explore whether therapists would have liked to have more flexibility or the extent that it is felt that flexibility is built into the MST model.

I am a trainee clinical psychologist, and this research project is undertaken as part of my doctorate in clinical psychology.

Deciding whether you would like to take part

I will ask for your permission and then ask you to sign a form. I will give you a copy of this information sheet to keep. If you do not want to take part in this study then you do not have to give a reason and no pressure will be placed on you to change your mind. If you do decide to take part you are still free to change your mind at any time without giving a reason.

What is involved in taking part?

If you agree to take part in the study I will call you to arrange a convenient time to come and interview you at your work. The interview will probably last about an hour to an hour and a half and will include open-ended questions about your experience as an MST therapist. It will be audio-recorded.

If you decide to take part, I may ask you later on in the study if you would like to feed back on my analysis. You are able to say no to this offer without giving a reason.

What are the possible benefits of taking part?

I cannot promise this study will help you. However, it will give you an opportunity to reflect on aspects of your work that you may not normally have time to consider. It will also provide a confidential space to explore issues without a fear of unforeseen consequences.

This study may help inform how MST is delivered in the UK in the future.

Questions, comments or concerns

If you have any questions, comments or concerns about any part of this study, please contact either myself (email, Caitlin.Kiddy.2010@live.rhul.ac.uk Tel: 01784 414636), or my supervisor, Dr Lyn Ellett (Lyn.Ellett@rhul.ac.uk)

Confidentiality

We will keep your information in confidence. This means we will only tell those who have a need or right to know. On my sheets I will remove your name and anything else that may identify you. I will then write a thesis about the interviews and all your identifying information will be removed and replaced with participant numbers or pseudonyms. The audio-taped recording of our talk will be kept in safe place at Royal Holloway University of London and may be looked at by authorised persons from

Royal Holloway, University of London.

Information may also be looked at by authorised people to check that the study is being carried out correctly. All these people will have a responsibility to keep your information private and we will do our best to make sure this is done.

If during our talk we have any worries for your safety, worries for other people's safety, or you tell us something that is against the law we have a responsibility to tell someone else about this. We will try to talk about this with you first to explain our reasons and what will happen next.

Who has reviewed the study?

Before any research goes ahead it has to be checked by a Research Ethics Committee. This project has been checked by the Royal Holloway University of London Research Committee and the Research and Development Team local to your MST workplace.

Further information and contact details

If you would like to take part in this study then please contact me on 01784 414636 (Researcher) or on email (Caitlin.kiddy.2010@live.rhul.ac.uk) or at the address below.

Researcher

Caitlin Kiddy
Clinical Psychology Department
Royal Holloway, University of London
Surrey
TW20 0EX
tel: 01784 414636
Email: Caitlin.kiddy.2010@live.rhul.ac.uk

Research Supervisors

Dr Simone Fox and Dr Lyn Ellett
Clinical Psychology Department
Royal Holloway, University of London
Surrey
TW20 0EX
Email: simone.fox@rhul.ac.uk
lyn.ellett@rhul.ac.uk

Appendix E

Consent Form

Research Title: Exploring the Tension Between Adherence and Adaptation When Delivering Multisystemic Therapy in England

Researcher: Caitlin Kiddy

<i>Please initial each box:</i>	
1. I have read the information sheet that describes this study.	
2. I have had an opportunity to ask questions and discuss this study.	
3. I have received satisfactory answers to all my questions.	
4. I understand that my participation is voluntary and I am free to withdraw at any time, without giving a reason.	
5. I agree for my information to be shared with authorised people from Royal Holloway University and understand that all personal data relating to me is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998).	
6. I have read and understood the limits of confidentiality regarding risk.	
7. I agree to being contacted for my comments on the findings of the study.	
8. I agree for anonymised quotes from my interview to be used in publications.	
9. I agree to take part in this study.	

MST Therapist Name:

Signed: Date:

Researcher Name:

Appendix F

Pre-interview Sheet

Adherence and Adaptation when Delivering MST in England

Pre-selection form to check suitability for participation

1. Are you an accredited MST therapist currently working in an MST team in England? (Yes /No)
2. Participant Name
3. MST Team:
4. MST Team address:
5. MST Team telephone number
6. Participant work mobile number
7. Professional background (i.e. Social Worker, Psychologist)
8. Nationality
9. Age: decade (20s, 30s, 40s, 50s, 60s)
10. Have you worked as an MST therapist for more than one year?
11. Have you lived in England for more than three years?
12. Have you worked under an American MST Consultant?

Appendix G

Debrief Form

Adherence and Adaptation when Delivering MST in England

Participant Post-Interview Information Sheet

Thank you for participating in the interview. Below is a description of the background, purpose and potential implications of this research project.

A wealth of research over the past 30 years has demonstrated the efficacy of MST. Its success has led to it being implemented across 14 countries and this has prompted investigations into the need for cultural adaptation.

High adherence (or 'fidelity') to the MST model is able to predict favourable long-term outcomes for juvenile offenders. Consequently, a number of adherence measures and supervision protocols are included in the MST programme. In this way, it is strongly communicated to MST therapists and teams that adhering to the MST model should be a priority in their working.

The MST model has not been adapted to ensure a cultural fit with the UK despite evidence that there are national differences between the cultural values of the UK and USA. Furthermore, when reviewing the process for implementing MST in different countries (not including the UK) a number of issues were identified that required consideration.

There is evidence that when models are transported to new countries, cultural adaptation improves outcomes. Also, no interventions have been demonstrated to achieve 100% adherence to the model, which suggests some level of cultural adaptation is inevitable.

This research aims to explore the extent that MST therapists in England have experienced a tension between the desire for model fidelity and the desire to adapt the programme to ensure cultural fit and understand how they managed this tension.

It is hoped that exploring therapists' experiences will further our understanding of the relationship between 'fidelity' and 'fit', as well as identifying useful areas for cultural adaptation of the MST model in England.

Further information and contact details

If you would like to receive a copy of the final report or have any questions or comments, please email Caitlin Kiddy at the address below.

Researcher

Caitlin Kiddy
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TW20 0EX
tel: 01784 414636
email: Caitlin.kiddy.2010@live.rhul.ac.uk

Research Supervisors

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lyn.ellett@rhul.ac.uk

Appendix H



DRAFT Semi-Structured Interview Guide

1. **Icebreakers**

1.1 How has work been this week?

1.2 How many families do you have on your caseload at the moment?

1.3 Have you always / How long have you lived in the UK?

2. **Adherence**

I'd like to start by thinking your experience of 'adhering to the model' within MST.

2.1 What does 'adherence' mean to you

2.2 What has been your experience of the TAM, SAM and the CAM?

2.2.1 How does working within an MST framework compare with your prior experience of being monitored in the workplace?

2.3 How has MSTs focus on adherence affected the way you've worked with families and their systems

2.3.1 In what ways has it had a positive impact on your work?

2.3.2 In what ways has it presented challenges?

2.4 How have you adapted your own working practices or preferences to fit with the MST model?

2.5 Can you think of a time when a family or system had to change to accommodate the MST model? Can you provide some examples?

2.5.1 Who suggested the change?

2.5.2 How did the family or system view the change?

2.5.3 What was your view of the change?

3. Adaptation

Now I'd like to think about times when you have changed or wanted to change the model to create a better fit for your client

3.1 Can you tell me about a time when an aspect of MST did not fit with your client?

3.1.1 What did you do? (in detail, including any decision making processes)

3.1.2 Were there any unforeseen consequences? If so, what?

3.2 Can you think of a time when an aspect of MST did not fit with another system you were working with?

3.2.1 What did you do? (in detail, including any decision making processes)

3.3 Can you think of a time when the MST model differed from your preferred way of working?

3.3.1 What did you do? (in detail, including any decision making processes)

3.4 Can you tell me about any times when adapting or deviating from the MST model has been unhelpful?

3.5 Do you feel that the MST model needs to be adapted for England? If so, how?

4. Culture

As MST was developed in America and transported to the UK, I'd now like to think about the role of Culture in MST.

4.1 What do you feel are the differences between English and American culture that might be relevant when thinking about MST?

Possible prompts:

4.1.1 Legal differences (court process, drinking age)

4.1.2 Social norms (leisure activities, types of support, religion, values)

4.1.3 Working practices

4.1.4 Minority ethnic group differences

4.2 What US/UK cultural differences arose during your five-day training?

4.2.1 How has this impacted on your implementing the MST model?

4.3 To what extent do you feel that the MST 9 treatment principles are universal?

4.4 What (if anything) do you think is specific to delivering MST in England as opposed to other countries?

4.5 What have been the challenges of working in your setting and fulfilling MST requirements?

4.6 Have there been challenges between what your supervisor and the American consultant have asked you to do you attributed to a US/UK cultural difference?

4.6.1 How was this managed?

5. Final Question

5.1 To what extent (if at all) do you feel there is a tension between adhering to the MST model and adapting the model to fit the family and systems you are working with?

5.1.1 To what extent do these adaptations relate to cultural differences in implementing MST in the UK?

5.2 Is there anything else that you think might be important for me to know about being a MST therapist in England?

Thank you!

Appendix I



AMENDED Interview Guide

1. **Icebreakers**

1.1 How has work been this week?

1.2 How many families do you have on your caseload at the moment?

1.3 Have you always / How long have you lived in the UK?

2. **Adherence**

I'd like to start by thinking your experience of 'adhering to the model' within MST.

2.1 What does 'adherence' mean to you

2.2 What has been your experience of the TAM, SAM and the CAM?

2.2.1 How does working within an MST framework compare with your prior experience of being monitored in the workplace?

2.3 How has MSTs focus on adherence affected the way you've worked with families and their systems

2.3.1 In what ways has it had a positive impact on your work?

2.3.2 In what ways has it presented challenges?

2.4 How have you adapted your own working practices or preferences to fit with the MST model?

3. **Cultural Tailoring**

3.1 Can you tell me about a time when an aspect of MST did not fit with your client?

- 3.1.1 What did you do? (in detail, including any decision making processes)
- 3.1.2 Were there any unforeseen consequences? If so, what?
- 3.2 Can you think of a time when an aspect of MST did not fit with another system you were working with?
 - 3.2.1 Prompts: Core principles, Direction from US Consultant, Focus of work
 - 3.2.2 What did you do? (in detail, including any decision making processes)
- 3.3 Can you think of a time when the MST model differed from your preferred way of working?
 - 3.3.1 What did you do? (in detail, including any decision making processes)
- 3.4 Can you tell me about any times when deviating from the MST model has been unhelpful?

4. Culture

As MST was developed in America and transported to the UK, I'd now like to think about the role of Culture in MST.

- 4.1 What do you feel are the differences between English and American culture that might be relevant when thinking about MST?

Possible prompts:

- 4.1.1 Legal differences (court process, drinking age)
- 4.1.2 Social norms (leisure activities, types of support, religion, values)
- 4.1.3 Working practices
- 4.1.4 Minority ethnic group differences
- 4.2 What US/UK cultural differences arose during your five-day training?
 - 4.2.1 How has this impacted on your implementing the MST model?

- 4.3 To what extent do you feel that the MST 9 treatment principles are universal?
- 4.4 What (if anything) do you think is specific to delivering MST in England as opposed to other countries?
- 4.5 What have been the challenges of working in your setting and fulfilling MST requirements?
- 4.6 Have there been challenges between what your supervisor (or the UK Consultant) and the American consultant have asked you to do you attributed to a US/UK cultural difference?
- 4.6.1 How was this managed?
- 4.7 Do you feel that the MST model needs to be amended for England? If so, how?

5. Final Question

- 5.1 To what extent (if at all) do you feel there is a tension between adhering to the MST model and fitting the model to the family and systems you are working with?
- 5.1.1 To what extent do these tensions relate to cultural differences in implementing MST in the UK?
- 5.2 Is there anything else that you think might be important for me to know about being a MST therapist in England?

Thank you!

Appendix J

Example Memo

Memo on using power to influence in MST. December 2013.

Most of the participants so far have talked about the impact having more or less power within MST. It has been a theme across different contexts. There was a sense that therapists in England lacked the necessary power in professional relationships with other services when compared with America. Some participants worried that they abused their power in their relationships with families by imposing the intervention on them and not respecting their choice to disengage.

MST therapists in the US were deemed to have more power over the authorities and systems they worked with, both in terms of deciding outcomes for families (such as halting court proceedings or instructing the police to attend with the MST Therapist).

“over here we can't do that” (Catherine)

“It's out of our control. And I think because in America they have this huge power over it – America - with all authorities, that they don't see why we don't have it here. So it is really really difficult.” (Amy)

The American consultant said *“We have the power to do that over here” (Deborah)*

“I think as well, MST in America carries a lot of weight” (Deborah)

“they [mst therapists in US] often have a lot of power” (Deborah)

“over here you just don't really have that much clout in terms of housing or benefits or things like that” (Deborah)

Participants talked of being in a position of power over families. By turning up at their homes and using a language that may not be accessible to families they were

positioned in the more powerful role. Deborah was particularly thoughtful and descriptive on this point.

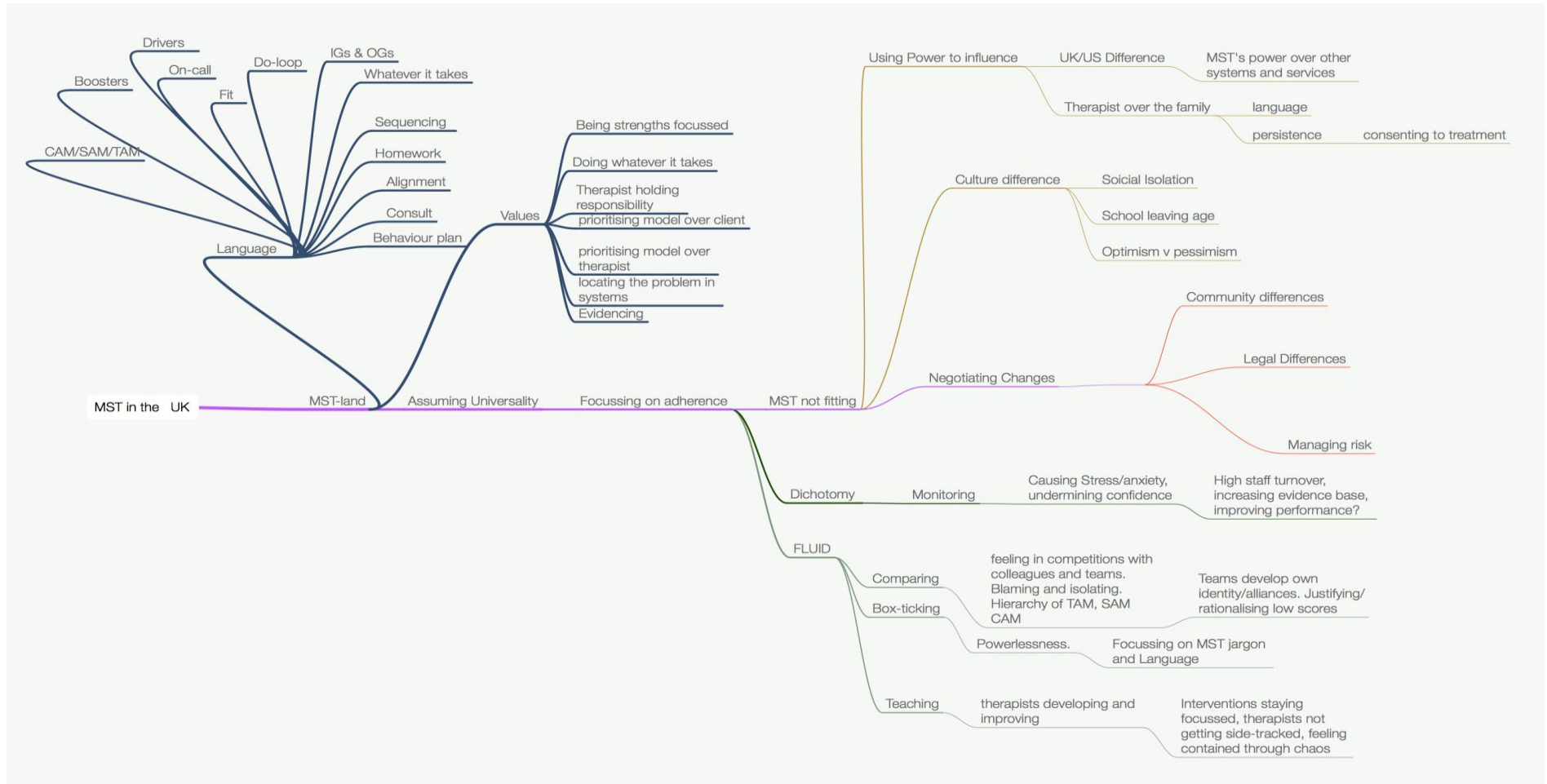
'but I don't like to use all the lingo with families because I just think sometimes it sounds a bit insincere and I don't feel comfortable so I will say to them 'you know, in MST we call this a fit, but I just call it a spider diagram' so that they know the lingo when it comes up in the TAMs but that it's not ... I dunno, I just think if I were them to use that language would feel quite, I dunno, you're differentiating yourself aren't you?' (Deborah).

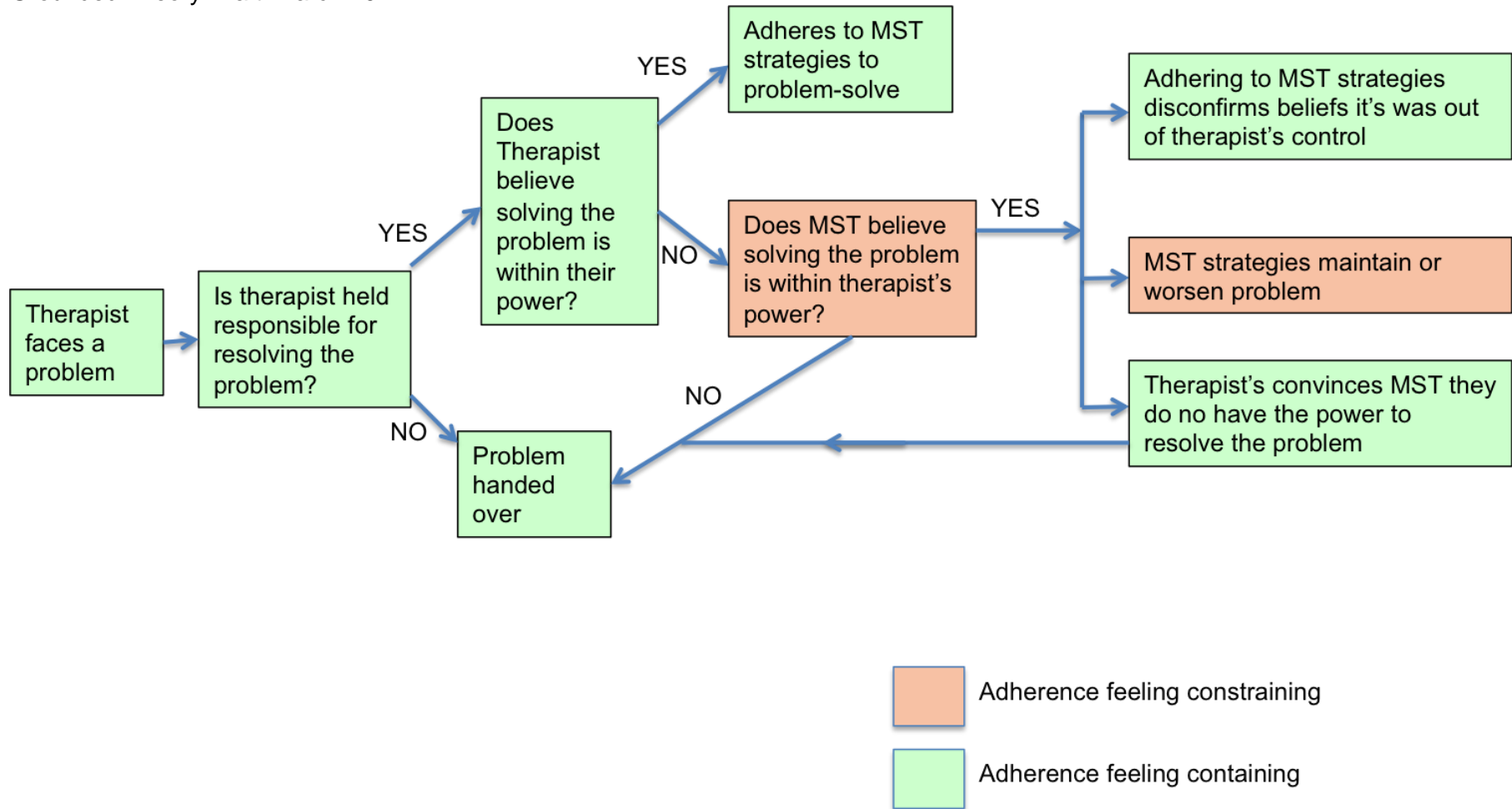
"[In previous job working with families] if someone cancels, they come to you and you might give them a ring... But if they didn't come they didn't come. And that kind of difference here when the expectation is 'well why didn't you go anyway?' Or, 'you really need to persist'. And that, I still sometimes feel really uncomfortable with. 'Cos it feels disrespectful and I feel like I'm stalking people sometimes".
(Beth)

It would be useful to consider whether there might be culturally specific reasons why it might feel less appropriate for therapists in England to be more assertive in imposing therapy on families. Consider context of NHS valuing patient choice and cultural differences around levels of assertiveness between US and England.

Appendix K: Drafts of the Grounded Theory

Grounded theory draft: January 2014





Appendix L

Sample Segment of Interview Transcript

Focused Codes

Initial Codes

Interview Transcript:

R = Researcher. P = Participant

R: OK. Can you tell me about a time when an aspect of MST didn't fit with your client?

MST not fitting for families

MST being sole professional not fitting for family.

Therapist being adamant you need more professionals to meet different needs.

MST not acknowledging difference

Consultant advising not to include other agencies.

P: Yeah, I would guess, recently I had a young person who was adopted but wasn't aware of it. And just, there was this ongoing issue about does mum tell him or not. MST tends to focus on we should just be the one that's doing all the work sort of. But I was very adamant that on that case, as with lots of ours, you can't just be the only one because they've so many different needs that you just cannot meet. So in that case I had done a joint piece of work with CAMHS so that they were going to work with mum around her worries about the adoption and what that was bringing up for her. Which was fine, but then also, mum was getting quite, not old, but poor health, but just had so much to deal with and his violence non-attendance at school and she physically couldn't do it all. So social care had referred to C_____ which is like a charity that will send a buddy type person out to do physical activities with young people and I know the consultant was saying they shouldn't be and mum should be doing that. Which I really felt strongly about, mum physically, emotionally could not. She was doing it all the rest of the time, but for 2 hours, once a week, actually she shouldn't have to. Someone else needs to come in

MST tailoring the model
 Consultant agreeing to applying model flexibly
 Feeling supported by supervisor

Therapist feeling supported and contained
 Deviating slightly from model.

MST not fitting for families
 Often needing support of other agencies.

Valuing each system's role with family.

Working with systems in a way that's conducive to positive change.

and do that. And this was sort of argued for a while but in the end the consultant agreed that actually, I wasn't prepared to change it. Because I was saying, that's fine but we're going to be leaving soon and then what is this mum left with? I just wasn't prepared to do that. But I had the support of the supervisor as well, but it really, I felt very uncomfortable with the thought that we should even dare to say what or what she shouldn't have. I just think she was doing as best as she could under very dire circumstances, that for 2 hours a week was the least that she deserved. In the end that went ahead, that support, But it really felt like it went against MST so that aspect I do often struggle with because I think we need the support of other agencies, let alone the families and I just... that still, I still struggle with that in some respects. So, I would never go into a network of professionals and go 'ok, you can all just clear off now because MST's here'. For me that's not the best approach I just think YOT are doing what they need to do Social care, whoever's involved is generally there for a reason or you can agree that while we're involved maybe you can take a step back and I'll feed in to you every couple of weeks. You can agree it in a way that's conducive to positive change.

R: And what are the negative consequences of taking the sole professional role with families?

MST often becoming the lead professional.

Undermining relationships between other services and families.

Services having different focuses

P: We will often become the lead, so the coordinator I guess, but I just think the negatives for me are that actually they have often built very good relationships with these people. And so for us to come in and go 'no we don't need them any more'. I think you're undermining that relationship, but also that service. And I just think that's not helpful. We all have different targets, we're working on different things. For example, the case I have at the minute, there's lots of people involved, but most with

MST not fitting for systems

and targets.

Families having so many needs.

Working collaboratively to Clearly defining professional roles and remits.

Aiming to pare down involvement whilst meeting needs.

Reintroducing professionals after MST intervention.

very good reason because there's so many needs going on. But one of the things that we have agreed is that the social worker will just provide the team around the child meetings, and the statutory aspect. The adult social worker will hold back whilst we're involved and then will take over once we've finished. So it's kind of like, working, or agreeing together what needs to be done and who can do it and have as little involvement as possible for the family but still get it done. With a view then that before we leave we'll meet and agree 'well this still needs to be worked on' and then reintroduce people perhaps. But I guess every case is different.

R: And with the case you were telling me before with CAMHS, did there need to be made CAMHS referrals, and referrals to the buddy service?

Therapist flexibly liaising across services.

MST not meeting family's needs. Prioritising needs of the family over the model

P: So it was actually CAMHS that referred the case to us for the work because his aggression was so bad. So they had agreed to stay involved whilst we worked on some of these things with a view that we would do some work together with mum about the adoption and telling him so I didn't need to do a referral. We did speak to social care though. Because he had a learning disability he was open to the team but we invited them to become more actively involved before MST ended because there was issues around his school, placement had broken down and we just couldn't meet his needs. So it was then social care that done the referral to the c_____. But we have done referrals to different places. I just think the needs of the family come first and then the model kind of comes after.

R: and if you had been being fully faithful to MST, how would they have managed the fact that CAMHS wanted to refer to social care and C_____.

Conflicting messages in the MST model

The model indicating a different course of action than was taken.

Considering how MST in its purest form was wrong for this family.

P: So they would have suggested that the IG would've been that if mum couldn't provide this physical activity then a member of the family would have. Which we had already addressed anyway. So the family members were becoming more involved but for its own development in this case, it really was felt by the network that it had to be someone from outside. So MST in its purest sense would've said a member of the family should take that role.

R: And that the therapist should negotiate that with the other services?

MST not fitting for families

MST prioritising the sustainability of the intervention.

Lots of families not having sufficient networks for a more 'sustainable intervention'. False logic of the sustainable intervention.

P: Yeah. And that's the best outcome for the family because it is more sustainable. Which, I can see, you can see the benefits of it being a family member but just in this case. And unfortunately in a lot of our cases, they don't have a network so to speak. It's very limited Often it's just them and maybe one other person.

R: And do you have a sense of how it was possible to do it the way that you wanted to do it? So you've mentioned that having the support of your supervisor and it took a lot of time. Were there other elements to the process?

MST not fitting for

Identifying the need to deviate from

P: We had just identified this need through the work, which then we discussed through supervision and to be honest social care had really identified this as well and felt that as part of their role they needed to be

families

the model through the intervention process.

offering some other support as well And just in that case it seemed to be the right thing at the right time for this young person.

Being supported by other services to deviate from model.

R: So was it enough to present that to the consultant for that to enable you to have MST permission in a way to go that way?

Consciously considering how deviations would be presented

P: Yeah, I was very conscious how I was going to present this, so I'd already planned.

R: and what were the things you were considering when you were planning?

Evidencing it not fitting

Aligning rationale for MST deviation with MST goals.
Emphasising how it fitted with 'sustaining' the parent child relationship.
Emphasising the risk of family breakdown.

P: It was just in terms of the sustainability of their relationship and I really believed that because being in there as often as you are you see it when it's at its worst And that was only a couple of hours a week in the grand scheme of things for me. This woman was in it 24/7. I was saying to the consultant, if we don't family breakdown we need to have some sort of release for him for the boy and mum.