Systemic Evidence-Based Practices for Children on the Edge-of-Care: A Qualitative Exploration of Leadership in Collaborative Implementation

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Lay Summary

Background

The mental health of children is a global health concern. Mental health disorders can negatively impact many aspects of a child's life (e.g., education, finances, development) that persist through adulthood. This makes supporting young people's mental health essential. *Evidence-based interventions* (EBIs) are interventions that support an individual's mental health and have proven efficacy in research. Although research has shown positive outcomes for many EBIs, these are not always seen when translated into services, and the evidence continues to be contested. This is where the significance of implementation science lies, as it helps comprehend the process of translating research to practice. Studies have demonstrated that leadership plays an important role when implementing EBIs and can hinder or facilitate the process.

Systematic Review

Many leadership and implementation theories have shown how leadership plays a crucial role when translating EBIs from research to practice. This systematic review aimed to understand how different components of leadership facilitated or hindered EBI implementation within child and adolescent services. Two previous reviews focused solely on the social care setting, which resulted in this review analysing and drawing themes from studies that looked across a broader range of child and adolescent services, including more than just social care (e.g., schools). Three electronic databases were searched for qualitative studies implementing EBIs. Eligible studies had to have explicitly researched leadership or had leadership or a closely related term (e.g., management) as a major or subtheme. Analysis of 23 studies found that 'developing a core purpose' in the initial implementation phases created a context facilitative to implementing EBIs. This required *'creating a shared vision'*, *'obtaining staff buy-in',* and leaders showing *'commitment to the EBI'*. Initial efforts into implementation were vital, but maintenance from leaders throughout the process was equally important. The leader's focus on 'maintaining implementation' through *'a collaborative*

approach' while working on *'effective communication'* and providing *'holistic support'* was crucial to prepare the professional system and conditions of clinical practice for implementation. However, 'power imbalances' was a prominent overarching theme that hindered implementation. Many leaders adopted a top-down approach with frontline staff, where leaders made decisions without consultation. This approach left frontline staff feeling that leaders' decisions were disconnected from the reality of implementation, leading to demotivation in fulfilling unrealistic implementation demands.

Findings revealed that collaboration was encouraged within child and adolescent settings. Collaboration adds a layer of complexity for leaders, and yet minimal research within collaborative implementation exists. Findings also showed the need for further research into psychological aspects of leadership, specifically interpersonal factors that enable or hinder the implementation of EBIs.

Empirical Study

Going into care can adversely impact different aspects of children's and young people's lives, ranging from negative education impacts to higher contact with criminal justice systems. Before entering care, many children are known as being on the edge of care. This is where the young person and their family are known to the local authorities under statutory safeguarding, but the young person has not yet moved into care. This vulnerable population requires effective support through EBIs. For this study, participants were recruited from Pan-London Positive Families Partnership (PFP) project, which ran from 2018 to 2021. PFP implemented two EBIs, Multisystemic Therapy (MST) and Functional Family Therapy (FFT), for young people aged 10 to 16 on the edge of care, intending to keep them safe and from entering care. This qualitative study involved interviewing 12 leaders from PFP to find out what interpersonal factors enabled or hindered effective collaborative leadership.

Interviews were analysed using reflexive thematic analysis to identify patterns of meaning across the data while considering the researcher's contribution to the process (e.g., knowledge, experiences, biases). Four themes and eleven subthemes were identified. The four main themes were:

‘establishing a secure foundation’, ‘navigating a complex context’, ‘the importance of a relationship approach’, and ‘adaptive and reflective way of being’.

Findings revealed that effective collaboration was supported by employing elements of trauma-informed leadership. Being aware of trauma experienced by the families and within the system while utilising data management to enhance outcomes enabled the leaders to navigate the complexities of social care. A relational approach to addressing challenges and the ability to reflect and adapt situationally enabled collaboration. Findings suggest that adopting trauma-informed leadership could enhance effective collaborative leadership and ultimately augment outcomes for young people and their families. Future research must consider theorising trauma-informed leadership models and evaluative tools linked to collaboration to encourage organisations to adopt such an approach.

Integration, Impact, and Dissemination

The experimental study sought to build upon the systematic review’s findings by exploring the interpersonal factors that contribute or hinder effective collaborative leadership when implementing EBIs in social care. Reflections were made on the research processes and how the researcher’s background and experiences could have influenced this. It is recommended that leaders are aware of factors that enable or hinder collaboration, specifically during the initial stages and throughout EBI implementation. Organisations must invest in leadership teams to ensure they are aware and actively working towards mitigating barriers while promoting facilitators to collaborative leadership and implementation. To ensure the findings reach a wide audience, they will be shared with participants, MST, FFT, and PFP, presented at conferences, and submitted to peer-reviewed journals.

Chapter 1:

Leadership in the Implementation of Evidence-Based Interventions in Child and Adolescent Services: A Systematic Review

Abstract

Psychological evidence-based interventions (EBIs) are commonly implemented in child and adolescent services. However, when translating research on EBIs into practice, comparable effective results are not consistently observed. Implementation science has developed frameworks to support the successful implementation of EBIs, with leadership being a fundamental tenet. Leaders have an integral role in supporting or hindering the implementation process. Existing reviews have predominantly focused on understanding leadership in implementation within the social care setting. Leadership exists in all children and adolescent services. Therefore, understanding the role of leadership across contexts is clinically valuable.

This systematic review aimed to identify components of leadership that enable or hinder EBI implementation in child and adolescent settings. Studies were required to be empirical, peer-reviewed, written or translated into English, and have a qualitative design. Studies explicitly researched leadership or had leadership or a closely related term (e.g., management) as a major or subtheme. Eligible studies had to name the implemented EBI overtly.

A systematic literature search of three databases resulted in 23 eligible studies for inclusion. Studies were critically appraised by two raters using Cochrane guidance. Study findings were analysed using thematic synthesis, which developed one overarching theme, two themes, and six subthemes. Findings demonstrated that 'power imbalances' were critical in hindering implementation. Moreover, 'developing a core purpose' involved *'obtaining staff buy-in'*, *'creating a shared vision'*, and leaders demonstrating their *'commitment to the EBI'*, which created a context conducive to implementing EBIs. Leaders' focus on 'maintaining implementation' through taking '*a collaborative approach*' while working on '*effective communication*' and *'providing holistic support'* was vital to facilitation.

Findings suggest that leaders are required to be upskilled and stay informed with implementation research to garner optimal outcomes for young people when implementing EBIs.

Future research could consider longitudinal studies to observe leaders' roles within implementation across time and whether barriers or facilitators change.

Introduction

Background

A third of mental health disorders begin before the age of 14 years, and almost half by 18 years (Solmi et al., 2022). Mental health difficulties are one of the leading contributors to the burden of disease in children and adolescents, making it a critical global concern (Polanczyk et al., 2015). Globally, 10% of children and adolescents experience mental health disorders, with suicide being one of the leading causes of death for young people (World Health Organization [WHO], 2020). Mental health disorders in young people have debilitating effects, including persistence across the lifespan and negative impacts on education, finances, development, personality, and much more. These impacts postulate a strong rationale for the investment in early prevention and treatment to assuage the problems and associated consequences of mental health difficulties in young people (Ribeiro et al., 2022).

Supporting young people experiencing poor mental health is an international public health priority to aid positive lifelong impacts (Carvajal-Velez et al., 2023). The National Health Service (NHS) Long Term Plan and Five Year Forward View for Mental Health are examples in the United Kingdom (UK) of how the government is attempting to improve access and the quality of mental health services for young people (NHS England, 2019). The aim is for an additional 345,000 children and adolescents to access mental health support through NHS and educational settings by 2024 (NHS England, 2019). Global government guidance, policy, and funding have all moved towards recommending EBIs within mental health settings (WHO & United Nations Children's Fund, 2021).

Evidence-Based Interventions

The term *evidence-based* was first coined in 1991 by a medical doctor, delineating that clinical decisions should be informed by scientific and clinically relevant research (Guyatt et al., 1992). The term evidence-based in psychology advanced the medical definition by including client characteristics. *Evidence-based practice* (EBP) is where practice is underpinned by the integration of the best available research, along with clinical expertise "in the context of patient characteristics, culture and preferences" (American Psychological Association [APA] Presidential Task Force, 2006, p.273). EBP encompasses an expansive range of clinical undertakings (e.g., formulation, assessments, therapeutic alliance). The EBP movement purported to advance the psychology field to increase positive outcomes for clients, reduce the utilisation of ineffective treatments, and eradicate the implementation of harmful treatments (Drisko & Grady, 2020; Prujean et al., 2022). The movement towards EBP has been adopted, adapted from medicine, and utilised by several disciplines, including clinical psychology (Spring et al., 2019). However, within the comprehensive framework of EBP, specific psychological treatments with established efficacy to treat disorders or difficulties within certain circumstances are known as *EBIs* (Rousseau & Gunia, 2016). For something to be conceptualised as evidence-based is when a considerable amount of research evidence, which comes from multiple highly controlled experimental designs (e.g., qualitative, single case experimental designs, randomised controlled trials) deem the intervention as safe and effective for a large number of people within a targeted population (Roth & Fonagy, 2004; Weisz et al., 2004). One consideration is the relationship between EBP and EBIs, whereby EBP can impact the implementation and use of EBIs.

Continued evidence of the positive outcomes of EBI utilisation across multiple methodologically sound studies conducted by numerous research teams has supported professionals in the field to view EBIs as the gold standard (Landsverk et al., 2011; Sakaluk et al., 2019). Research has supported prolific knowledge expansion in this area in recent years, resulting in evidence-based

becoming a buzzword that has flooded the field. However, despite many services adopting EBIs, they are not achieving the positive outcomes evinced in research. As the definition highlights, EBIs are complex, and many factors impact their adoption and sustainment. The low rates of clinicians adopting EBIs and some services delivering adapted and low-intensity versions of EBIs have vastly increased the gap between research and practice rather than narrowing it (Williams & Beidas, 2019).

Implementation of Evidence-Based Interventions

Translating research to clinical practice is not a linear process. Many factors can interfere with knowing whether the absence of desired outcomes is due to a lack of implementation integrity or intervention validity (Testa & White, 2014). *Implementation* is the study of aspects influencing the conversion of research to practice and aims to reduce the gap between the two spheres, to prevent diminished positive effects of EBIs (Weisz et al., 2014). The interplay between research evidence and implementation context is an onerous task that requires a multiplicity of facets to be considered (Kazdin, 2008). The rapprochement between research and practice is essential to contribute to the global and local priorities of improving care for young people (Pelletier et al., 2013). This has subsequently instigated researchers to study factors that lead to successful EBI implementation to achieve the desired positive outcomes published in research (Aarons, Green, et al., 2014).

Resultantly, empirically rich evidence has supported the emergence of over 60 frameworks that have established focal areas that are the fulcrum of successful EBI implementation (Century et al., 2012; Fixsen et al., 2009). These frameworks now assist a systematic process in developing, managing, and evaluating EBI implementation (Tabak et al., 2013). These frameworks demonstrate how implementation is a complex, interacting, and transient process that spans multiple levels, including system, organisational, and practitioner levels (Damschroder et al., 2009; Moullin et al., 2019). Such frameworks, methods, and outcomes propose variables conceptually related to EBI implementation (Breimaier et al., 2015; Michie et al., 2005). Specifically, within various child, adolescent, and family services, theory and research have outlined leaders' role in EBI

implementation and sustainment (Aarons et al., 2016; Aarons et al., 2015; Albers et al., 2017; Weeks, 2021). Translating research to practice requires services to embody confident skillsets, consistency, and change commitment (Weiner, 2020), all of which are leadership requirements (Carnochan et al., 2017).

Leadership

Defining *leadership* as a construct is arduous due to its multifaceted components that are shaped and evolve by cultural, historical, and societal influences (Oyinlade, 2008). Burgeoning research into leadership styles, factors, and components has been crucial in understanding its innate contribution to either diminishing or increasing EBI implementation and effectiveness (Montano et al., 2023; Skar et al., 2022). A previous systematic review demonstrated that many inner context factors (e.g., organisational resources, leadership) impacted the implementation, adoption, and sustainment of interventions for children and adolescents, with leadership playing a significant role (Novins et al., 2013). Research from organisational psychology and implementation science indicate that leaders at all levels, ranging from stakeholders who decide to implement EBIs, to first-level leaders (managers supervising clinicians implementing EBIs), are key levers that can be targeted to improve adoption, utilisation, and sustainment of EBP (Aarons et al., 2011; Birken et al., 2012; Stetler et al., 2014).

Implementation and Leadership Theory

Leadership is a broad concept, but theories have endeavoured to ascertain more specific leadership factors and processes that impact implementation. Implementation theory posits a basis for improving the understanding, design, and evaluation of implementation processes (Grol et al., 2007). Implementation leadership theory (Aarons, Ehrhart, et al., 2014) and organisational theory (Birken et al., 2017; Weiner, 2009) both contend that leadership is a critical mechanism in supporting a team's ability to uptake change when introducing EBIs, specifically related to developing

structures, applying practical strategies, and aligning innovation-values of leaders across multiple levels.

Implementation leadership theory has been subject to extensive research and scholarship. It hypothesises that first-level leaders can use leadership behaviours to develop the organisation climate to embody EBP implementation (Aarons, Ehrhart, et al., 2014). This climate is where organisation members have shared expectations of the required skill set to deliver EBP, provisions for support, and incentives for EBP utilisation (Ehrhart et al., 2014). This climate of EBP implementation subsequently improves clinicians' use of EBP. The theory also proposes that first-level leaders' behaviours have a proximal, pertinent, and powerful impact on clinicians implementing EBIs (Aarons et al., 2017). Such behaviours have been a focal point in research, including how first-level leaders have the opportunity of (a) longevity in organisations, supporting with shaping long-term implementation processes, (b) high frequency of provider contact, and (c) the ability to align values and organisation priorities across multiple levels (Aarons, Farahnak et al., 2014; Birken et al., 2012). All the behaviours outlined above hold a focus within leadership models, which are linked to transformational leadership (Bass, 1999), and focused leadership behaviours, now operationalised as EBP implementation leadership (Aarons, Farahnak et al., 2014). When this theory was tested, research showed that first-level leaders implementing EBP increased implementation leadership behaviours frequency, and the organisation's EBP implementation climate improved, which amplified clinicians' use of EBP (Williams et al., 2020; Williams et al., 2022).

Summary

Much research in recent years has focused on factors impacting the implementation of EBIs within child and adolescent settings, including social care, general child and adolescent mental health services (CAMHS), education, and juvenile justice. However, systematic reviews have predominantly focused on the social care setting, restricting the understanding of impacts across settings (McCarthy & Griffiths, 2021a; Weeks, 2021). Child and adolescent settings are laden with

idiosyncrasies compared to other contexts due to multiple family member involvement, time-limited demands, policies, numerous stakeholders, and the collaboration and communication across services involved with the young person (Aarons & Palinkas, 2007). Such idiosyncrasies may hold unique challenges to service delivery, specifically EBI implementation and sustainment.

Previous Reviews

To date, two systematic reviews have addressed the role of leadership in implementing research-supported practice, evidence-based programs, and evidence-informed practice in the social care setting (McCarthy & Griffiths, 2021a; Weeks, 2021). Both studies utilised the term child welfare, the equivalent of social care in the UK. Findings from both reviews aligned by highlighting the pivotal role of effective leadership in facilitating implementation. Firstly, collaboration emerged as essential for cultivating positive relationships among internal and external leaders. Adequate funding and leadership support, characterised by well-defined structures and processes, was vital for successful implementation. These elements demonstrated the commitment and vision of leaders. Lastly, the reviews emphasised the significance of securing buy-in from frontline staff, accentuating the importance of their active involvement and support in effectively executing implementation efforts.

One review limited their inclusion to the United States (US) (Weeks, 2021), with the other to comparable sociocultural backgrounds in Australia (McCarthy & Griffiths, 2021a), restricting the generalisability of the findings. Therefore, this review does not exclude studies based on their origin to augment the generalisability of findings. Additionally, the previous reviews approached the topic from an implementation perspective, either by structuring the analysis through an implementation framework (McCarthy & Griffiths, 2021a) or analysing studies that have only implemented an EBI through an implementation framework (Weeks, 2021). This methodological approach may influence the overall understanding and interpretation of results from the included studies, highlighting the need for a different approach.

Previous reviews included an evaluation of EBIs and EBP, which could have influenced results, as implementing a whole practice compared to an intervention may hold different requirements of leaders. The findings from this review aim to add clinical value by understanding how leaders are associated exclusively with EBI implementation.

Findings from this review aim to add to the literature by looking at leaders' roles in a broader range of child and adolescent services to see if findings from social care can be translated to other organisations (e.g., schools). Leadership subsists in all services for children and adolescents and plays a crucial role when implementing EBIs. Additionally, the reality when working with children and adolescents is that collaboration among numerous sectors is required to address complex needs (Winters et al., 2016). Therefore, clinicians should not aim to work in silos but instead take a holistic view of a child (Albuquerque et al., 2020). This should therefore be replicated in research. Accordingly, understanding components of leadership across settings will be valuable for informing practice and implementation scientists developing implementation frameworks.

Aims

The current body of literature requires further elucidation, as synthesisation is needed. This review expands on the current literature regarding how leadership plays a role in implementing psychological EBIs in child and adolescent services. It aims to provide further insight into how leadership serves as a barrier or facilitator to EBI implementation processes by understanding the perspectives of individuals involved. Qualitative studies offer a comprehensive understanding of people's experiences (Groleau et al., 2006), allowing the depiction of how rather than why questions. Additionally, the aims listed below are not readily applicable to quantification or experimental approaches.

A systematic review would allow the compilation of the leadership components that have been identified from a multitude of studies. Through identifying, appraising, and synthesising the empirical literature on this topic, this review could provide a roadmap to guide future research into

the settings by deliberating gaps and limitations in the existing literature. This review aims to systematically examine the perspective of individuals implementing EBIs through the question: What is the impact of leadership during the implementation of psychological EBIs, within child and adolescent settings? The review's aims are as follows:

1) To identify leadership components that act as a barrier or facilitator when implementing EBIs in child and adolescent settings.
2) Synthesise the current literature on leadership components associated with impacting EBIs in child and adolescent settings.
3) Identify gaps and limitations in the existing literature to guide future research concerning the role of leadership in EBI implementation.

Method

Search Strategy

Systematic review methodology was used in accordance with the Cochrane guidelines (Higgins & Green, 2011) and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines informed the review process (Moher et al., 2009; Page et al., 2021). The PRISMA statement was developed to augment the rigour of systematic reviews and meta-analyses methodology and includes 27 items (e.g., quality assessment, excluded study reasoning). Initially, a protocol to direct the procedure and research strategy was developed. Prior to undertaking the searches, the full protocol was registered on PROSPERO (CRD42023395082). Registration reduces the risk of bias by adhering to rigid eligibility criteria and facilitating transparency to assist replication, which increases strength in reproduced findings (Transparency Open Science Collaboration, 2015).

The search terms were conceived from preliminary scoping searches and through the considerations of the key areas of the research question. The selected terms were reviewed and

refined through discussions with a librarian from Royal Holloway, University of London, specialising in systematic reviews. The search was conducted using three electronic databases: Scopus, PsycINFO, and Web of Science in January 2023. Identification of studies via other methods included hand-searching reference lists and Google Scholar. PROSPERO was also checked for any ongoing publications.

Search terms, Boolean operators, and truncations were applied across search databases. Asterisks following the key terms initiated the search for variations of the truncated term to generate maximum relevant citations. Whilst databases vary with definitions, searches were applied to 'titles', 'abstracts', and 'keywords'. The following search terms were used:

- "leader*"
- "implement*"
- "evidence base* pract*" OR "evidence-base* pract*" OR therap* OR program* OR interven* OR model"
- "chil* OR juvenile* OR "young pe*" OR minor* OR teen* OR youth* OR adolescen* OR "young offend*"
- "experience" OR "qualitative" OR "thematic analysis" OR "grounded theory" OR "interpretive phenomenological analysis" OR "IPA" OR "phenomenological model" OR "discourse analysis" OR "focus group" OR "semi-structured interview" OR "interview" OR "narrative analysis" OR "narrative model" OR "content analysis" OR "ethnography" OR "ethnographic model" OR "case study" OR "case study model" OR "historical model"

The full search strategy used can be found in Appendix A.

Eligibility Criteria

To be included, studies were required to meet several criteria.

Types of Studies

Only qualitative studies were included, including data collected through focus groups, quotes from interviews, interviews, qualitative questionnaires, or other qualitative methodologies. Studies must have been published in peer-reviewed journals, excluding books and dissertations, as they are not typically peer-reviewed, decreasing their reliability (Leech & Onwuegbuzie, 2011). Studies had to be available in English, which could have included studies from non-English speaking counties if they had been translated into English. There was no limit on the publication date.

Specific Constructs

Studies were not limited to whom the qualitative method (e.g., interviews or focus groups) was carried out with. Given that the research question relates to leadership, eligible studies included those that explicitly investigated leadership, had leadership as a major and/or subtheme, or a closely related major and/or subtheme that was equivalent (e.g., organisational support, management).

EBIs were defined as interventions, programmes, treatments, or models tested and validated in line with current, valid, and relevant evidence and research (APA Presidential Task Force, 2006; Dawes et al., 2005). The EBI had to be named explicitly within the study to be eligible for inclusion. No exclusion criteria existed concerning the type of intervention (e.g., family, group, individual, remote). Eligible EBIs included a focus on mental health.

Context

Eligible studies included EBIs implemented within the context of child and adolescent services, including but not limited to residential care, community, schools, inpatient units, and local authority settings. Physical health settings were excluded.

Study Selection

All searches on the three databases required the ‘advanced search’ function, with no restriction filters applied for language and publication date or type. One reviewer (CR, Trainee Clinical Psychologist) collected data, completing the search to identify studies based on the inclusion

criteria. Please see Figure 1 for the full PRISMA flowchart, highlighting the process through which studies were deemed eligible and the reasons for exclusion.

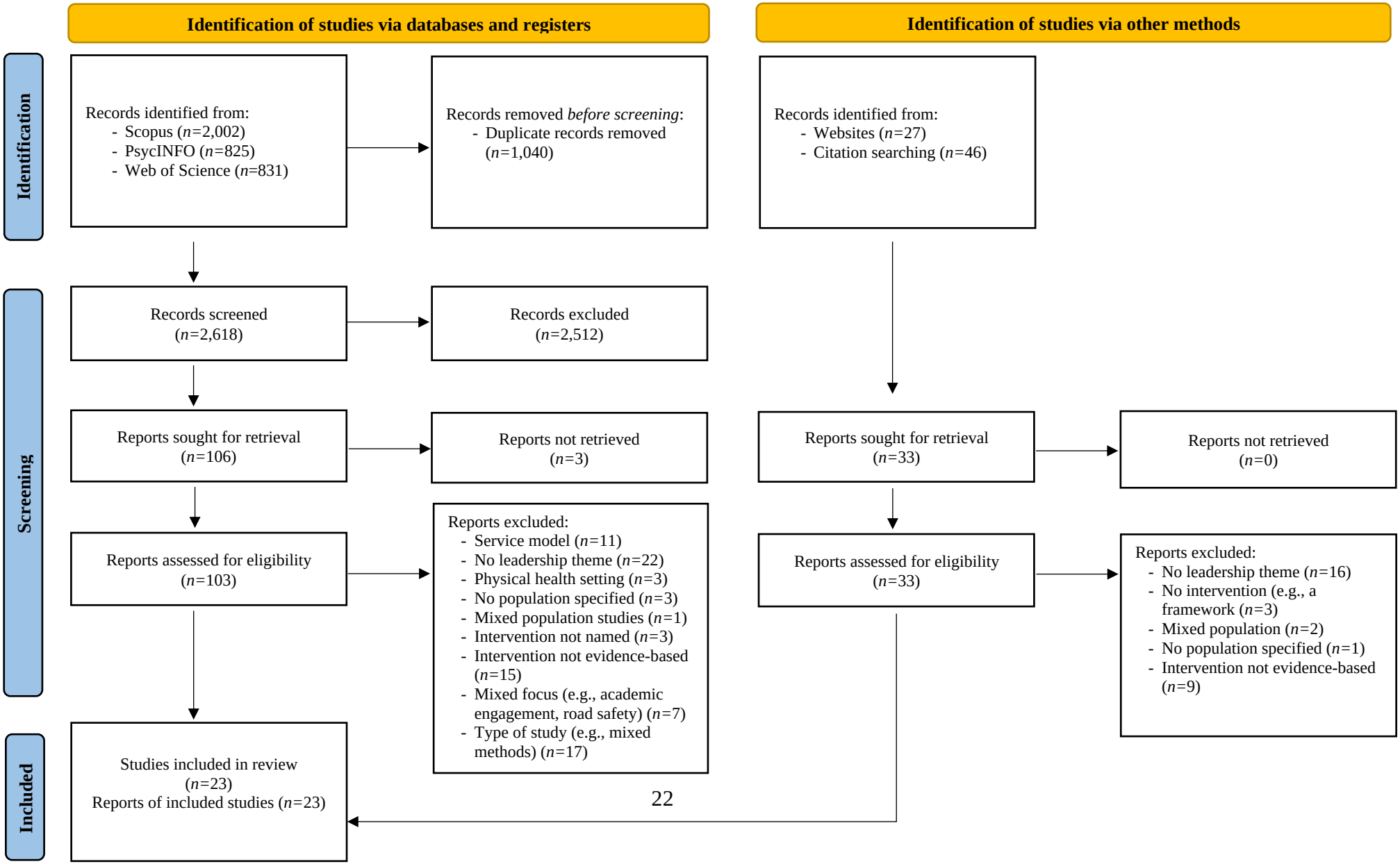
The searches were completed on 31st January 2023 (Scopus, PsycINFO, and Web of Science). All identified studies were exported to Rayyan reference management software. Initially, duplicates were removed. One reviewer (CR) subsequently screened the remaining studies against the eligibility criteria based on title and abstract. For the remaining studies, full texts were retrieved and read in full to see if they met the review's inclusion criteria. Studies that satisfied the eligibility criteria were included in the data synthesis. Of the included studies, reference lists were hand searched for studies which potentially met inclusion. Google Scholar was also searched. Potential eligible studies then had their full text retrieved to assess against the eligibility criteria.

A second independent reviewer (NM, Trainee Clinical Psychologist) screened 50% of the full-text studies against the eligibility criteria to determine the reliability of the included studies. Reliability was calculated using Cohen's Kappa, resulting in a value of 0.84, displaying almost perfect agreement between reviewers. Disagreements between the two reviewers (CR and NM) were thereafter discussed by referring to the inclusion criteria. When agreement could still not be reached, a third independent reviewer was consulted (JH, Clinical and Forensic Psychologist).

One reviewer (CR) conducted an independent quality assessment of each included study. A second reviewer (NM) conducted the quality assessment process on 10% of the studies, resolving disagreements through the third reviewer (JH). Interrater concordance was Cohen's Kappa 0.72, suggesting good interrater reliability.

Figure 1

PRISMA Flow Diagram Showing Study Selection Process.



Quality Assessment

The Critical Appraisal Skills Programme ([CASP]; 2018) was used to formulate and facilitate the methodological quality appraisal of the 23 included studies. This quality appraisal was used because it is the prevailing checklist for assessing the quality of qualitative evidence synthesis in health and social care (Long et al., 2020). It is also endorsed by Cochrane and World Health Organisation for use in qualitative synthesis (Noyes et al., 2017). The tool offers a consistent approach for evaluating research and has been used in numerous qualitative syntheses (e.g., Douglass et al., 2023). A comprehensive guide that comes with the tool was used to inform the process, whereby 10 questions based on study characteristics relating to ethical standards, data collection, appropriateness of study methods, and findings were critically appraised based on their trustworthiness, value, and relevance (CASP, 2018; Appendix B). For this review, the questions were marked out of one (0 = no; 0.5 = somewhat; 1 = yes). Subsequently, studies were categorised according to Babb et al.'s (2022) methodology. Studies scoring 8.0 and above were categorised as high-quality, denoting a low likelihood of methodological flaws; studies scoring between 4.5 and 7.5 were categorised as moderate, indicating a moderate likelihood of methodological flaws; and studies scoring 4.0 and below were deemed poor quality, suggesting a high likelihood of methodological flaws. These classifications were characterised as A, B and C, respectively. No studies were excluded based on quality ratings to support the identification of novel findings and due to the tool not being used to establish a standard for inclusion or sensitivity analysis (Thomas et al., 2012). A summary of the methodological quality of the included studies is presented in Table 2.

Data Extraction

Each eligible study had the following data extracted: (a) details relating to the publication: first author, year of publication; (b) setting and country of origin; (c) sample; (d) the implemented EBI; (e) data collection method; (f) data analysis method; (g) and findings.

Data Analysis

A thematic synthesis was used in this review. Following Thomas and Harden's (2008) guidelines included a three-stepped process of analysis: (1) line-by-line coding, (2) developing descriptive themes, (3) and developing analytic themes (subthemes) to address the question: What impacts does leadership have on the implementation of EBIs in child and adolescent services? The researcher focused on content from the headings labelled 'findings' and 'results' within the included studies. Themes were established and presented in the results section, with study quality being considered to inform the synthesis and the interpretation of the reliability of findings. This synthesis method was chosen to facilitate an appropriate process of addressing the question encompassing individuals' perspectives and experiences. This synthesis method is widely used within health and social care research, making it relevant to this study (Thomas & Harden, 2008). This synthesis method was chosen to address the research question for several reasons. Firstly, it facilitates identifying patterns within existing evidence pertaining to the role of a systematic review (Booth et al., 2016). Secondly, it supports synthesising individual experiences and perspectives in health-related research, allowing for transparency and accessibility of outcomes (Thomas & Harden, 2008).

Results

The Search

Electronic database searches identified 3,658 citations from Scopus (*n* = 2,002), PsycINFO (*n* = 825) and Web of Science (*n* = 831). Overall, 1,040 were duplicates, resulting in 2,618 studies for consideration. Title and abstract screening excluded 2,512 studies, leaving 106 for full-text review. Three studies were unable to have full texts retrieved. Of the 103 full-text studies, 21 met full eligibility criteria. During the study selection, 82 studies were excluded during full-text screening. The chief reason for exclusion was due to the study not investigating leadership, or finding it as a major or subtheme, resulting in excluding 22 studies.

Reference lists of included studies were searched for eligible citations, with 73 being found. After screening these, 33 were retrieved to screen against eligibility criteria. Sixteen records were excluded based on not meeting the criteria of leadership (*n* = 16), no intervention (e.g., a framework) (*n* = 3), mixed population (*n* = 2), no population specified (*n* = 1), and the intervention not being evidence-based (*n* = 9). Two studies met inclusion for full criteria. Therefore, overall, twenty-three studies met full eligibility criteria and were included in this review. Figure 1 shows the flow of studies considered for inclusion in this review (Moher et al., 2009; Page et al., 2021).

Characteristics of Included Studies

Please see Table 1 for the included study's characteristics and findings.

Year, Location, and Study Settings

Twenty-three studies published between 2014 and 2022 were included in the review. Predominantly, studies were carried out in the US (*n* = 16), with some studies being single-state studies (*n* = 9), others spanning across multiple states (*n* = 1), and other studies not stating a specific location (*n* = 16). Three studies (Aarons et al., 2014; Willging et al., 2015; Willging et al., 2018) were on the same longitudinal state-wide implementation of SafeCare. However, each study had a different focus and used different data. The remaining studies were in the UK (*n* = 2), Canada (*n* = 1), Norway (*n* = 1), Australia (*n* = 1), and Belgium (*n* = 1). One study did not have a location because the participants were from an international sample (Garcia et al., 2019). The setting in which the studies were conducted varied, including social care (*n* = 13), education (*n* = 5), community mental health (*n* = 1), mental health and education combined (*n* = 1), adolescent inpatient and residential units (*n* = 1), and mental health and social care combined (*n* = 2).

Sample and Evidence-Based Intervention

A total of 541 participants were included across the 23 studies, with sample sizes ranging from 5 to 54 participants, with the mean sample being 24. Participants ranged from stakeholders (*n* =

27) and organisational leaders (*n* = 61) to frontline practitioners (*n* = 232) and EBI coordinators and managers (*n* = 68).

The studies investigated many EBIs, including SafeCare (*n* = 6); Strengthening Families Program and Celebrating Families! (*n* = 2); Parent Management Training, Oregon Model (*n* = 1); The Incredible Years® Teacher Classroom Management Programme (*n* = 1); Classroom Pivotal Response Teaching and an Individualized Mental Health Intervention for ASD (*n* = 1); Mindfulness-Based Stress Reduction (*n* = 1); Multisystemic Therapy, Parent Child Interaction Therapy, Trauma-Focused Cognitive-Behavioural Therapy, and Positive Parenting Program (TripleP; *n* = 1); TripleP (*n* = 1); Cognitive Behavioural Therapy (CBT) plus Trauma-Focused CBT (*n* = 1); mindfulness, whole school approach (*n* = 1); Walk away, Ignore, Talk it out, and Seek help Programme (*n* = 1); Remaking Recess (*n* = 1); Treatment Foster Care Oregon, SafeCare and Functional Family Therapy-Child Welfare (*n* = 1); Family Spirit (*n* = 1); Attachment-Based Family Therapy (*n* = 1); The Olweus Bullying Prevention Program (*n* = 1); and Milieu-Based CBT (*n* = 1).

Methodology

All studies used qualitative designs. For data collection, the studies employed a range and combination of methods, including semi-structured interviews (*n* = 14), interviews or focus groups (*n* = 4), interviews or small group interviews (*n* = 2), interviews or small groups and focus groups (*n* = 1), multi-person interviews or focus groups (*n* = 1), and focus groups (*n* = 1). Various methods of analysis were used, including thematic analysis (*n* = 6), grounded theory (*n* = 5), an iterative approach to analysis (*n* = 5), a modified analytic induction approach (*n* = 2), framework analysis (*n* = 1), integrated approach (*n* = 1), combined thematic and content analysis (*n* = 1), coding, consensus, co-occurrence, and comparison, rooted in grounded theory (*n* = 1), and one was undefined (*n* = 1).

Table 1

Summary of Included Studies.

	Reference	Setting	Sample	Intervention	Data Collection	Analysis	Findings	CASP Rating
1	Aarons et al. (2014)	Southwestern state, US Child welfare	Child welfare administrators (*n* = 3), CBO executive directors (*n* = 3), local foundation leaders (*n* = 9), home visitors/seed team members (*n* = 32), supervisors (*n* = 4), and trainers/coaches (*n* = 3)	SafeCare	Semi-structured individual interviews, small-group interviews, or focus groups	No clearly defined methodology. Authors refer to using an 'iterative approach'	Eight themes: • Organizational culture • Changes in organizational strategy • Leadership forms and roles. • Shared authority and responsibility • Power struggles and their resolution • Role ambiguity • Effectiveness of communications • Keys to overcoming implementation challenges	7.5 (B)

2	Aarons & Palinkas (2007)	State-wide, US Child welfare	Case managers (*n* = 15) and consultants (*n* = 2)	SafeCare	Semi-structured interviews	Coding, consensus, co-occurrence, and comparison, rooted in grounded theory	Six themes: • Acceptability of the EBP to the caseworker and to the family. • Suitability of the EBP to the needs of the family. • Caseworker motivations for using the EBP. • Experiences with being trained in the EBP. • Extent of organizational support for EBP implementation. • Impact of the EBP on the process and outcome of services.	6.5 (B)
3	Akin, Brook, Byers, et al. (2016)	Oklahoma, US Child welfare	Frontline service providers (*n* = 5), administrators (*n* = 3), and administrative staff (*n* = 2)	SFP and CF!	Semi-structured interviews	Modified analytic induction approach	Themes reported through six implementation factors: • Process • Provider • Innovation • Consumer	8 (A)

							• Organisational • Structural factors	
4	Akin, Brook, Lloyd, et al. (2016) Child welfare	Midwestern State, US	Grant director (*n* = 1), state-level site coordinators (*n* = 3), county-level site coordinators (*n* = 4), agency CEOs (*n* = 2), and practitioners (*n* = 5)	SFP and CF!	Semi-structured interviews	Modified analytic induction approach	Themes reported through six implementation factors: • Process • Provider • Innovation • Consumer • Organisational • Structural factors	7 (B)
5	Akin et al. (2014) Child welfare	Kansas, US	Practitioners (*n* = 28)	PMTO	Semi-structured interviews	Thematic analysis	Themes reported through six implementation factors: • Process • Provider • Innovation • Consumer • Organisational • Structural factors	7.5 (B)

6	Allen et al. (2022)	UK Primary Schools	Teachers (*n* = 44)	IY - TCM	Semi-structured interviews or focus groups	Thematic analysis	Three major themes: • Acceptability of TCM • Facilitators of implementation • Barriers to implementation	8.5 (A)
7	Brookman-Frazee et al. (2020)	US ASD in mental health and education contexts	Study managers (*n* = 3), intervention developers (*n* = 2), and EBI trainers (number unknown)	CPRT & AIM HI	Semi-structured multi-person interviews or focus groups	Thematic analysis	Nine themes: • Leadership factors • Structure • Program/district factors • Leadership factors • Provider factors • Client factors • Intervention characteristics • Research staff factors • Relationships	7.5 (B)
8	Byron et al. (2015)	Massachusetts, US Adolescent inpatient and	Organisational leaders (*n* = 3), unit managers and care staff (*n* = 15)	MBSR	Semi-structured interviews or focus groups	Grounded theory	Eleven concepts: • Buy-in with state agency • Funding buy-in with state agency • Mutual mindfulness experience • Academic	8.5 (A)

		residential units					• Personal • Professional • Staff buy-in • Invitation • Training attendance • Space • Benefits	
9	Garcia et al. (2019)	Not specified as all EBP origins differed Child welfare	Directors and scholars who originally tested EBP effectiveness (n = 11)	MST, PCIT, TF-CBT, and Triple P	Semi-structured interviews	Grounded theory	Six themes: • Outer context • Implementation climate • Cultural exchanges • Subjective perceptions of EBP are solidified • Implementation • Belief that EBPs achieve intended outcomes	9 (A)

10	Garcia et al. (2020)	Mid-Atlantic City, US Child welfare	Child welfare workers or staff referring parents to TripleP (*n* = 12), supervisors and staff (*n* = 4), and TripleP providers (*n* = 2)	TripleP	Semi-structured interviews	Grounded theory	Seven major themes: • External context • Implementation climate • Transformational leadership • Cultural exchanges • Subjective perceptions of EBPs are established. • Implementation • Intended outcomes	9.5 (A)
11	Gopalan et al. (2021)	US Mental health and child welfare services	Frontline, supervisory, and executive child welfare staff (*n* = 15) and mental health providers (*n* = 14)	CBT +	Semi-structured interviews or focus groups	Grounded theory	Three major themes: • Partnership features • Organisational resources and capacities • Provider and client characteristics	9.5 (A)

12	Hudson et al. (2020)	UK Comprehensive, academy, and special needs schools	School staff (*n* = 15), including head teachers (*n* = 2)	M-WSA	Semi-structured interviews	Framework analysis. Guided by CFIR	Strongest distinguishing constructs: • Leadership engagement • Relative priority • Networks and communications • Formally appointed implementation leaders • Knowledge and beliefs about the intervention • Executing	9.5 (A)
13	Hurlburt et al. (2014)	California, US Child welfare	Stakeholders (*n* = 27)	SafeCare	Semi-structured interviews	No clearly defined methodology, although authors refer to using an 'iterative approach'	Six themes: • Commitment and collaboration • Leadership • Communication, fit with existing practice and fidelity. • Negotiation of rights, roles. • Responsibilities and interests • Early successes	7.5 (B)

14	Leadbeater et al. (2015)	British Columbia, Canada School (elementary)	Principals (*n* = 7), vice principal (*n* = 1), teachers (*n* = 9), counsellors (*n* = 2), librarians (*n* = 2), community leaders (*n* = 2)	WITS	Semi-structured interviews	Grounded theory	Four statement codes: • Within school • External context • Programme characteristics and support • Variation in sustainability	7.5 (B)
15	Locke et al. (2017)	North-eastern States, US School (elementary)	School administrators (*n* = 15), teachers (*n* = 10), and other school personnel (*n* = 14)	Remaking Recess	Semi-structured interviews	No clearly defined methodology, although authors refer to using an 'integrated approach'	Six codes: • Implementation process • Staff • Leadership • Support • Barriers • Facilitators	8 (A)
16	McCarthy & Griffiths (2021b)	Australia Child welfare	OzChild leaders and managers (*n* = 6)	TFCO, SafeCare, and FFT-CW	Interviews	Not outlined	No specific themes reported. Key results included: • Consistent communication and adaptive management • EBPs and organizational change • Embracing an evidence-based way of working	2.5 (C)

							• Articulating the meaning of evidence • Restructuring the organization to support EBP implementation. • Implementing the EBPs • Addressing resistance to the "new and shiny" EBPs	
17	Russette et al. (2022)	Michigan, US Community mental health	Registered nurses, outreach worker, supervisor, social workers (*n* = 6) and precision approach staff (*n* = 6)	Family Spirit	Semi-structured focus groups	Thematic and content analysis	Three broad categories: • Model/curriculum • Relational • Contextual	7.5 (B)
18	Santens et al. (2020)	Belgium Child welfare	Counsellors (*n* = 13) and supervisors (*n* = 4)	ABFT	Semi-structured interviews	Thematic analysis	Two main themes: • Facilitators and barriers related to ABFT • Facilitators and barriers related to the child welfare context	7.5 (B)

19	Snell-Rood et al. (2022)	US Child welfare, mental health, and social services	Government administrators (*n* = 16) and organisation leaders (*n* = 25)	SafeCare	Semi-structured interviews or small-group interviews	No clearly defined methodology, although authors refer to using an 'iterative' approach	Five themes: • Bidding for contracts as a process of organizational "self-fashioning" • Market freedom? • Building organizational infrastructure to facilitate supply and demand of EBIs • Collaborative relationships among CBOs • Consequences of the EBI marketplace for equity	6 (B)
20	Sullivan et al. (2021)	Southeastern, US Schools (public middle schools)	Teachers (*n* = 26), school staff (*n* = 8) and administrators (*n* = 8)	OBPP	Semi-structured interviews or focus groups	Thematic analysis	Seven themes (impeded): • Lack of time • Unanticipated changes and events • Varying staff commitment and implementation consistency • School context, climate, and structural changes	7.5 (B)

			• Difficulty identifying bullying incidents • Social media influences that exacerbated bullying behaviours • Limited fiscal and staff resources Four themes (supported): • Endorsing OBPP as seen by administrator prioritization of the program and staff presence, involvement and commitment • Staffs' clear communication about OBPP roles and responsibilities, and teamwork and collaboration within and across levels of organizational leadership

							• Intervention dynamics • Logistics - having support materials for class meetings and staffing resources	
21	Vaskinn et al. (2021)	Norway Child welfare	Residential youth care staff (*n* = 16)	MB-CBT	Semi-structured interviews	Thematic approach, template analysis	Three themes: • Change-oriented behaviour • Relations-oriented behaviour • Task-oriented behaviour	9 (A)
22	Willging et al. (2015)	US Child welfare	State and county-level social service stakeholders, including directors (*n* = 3), deputy directors (*n* = 6), division directors (*n* = 5), program managers and administrators (*n* = 7), and analysts (*n* = 3)	SafeCare	Semi-structured interviews	No clearly defined methodology, although authors refer to using an 'iterative approach'	Eight themes: • EBP adoption decision • Leadership • Funding variability • Policies and contracts • Partnerships • SafeCare staffing • System challenges • Political and legal pressures on the outer context	9 (A)

23	Willging et al. (2018)	US Child welfare	CBO managers (*n* = 25)	SafeCare	Semi-structured interviews or small group interviews	No clearly defined methodology, although authors refer to using an 'iterative approach'	Six themes: • Policy and ideological trends • Leadership in systems and organisations • Public–private partnerships • Procurement and contracting • Collaboration and co-opetition between CBOs • Support for CBO staff.	8 (A)

Key: ABFT = Attachment-Based Family Therapy; ASD = Autism Spectrum Disorder; CBO = community-based organisation; CBT+ = Cognitive Behavioural Therapy plus Trauma-Focused CBT; CF! = Celebrating Families!; CPRT = Classroom Pivotal Response Teaching; AIM HI = An Individualized Mental Health Intervention; CSFIR = The Consolidated Framework for Implementation Research; EBIs = evidence-based interventions; EBP = evidence-based practice; FFT-CW® = Functional Family Therapy-Child Welfare; IY-TCM = The Incredible Years® Teacher Classroom Management Programme; M-WSA = Mindfulness, whole school approach; MB-CBT = Milieu-Based Cognitive Behavior Therapy; MBSR = Mindfulness-Based Stress Reduction MST = Multi-Systemic Therapy; OBPP = The Olweus Bullying Prevention Program; PCIT = Parent Child Interaction Therapy; Partnering for Success = Pfs; PMTO = Parent Management Training, Oregon Model; SFP = Strengthening Families Program; TF-CBT = Trauma-Focused Cognitive-Behavioural Therapy; TFCO® = Treatment Foster Care Oregon; TripleP = Positive Parenting Program; WITS = Walk away, Ignore, Talk it out, and Seek help Programme.

Quality Assessment

The quality assessment carried out with the CASP indicated that other than one study categorised as a C (McCarthy & Griffiths, 2021b), studies were classified as A or B, demonstrating a high level of rigour. Studies scored between 2.5 and 9.5, with an average CASP rating of 7.76. Variations existed in which criteria were met by the studies in the quality assessment. Specifically, question six of the appraisal tool evaluated whether studies considered the relationship and potential bias between the researcher and participants. Only three studies met the full criteria, while six lost half a point because of insufficient consideration. This indicates a lack of reflexivity in the remaining 14 studies.

A substantial number of studies also had points removed for not considering ethical issues and justifying the data collection method. However, critical consideration is owed to how these studies potentially carried out these research processes, but journal reporting conventions and requirements may limit their explanation within published research (Long et al., 2020). Table 1 presents each study's categorisation and overall CASP score, with the complete quality appraisal shown in Table 2.

Table 2

Quality Assessment Outcomes of Included Studies.

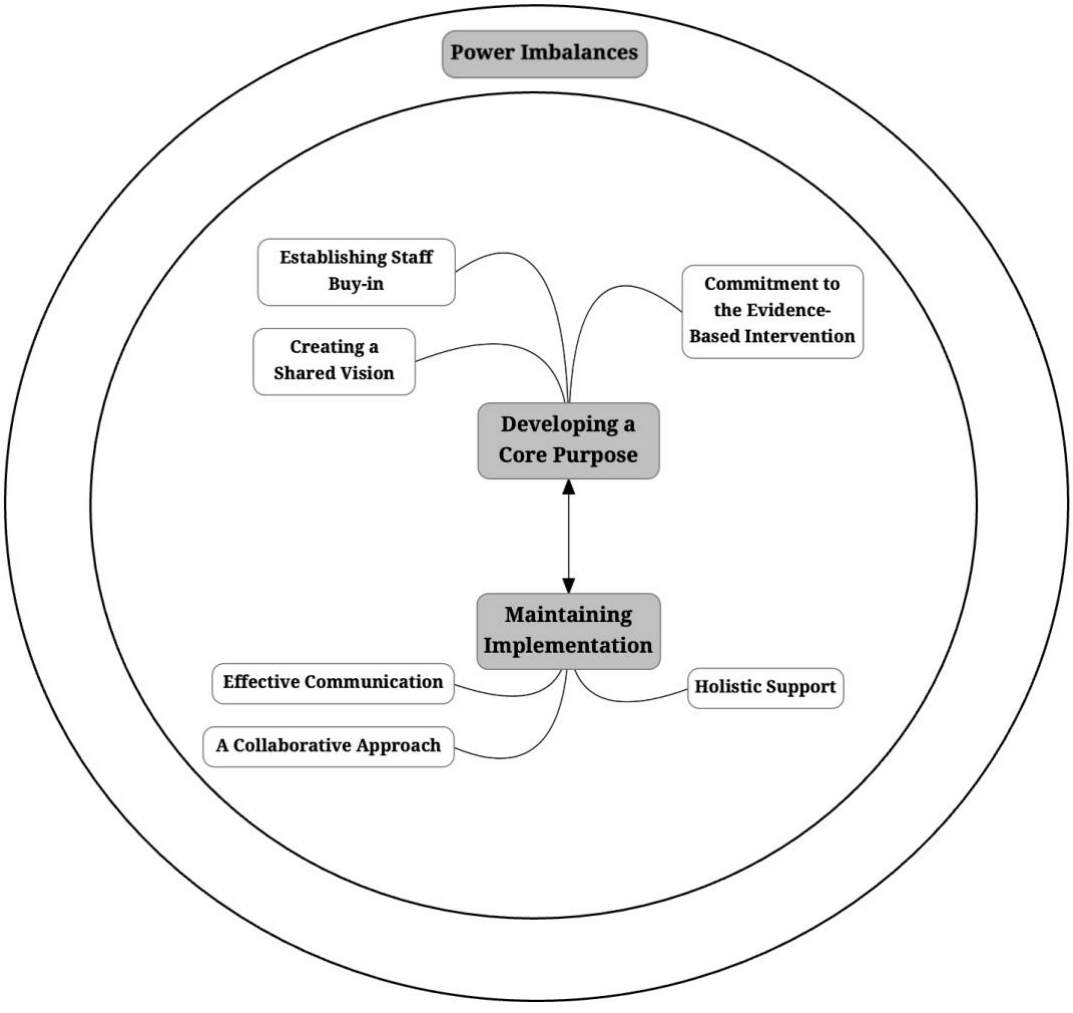
CASP Criterion	Included Studies																						
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
1. Was there a clear statement of the aims of the research?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0.5	1	1	1	1	1	1	1
2. Is the qualitative methodology appropriate?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
3. Was the research design appropriate to address the aims of the research?	1	0.5	0.5	0.5	0.5	1	1	1	1	1	1	1	1	1	1	0.5	0.5	0.5	0.5	0.5	1	1	0.5
4. Was the recruitment strategy appropriate to the aims of the research?	0.5	1	1	0.5	1	1	0.5	1	1	1	1	1	0.5	1	0.5	0.5	1	1	1	1	1	1	1
5. Was the data collected in a way that addressed the research issue?	1	0.5	1	0.5	0.5	1	0.5	0.5	1	1	1	1	0.5	1	1	0	1	0.5	0	0.5	1	1	0.5
6. Has the relationship between researcher and participants been adequately considered?	0	0	0.5	0	0	0	0.5	0	0.5	1	1	1	0	0	0	0	0.5	0.5	0	0	0.5	0	0
7. Have ethical issues been taken into consideration?	0.5	0	0	0.5	0.5	0.5	0	1	0.5	1	0.5	1	1	0	0.5	0	0.5	0.5	0.5	0.5	1	1	1
8. Was the data analysis sufficiently rigorous?	0.5	1	1	1	1	1	1	1	1	0.5	1	0.5	1	0.5	1	0	0.5	1	0.5	1	1	1	1
9. Is there a clear statement of findings?	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	0.5	1	0.5	1	1	1	1
10. How valuable is the research?	1	0.5	1	1	1	1	1	1	1	1	1	1	0.5	1	1	0	1	0.5	1	1	0.5	1	1
Total score	7.5	6.5	8	7	7.5	8.5	7.5	8.5	9	9.5	9.5	9.5	7.5	7.5	8	2.5	7.5	7.5	6	7.5	9	9	8

Data Synthesis

The research implemented aimed to maximise rigour in the analytical procedure. Within the development of synthesis, the researcher employed a collaborative process, which required involving supervisors in reflective discussions throughout the process, ensuring validity and transparency of the data, with the researcher regularly reviewing the data and its context (Harris et al., 2018; Thomas & Harden, 2008). The thematic synthesis identified one overarching theme ('power imbalances'), two themes ('developing a core purpose' and 'maintaining implementation'), and six subthemes to understand how different components of leadership facilitate or hinder the implementation of EBIs into child and adolescent services. Please see Figure 2 for the thematic map outlining the relationship between the themes.

Figure 2

Thematic Map: Themes and Subthemes From Thematic Synthesis.



Power Imbalances

Power, specifically when displayed as a top-down approach within leadership teams, emerged as an overarching theme that served as a pervasive obstacle impeding implementation across all stages and processes. A top-down approach involved leaders making decisions and changes without consulting frontline staff, resulting in relationship breakdowns, inadequate implementation preparation, reduced engagement, and an absence of collaboration (Aarons & Palinkas, 2007; Akin, Brook, Byers, et al., 2016; Akin, Brook, Lloyd, et al., 2016; Hudson et al., 2020; Locke et al., 2017; Santens et al., 2020; Willing et al., 2015; Willing et al., 2018). Some studies explained that to address power imbalances, involving individuals at all levels of implementation fostered a sense of ownership and demonstrated the value of their contributions (Byron et al., 2015; Hurlburt et al., 2014; Garcia et al., 2019). Nevertheless, this overarching theme requires consideration when cogitating how the themes below facilitated or hindered implementation.

Developing a Core Purpose

Studies referred to a leader's ability to develop a shared vision and effectively integrate the EBI into the organisation. Establishing a framework that promoted and sustained the adoption of an EBI, including gaining staff's buy-in to the shared vision, was essential and required commitment to the EBI from the leadership team.

Creating a Shared Vision

The first step in EBI implementation involved leaders establishing a collective vision. There was a sense that leaders were responsible for bringing together staff from multiple levels and across all involved agencies to establish a clear direction and purpose for implementing the EBI. The initial process required having discussions to understand whether the vision of EBI implementation aligned with individual and organisational values and motivations. A shared vision fostered enhanced staff engagement, and engendered commitment for change from the leadership team, *"in the more*

successful schools, the drive to implement was driven more by a set of collective values and involved people from all levels of the organisation" (Hudson et al., 2020, p.8). It was delineated that despite a vision being crucial in the pre-implementation phase, ongoing efforts to revisit this was also required from leaders to enhance the likelihood of sustainment, *"participants … requiring ongoing communication and renewing of commitments to sustain the program"* (Leadbeater et al., 2015, p.126).

It was shared that staff and leader's understanding of how to achieve the created shared vision was as equally important, *"stakeholders often had very different ideas about how to pursue change and their respective roles in this process, which at times led to tension and conflict that added complexity to the implementation"* (Hurlburt et al., 2014, p.164). When ambiguity existed regarding how the shared vision would be achieved, collaborative relationships with external organisations were impacted.

Establishing Staff Buy-In

It was deemed essential for leaders to attain staff buy-in and engagement to achieve a shared vision. Participants signalled its essentiality for EBI sustainability and for staff to feel part of the process, rather than the EBI implementation simply being added to their current workload, *"I think they need to be more involved and take some ownership of it rather than it being given to them"* (Leadbeater et al., 2015, p.124).

For staff to successfully buy-in to a new EBI, leaders were seen to take a whole systems approach, whereby leaders at all levels were involved with the implementation process. According to a deputy headteacher, it was advantageous to obtain staff support by demonstrating how the incorporation of the EBI was not merely a temporary measure but rather an effort to integrate it into the organisation for a sustained period, *"it's about that whole system approach, and it's about driving it forward and making everybody realise that this is definitely part of us, so it's here to stay,*

it's not something that's just going to be a flash in the pan" (Hudson et al., 2020, p.8). As a result, leaders needed to display the EBI as a top priority.

Preponderance of studies outlined the difficulties posed by significant staff turnover in child and adolescent services, which could compromise EBI implementation and sustainability. Once leaders succeeded in obtaining staff buy-in, it was considered a crucial responsibility for them to maintain this throughout the entire implementation process. This maintenance was applicable for frontline staff and leaders, whereby if high turnover existed, continual buy-in had to be worked on, *"…even if you win the buy-in of one cohort of frontline workers, you then have another cohort that comes in and has to be engaged as well"* (Garcia et al., 2019, p.319). High staff turnover led to leadership teams adopting a more strategic approach towards recruitment. Screening candidates for prior EBI experience and willingness to participate in implementation was important, as leaders recognised that those who were non-supportive of EBIs lacked motivation, potentially impacting outcomes. This highlighted the significance of the recruitment process.

Predominantly in the early stages of implementation, the lack of clarity that leaders provided staff and fellow leaders with regarding their responsibilities led to conflict, tension, and resentment, resulting in a lack of staff endorsement of the EBI implementation, *"ambiguity in the Preparation Phase led to some members asserting that roles were not previously agreed-upon, which caused some resentment between stakeholders"* (Aarons et al., 2014, p.921). If staff were unsure about their role during implementation, they were uncertain whether they should support the process as they were ambiguous about what it would involve for themselves and others. It was more common than not that leaders did not establish role clarity. However, staff buy-in was achieved via many conduits aside from role clarity. For example, understanding the potential benefits of the EBI, learning that the EBI is a long-term plan, and leaders believing and sharing positivity about the EBI.

Commitment to the Evidence-Based Intervention

Leadership engagement was a strongly distinguished theme within 18 studies. A key facilitator of EBI implementation was leaders' active engagement in the implementation process and their belief in the EBI itself. Leaders who held positive beliefs about the EBI believed that it was an effective and appropriate approach for the target population, realistic to implement, and could be sustainable in the service. It was interpreted that leaders' supportive beliefs for the EBI subsequently impacted their behaviours. For example, leaders were more likely to make decisions that aligned with providing resources and meeting the needs of staff working on implementation, *"participants perceived engaged leadership as fundamental to implementation success due to their decision-making powers: because it does take a commitment from her [headteacher] because she is the only person who can make it happen"* (Hudson et al., 2020, p.6).

Leaders needed to comprehend the benefits that the EBI could offer their service. This further strengthened their endorsement, which instilled optimism and confidence at all levels of leadership and among frontline staff. Although leaders needed to express their support of the intervention to facilitate its implementation, multiple studies stated that several leaders were disinterested in the programme. Leader's disinterest and ambivalence about EBI effectiveness inhibited their support, *"failure to implement CF! was because leadership was not interested in the program … after having staff attend the CF! training, they decided that implementing CF! was unnecessary"* (Akin, Brook, Lloyd, et al., 2016, p.36).

For leaders to promote the EBI to their colleagues with authenticity, they were required to have a comprehensive understanding of the EBI. The extent of the leader's knowledge about the intervention was thought to correlate with the success of EBI implementation and sustainability. This process constituted of leaders proactively seeking to understand the EBI, whether that was by reviewing current research, consulting with other leaders with previous EBI experience, or undergoing training, *"…a number of examples of how they felt prepared and motivated to gather*

knowledge from a variety of sources to overcome unfamiliarity and inform the implementation process, including evidence-based clearinghouse websites, research articles, academic partnerships, and training" (Garcia et al., 2019, p.320). These efforts from leaders were recognised by staff, which had a domino effect of positive attitudes towards the EBI. However, one study identified that it was not just about understanding the EBI but also comprehending the practical requirements for staff to implement it (Leadbeater et al., 2015). If leaders were aware of these requirements, they could support frontline staff better.

According to 12 studies, leaders' physical presence had a positive impact. Their presence came in many forms, such as attending meetings, delivering important reminders about the EBI, holding meetings to discuss the EBI (e.g., brainstorming improvements), seeking regular feedback about the EBI, observing staff delivering the EBI, participating in training sessions, or sending emails. This presence reinforced leaders' EBI commitment and its priority to them, *"they are not just sitting in their offices and saying do this and that, but they are experiencing this with us first-hand"* (Vaskinn et al., 2021, p.393).

Maintaining Implementation

The leader's ability to maintain EBI implementation was essential in the initial phases but also throughout the entire process. This involved leaders effectively communicating and collaborating with all those involved in the implementation process. Taking a holistic, supportive approach enabled emotional and instrumental support to facilitate EBI implementation.

Effective Communication

One of the most prevalent findings was the importance of effective communication from leaders. Establishing clear communication structures from the outset to prevent communication breakdowns was essential. Setting mutual expectations for content and frequency of communication minimised challenges from escalating. Additionally, having multiple communication methods,

including leaflets, emails, forums, supervisors, and in-person contact, avoided relationship breakdowns and enhanced information flow. The content of communication was also significant. For example, allowing staff to ask questions and share their concerns about the EBI and providing clear rationales for decisions supported more collaborative ways of working. Additionally, discussing the potential benefits of the EBI and its successes motivated staff to engage in the EBI implementation process, *"…celebrating the successes of existing programs in communications within the organization and providing opportunities for staff from across the organization to come together to discuss concerns"* (McCarthy & Griffiths, 2021b, p.278).

Participants believed effective communication could foster peer support, teamwork, and a collaborative approach, promoting EBI implementation. Maintaining consistent, open, and transparent communication led to significant benefits, including individuals having the confidence to have difficult conversations without feeling judged, building collaborative relationships into stable networks, allowing staff to feel heard, and faster and smoother resolution of difficulties. All these factors contributed to increasing the likelihood of successful implementation, "*fluid and effective communication throughout the implementation process; they felt their voices were heard by their agencies, describing how their agencies "listened" when participants had questions, frustrations, anxiety, or stress*" (Akin et al., 2014, p.290). Leaders who demonstrated effective communication appeared to build better relationships at all organisational levels, including with fellow leaders and administrative staff. Leaders actively communicating recognition and appreciation of staff's efforts to implementation, particularly regarding adapting their caseloads to support, allowed staff to feel valued, making them better engage with the EBI, *"[leadership] are good at complimenting and recognizing me and my cosupervisor's work"* (Vaskinn et al., 2021, p.393).

Nevertheless, many studies discovered a lack of communication or the presence of didactic communication, which was acknowledged as an obstacle to implementation. Leaders played a crucial role in modelling effective communication, and when this was absent or infrequent, fellow leaders

and staff felt uninformed, consequently decreasing engagement. Infrequent communication also resulted in misinformation, meaning teams found it hard to keep up with frequent changes, leading to relationship breakdowns between leadership and frontline staff, *"other stakeholders reported feeling "out of the loop" due to the absence of a clear communication structure*" (Aarons et al., 2014, p.923). A fundamental tenet of effective communication was its support of collaboration.

A Collaborative Approach

Collaboration within the leadership team and with external agency partnerships was a vital facilitator in the implementation process. The support of external agencies, such as fellow organisation managers and policymakers, played a crucial role in sustaining services. Their resources, knowledge, and expertise were instrumental in meeting the challenging requirements of delivering EBIs, *"collaboration was imperative to enable the survival of multiple organizations facing intensive demands to deliver a menu of evidence-based services"* (Snell-Rood et al., 2022, p.9). However, effective collaboration between organisations often encountered difficulties, as organisations (e.g., private and public services) usually had different values and objectives, often creating friction. Moreover, the high turnover of leaders experienced by organisations further complicated the process of building and maintaining relationships.

Promoting collaboration within leadership teams fostered the integration of diverse perspectives and expertise in decision-making, thus maximising the potential for successful implementation. Multiple leaders working collaboratively allowed them to draw on previous experience from similar EBI implementations and seek advice and support from one another to address challenges effectively. Specifically, the prominent finding was how collaboration ensured the ongoing and seamless operation of the EBI, even in the absence of specific leaders or amidst high staff turnover within the leadership team, *"the show didn't stop because one person didn't show up … they were able to keep it going and … implement whatever ideas … that we were interested in"* (Sullivan et al., 2021, p.333). Certain studies indicated that regular in-person meetings and sharing

workspace effectively promoted collaboration, as they allowed for the development of personal relationships. Nevertheless, leaders providing holistic support was essential in ensuring collaboration was present.

Holistic Support

Fifteen studies commented on the significance of having supportive leaders. Support was conceptualised within emotional and instrumental areas of the process; emotional support consisted of leaders praising and recognising the work of the frontline staff, which motivated staff and allowed them to feel appreciated. Instrumental support entailed having sufficient resources (e.g., supervision, training, materials, staffing levels, reasonable work expectations, and space), *"…making sure that we have the resources … and that we have the time, and … we are not overworked, but still able to meet what we are needing to do"* (Akin et al., 2014, p.289).

Leaders also showed support in understanding others' thoughts, feelings, and intentions, which enabled effective communication and helpful responses to others' needs and emotions. This understanding reduced conflict, resulting in more positive, empathic, and supportive interactions. However, this ability and general support were not experienced by staff from all leaders, which led to them feeling unsupported, *"overlooked and undervalued"* (McCarthy & Griffiths, 2021b, p.278), and sometimes resulted in staff leaving services.

Planning was a notion that evoked importance from multiple studies for staff to feel supported by leaders. It was believed proactive planning provided sufficient support, as resources could be considered ahead of challenges arising. However, seven studies stated that planning was not employed. Garcia and colleagues (2019) stated that leaders should plan and thoroughly establish a supportive infrastructure before formal EBI implementation begins. Planning was also linked to the problem-solving abilities of leaders, as they were thought to be important when helping leaders address and resolve issues that arose. Generating solutions to challenges prevented difficulties from escalating and instead allowed individuals to feel heard, *"…implementation required the use of*

careful planning processes that encouraged stakeholders at all levels … to be problem solvers, anticipate system challenges in advance, and design and enact solutions" (Willging et al., 2015, p.30).

Problem-solving required open and honest discussions, particularly about challenges encountered, which was fundamental in establishing and nurturing positive relationships. Leaders were seen to adapt to ongoing changes and adjust language and expectations. Being receptive to new ideas and perspectives supported processes of compromise and flexibility, which led to leaders being approachable. Many participants felt that their leaders were open to feedback and were willing to adjust to improve their experience at work, *"participants valued senior leadership for their responsiveness and accessibility, as well as "real-time" efforts to resolve challenges"* (Gopalan et al., 2021, p.846).

Having a dedicated leader responsible for EBI implementation was deemed essential by 13 studies. A dedicated leader served as a point of contact for staff to seek guidance from, problem-solve, answer questions, adapt to difficulties accordingly, and offer additional support when needed. Knowing where to seek support and receiving consistent messages instilled confidence among the staff, minimising team confusion and facilitating a smoother implementation process. However, other studies identified that the dedicated leader was not always sufficiently equipped to answer questions, leading to some organisations employing a research or academic link to also liaise with. This link was beneficial in ensuring leaders stayed up to date with research and sought support and advice as needed, meaning they were better prepared to support their staff during implementation, *"…when the intervention got underway, the expert came to be seen not as an outside actor but as a local champion and part of the unit's organizational culture"* (Byron et al., 2015, p. 268).

Discussion

Given the recognised impact of leadership on EBI implementation in child and adolescent services, this review sought to systematically explore the literature to examine how components of leadership influence EBI implementation in child and adolescent services. Thematic synthesis from 23 articles developed one overarching theme, 'power imbalances' and two themes, 'developing a core purpose' and 'maintaining implementation'. The findings exhibited a degree of homogeneity across the studies, particularly the importance of leadership's '*commitment to the EBI*'. This included leaders learning about the EBI, which 19 studies deemed important. Other shared characteristics across the studies included using semi-structured interviews, small group interviews, and/or focus groups for data collection. The methodological appraisal revealed that quality was comparable across studies, except for one study where its reliability and validity were questioned due to its low-quality rating (McCarthy & Griffiths, 2021b). It is worth noting that the poor-quality study contributed comparatively little to the synthesis and did not contain unique themes.

Main Findings

The themes from the thematic synthesis demonstrated how various components of leadership serve as barriers or facilitators to implementation. When deliberating the notion of barriers and facilitators, it was essential to consider previous comparative research on risk and protective factors, which outlined that the absence of a risk factor does not imply a protective factor (Farrington et al., 2016). Therefore, this means that the absence of a barrier does not indicate that a protective factor is present. Whether something is, an interactive facilitator or a barrier-based facilitator to implementation is something that the included studies did not actively discuss. The first part of the discussion will focus on the theory's connection to the overall results. Following, the initial implementation phase and subsequent maintenance processes will be examined, with the overarching theme being considered last.

The finding's overarching premise suggested that leaders can effectively support EBI implementation in child and adolescent settings by developing a supportive, adaptable, and resilient organisation to navigate challenging contexts within which these services operate. The findings indicated a transformational leadership approach that created a facilitating environment (Bass & Avolio, 1994). The characteristics of transformational leadership were evident in numerous themes: idealised influence was shown through the leader's *'commitment to the EBI'*; inspirational motivation was exhibited through *'creating a shared vision'* and embodying *'holistic support'*; intellectual stimulation was present in '*creating a shared vision'*; and individualised consideration was visible through leader's approach to *'holistic support'* and *'effective communication'* (Bass, 1999).

'Developing a core purpose' was essential during the initial stages of implementation. In particular, *'creating a shared vision'* was rooted in transformational leadership theory, which posits that leaders must establish a positive vision that pertains to enhancing organisational effectiveness after implementing change. Previous research has demonstrated that staff become more motivated to work beyond their capacity to accomplish objectives when leaders *'create a shared vision',* with this phenomenon being observed in various organisational (Khan et al., 2020), educational (Andriani et al., 2018), health (Chen et al., 2022), and social care settings (Park & Pierce, 2020). However, the previous research has not explicitly addressed implementing EBIs. As a result, future research is encouraged to examine whether these findings remain applicable during EBI implementation processes.

Despite these limitations, this review found that *'creating a shared vision'* was essential but only sustained when staff buy-in was established in the initial implementation phase and continually revisited. This was especially important given the high prevalence of staff turnover. Corroborating these findings, a longitudinal study confirmed that staff's positive attitudes were only maintained with periodic reviews of staff buy-in to a shared vision (Henricks et al., 2020). *'Obtaining staff buy-*

in' relied on the leader's *'commitment to the EBI'*. Leaders voicing EBI support, joining training sessions, and demonstrating their knowledge and understanding of the EBI all positively impacted the staff. This supports previous findings where transformational leadership facilitated successful implementation, explicitly relating to leaders' attitudes towards implementation, subsequently promoting staff attitudes towards the EBP (Farahnak et al., 2020).

Despite all the possible factors that impact implementation, the context of child and adolescent services is owed consideration. Significant pressures in these services have been shown to impact staff turnover, staff and leaders' mental health and wellbeing, particularly job-related stress and burnout (Kelly & Hearld, 2020; Marsh et al., 2022). The demands on leaders are further exacerbated when implementing an EBI within such challenging contexts. 'Developing a core purpose' is vital, but studies also outlined the importance of maintaining these original ideas and working on building them using *'effective communication', 'a collaboration approach', and 'holistic support'*. Leaders are believed to be responsible for establishing a functional environment where implementation is succour (Dishop et al., 2019). Research has shown that leadership styles can hold importance when navigating complex contexts within health and social care and education, with transformational leadership demonstrating positive impacts on minimising staff turnover, stress, and burnout while maximising organisational commitment and motivation (Mishra & Upadhyay, 2022; Park & Pierce, 2020; Rinfret et al., 2020). Providing '*holistic support*' is imperative for staff's wellbeing, particularly those working with children and families experiencing mental health difficulties.

Supportive environments created by leaders promote resilience, as staff are better equipped to overcome challenges and develop resilience. *Resilience* is adapting positively when adversity presents itself (Vella & Pai, 2019; Wright et al., 2013). While much research has been conducted on resiliency in leaders, it is striking that physical health settings have primarily taken the focal point (Förster et al., 2022), with little attention on child protection services (Kalergis & Anderson, 2020;

Lonne et al., 2020), and a complete dearth in mental health and educational settings. However, given the demanding nature of physical health organisations, specifically high workloads, lack of resources and staff shortages, similar challenges likely exist within mental health and education settings. This review's findings imply that a resiliency framework could be applied within educational and mental health settings. Resilience research has comprised the Organizational Resiliency Model (ORM), an evidence-informed model that integrates resilience theory and research to support developing healthy and resilient workforces (Geoffrion et al., 2016). This framework highlights the importance of team relationships, a finding this review did not specifically identify. However, this review acknowledged that taking *'a collaborative approach'*, employing '*effective communication'*, and providing '*holistic support'* within relationships were effective for implementation. Nevertheless, the studies within this review did not explore *how* to form bonds with staff and other organisations, which were all considered essential in instilling resilience into others and the system, particularly within social care settings (Kalergis & Anderson, 2020; Molnar & Fraser, 2020).

Resilience is not a single entity and is needed within individuals and systems. This links to Bronfenbreener's (2005) theory of ecological systems, whereby individuals exist within interconnected systems, which can either hinder or support processes. Despite the ecological systems theory proposing that the influence becomes broader and less direct the further we get from an individual, this review highlights the level of impact leaders can still have, despite working at the mesosystem level. Leaders within this review shared that the macrosystem also influences this, as the cultural and societal contexts, particularly those in which the organisation operates, have significant impacts. Leaders within this review appeared to recognise their importance and role at the various system levels, from supporting frontline staff implementing the EBI to collaborating with external agencies to obtain referrals for the EBI. Adopting a resilience approach that aligns with the ecological systems theory can create a system that responds positively to adversity, building a more resilient organisation better equipped to navigate implementation challenges.

The subtheme '*holistic support'* closely links to resilience. The ability for leaders to adapt in the context of challenges and absorb shocks when they arise assimilates to transformational leadership characteristics. However, it is noteworthy that transformational leadership is not commonly linked to resilience within the literature, as noted by Madi Odeh and colleagues (2023). Nevertheless, leaders' resilience noticeably permeated the organisation, creating a more resilient system. Leaders injecting resilience into the system allowed the organisation to manage challenges that arose during implementation. This process of infiltrating resilience from leadership has been recognised in much research to improve a leader's wellbeing and job satisfaction, therefore having subsequent positive impacts on the health and efficiency of a workforce (Bernard, 2019; Foerster & Duchek, 2018; Hillmann, 2021). Lastly, *'holistic support'* pointed to leaders acknowledging others' emotions and thought processes, demonstrating leaders' abilities in mentalising for their colleagues. *Mentalising* is the ability to understand one's and other's mental states and how these may underlie behaviours (Slade, 2005). Evidence has shown how a decreased ability to mentalise leads to increased emotional arousal (Wilson et al., 2022), which could be attributed to how the review found that reduced conflict was seen from increased mentalising from leaders.

Aspects of transformational leadership, resilience, and the ability to mentalise, communicate, and collaborate all facilitated implementation. However, an apparent dissonance surrounding these aspects was the overarching presence of *'power imbalances'*, which disrupted the equilibrium and posed obstacles to each theme discovered. Numerous participants discussed an inappropriate use of power within the leadership team and between leaders and frontline staff (Aarons & Palinkas, 2007; Akin, Brook, Byers, et al., 2016; Akin, Brook, Lloyd, et al., 2016; Hudson et al., 2020; Locke et al., 2017; Santens et al., 2020; Willing et al., 2015; Willing et al., 2018). It was evident throughout the studies, even in those where top-down leadership was not present and flat leadership was evident, that a lack of clarification of where power sat hindered collaboration. This moved away from transformational leadership theory and towards a top-down, autocratic leadership style. Research has

shown that autocratic leadership leads to emotional exhaustion and suppression, negatively impacting team performance (Chiang et al., 2021). Authoritarian leaders who enforce decisions on staff without discussion impede team safety, discouraging staff from engaging with service goals and values (Remtulla et al., 2021). Psychological safety has not been examined within implementation. However, it has been demonstrated that establishing psychological safety during change is paramount for supporting staff engagement, continuous learning, and a supportive environment (Adair et al., 2023).

Evaluation of the Current Review

This review had several strengths. It is the first to systematically synthesise literature on leadership's role in implementing EBIs across child and adolescent settings. The broad search strategy yielded the maximum number of studies, and manual searches further heightened the review's reach. Despite utilising broad keywords that may have benefited from specification (e.g., intervention), the reduced specificity minimised the risk of missing key studies. This was particularly important regarding the term 'evidence-based', as there is a persistent lack of consensus on the language used across settings (e.g., models, programmes, practices, interventions).

The rigorous methodology followed the Cochrane Guidance (Higgins & Green, 2011) and the PRISMA statement (Moher et al., 2009; Page et al., 2021) to reduce bias and increase transparency for replication. Only peer-reviewed studies were considered, which added credibility to the findings due to the thorough evaluation process these studies undergo. However, this approach owes consideration to potential publication bias and substantial loss of relevant data (e.g., dissertations). An independent reviewer reviewed a percentage of the full-texts and conducted a percentage of the quality appraisal. Despite reducing the risk of methodological error and researcher bias, this process was not conducted on all studies, which cannot wholly eradicate research bias or error.

Several other limitations to the review existed, including excluding studies exploring EBP, even if they included a specified EBI (e.g., Galvin et al., 2021; Galvin et al., 2022). The rationale for

this criterion was that studies may not have focused exclusively on the EBI implementation but on other EBP implementations (e.g., assessments, policy) during interviews, diluting the impact of leadership components specifically related to EBI implementation. Although this decision allowed a precise examination of leadership impacts on specific EBIs, health and social care practices are increasingly adopting EBP models. Future reviews should consider examining both EBP and EBIs.

Acknowledging the heterogeneity in EBI implementation is essential because it varied in set-up, age group, client characteristics, session number, context, and different EBIs. While such discrepancy is likely to reflect everyday clinical practice across services, these distinctive aspects impact implementation and the perceptions of how leadership supported or hindered processes. Additionally, the context, organisation's structure and ethos were not accounted for across all studies, which could influence findings (e.g., school funding for an EBI may differ from the social care setting). Consequently, comparing qualitative experiences across studies proved difficult. Additionally, all studies originated from high-income countries, limiting the generalisability and transferability to other cultural contexts. This review's inclusion criteria only included named EBIs with proven efficacy, which exacerbates this gap, as Western countries typically have more resources and funding for research, meaning most EBIs are tested within Western contexts (Singh, 2006). However, research has demonstrated that EBIs can be transferred from Westernised countries and still demonstrate comparable effects in the origin countries (Gardner et al., 2016; Murray et al., 2013).

Qualitative methods supported illuminating rich and comprehensive perspectives from participants that cannot be readily captured or bound by investigator conceptions and the rigid process of qualitative methodology. The considerable diversity of the participants within this synthesis, from administrators to directors, supports an extensive view of leadership. While this sample offers a holistic view of leadership, which is extremely important when translating this knowledge into real-world settings, leaders' views on leadership may differ from those of

administrators. Moreover, there was an inconsistency in how leadership was incorporated into the included studies. For instance, some studies specifically focused on the role of leadership, while others examined implementation factors and found leadership as an outcome. This inconsistency makes it challenging to compare and synthesise findings across studies.

Implications for Research and Clinical Practice

The findings provide an impetus for future research. Organisations are moving more towards an EBP approach, which includes EBI implementation and would benefit from understanding the role of leadership in how it supports and hinders EBP implementation. Whether this differs from leaders' role in implementing EBIs would be of interest and use to leaders. Furthermore, more prospective, longitudinal studies of the role of leadership in implementation are required to augment understanding of leadership elements that aid or inhibit implementation over time, given that requirements have been shown to change throughout implementation (e.g., resources). This would have the clinical benefit of understanding leader's role in sustaining EBIs. Although this review has synthesised various aspects of leadership that impede implementation, it would be advantageous for leaders to be aware of specific strategies to actively mitigate these barriers and increase the use of facilitators that promote implementation and intended outcomes.

Lastly, a noticeable gap in the studies included was their lack of focus on psychological and interpersonal aspects of leadership. Despite the pragmatic aspects of leadership being important for implementation, the psychological underpinnings of leadership are fundamental when considering the processes behind it, particularly collaboration. Interpersonal aspects are thought to increase in complexity the more collaboration presents, which is prevalent in child and adolescent services. This means that further research on the role of leadership in collaboration and how this relates to the adoption and sustainment of EBIs within organisations is required.

Leaders can utilise the findings to adapt their leadership approaches to increase the likelihood of successful EBI implementation. Implementation needs to be addressed from all levels of

organisations, first and foremost within policies (Aarons, Ehrhart, et al., 2014). Policymakers are essential in considering their contribution to ensure the successful and sustained implementation of EBIs. This review has revealed that collaboration with internal staff and external agencies supports EBI uptake and implementation. Therefore, policymakers and stakeholders must promote this through contracts and processes.

It is essential to encourage leadership teams to consider the findings but also to recognise that it is unreasonable for organisations to assume that existing or new leaders will naturally develop these skills and attributes. Therefore, organisations need to support leaders through this challenging task, which could consist of adopting a leadership implementation model, undergoing ongoing training, or adapting policies and procedures. These findings indicate that leadership's role within implementation is not a straightforward approach. Therefore, organisations must continuously evaluate and monitor to ensure adaptations are employed to support EBI implementation and respond to unexpected challenges. The rate research now burgeons makes it essential to adapt and change processes and interventions suitably. Leaders must stay informed of recent research and translate it into practice. Staff buy-in should not be assumed, making it crucial that this is also an ongoing, revisited task for leaders.

Conclusions

Synthesis and appraisal of 23 studies developed themes relevant to understanding components of leadership that facilitated or hindered EBI implementation in child and adolescent services. Findings relate to existing implementation science, leadership, and psychology research and theory. For example, the theme 'developing a core purpose' is relevant to existing transformational leadership theory (Bass, 1999). However, theories and research linked to resilience and mentalising are connected to 'maintaining implementation'. Nevertheless, in synthesising the key findings, the review highlighted that the psychological underpinnings of leadership, specifically interpersonal factors, and the examination of collaborative leadership are absent and require further exploration.

Additionally, the lack of heterogeneity across the studies regarding their design, analysis, and methodological quality made it challenging to draw meaningful comparisons between the different studies. Therefore, future research is required before definitive conclusions can be made. The discussion highlights areas where future research can address existing shortcomings to advance the knowledge within this field. Leaders' role in EBI implementation could potentially increase the likelihood of positive outcomes for children, adolescents, and their families, making future research in this field *sine qua non*.

Chapter 2:

Systemic Evidence-Based Practices for Children on the Edge-of-Care: A Qualitative Exploration of Leadership in Collaborative Implementation

Abstract

Empirical studies have confirmed leadership's impact on implementing evidence-based interventions (EBIs). Research has primarily focused on pragmatic components of leadership, and a dearth of literature exists regarding the interpersonal factors of leaders, particularly when considering collaborative leadership. Collaboration is crucial in improving clinical outcomes within child and adolescent services. However, a significant knowledge gap exists regarding how leaders facilitate or impede this collaborative process. Thus, the present study examined interpersonal factors contributing to and hindering effective collaborative leadership when implementing psychological EBIs.

Semi-structured interviews were conducted with 12 Pan-London Positive Families Partnership (PFP) project leaders. PFP comprised multiple organisations coming together through an established outcomes-based contract to implement multisystemic (MST) or functional family therapy (FFT) for children on the edge of care. Interpersonal factors that contributed or hindered effective collaborative leadership when implementing EBIs were explored. Interviews were analysed using reflexive thematic analysis, which developed four themes and eleven subthemes. Themes included 'establishing a secure foundation', 'navigating a complex context', 'the importance of a relational approach', and 'adaptive and reflective way of being'.

Themes demonstrated how 'establishing a secure foundation' in the initial implementation stages allowed leaders to traverse the intricacies of collaboration and the complex context. Being aware of trauma experienced by the families and within the system, and utilising data management enabled navigation of the complex settings and partnerships. A relational approach to address challenges and the ability to reflect and adapt situationally enabled effective collaboration. The overarching outcomes denoted employing elements of trauma-informed leadership to support effective collaboration. For services to adopt such processes, further research is required to theorise leadership models encompassing a trauma-informed lens, specifically within collaboration

frameworks. This could enhance collaborative leadership and improve outcomes for young people and their families.

Introduction

Background

Nearly 400,000 of the 12 million children living in England are in the social care system at one time, with over 80,000 in care (Ofsted, 2022). By age group, adolescents occupy the most significant proportion of children in care (Department for Education [DfE], 2017). The term *in care* refers to children being looked after by the local authority (e.g., by foster carers), including those looked after voluntarily through parental agreement or those subject to a care order under Section 31 of the Children Act (1989). Whilst some individuals report positive experiences of being in care, it is widely acknowledged that going into care can be immensely detrimental (Biehal et al., 2014). The effects can stem from a multiplicity of factors, whether it be the traumatic experiences that have caused care entry, the trauma of caregiver separation, cumulative loss from frequent placement and school moves, overlooked health needs, disrupted friendships, or education interruption (Fraser et al., 2014; Townsend et al., 2020). Additionally, compared to early childhood, adolescent care entry is linked to higher placement breakdowns and increased contact with the criminal justice system (Williams, 2017).

When children experience prolonged exposure or multiple traumatic experiences, particularly within a caregiving relationship, they can form disrupted attachments that impact physical, sensory, brain, and emotional development (D'Andrea et al., 2012). This is conceptualised as *developmental trauma* (van der Kolk, 2005). Trauma can cause an increased risk of poor education and social, mental, and physical health impacts, which can persist through adulthood (Denton et al., 2017; Seker et al., 2022). Resultantly, there is an imperious need for local authorities to support children to remain at home in a safe and healthy environment. It is also within the financial interest of the local authority for children to remain at home as care costs are extremely high; per annum, it costs around

£42,640 for a child in foster care and £199,160 for a child being looked after in a local authority children's home (Competition and Markets Authority, 2022). Nevertheless, the number of children in care is rising (Thomas, 2018). This number is estimated to increase due to COVID-19 having impacted domestic abuse, parental drug and alcohol dependency, parental mental health, and the reported 27% increase in child abuse and neglect (Foster, 2021).

A large proportion of the 400,000 children in the social care system are at the edge of care (Ofsted, 2022). There is no universal definition for the *edge of care*, but it refers to children at risk of entering care but who have not yet moved into care (Percy-Smith & Dalrymple, 2018). However, these children are known to social services, and care entry is possible. Children could be considered for placement in care for various reasons, including but not limited to parental emotional and physical abuse, neglect, family dysfunction, parental mental health, children's serious behavioural problems and many more (Jones et al., 2011). It is also likely that these children are also at risk from entering custodial settings due to their extent of challenging behaviour and involvement with youth offending teams (Hayden & Jenkins, 2015). Therefore, children at the edge of care are an extremely high-risk population and in a critical place where support is essential to reduce the risk of going into care and increase the likelihood of remaining safely at home (DfE, 2015).

Local authorities are tasked with responding to complex family difficulties amidst shrinking budgets, increased demand for support, and stringent policy and paradigm shifts (Percy-Smith & Dalrymple, 2018). This complex and sensitive task requires copious cognisance of the type of support provided. The Department for Education (2011) delineated that providing EBIs for children on the edge of care is paramount to increasing their chance of remaining with their families. The similarity of children on the edge of care is that they reside within a family system, which guides the type of support necessary, often systemic-based interventions. From 2015, funding to local authorities was prioritised when implementing the following EBIs for children at the edge of care:

FFT (Alexander & Parsons, 1982; Alexander et al., 2013), MST (Henggeler, 1998), multidimensional treatment foster care (MTFC; Chamberlain, 2003), and other systemic EBIs.

Systemic Evidence-Based Interventions

Systemic EBIs are widely utilised in social care settings and consider that challenges reside within relationships rather than solely within an individual (Stanton & Welsh, 2012). Focusing on the family's role and context in social care accentuates the alignment with systemic interventions. MST is an evidenced, family-based, community EBI that supports young people aged 10 to 15 at risk of going into care or custody due to offending or severe behavioural problems (Henggeler et al., 2019). MST was developed due to the limited support for this high-risk population and consists of short-term intensive, focused treatment that typically lasts 3 to 5 months. MST has lent itself to empirical scrutiny, demonstrating high efficacy and effectiveness in reducing out-of-home placements, delinquent behaviour, recidivism, and substance abuse (Littell et al., 2021). FFT is also a systemic, short-term EBI that supports young people aged 11 to 17 on the trajectory to institutionalised care due to severe behavioural and emotional problems (Robbins & Alexander, 2021). FFT is a manualised approach, delivered weekly over 3 to 5 months. Like MST, FFT has been subject to research inquiry and has demonstrated efficacy in reducing delinquent behaviours, criminal behaviours, and substance misuse (Hartnett et al., 2017). With MST and FFT's overlapping target populations and treatment goals, projects implementing them alongside one another appear unabated, despite mixed outcomes.

In 2007, the Blue Sky Project in New York implemented MST, FFT, and MTFC to reduce the number and length of stay of young people in residential facilities, prevent recidivism, and improve family functioning (Schiraldi et al., 2011). Although the project yielded positive outcomes, its effectiveness was enshrouded by the simultaneous operation of Project Zero, which aimed to promote alternatives to prison for young offenders. Transitioning to London in 2015, the Step Change Project implemented MST and FFT for young people aged 11 to 17 across three local

authorities (Blower et al., 2017). It aimed to reduce risk-taking behaviours, increase education employment and training engagement, improve familial relationships, and reduce care or custody need. Many baseline difficulties persisted despite interviews with families outlining positive impacts (Blower et al., 2017). However, large amounts of missing and unreliable data provided a flawed analysis, limiting the validity of the findings. Implementation facilitators included staff's teamwork and problem-solving abilities, while unrealistic timescales posed a barrier. While these factors were connected to leadership, the study did not explicitly examine leadership.

Though considerable attention has been devoted to designing EBIs, efforts to implement them with fidelity in real-world practice settings are lacking (Axford & Morpeth, 2013). Despite efficacious outcomes being documented in highly controlled settings, many factors have been highlighted in research and implementation frameworks (e.g., Exploration, Preparation, Implementation and Sustainment [EPIS] model) that influence dissemination and implementation in social care contexts, with an eminent focus being leadership (Jaramillo et al., 2023; Moullin et al., 2019). For more detailed information on implementation, leadership, and relevant theory, please refer to Chapter 1 (p.13-15).

Leadership

Leadership is not universally conceptualised but generally reflects the application of guidance and motivation to influence people to achieve shared goals (Bennis, 2007; By, 2021). Despite the emergence of leadership research unfolding across multiple disciplines, including management (Hu et al., 2019), criminal justice (Bishopp, 2013), education (Leeming, 2019), and psychology (Schaumberg & Flynn, 2012), a preponderance of the studies focus on the private sector. However, an organisation's unique context plays a pivotal role in leadership, making this an essential factor to account for, as findings from corporate-based organisations may not necessarily apply to public health and social care processes and goals (Peters, 2018).

Regarding implementation, research has primarily focused on processes and organisational and adopter characteristics rather than leadership individualities (Meza et al., 2021). This has predominantly been through exploring various leadership models and how these approaches impact implementation (Aarons & Sommerfeld, 2012). Conversely, a profusion of research has explored behaviours and individual qualities that set accomplished leaders apart from others (Bass, 1990; Smith & Foti, 1998). Leaders promoting positive psychological qualities, ethical and moral practices, interoception, and transparency with colleagues are thought to make authentic and effective leaders (Walumbwa et al., 2008). Although research has suggested that these traits require possession of the Big Five personality traits (extraversion, agreeableness, conscientiousness, openness to experience and neuroticism), the multidimensional construct of authentic leadership makes it difficult to test (Banks et al., 2018), leading to dissonance in research findings (Shahzad et al., 2021). Nevertheless, these individualities of effective leadership are not explicitly studied in relation to implementation, questioning whether they are applicable and translatable.

Research has encouraged the adoption of an interactionist perspective to cogitate the complex interplay between an individual's antecedents (e.g., personality or attributes) and their context when understanding leadership (Badura et al., 2022). This inference is justified, given how research has demonstrated, for example, that social care's uniquely bureaucratic nature amplifies leadership's influence (Falconer et al., 2020). This could stem from how collaboration is particularly sought after in child and adolescent services, making organisations in this field complex. Such services entail complexity regarding hierarchies, competing aims, ambiguous role clarity, organisational value conflicts, and structural inequalities (Morrison & Arthur, 2013). EBI implementation further compounds this due to its innumerable challenges, exacerbating leadership complexities.

Collaborative Leadership

Leadership theory has struggled to extend beyond the assumption that theories tested and validated in single services are transferable to multi-organisational contexts in the social care setting

(Aarons et al., 2017; Borge et al., 2022). Despite nascent research emerging regarding collaboration between multiple organisations, the siloed nature of research means that many disciplines overlook highly relevant studies published in other areas. *Collaboration* refers to individuals from different organisations and backgrounds working together to offer services to achieve desired outcomes (Hammick et al., 2009). Implementation science has recognised the importance of collaboration and places it as a critical element in most implementation approaches (Pelletier et al., 2013). For example, the EPIS implementation framework emphasises how collaboration is essential throughout all implementation phases (Aarons et al., 2011). Although the benefits of collaboration within EBI implementation are widely eminent in research, including improved service delivery, increased social capital, and increased problem-solving (Hajjar et al., 2020; Palinkas et al., 2011), evaluation of leadership's role within collaboration is limited relative to its assumed importance (Purtle et al., 2022).

Coalitions, where organisations form alliances to combine action, do not necessarily imply collaboration. Instead, individuals involved in the processes decide whether the process will be collaborative (Ainsworth & Chesley, 2020). Therefore, the success of any coalition is intertwined with an individual's capabilities and competencies to be collaborative. The evidence base on what supports successful collaboration is not definitive. Nevertheless, many concepts have been explored, with facilitators relating to leaders sharing resources, responsibilities, values, and respect for each organisation's culture (Butterfoss, 2007).

Collaboration is considered the most complex and intense level of working relationships (Appleton-Dyer et al., 2012). It entails leaders adapting to new processes and goals that their organisation is not usually accustomed to, which necessitates time and compromise from everyone involved (Aarons et al., 2014). These changes, expectations, and adjustments leaders must make to ensure successful collaboration requires further elucidation. Understanding interpersonal qualities that are prerequisites in reaching these expectations and achieving collaboration is needed, as

collaboration failures across organisations remain widespread (Marek et al., 2015). It is also necessary to acknowledge that collaboration brings together leaders who differ in knowledge, competencies, experience, power, and interests (Corbin et al., 2018), adding a further layer of complexity. Research has devised and underpinned several collaborative evaluation tools (Tabbutt et al., 2022). These have highlighted several factors that impede collaboration, including insufficient trust, communication, commitment, and power and resource imbalances (Heo et al., 2020). Research suggests these obstacles are rooted in an organisation's culture and relationship power dynamics (Cicognani et al., 2020). Still, knowledge of what contributes to these barriers and how to specifically prevent these remains elusive.

Collaboration is integral to several theories and models that guide change to aid collaboration. For instance, situational leadership theory highlights increased collaboration when leaders adapt to meet individual and situational needs (Hersey & Blanchard, 1982, 1997). The theory postulates that effective leadership requires high levels of social intelligence, education, analytic and cognitive ability, social-emotional skills, and adaptability (Goswami, 2022; Mulyana et al., 2022). Similarly, Goleman's emotional intelligence theory signifies that a leader's ability to collaborate and maintain relationships relies on emotional intelligence, self-awareness, emotion management, self-motivation, empathy, and relationship management (Miao et al., 2018). Emotional intelligence theory also underpins the vastly studied transformational leadership style, where collaboration enables working together to achieve common goals (Burns, 1978; Goleman, 1995). This makes transformational leadership sought after in hospitals, schools, and government agencies, where multiple services collaborate to achieve common goals. Clear communication, openness, valuing differing perspectives, and empowering all team members are acquired from transformational leadership and function as critical facilitators of collaboration (Momeny & Gourgues, 2019).

While transformational leadership was not intended for trauma-infused systems, trauma-informed leadership is recognised as vital for implementing EBIs within such contexts (Fink-

Samnick, 2022; Moullin et al., 2018). *Trauma-informed leadership* embeds a consistent, system-level, trauma-informed approach to create a nurturing atmosphere that supports the context to feel safe and supported (Esaki, 2019). A *trauma-informed approach* aims to deliver services sensitive to potential trauma individuals have, or are experiencing (Cutuli et al., 2019). A substantial component of trauma-informed leadership involves cross-sector collaboration and implementation of best practices while increasing awareness of how trauma affects individuals (Conradi et al., 2011). One example of trauma-informed leadership in social care was the Trauma-Informed Leadership Teams created by the Massachusetts Child Trauma Project (Bartlett et al., 2015), demonstrating trauma-informed care integration into system-level implementation. Evaluation found enhanced implementation success through enhancing organisation collaboration, relationships and establishing a shared language. Other research has shown how it increases workforce resilience, reduces staff burnout and turnover, and increases meaningful interactions, subsequently enhancing patient care (Fink-Samnick, 2022; Purtle, 2020).

Several methods to enhance trauma-informed leadership exist, including accountability, creating a holding environment, improving communication, being visible, and recognising strengths (Fink-Samnick, 2022). Trauma-informed leadership is embedded in trauma-informed organisation frameworks, yet more recently, there has been a shift to considering trauma-responsive organisations (Strand, 2018). This language shift represents the need to incorporate trauma-responsive practice at a system-level (e.g., operational, policy, and values) (Messina et al., 2019). Much of the impetus for creating a trauma-responsive organisation is the assiduousness of not repeating the patterns of trauma within the organisation (Mahon & Jeawon, 2022).

Consideration is owed to how much of the theories and models have been researched in the context of corporate US-based organisations, which are heavily influenced by white male perspectives (Lawler, 2007). Additionally, unlike corporate organisations that aim to increase profit, health and social care leaders work towards decreasing service demand (Peters, 2018). There is also

a vital emotional component within health and social care that is eschewed in many models or theories, pointing to the need to acquire research within multi-organisational contexts within health and social care to look specifically at collaboration within EBI implementation.

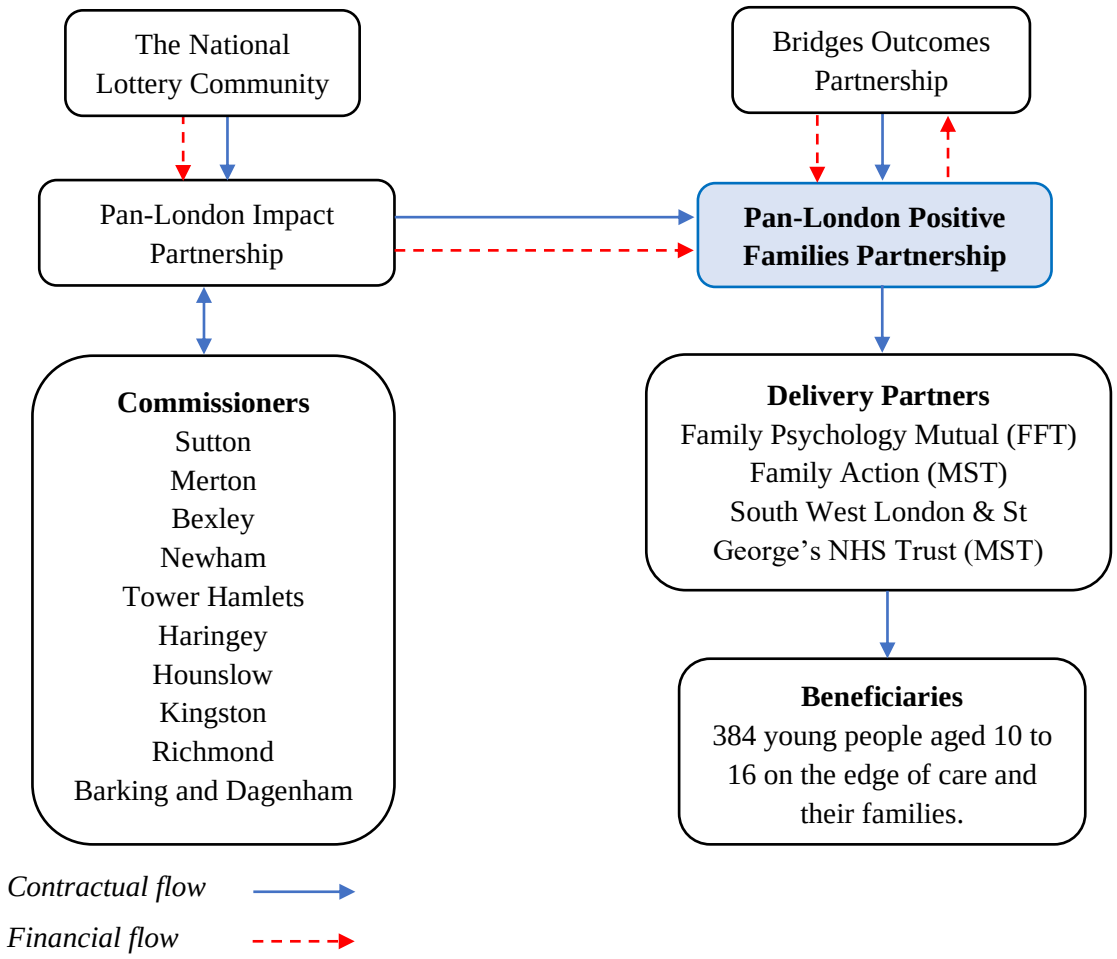
Study Context – Pan-London Positive Families Partnership Project

The study was conducted in the context of a social impact bond (SIB) model, which involves a contract between government agencies, investors, and service providers to achieve social outcomes (Carè & De Lisa, 2019). The PFP project was established and ran for three and a half years from 2018 to 2021, with a two-year follow-up period until March 2023. The project aimed to support at least 384 young people aged 10 to 16 on the edge of care by offering MST or FFT. The purpose was to improve family functioning and manage challenging behaviours and relationships to keep young people safe and prevent them from entering care.

PFP consisted of a collaboration of multiple organisations. Ten London boroughs entered a collaboration agreement, with the original group consisting of Sutton, Merton, Bexley, Newham, and Tower Hamlets. Later, Barking and Dagenham, Haringey, Hounslow, Kingston, and Richmond joined the partnership between the summer of 2018 and September 2019. Sutton served as the lead commissioner for the boroughs. This borough collaboration was coined Pan-London Impact Partnership. The project involved three delivery partners, including Family Action and South West London and St George's Mental Health NHS Trust (SWLSTG) who delivered MST, and Family Psychology Mutual (FPM) who provided FFT and acted as the project programme manager. Bridges Outcomes Partnership were the social investors within PFP and managed social investment resources, performance management, and delivery coordination. The Better Outcomes Lottery Fund also played a role as a funder, incentivising the commissioners to pay for outcomes. For a visual representation of the project's contractual and financial flow, please refer to Figure 3.

Figure 3

PFP Contracting and Investment Model Outlining Contractual and Financial Flow.



Follow-up data and evaluation of the project will continue until June 2023. However, as of December 2022, outcomes showed that it supported 410 families across ten London boroughs, achieving a 90% success rate in keeping children with their families and out of care.

The leaders who were responsible for the partnership had differing levels of involvement. A small core group of leaders worked wholly on the project. Others held leadership roles more on the project's periphery or had dual responsibilities to PFP as the partnership lead or link manager whilst carrying out their agency position. Moreover, the project's leadership structure was uniquely complex by involving three delivery partners and implementing two different EBIs across ten

different London boroughs, all while considering the interplay of multiple investor and stakeholder dynamics. Although literature determines the multidimensional nature of leadership as having a significant influence on implementation, research has failed to comprehensively investigate this, particularly when considering collaboration within implementation (Soper et al., 2015). Additionally, while there is abundant research on frontline clinician perspectives of leadership, a paucity exists on senior leadership in this context (Cooper et al., 2022). Therefore, it is crucial to examine the function of leadership at a senior level working in collaboration to gain a more comprehensive understanding of its role in EBI implementation.

Aims

The literature review highlighted limitations in research pertinent to understanding how senior leaders work in collaboration within the social care setting. It is important to consider the psychological processes underpinning this collaborative process, including factors that hinder and support implementation. This study aimed to explore the role of interpersonal factors within leadership when collaborating to implement psychological EBIs. The following research question is put forward:

1. What interpersonal factors contribute or hinder effective collaborative leadership when implementing psychological EBIs?

Method

Design

This study adopted a qualitative, reflexive thematic analysis (TA) methodology to address the research question (Braun & Clarke, 2006). Semi-structured interviews were conducted to support reliable and comparable data collection across participants while allowing for the exploration of additional areas emerging during interviews (Patton, 2015).

Ethics

Royal Holloway, University of London Ethics Committee (REC Project ID: 3164) granted ethical approval for the project on the 8th of June 2022 (Appendix C). Ethical issues regarding consent, confidentiality, study withdrawal, and data storage were covered in the participant information sheet and consent form (Appendix D and E). Health and Research Authority within the NHS ethical approval was not required because recruitment was within the local authority setting. Study details were reviewed amongst senior managers and leadership teams, and approval within each therapeutic modality within the project, MST and FFT, was sought and confirmed (Appendix F and G).

Recruitment

Participants were recruited from the PFP project. The Clinical Director and Business Development Director were provided with information about the study, including specific inclusion and exclusion criteria, and were responsible for identifying potential participants. The lead researcher (CR, Trainee Clinical Psychologist) was provided with participant details and subsequently emailed an offer of participation in the study alongside an information sheet. Recruitment took place between July and November 2022.

Sample

Traditionally, data saturation in TA has been commonly used. However, recent scrutiny has challenged this phenomenon (Low, 2019). Extensive variation in the recommended sample sizes in qualitative research exists, resulting in Braun and Clarke (2019, 2022) outlining the importance of sitting with uncertainty and acknowledging that meaning is generated through data interpretation and information power instead of striving for data saturation. A total of 17 participants were identified and contacted. Three of these individuals did not respond, and two people consented to take part but did not proceed with an interview due to one being on maternity leave and two for unknown reasons. A total of 12 participants were recruited for the study. Due to the limited sample of leaders within the

project, demographic data from the participants is not disclosed to minimise the risk of deductive disclosure. Similarly, pseudonyms were used in the quoted text in the results section to ensure confidentiality. Furthermore, pronouns, job titles, and EBIs were anonymised.

Eligibility

Inclusion criteria required participants to have worked within the PFP project in the capacity of a leader within the implementation process. For this study, a leader was defined as someone involved in decision-making (e.g., financial decisions, referral pathway decisions) or who managed individuals implementing the EBIs. Examples of leaders could have included but were not limited to, funders, commissioners, delivery partners, or clinical leads.

Procedure

An invitation to participate was sent via email to potential participants. The email contained the study information sheet (Appendix D), which provided details about what participation in the research would consist of, how the information obtained during the interview would be stored and used, as well as how they could withdraw from participation without providing any reason. All participants had the opportunity to ask questions before consenting to the research and at the start of the interview. Obtaining written consent was carried out prior to the interview by participants remotely completing the consent form (Appendix E) and emailing this to the lead researcher. This consent form also obtained agreement to audio-record the interviews. Three participants requested to review and confirm their approval of the quotes from their interviews before the write-up. Participants were also asked to complete a demographic form (Appendix H) before the interview. Interviews were conducted between July and November 2022 on the online platform Microsoft Teams. No interviews were terminated, and no participants withdrew from the study. The duration of interviews ranged from 57 minutes to 1 hour 59 minutes, with an overall average of 1 hour, 37 minutes. Each participant was allocated a study number, and all participant data was saved using

their allocated number. Participant data was stored securely and separately to ensure confidentiality and anonymity.

Materials

The present study used a semi-structured interview schedule to explore the research questions. The interview schedule was developed in consultation with research supervisors and existing theories and literature. An expert by experience assisted in piloting the interview schedule and advised on question comprehension, identifying gaps, and sharing their overall experience. Based on the feedback, subsequent adjustments were made to the wording of the questions to ensure that less jargon was used to make the interview more accessible. The interview schedule consisted of open-ended questions with follow-up prompts (Braun & Clarke, 2022) designed to explore interpersonal factors that contributed to or hindered leadership when collaboratively implementing EBIs. It also explored how effective leadership can impact the implementation and delivery of EBIs. Prompts were used when appropriate throughout the interview. A semi-structured interview design allowed participants to provide in-depth accounts pertaining to specific phenomena (e.g., their perceptions and experiences). Appendix I shows the fully developed interview schedule.

Analytic Approach

All 12 interviews were transcribed verbatim, with reflections documented throughout the process to immerse and familiarise with the data thoroughly. Transcriptions were stored on a password-protected laptop in an encrypted folder that only the lead researcher could access. All data was held in accordance with General Data Protection Regulations (Macenaite, 2017) and in line with Royal Holloway, University of London Ethics Committee's data management guidance.

Reflexive TA was used in this study to obtain in-depth data on participants' perceptions and experiences (Braun & Clarke, 2022). Reflexive TA offered the possibility of an inductive-oriented experiential analysis that supported the illumination of experiences from the participant's perspective by focusing on manifest and latent content whilst being able to draw on patterns of meaning across

participant interviews (Braun & Clarke, 2022). The theoretical flexibility of reflexive TA meant that it could be informed by systemic perspectives on leadership and give voices to leaders with experience of a collaborative approach to implementation while also locating these experiences within broader sociocultural discourses (Braun & Clarke, 2006; Elo & Kyngäs, 2008). The analysis took an inductive approach, meaning the data did not attempt to fit into existing theory (Braun & Clarke, 2022). This supported delivering rich, idiosyncratic, complex themes that were not anticipated prior to analysis (Byrne, 2022) and instead allowed the author to apply their theoretical framework of organisational and psychological theories. This was favourable compared to other qualitative methods with more predetermined theoretical positions. Again, lending to TA's flexibility, an inductively developed analysis captured semantic and latent meanings and offered descriptive and interpretive data accounts. Differing from the originally developed TA approach, the reflexive process emphasises the importance of the researcher's subjectivity as an analytic and valuable resource through their reflective engagement with theory, data, and interpretation (Braun & Clarke, 2021).

A six-phase reflexive TA was undertaken to explore patterns across interviews (Braun & Clarke, 2022; Terry et al., 2017). Each phase was clearly documented to ensure the themes were traceable. Despite the six distinct phases, the author employed an iterative process to the analysis, whereby the process was not linear and instead remained progressive but recursive. The use of NVivo 12, a software designed for qualitative data analysis, supported primary data coding and analysis.

The first stage comprised *data familiarisation*. This included reading and rereading the transcripts line-by-line to be immersed in the data and noting any initial codes. This stage also involved cross-referencing the reflexive journal to recall initial thoughts before and after the interviews. There was a noticeable shift from an initial semantic to a more latent orientation as analysis moved into the more systematic and rigorous stage where *coding* took place (Appendix J).

More than one sweep of coding was employed to ensure that no areas of data were overlooked. Subsequently, codes were organised into *initial themes*, whereby similar codes were clustered together. This is where the author began considering the relationship between themes and the narrative of the data. The author used electronic and hard copies of the codes for this process and found that movement between different environments prompted new reflections and insights into the data. This process was also carried out alongside the author's supervisor in person to bring new perspectives that supported shaping the analytic story (Appendix K). A visual representation of themes and subthemes was created through a thematic map, illuminating the relationship between themes. The nature and character of themes were reviewed by *reviewing and developing themes* across the entire dataset. *Refining, defining, and naming* the themes included discussions with supervisors to confirm definitions of themes and subthemes to ensure a coherent narrative of the dataset was represented. A draft table of themes and a thematic map were then shared with the 12 participants to gain reflections on relatedness to the themes, the theme title language, and the comprehension of the narrative. The thematic map was then confirmed (Figure 4). *Producing the report findings* involved presenting the outcomes meaningfully, where data exerts are shared in line with the themes in the subsequent results section.

Quality

Independent of reflexive TA, Elliot and colleagues' (1999) seven-step quality framework was employed to ensure optimal standards of qualitative research were maintained throughout. This framework aligns most with reflexive TA, highlighting the importance of reflective research practice. The following seven steps were adhered to:

1. Owning one's perspective – the researcher initially specified their theoretical orientation stance. Additionally, personal perspectives were outlined during the development of the research phase and throughout the process by using a reflexive journal to monitor the influence of their values and assumptions.

2. Situating the sample – participants' demographic information was collected for the author to situate the sample to gauge their context's impact and the research's generalisability.
3. Grounding in examples – The results section presents quotations from the interviews for each theme. This allowed appraisal of the fit between the data and the researcher's interpretation of themes. Transparency of the code development process from raw data is outlined in Appendix J.
4. Providing credibility checks – initial codes developed within the transcripts were shared with the supervisor, who has extensive experience within the field. This ensured that the raw data supported the chosen themes and subthemes.
5. Coherence and resonating with the reader – a thematic map was created to represent the themes and subthemes visually. This process, alongside the narrative summary, facilitated showing the broader context of relationships between the themes. Member reflections were carried out, which provided space for feedback to add to the analytic process.
6. Accomplishing general versus specific tasks – participants were recruited from different locations and organisations within the project to enhance the possibility of generalisability of findings. However, it is of note that participants were recruited from a specific project. This limits the generalisability of the findings due to the strategic and operational processes within this project differing from those in other projects and systems.
7. Resonating with readers – dissemination of the study's findings was written in an accessible narrative so readers can understand the interpretation of findings and clinical applicability.

Reflexivity

This study's epistemological stance adopted a critical realism position (Braun & Clarke, 2022; Fryer, 2022). Qualitative analysis demands the use of self, therefore encompassing subjectivity, whether asking questions in the interviews or interpreting the data (Luttrell, 2019). The author considered their subjectivity a valuable resource, highlighting that one's values, beliefs, and

identity can be integral to the analysis (Gough & Madill, 2012). However, to ensure subjectivity is meaningful, Braun and Clarke (2022) outlined that a level of interrogation is necessary to capture the author's role in the research and their insight and articulation around it. The author's values and assumptions were considered, and the author remained aware of their position as a white, British, twenty-nine-year-old, middle-class, cis female from a working-class background. Therefore, throughout the research process, the author's subjectivity was reflected on, specifically regarding the impact on the perception of the data. All researchers within the process have had experience with delivering systemic EBIs to young people and their families but have not worked explicitly within this project. A reflexive journal was maintained throughout the process, from the ethics stage to the write-up phase, to assist the important process of reflexivity. The journal consisted of recording thoughts, emotions, personal positions in relation to intersectionality, theoretical assumptions, values, and much more. This was critical, as the author acknowledged that who they are and what they bring shapes the research.

Results

Four main themes and eleven subthemes came from the combined reflective TA of 12 participants (Table 3). Several iterations of the thematic map were produced before arriving at the final version. Figure 4 outlines the themes, subthemes, and relationships between them.

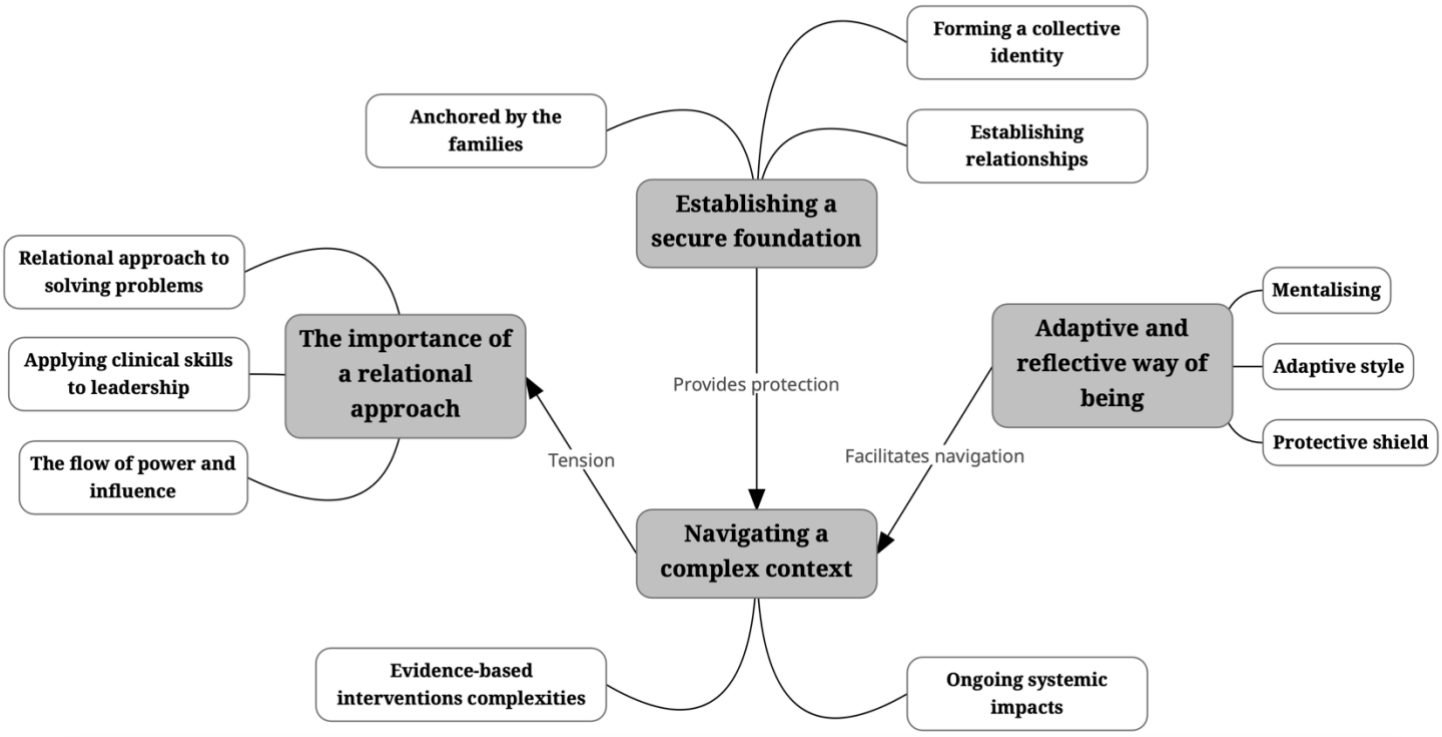
Table 3

Summary of Four Themes, Eleven Subthemes, and Accompanying Definitions.

Themes	Subthemes	Theme Definition
Establishing a secure foundation	Anchored by the families Forming a collective identity Establishing relationships	This theme described the importance of establishing a secure foundation during the initial stages of implementation. Leaders achieved this by being anchored by the family's stories and the vision to support them, developing a collective identity, and establishing relationships among leaders. A secure base to return to throughout the project was fundamental, particularly during challenges and complexity.
Navigating a complex context	EBI complexities Ongoing systemic impacts	This theme referred to the project's complex context that leaders navigated, which occasionally threatened the secure foundation leaders had established. Implementing multiple EBIs alongside the systemic complexities impacted collaboration, yet leaders employed strategies to mitigate these.
The importance of a relational approach	Relational approach to solving problems Applying clinical skills to leadership The flow of power and influence	This theme depicted how relational skills were required when leaders worked collaboratively to solve problems and towards shared goals. It highlighted the significance of adopting and applying clinical skills to leadership to achieve collaboration. Nevertheless, the relational approach was impacted by the flow of power and influence.
Adaptive and reflective way of being	Mentalising Adaptive style Protective shield	This theme related to the importance of a leader's ability to hold in mind and continually reflect and interpret their own and others' internal states and processes, as well as the impacts. This required regular adaptive behaviours and employing a protective shield for their colleagues and fellow leaders.

Figure 4

Thematic Map Illustrating Themes and Subthemes from Thematic Analysis.



Establishing a Secure Foundation

This theme described the importance of establishing a secure foundation during the initial stages of implementation. Leaders achieved this by being anchored by the family's stories and the vision to support them, developing a collective identity, and establishing relationships among leaders. A secure base for leaders to return to throughout the project was fundamental, particularly during challenges and complexity.

Anchored by the Families

The shared vision of putting families first was collaboratively created at the beginning of the project. This required leaders to hold the families at the forefront of all their decisions. Having a vision that was agreed upon and shared amongst all leaders was particularly beneficial when disagreements occurred and consensus could not be achieved; the secure foundation where all

leader's main objectives aligned allowed them not to make adverse decisions and work through complex decisions that the project presented them with, *"the shared vision is helping as many families as possible stay together … if everybody's focused on that, then you can kind of cut through the arguments and say, well, actually it's our duty"* (Sarah).

Training sessions, workshops, and discussions were instrumental in identifying and resolving any inconsistencies in the shared vision of prioritising families and ensuring leadership investment. Additionally, critical components of the project were aligned with the commitment to families, further reinforcing the vision. For instance, MST and FFT have significant empirical support for their effectiveness. Moreover, policies were established to guarantee that in cases where conflict arose between financial benefits and the children's best interests, the decision-making process always prioritised the children.

> *We took a formal decision … that if there's ever a scenario that the financial objectives of the company, the best interests of the child are at conflict, always do what's in the best interest of the child, despite the interests of the company* (Peter).

Many leaders stated that understanding the stories of the families involved in the project was essential and allowed them to connect emotionally and understand their needs. This permitted increased appreciation of the potential impacts of their decisions, *"I think case studies are super, super important … they create sort of emotional attachment to a story"* (Joseph). However, other leaders stated that they did not require an understanding of the families. This may have been because all leaders stated that they already possessed an inherent quality of being passionate about supporting families. This quality allowed natural alignment of the leader's values, which supported collaboration from conception, and reinforced the collective vision promoted by the organisation, in turn enhancing the secure foundation, *"you've got a common piece of DNA that you could always refer back to. This is why we're here"* (Lewis).

Forming a Collective Identity

Alongside a shared vision, forming a collective identity was fundamental to further ascertain a secure foundation amongst leaders. The leaders in the project came from multiple organisations that already held unique values and goals. Therefore, creating a new collective PFP identity was paramount to achieving alignment. Additionally, leaders were based across various London boroughs, so establishing this pre-implementation was important. The collective identity, which was underpinned by prioritising families, allowed leaders to further relate to one another by providing a sense of unity.

> *We spent a lot of time at the beginning doing everything collaboratively and setting up, setting the shared identity of PFP … although we are coming from different organisations and different boroughs, we are all PFP and our main reason for existence is to help as many families as possible.* (Sarah)

Recruitment further promoted staff to align with the PFP collective identity, as leaders prioritised recruiting individuals whose values pre-aligned with PFP instead of attempting to impose new values upon individuals, *"…we try and recruit people with the right values in the first place"* (Peter), *"so we'll look for people that already have that commitment to provide services to very deprived families and complex family. It's not for everybody"* (Avery).

Despite developing a collective identity for PFP, many leaders explained that the separate organisation identities manifested within discussions and decisions. Nevertheless, many saw this as beneficial, as it supported rich, complex, and innovative discussions within the project. Still, when agencies presented PFP with challenges (e.g., lack of referrals), the PFP collective identity would take effect, giving leaders a shared, secure base to return to, which allowed leaders to come together and support one another through the display of a cohesive and unified stance, *"we wouldn't have gone to a local authority and shown that that sort of questioning, those sort of questions … those cracks if you would …. we were a very unified front in terms of the local authority"* (Lucinda).

Establishing Relationships

Alongside prioritising families and having a collective identity, establishing relationships was a prerequisite in further securing the foundation for leaders. Relationships were crucial to develop and nurture throughout the project, to obtain a good synergy to procure a durable foundation for when challenges arose. Leaders with pre-existing relationships with other leaders from previous collaborations harboured a head start. Pre-established relationships among leaders provided familiarity with others' work styles, decision-making processes, and problem-solving approaches, which was instrumental in facilitating collaborative work on the project. Nevertheless, leaders also specified that relationships constantly evolve, and investing time and effort to understand one another's approach was essential in building positive relationships. Establishing relationships in the initial stages required intentional workshops, training, team-building exercises, and formal and informal in-person meetings. A variety of methods permitted leaders to get to know one another holistically, to learn about one another's strengths, to work more effectively together, *"...getting to know people in 360 degrees and then working out how, you know, and then reacting to what they say and how they .... behave ... in the light of your knowledge of how they operate"* (Lewis).

Nevertheless, the dynamic nature of relationships necessitated continual support to sustain relationships for the project's duration. For example, when brought together further into the project, leaders expressed how family success stories were shared, rippling hope among team members. Further, cross-team meetings and socials events outside of work allowed team members to connect and celebrate successes, translating positive relationships to the workplace, *"...sharing stories of interventions that have worked with other families can be ... motivating for ... instilling hope with people"* (Hannah).

Leaders initially recognised an absence of role clarity, which did not support establishing positive and collaborative relationships because it led to leaders unknowingly infringing on others' responsibilities. This lack of clarity did not support establishing a secure foundation, as a lack of

understanding of who was responsible for making decisions or taking charge of different aspects of the project existed. This caused tension and conflict among leaders.

> *...we might have made some assumptions that roles were completely clear, but they weren't necessarily clear for all. … But that role confusion added some layers of stress to different people over the first year.* (Hannah)

Leaders outlined that understanding one another's roles from the start would have allowed them to set boundaries where necessary and feel more confident in knowing whom to ask for support, resulting in reduced stress levels and increased effective collaboration, *"the other thing that's important in this setting is the clarity about the role definition, what my role is, what someone else's role is, and I think that does help avoid too much disagreement or conflict"* (Joseph). Nevertheless, one leader indicated that since the collective identity and shared vision had been created, if there had been an acknowledgement of overstepping due to good intentions (e.g., prioritising families), other leaders may have felt less irritated, as they could have related and understood this. Leaders acknowledged that building and nurturing strong relationships was crucial for establishing a secure foundation to move forward with the project collaboratively. These relationships served as a source of support when challenges arose, especially during the later stages of the project when there was limited time to focus on relationship building and more time was spent navigating the complex context.

> *I think business could have hindered it [relationships] at times, not having time because you're trying to manage lots of other things ..., it can be downgraded in importance during the week and the month, and you try and catch up and that's not good.* (Joseph)

Navigating a Complex Context

This theme referred to the project's complex context that leaders navigated, which occasionally threatened the secure foundation leaders had established. Implementing multiple EBIs

alongside the systemic complexities impacted collaboration, yet leaders employed strategies to mitigate these.

EBI Complexities

Implementing MST and FFT led to tension between leaders. Although the models had similarities, they also held key differences, creating ambiguity among leaders regarding which EBI would best support a family. These differences between the models led to a perceived competitiveness among leaders directly working with FFT or MST, which was thought to be created through having to prove the effectiveness of the model they were linked to. However, some leaders did not necessarily view competitiveness as detrimental to the project and instead allowed individuals to feel motivated by it. Nevertheless, to add to this tension, some leaders considered MST more established than FFT, leading to referrals being a point of contention for leaders and numerous leaders feeling a sense of unfairness between the teams. Some leaders thought that the other EBI team was more discriminating and gatekept against referrals, allowing them to appear to have better outcomes.

> *…slight tension between FFT and MST is … there were at times difficulties around who took what referrals … it sounds really wingy, and I hate it, but I just know that at times [MST/FFT] supervisors and staff just felt that they weren't almost taken as seriously or prioritised.* (Lucinda)

This tension was exacerbated by MST being delivered through an existing MST NHS team. Leaders felt they had less collaboration and control over this service due to the NHS having their own processes and infrastructure already established. This was thought to prevent the MST team from fully aligning with the collective identity of PFP. Therefore, collaboration was hindered when FFT was brought into this existing setup. The supervisor's efforts to address such tensions by pushing the organisation's boundaries to what was allowed supported integration into the PFP

identity. However, a collaborative approach developed much quicker in other teams where FFT and MST were simultaneously established at the outset.

> *The NHS was more difficult to get hold of … and we had less control over … what was happening there. I think they were holding the MST team to their chest rather than allowing it to be under our umbrella. … it would have been better if it would have been either another provider with more flexibility umm to belonging more to the Pan-London kind of ethos.* (Avery)

Regardless of the tensions and competitiveness, it never escalated to the point of relationship breakdown due to the level of professionalism demonstrated by leaders. In fact, when challenges presented, MST and FFT pulled together to support one another, enhancing relationships, *"it felt very much we were one provider, and so when [MST/FFT] struggled because they had staff turnover, [MST/FFT] would do all what they can to take an extra case … and the same for [MST/FFT] if [MST/FFT] struggled"* (Avery). Leaders recognised that FFT and MST shared more similarities than differences, allowing them to complement each other. This facilitated effective vertical and horizontal leadership collaboration with those at strategic and operational levels. Having two EBIs made it easier for leaders to promote the project, as this is rare in most services. Many leaders also recognised the advantages of implementing two EBIs, and although taking slightly different approaches, both interventions held the same aims, and their flexibility meant more families were accommodated because of their distinctions. This aligned with the leader's secure foundation of being anchored by the families and having a collective identity as PFP, *"it felt like it was a professional collaboration and thinking about the needs of families"* (Linda).

Assisting the complexity of having two EBIs, was Bridges Outcome Partnership's data feedback within the project. Data provided a containing function by encouraging discussions among leaders and strengthening relationships through support-based conversations. Despite some leaders finding data collection initially a laborious task, its value became apparent as the project progressed,

particularly when addressing barriers between teams and getting ahead of difficulties to prevent them from escalating. Leaders explained that data strengthened the collaborative approach to addressing challenges among leaders, as objective information from the data felt less confrontational compared to subjective opinions. It also permitted conversations to revolve around supporting teams based on data insights rather than being problem saturated.

> *… 'this is an interesting trend, we'd love to discuss with you why and unpick so we can fix it'. So, I think on that kind of problem-solving mentality, having those sorts of non-confrontational, 'we want to understand why this…' is quite a good starting point.* (Katie)

Ongoing Systemic Impacts

In 2021, the UK was affected by COVID-19, meaning a large proportion of people worked remotely from home with no physical interaction with one another for an extended period. The shift to virtual meetings accentuated how the lack of informal interactions in person inhibited impromptu conversations, which previously helped nurture relationships and enhance communication and teamwork, *"instead of having to have a formal meeting, you can sort of nip over to somebody's desk and have a conversation. It just takes the place of a half hour Teams"* (Daniel). Likewise, leaders outlined that before meetings, they would previously meet for a coffee to discuss salient points they were planning to consider in upcoming meetings to ensure alignment with one another. Without these opportunities, leaders said it was more challenging to establish relationships among various leaders from the different organisations, limiting their ability to make impacts in meetings, as there was less of a united front.

Notwithstanding London's already high staff turnover, COVID-19 caused considerable redundancies among the collaborating local authorities. This made it an arduous task for leaders to maintain relationships with such partnerships, particularly with the departure of passionate individuals who supported PFP's vision. New leaders did not always align with PFP's values and

goals, which created obstacles with processes and previously established collaborative working processes.

> *…if you're working with ten boroughs around London, and you're working at different levels, … the director of children services, … social workers within the teams, all those people are going to change over the course of projects. So actually, you have to spend a lot of time building those relationships, and then rebuilding them when the new person comes in.* (Peter)

However, low turnover in the central leadership team meant they provided continual support and induction of new leaders into PFP, which facilitated effective collaboration among partnerships. Aside from relationship disruption through high turnover, financial implications also strained relationships. Although financial matters were seldom discussed, as the focus was predominantly on positive family outcomes, considerations still had to be present, *"you've got this sort of built-in burning urgent imperative to find ways to get the therapy to achieve its potential. Otherwise, you go bankrupt"* (Peter). Leaders explained how finances added rigidity to processes within the project, prohibiting nurturing relationships among leaders. Moreover, some leaders found the financial discussions challenging, mainly because their precedence was ensuring the families were prioritised, and they were doing everything possible to increase the young people's chances of staying out of care. However, financial concern appeared at the forefront of many conversations for local authorities, particularly regarding whether they were spending their budgets on worthwhile resources. This led to a common dispute of the term edge-of-care, with local authority leaders worried about spending money on families who may not have ended up in care, which subsequently limited referrals to the project. This led to multiple complex discussions and misalignment with borough leaders, highlighting how the secure foundation may not have been as established with leaders more on the periphery.

The Importance of a Relational Approach

This theme depicted how relational skills were required when leaders worked collaboratively to solve problems and towards shared goals. It highlighted the significance of adopting and applying clinical skills to leadership to achieve collaboration. Nevertheless, the relational approach was impacted by the flow of power and influence.

Relational Approach to Solving Problems

A good problem-solving ability was prominent in the project, with leaders taking a relational approach. Leaders proposed that effective problem-solving hinged on communication skills. Given the complex leadership structure, communication was seen to occur on multiple levels, despite some leaders sharing that this took time. Communication frequency was important, but the leader's style held more significance. As difficulties arose, how leaders communicated with each other prevented relationship breakdowns. All leaders outlined how their approach involved brainstorming ideas and allowing everyone to share and have their perspectives considered. Leaders believed that by allowing their colleagues to feel heard, presenting various options to consider, and basing their decisions on evidence, their colleagues would view the process as fair. This allowed leaders to feel validated and respected and decreased competitiveness, increasing subsequent engagement and collaboration between leaders.

> *If you can have a debate which is broad enough and deep enough, … which enables everyone to understand that they have been listened to, then if a conclusions reached which isn't the conclusion they would have come to, then the less they think that the debate was in some ways not a fair one, and the outcome process was a fair one, then you know, the debate's been had*. (Lewis)

If we can communicate, if we can liaise, if we don't see each other as competitors but complementing, I think all those things … made it fairly … sort of open arena of discussion. (Joseph)

All 12 leaders discussed the concept of curiosity, which helped them approach problem-solving from an open, transparent, and receptive outlook, facilitating deliberation rather than avoiding problems. Transparency exposed more difficulties, as individuals felt comfortable expressing their needs. However, this resulted in individuals' needs being met more frequently, promoting supportive relationships. Conversely, some leaders detailed instances where transparency was not present, leading to confusion and uncertainty among team members, as necessary information appeared to be withheld during some discussions. Certain leaders found collaborating and reaching resolutions challenging without an articulated and transparent rationale behind individual decisions.

…in local authority sometimes, like you can reach a little bit of a 'computer says no' and not because of anything to do with your project, but because of internal politics or internal funding and … you don't even necessarily always have clarity on what the blocker is. (Katie)

Contrary to this, other leaders highlighted that it was essential not to spend too much time discussing problems because it was vital to problem-solve and implement action promptly. This enhanced effective problem-solving, enabling continual project development and reduction of frustration among leaders, *"…if people come into a room and they just talk about all the problems and … every meeting can just be like talking about all the problems, and actually rather it's a much more action-oriented solution orientated needed"* (Katie). Moving conversations to more action-oriented dialogues was supported by using data aligned with the project's family-centric identity. This resonated with the shared vision and enabled leaders to listen actively, as discussions were rooted in evidence rather than subjective opinions. This decreased conflict, resulting in more productive conversations and increased trust among leaders.

Several leaders discussed that there were times not to show curiosity, and instead, a directive communication style was adopted. Certain leaders felt this directive approach could impede relationships and problem-solving, as sometimes it could be interpreted as not providing room for negotiation. This created a non-supportive and blaming atmosphere, which served as a barrier to positive working relationships. However, other leaders acknowledged the benefits of naming difficulties that were not being openly discussed. Despite these dissonant beliefs, in situations where a directive approach was necessary, the leadership team's different styles complemented one another, which promoted problem-solving, strengthened relationships, and enabled collaboration.

> *[Another leader] can be very direct, and you know [they] call something out if [they] see it, and you know sometimes that can rub people up the wrong way, … but you know what it does do is it gets everything on the table, forces the conversation and means that action does happen quite quickly. … it's … creating a culture where people air their views and they talk about things and I think that's … really helpful and essential.* (Katie)

Despite leaders outlining the importance of not dwelling on problems and moving to action promptly, several leaders shared the value of openly recognising others' contributions within these discussions. The process of validating before moving straight to action was meaningful for leaders to feel appreciated, respected, and motivated to continue, despite the ongoing obstacles they regularly encountered. Furthermore, leaders said it allowed them to feel seen and supported by other leaders.

> *[Other leaders] did a good job at making me feel like my voice was valued, my ideas would be heard, that I had an important role. … I think then, that really enables you to perform and motivates you through some very difficult times. You feel valued. You feel absolutely key part of the system.* (Joseph)

Applying Clinical Skills to Leadership

Leaders employed clinical skills within the organisational context, comparable to those employed by clinicians working with clients. Leaders described the value of leaders having the ability to assume multiple roles, such as transitioning from clinical discussions with social workers to participating in strategic meetings. This helped leaders link the project's different aspects (e.g., clinical difficulties and finances), ultimately contributing to maintaining relationships on organisational and clinical levels. However, only some leaders had both clinical and organisational knowledge. Many leaders had insight into the skills they lacked, leading them to ensure that leaders with such skills were present in discussions to fill these gaps. This certified that a well-rounded discussion with multiple perspectives was had. Leaders reflected on the diverse composition of the leadership team and how this contributed to achieving a balance between clinical and organisational viewpoints. This facilitated the merging and collaboration of the two domains, supported by a shared vision grounded in both clinical and organisational values, *"…the board comprised people who were at one extreme very driven by finances and … a practitioner in using [an EBI] to keep kids out of care. And everyone approached each problem from a totally different angle"* (Lewis).

The overall thinking held by the leaders was systemic. Leaders saw the benefit in having *"…an ability to see issues as relational and contextual, not as located in people"* (Joseph). This approach promoted a non-judgemental style, making it easier to resolve challenges, and prevented confrontational language and defensive behaviour. Challenges expectantly subsisted within the project, requiring leaders to remain flexible. When difficulties arose, for example, taking on excessive workloads and needing extra support or adapting FFT processes, leaders felt that the team was highly flexible to accommodate and work together to support one another.

> *I think we would've certainly lost [a leader] the year following if we hadn't had been supportive a bit more. … We were probably able to, with various feedback things, act on the decisions and justify and talk to the reasons why decisions were made.* (Daniel)

It was shared that some leaders were less flexible in their thinking on some matters, leading to people feeling frustrated and demotivated, resulting in communication breakdown, *"I think it was quite difficult, but it kind of felt like they [another leader] came with their agenda, and they didn't want to adjust"* (Vanessa). Nine leaders emphasised that listening was integral to developing and sustaining relationships with other leaders and frontline staff. Leaders recognised the significance of active listening in resolving conflicts, highlighting the need to ensure that all colleagues felt heard to facilitate progress, *"I tried to sort of again create an atmosphere of sort of a relaxed atmosphere where everybody's voices were heard. So, if I heard someone that was quiet, I would sort of invite their voice and get some ideas"* (Michael). Conversely, there was a balance between listening to others and being persistent about personal views and needs as a leader. Many leaders acknowledged that persistence was necessary to feel heard and ensure tasks by fellow leaders were completed to drive change. Persistence was also needed when liaising with boroughs. For instance, reaching a collaborative decision about the definition of edge-of-care required persistence to reinforce the definition to certify that appropriate referrals were being received. Regular reviews were also required to ensure the identity of the project's goals, not just during the initial phase but throughout the project's longevity.

Another therapeutic skill noticed was how leaders demonstrated their capacity to enforce boundaries, whether that be to confine discussions to essential matters, personal boundaries to communicate when the workload was overwhelming, or defining expectations of role limits, *"to understand what they wanted from us, … as a service, and setting boundaries as well, because sometimes social workers were so busy, that they wanted us to do social work"* (Michael). Boundaries supported collaboration by enabling clear and consistent communication, which fostered trust.

The Flow of Power and Influence

Leaders discussed the crucial role of power, evoking the idea that it was possible to have power without influence. Within this complex leadership structure, moving from organisation to organisation, the role of power and influence remained dynamic and fluctuating. Leaders shared that they held more influence than power because power was not their priority. Instead, prioritising families were. However, individuals who held financial control were considered to possess power rather than influence.

> *…if you're within one organisation, leadership actually have actual power over people, and influence. Whereas if you're going from one organisation to another, you might have power because you might be the funder, but you might not have power, but you might have influence … but a lot of our role is about influence, not having power. (Linda)*

Leaders acknowledged that power also resided in experience and knowledge. Resultantly, the diverse backgrounds of the leadership team (e.g., psychology, social care, finances) inherently held power. Numerous leaders shared that a flat leadership structure positively impacted power among leaders within the project, allowing everyone to feel heard and respected, permitting them to feel empowered. Contrary to this, when leaders interacted with external agencies, the role of power differed. The complex leadership hierarchies in external agencies particularly challenged accessing those with decision-making powers. Consequently, conflict and frustrations appeared within relationships as a lack of trust was present and a perceived lack of support for the agreed project goals. This strain on the relationship caused increased stress among leaders, *"not dealing directly at a senior level with members of the partnership … really added to the complexity because they couldn't access those with power to make decisions. It was extremely hard to have meaningful conversations through third parties"* (Lewis).

Upon reflection, leaders recognised a significant power imbalance when relationships were not established early on. Several leaders outlined that the clinical director, alongside other leaders,

overcame this obstacle by intentionally working on relationships. For example, with borough leads, this meant giving them the power of a voice to understand their decisions and needs, to reach a mutual understanding. This meant that power imbalances dispersed over time, facilitating collaborative working.

> *When for whatever reason, like the service, an individual at whatever level of the borough was the borough point of contact and was making all the decisions, umm yeah in that instance not that we didn't have a good relationship with that person … we didn't have the access to integrate properly in that local authority.* (Daniel)

Adaptive and Reflective Way of Being

This theme related to the importance of a leader's ability to hold in mind and continually reflect and interpret their own and others' internal states and processes, as well as the impacts. This required regular adaptive behaviours and employing a protective shield for their colleagues and fellow leaders.

Mentalising

Having the capacity to mentalise fostered increased empathy for fellow leaders. Despite leaders identifying how everyone took different approaches to reach the desired goal, holding in mind that they were working towards the same shared vision supported embracing difference rather than pushing back against it, *"…if people can keep in their mind, … this is not to undermine, this is not to critique, this is to really try to help make this project be successful"* (Hannah). The ability to mentalise reduced conflict, as it allowed leaders to appreciate other's behaviours, perspectives, and emotions more, which provided an understanding of the meaning behind decisions being made. Subsequently, engaging in respectful and constructive interactions was witnessed.

Consistent communication was seen as instrumental in promoting mentalisation among leaders. Though, leaders under pressure found it harder to mentalise. Being unaware of how their

behaviours and interactions impacted other team members was a crucial lesson for some leaders, as this caused tension in relationships. At times, some leaders did not feel mentalised for, particularly when they were not the ones with the power to make the final decision, *"I think I could understand both sides, but I think sometimes I felt that it was hard to make them [other leaders] understand that"* (Vanessa). From this, leaders felt unheard, frustrated, and lacked the motivation to invest efforts into those relationships, leading to relationship breakdowns on occasions. Nevertheless, Hannah identified that acknowledging fellow leaders and frontline staff's emotions during stressful periods was the most important time, as it created a culture of validation, which supported effective problem-solving, *"…if there isn't space for emotional recognition when things are very stressful, you can't problem solve".*

Leaders discussed that understanding perspectives promoted mentalising for fellow leaders within the project. The project sat in a complex structure, with many distinct perspectives and positions. Therefore, giving everyone a voice was important. This also implied that if individuals felt heard, working as a team would naturally feel easier.

> *I tried to sort of again create … a relaxed atmosphere where everybody's voices were heard. So, if I heard someone that was quiet, I would sort of invite their voice and get some ideas … I think that quite a lot of the work was again helping everybody to see each other's perspective.* (Michael)

Leaders highlighted that all leaders brought differing views to discussions, which was perceived as a positive quality of the leadership team. Being able to see strength in difference was vital in enabling leaders to open their own perspectives, beliefs, and biases and allow the desired goal to be achieved through a collective approach, *"I saw strength in different perspectives and were approaching … problems from that collective problem-solving perspective where we were looking at, okay, well, collectively, … what are the things that we can bring to the table to really make a*

difference" (Sarah). The ability to mentalise enabled leaders to respond appropriately in different situations as they were able to regulate their emotions.

Adaptive Style

This theme expressed the importance of situational adaptation. For instance, Michael recognised the need to be optimistic, curious, and encouraging when interacting with frontline staff, but a more authoritative stance was essential when going into stakeholder meetings. Some leaders felt they could leverage their skillset by utilising their different roles. For example, some leaders explained that they could wear a clinical hat during clinical-related discussions, while in other contexts where an organisational frame of thinking was needed, they could assume that role. Some leaders found this switch easy to carry out, while others found knowing which hat to wear in different contexts more challenging, *"I think … you had lots of hats you had to put on and sometimes knowing what hat to put on in what context was a really key sort of challenge really"* (Joseph). Differences in working styles among leaders could have posed a challenge in sustaining relationships. However, leaders witnessed how the leadership team's varying approaches supported obtaining buy-in and progress within the project.

Leaders acknowledged the gravity of how adapting communication supported collaborative ways of working. Based on whether they were communicating up or across to fellow leaders or therapists, adaption was essential to building rapport with others.

> *…vary your style of communication depending on who you're talking to. So, you're not … approaching everyone with exactly the same ways of communicating. … I think what I did as a leader more and more is also hold very clear positions. … I think there were times not to show curiosity. You might be curious, and you might want to say, 'I wanna understand why that's happening', but I'm closing curiosity at the point of, 'I'm not sure this is good enough and I want that to change'… so a little bit more, I suppose traditional assertive communication.* (Joseph)

Katie explained how the capacity to be agile and adjust one's approach during meetings and communications was crucial to make progress with certain individuals. This involved displaying humility to gain the trust of others, while in other circumstances taking a firm stance to uphold the project's values was needed. To support this, the leadership team created an open and safe environment where mistakes could be made, *"…you can ask silly questions then, I found that you could. You could be more curious. You don't have to pretend like you know"* (Joseph). This enabled deeper connections between leaders and allowed problems to be addressed and worked through. Moreover, this theme showed leaders' agile ability to protect their colleagues from the complex nature of the project, where challenges and detriment were possible.

Protective Shield

Leaders shared a common worry about how the complex context of the project (e.g., SIB model, financial implications) could have undermined the effectiveness of the EBIs if it percolated to the frontline staff or among the leadership team. Leaders actively mitigated this risk by employing a protective shield. This consisted of leaders taking a cohesive stance that protected the frontline staff and one another from the context. This entailed collectively fighting the system to ensure everyone could perform to their optimum, *"we were fighting with the system, and they could just focus on their job"* (Avery).

Numerous leaders felt that their senior leaders should also adopt this role to protect them from pressures from above. While some leaders felt that this protection was provided, others experienced stress, pressure, and a lack of support, leading individuals to react defensively and feel less inspired to carry out their roles. This caused some leaders to question whether others respected them, impacting collaboration and alignment.

> *…I think [they were] under a lot of pressure continually to justify, 'why hasn't this case been opened? Why is it been open this long?' … But then [the team would be asked] those*

questions, which would feel quite, you know, people would feel like they needed to defend themselves a bit. (Lucinda)

This lack of support instilled worry that senior leaders would put this pressure on their staff, which they were attempting to protect them from. However, leaders recognised that senior leaders would adapt around frontline staff and put a shield in place to protect them from the organisational complexities.

…but when it came to the therapists, I learned then that [they were] much more flexible, much more positive, and much more smiley, and much more connected. And so, at that point I felt like, okay, I don't need to do that, I don't need to protect these people really. (Michael)

Nevertheless, when leaders were subjected to increased pressure from their superiors, several leaders described how they safeguarded their fellow leaders by making themselves present and available in case of need. This entailed adding meetings and drop-ins to ascertain how others were coping and if support could be provided, illustrating that hardship sometimes fortified relationships.

If relationships were not wholly established at the outset, inaugurating the protective shield was more challenging. Vanessa explained that the relationship grounding at the start made her feel supported when she needed it later in the project. Although Joseph identified that the right level of support and challenge was a tricky balance, it was imperative to ensure staff performed to their maximum capabilities while feeling adequately supported to rise to the challenge.

You should need maximum support and maximum challenge … so that everyone feels very supported, very encouraged to contribute, very validated. But also challenged as well and … able to offer feedback in a really open way and not fear that that's frightening or threatening. That balance, I think super, super important, very hard to get, but I think to create a culture of that is important. (Joseph)

Member Reflections

Four participants completed member reflections by reviewing a draft table of themes and a thematic map. One participant shared that they felt the themes spoke to the clinical aspects of the project, which did not align with their specific role. The remaining participants felt that the themes effectively summarised their experiences. One participant highlighted that the themes accurately portrayed the facilitators and the challenges they experienced throughout the project. Based on this feedback, no modifications were made to the themes.

Discussion

This study utilised a qualitative design to explore leaders' experiences of collaborative leadership. The primary aim of the research was to explore the interpersonal factors that contributed to or hindered effective collaborative leadership when implementing systemic EBIs for children on the edge of care. The study's main findings will be discussed in relation to existing literature along with the study's strengths and limitations. Furthermore, recommendations for future research will be presented.

Main Findings

It was found that sustaining secure and trusting relationships within the core leadership team and leaders more on the periphery of the project required acknowledging the impact of systemic and family trauma. The theme of 'establishing a secure foundation' illustrated how the initial phase was pivotal in setting the core infrastructure for implementation, which subsequently served as a holding environment (Winnicott, 1960). This consisted of understanding and considering trauma within policy, procedures, decision structures, and collaborative engagement with local authorities. Recruitment was also tailored to recruit staff motivated by this vision and approach. The holding environment created a regulated system which enabled leaders to remain regulated to perform their responsibilities in a trauma-infused system while containing distress and complexity. Leaders having

a shared knowledge of the trauma that exists within a system has been shown in research to have the power to shift attitudes and behaviours (Brown et al., 2012).

These findings relate to aspects of trauma-informed leadership. A trauma-informed approach to leadership originates from a system level, with leaders playing a pivotal role in establishing an organisation's culture due to their interrelated and multi-layered relationships that impact direct work with young people (Bendall et al., 2021). Trauma-informed leadership can contribute to a trauma-responsive approach, which is crucial in avoiding the unintentional creation of parallels akin to trauma (Bloom, 2010; Galvin et al., 2022), something the leaders were extremely conscious of throughout the project. Conversely, research suggests that leaders who fully exemplify a trauma-informed leadership approach acknowledge the significance of self-care (Koloroutis & Pole, 2021). Leaders within this study did not outline the importance of taking care of themselves, neglecting the potential benefits of self-care in enhancing their ability to support others.

Research has shown that trauma-informed leadership enables collaboration among leaders (Bartlett et al., 2016). The findings illustrated aspects related to this approach within leadership, with an integral component being the leaders' abilities to hold the people they managed and worked with in mind. This approach enabled collaboration and was seen through their approach to solving problems, taking a flat leadership approach, their ability to mentalise, protecting their colleagues and frontline staff from systemic trauma, and their adaptable approach. However, when relationships between the core leadership team and leaders on the periphery were less established, connection to aspects of trauma-informed leadership was inhibited. Leaders on the periphery having to hold the goals and values of their own agency as well as PFP's potentially led to less attunement to the core leadership team. Having less attuned relationships meant there was less space for the integration of trauma-informed leadership. Nevertheless, leaders attempted to share knowledge, employ new policies, and add processes to recognise and respond to trauma sensitively (e.g., adding consultation panels to address unique challenges), irrespective of the lack of established relationships.

Additional aspects of 'establishing a secure foundation' encompassed *'forming a collective identity'*, which empowered leaders to align with staff at all levels throughout the project. Research has exhibited that when an organisation's identity and alignment are absent, a lack of safety, emotional dysregulation, and miscommunication can permeate a system (Bloom, 2010). Instead, what was seen was how creating a collective identity enhanced leaders' sense of unity, belonging, and safety. This collective identity encompassed a systemic frame of thinking, shaping the meaning and narrative which directed the rest of the project. This identity was further solidified by the low turnover in the core leadership team, which supported relationships and the instalment of the discernible PFP identity, shared values, and collaborative endeavours within the partnerships.

Alongside developing a collective identity, *'establishing relationships'* among leaders and understanding each other's motivations occurred. This mirrored the initial phase of the therapeutic process of FFT, where balanced relationships, adopting a strength-based approach, and reinforcing protective factors are focal points. Leaders showed their commitment to supporting the families while considering the context of culture, values, beliefs, and perspectives of the families and the system, all of which FFT also accentuates (Weisman & Montgomery, 2019).

The complex context in which the project subsisted threatened the stability despite 'establishing a secure foundation'. The theme 'navigating a complex context' highlighted how the project context mirrored the complexities of the families in the project (e.g., staff turnover, SWLSTG delivering MST). The complex system could have pervaded the collaborative relationships if a secure foundation had not been developed. Instead, leaders' awareness that the system was suffused with trauma allowed them to dedicate resources and time to managing and preventing aspects from impacting families and staff. This sense of responsibility enriched the leader's identity within the project, which research has deemed responsible for creating meaning (Burke, 1991; Frémeaux & Pavageau, 2022). This navigation continuously proved challenging, which prompted leaders to create a *'protective shield'* for fellow leaders and frontline staff. Research has established that leaders who

conscientiously carry out such protective behaviours facilitate coping and growth when working with trauma (Koloroutis & Pole, 2021). Leaders provided a scaffolding frame to minimise the complex context from impacting the EBI effectiveness and to sustain positive relationships among the leadership team, highlighting that collaboration and connection augmented when leaders faced adversity.

Complexity is inherent in relationships, particularly when considering intersectionality, which is a valuable framework for understanding the multifaceted nature of an individual's experiences and how they impact interactions. Consideration is owed to how intersectionality was not identified as a theme. This could be attributed to numerous factors, such as researcher bias or sample characteristics. Nevertheless, power was a central thread in the data, and intersectionality links to power and serves as the observance and analysis of power imbalances, particularly for those most marginalised in society (Fisher, 2020). This also allows reflection on relationships where power imbalances are maintained through systemic processes, and only through systemic change can equalising be seen (David et al., 2019).

Participants acknowledged a flat leadership structure until external agencies were involved, at which point a hierarchical arrangement became apparent. Curiosity remains regarding the level of leader awareness of the *'flow of power and influence'* and the sentiments of frontline staff. Leaders disclosed not actively seeking power. This could have stemmed from them outlining feeling heard, meaning power was unnecessary to exploit to leverage gains. However, it became evident that communication, problem-solving, motivation, protecting colleagues, and supporting the shared vision to support the families were crucial factors in resolving power struggles.

Interestingly, power subsisted within the data that was collected in the project. Bridges Outcomes Partnership was responsible for performance management, which required data collection within the project. Despite initial hesitations, data from Bridges became the catalyst for problem-solving, decision-making, and confronting challenging topics, ultimately enhancing collaboration.

The level of objectivity the data provided mitigated subjective discussions where conflict could reside. This discovery aligns with earlier studies demonstrating the positive impacts of transparent data reporting when implementing EBIs within mental health settings (Clark et al., 2018).

Despite data underpinning many discussions, *'applying clinical skills to leadership'* (e.g., active listening, boundaries, and persistence) was also vital and revealed increased psychological safety in the leadership team. *Psychological safety* is where individuals can freely express themselves without fear of rejection or judgment (Edmondson, 1999). This environment respects people's competence, promotes positive intentions, stimulates genuine interest in others, encourages constructive feedback, and fosters risk-taking and experimentation. Psychological safety was evident, as leaders felt safe to make mistakes, express their perspectives, and be authentic, even if their approaches differed. Employing an open and transparent style when discussing challenges further enhanced a psychologically safe environment. However, due to Bridges Outcomes Partnership's intense data monitoring, many leaders explained they felt under pressure, potentially threatening the developed psychological safety in the secure foundation. Previous research is concurrent with such interpretations (Lee, 2021). However, Bridges began making it apparent that their monitoring came from a supportive standpoint, which shifted this sense of pressure, and instead increased a sense of safety and trust. Overall, research has demonstrated that psychological safety reduces team conflict (Joo et al., 2023), meaning the development of this safety bourgeoned collaboration between leaders.

An 'adaptive and reflective way of being' was needed for leaders to effectively employ a *'relational approach to solving problems'*, obtain psychological safety, and navigate the complex context and partnerships. This theme underpinned the importance of *'mentalising'* and the ability to adapt situationally. *Mentalising* is the ability to comprehend one's own and others' mental states (Duschinsky & Foster, 2021). Leaders mentalising for one another increased empathy for others' decisions, which permitted valuable and more sensitive negotiation. This empathy also allowed

leaders to regulate their emotional responses, enhancing collaboration by embodying epistemic trust. Attachment theory outlines that individuals who cannot mentalise are subsumed with fear and the need for attachment, resulting in inhibited cognitive ability (Heinskou & Beck, 2022), which would have been counterproductive in this context. Some leaders exhibited high degrees of explicit mentalising, while others demonstrated implicit mentalising. This discrepancy could have resulted from the leader's diverse backgrounds (e.g., psychology, social work, finances) and prior exposure to developing this skill.

Nonetheless, research supports the link between mentalising and the quality of relationship attachment, signalling that secure attachments were formed between leaders. This was further enriched through the leader's *'relational approach to solving problems'*, whereby they appeared attuned to one another. This meant that conflict among leaders necessitated proactive repair through open-mindedness, transparency, and presence, which encouraged new patterns of attachment and affect regulation (Fear, 2017).

The ability to mentalise allowed leaders to employ an *'adaptive style'*, thus enhancing their ability to manage relationships. Analogously, architects do not design a tall building with a rigid frame because of the unsuitability of such a design for the context in which it stands (e.g., seismic and wind forces). The project structure and leadership team mirrored this approach as leaders accepted the inevitability of challenges and adapted by working collaboratively to address them effectively.

The leaders' ability to adapt relates to *impression management*, an adaptive social coping mechanism that individuals naturally acquire to navigate social realms while maintaining relationships (Emery et al., 2014). Leaders employed multiple acts of impression management, depending on the situations and the leaders they were working with, enabling them to navigate the complex system. Impression management was apparent in enabling collaboration, particularly when responding to threats that impact psychological or physical safety, social status, or sense of

connectedness to others (Harvey & Drake, 2023). Impression management is rooted in attachment theory, which hypothesises that one's perception of survival is linked to their connectedness to others (Flynn et al., 2018). This connects to how leaders adapted to their colleagues in terms of communication, perspectives, and ability to mentalise. However, it was apparent that leaders found it more challenging to consider the internal beliefs and biases driving their behaviours. This could be justified by the lack of insight into what motivates their work. A shared vision can help refute internal biases' impact while aligning individuals, making the biases less apparent.

Strengths and Limitations

Using a qualitative exploration was a strength of the study. Incorporating the perspectives of service users and frontline staff in qualitative research is crucial in ensuring that policies and organisations are pertinent and adaptable to the needs of both the staff and service users. However, it is also vital to understand leaders' perspectives regarding working collaboratively with other leaders, a highly prevalent process in child and adolescent services. The study included expert-by-experience involvement, which included role-play interviews before data collection. This supported interview schedule modifications, particularly replacing psychology-specific jargon with more accessible language. Additionally, the study employed member reflections to obtain general reflections on the analysis and to acquire feedback on the language used for the themes and subthemes. Nevertheless, regarding the adherence to qualitative quality guidelines (Elliot et al., 1999), it would have been beneficial for this study to engage an independent reviewer to examine a greater number of coded transcripts and validate the identified themes. This could have augmented the credibility of the findings.

Purposive and snowball sampling methods may have led to selection bias, potentially skewing the data as leaders could have recommended interviewing colleagues with whom they had positive collaborations, creating a skewed sample. The sample consisted of leaders from MST and FFT teams, different regions, and organisations, attempting to comprehensively represent the leaders

across the project. These sampling methods attempted to ensure homogeneity of the sample, but to derive broader perspectives and enhance the confirmability of the findings, incorporating viewpoints from frontline staff would have been beneficial. Interviewing twelve participants allowed for varying experiences. However, leaders joined and left the project at different times, making comparing experiences more challenging, particularly as the findings suggested that different leadership styles were needed at various stages of the three-year project. The project had a distinct structure with different organisations collaborating. While there is no reason to consider that this structure would significantly differ from other organisations offering similar services within social care, it remains unknown whether these findings can be generalised beyond this project. Further study with larger and more representative samples is needed to ensure the findings can be translated to a broader range of services.

Upholding the confidentiality of the participants was crucial to ensure they could remain open and honest during the interviews. Nonetheless, their apprehension about being identified could have impacted their responses, leading to social desirability bias. Despite the researcher taking steps to mitigate this by assuring confidentiality, consideration is owed to how it is unattainable to eliminate response tendencies related to social desirability in interviews, implying that the findings should be interpreted with caution. Similarly, for the researcher to uphold confidentiality, intersectionality analysis is not disclosed, reducing generalisability.

Conducting retrospective interviews after project completion meant leaders could reflect on the project and its outcomes. This hindsight may have led to bias in multiple ways. Memory or recall bias may have been present, whereby leaders may not have recalled details accurately (Neusar, 2014), particularly the more intricate components of collaborating with several leaders. Additionally, hindsight bias may have occurred, where leaders may have had an altered perception of the events from the project, either skewed positively or negatively. However, the research aimed not to ascertain the leader's interpretation but to investigate what occurred. The author attempted to

manage this by asking the interviewee for examples, not asking leading questions, and employing a semi-structured interview guide with open-ended questions.

The author lacked experience working with senior leaders within social care, which could have influenced the findings, as interpretations of the data are affected by researchers' skills, training, values, and experience (Braun & Clarke, 2022). However, the researcher used a reflective journal to acknowledge their contribution to the research process. Conducting remote interviews made building trust and rapport more challenging. The absence of body language or emotional responses inhibited a richer data interpretation. However, video interviews are thought to relieve pressure on participants and put them at ease (Weller, 2017). On average, interviews lasted 1 hour and 37 minutes, indicating that participants felt comfortable talking with the researcher about their experiences.

Implications and Recommendations

The findings from this study highlight important clinical implications. This study is the first to qualitatively explore the PFP project and examine the psychological processes underpinning collaborative leadership. Findings from the current study demonstrated how many interpersonal factors impact leaders' ability to work collaboratively to implement EBIs. Notably, these factors were relational in nature and should be considered in line with contextual factors. This study has subsequently contributed to the growing area of the psychological underpinnings of collaborative leadership, with implications for future leaders and stakeholders setting up collaborative projects and services for children on the edge of care. Despite the limitations outlined in the study, it provides valuable insights into how employing elements of trauma-informed leadership enables collaboration within the social care context. The findings indicate that relying solely on frontline staff to ensure the successful implementation of EBIs is flawed. It is insufficient to just deliver trauma-informed EBIs. Instead, it is recommended that organisations consider incorporating a system-level approach that embodies trauma-informed leadership, which can contribute to employing trauma-responsive

practice. This knowledge should inform future policymakers, leaders, and social care professionals, specifically when leaders collaborate to implement EBIs. By employing aspects of trauma-informed leadership, leaders can effectively navigate complex systems and set a new standard for implementing EBIs within social care and other contexts.

Implementing trauma-informed leadership in collaborative endeavours would expect to observe greater workforce resilience and reduced staff turnover (Fink-Samnick, 2022), meaning better implementation and sustainability of EBIs. Clinical outcomes could therefore be improved. If leaders demonstrated a particular focus on enhancing collaboration with colleagues, it would highlight a commitment to an organisation's values and vision to improve outcomes for young people and their families (Karam et al., 2018). Although PFP achieved positive outcomes for young people and families at follow-up, whether this correlates to collaborative leadership is unknown. Future research is required to comprehend the impact of collaborative leadership on the implementation of EBIs and the success of clinical outcomes for young people and their families. It is worth noting that PFP was established with a collaborative aim. However, already existing organisations are not necessarily created with collaboration in mind. Therefore, developing trauma-informed collaborative leadership structures may be challenging for some organisations, particularly those lacking resources and support.

The field would benefit from understanding whether the identified interpersonal factors can be taught or are solely inherent. It would indicate whether organisational leadership training needs to be adapted accordingly or whether recruitment methods need tailoring. If future research addresses this gap, collaborative leadership will develop beyond practice-based training, and more theory-practice links will exist. Theorising these theory-practice links is crucial for developing collaborative leadership models and collaboration evaluation tools, which could support organisations to guide and alter collaborative leadership to achieve desired outcomes. Likewise, research should focus on how fidelity monitoring and data will be built into services. Bridges Outcomes Partnership's contribution

to the project was essential and enabled the project to adhere to its aims and work towards optimal outcomes.

The purview of the study was to understand collaboration at the organisational level. Further study is needed to identify the interplay between interpersonal factors and their influence on service providers and clients receiving care. It is important to acknowledge that the interviews focused solely on capturing leaders' perspectives, which may not fully represent the perspectives of frontline staff. Leaders may have focused on factors most salient to themselves, such as their perception of developing a *'protective shield'* to protect one another and the frontline staff from the complex context. However, whether these factors align with frontline staff views is unknown. Attention should be directed towards addressing this limitation in future research.

Conclusions

This study employed a qualitative approach, using reflexive TA to understand leaders' perspectives concerning what interpersonal factors contribute to and hinder effective collaborative leadership. Despite acknowledged limitations, this study enabled PFP leaders' insights to be comprehensively explored and produce an understanding of interpersonal factors that can play a role in collaborative leadership when implementing EBIs in a social care setting. The study findings suggest that employing aspects of trauma-informed leadership contributes to effective collaborative leadership. While it is not possible to draw a clear causal link between effective collaborative leadership and improved clinical outcomes, the study's findings represent a promising advancement in our understanding of how this approach to collaborative leadership can inform policy and services. Nevertheless, the term collaboration oversimplifies the intricate nature of the scale-up process needed for it to eventuate. Organisations would benefit from future research theorising leadership models that explicitly encompass a trauma-informed lens, specifically within collaboration frameworks. This research would support effectively evaluating leaders working in collaboration to

ensure that deserving young people and families receive the highest likelihood of positive outcomes from EBIs.

Chapter 3:

Integration, Impact, and Dissemination

Integration

The systematic review (SR) and the empirical study (ES) were closely connected in their shared focus of investigating the role of leadership within evidence-based intervention (EBI) implementation in child and adolescent services. The ES utilised the SR's findings as a basis for its rationale, as the SR revealed the need for collaboration within child and adolescent services and a gap in the research explicitly related to interpersonal factors of leadership. The ES, therefore, expanded the SR by exploring interpersonal aspects of leadership that facilitate or hinder effective collaborative leadership when implementing systemic EBIs in social care. The research processes undertaken in the SR and ES ensured that the two formed a unified whole to develop recommendations for future research, theory, and clinical practice.

The SR stemmed from recognising that aspects of leadership are pivotal in facilitating and impeding EBI implementation in child and adolescent services, evidenced throughout multiple implementation frameworks and models (Albers et al., 2017). While two SRs had already synthesised the role of leadership in implementation (McCarthy & Griffiths, 2021a; Weeks, 2021), these findings were limited to the social care setting. Knowledge about whether these findings translated to other child and adolescent contexts was required. Subsequently, the SR sought to review and synthesise how components of leadership facilitate or impede EBI implementation across child and adolescent settings. The systematic analysis of 23 qualitative studies revealed one overarching theme and two key themes. Findings revealed that 'developing a core purpose' from the outset of implementation necessitated staff buy-in, leadership commitment, and the creation of a shared vision. Many factors that leaders also had to maintain throughout implementation were exposed. The review highlighted the need for further research to understand what psychological processes, particularly interpersonal factors of leaders, impact implementation.

Fifteen studies in the SR were conducted within the social care setting in the US. This emphasised the need for additional UK-based research within social care. Likewise, only one study

within the SR focused specifically on collaborative leadership, something ubiquitous in child and adolescent settings. Despite the SR's limitations, it highlighted the significance of qualitative methods in achieving a richer comprehension of concepts, which informed the ES's methodological approach. These identified confines informed the ES, whereby a methodological robust qualitative design was employed to explore interpersonal factors that underpin effective collaborative leadership during systemic EBI implementation in social care.

Research into collaborative leadership has burgeoned over recent years. The importance of collaboration is situated within multiple theories and frameworks, including situational leadership theory (Hersey & Blanchard, 1982), emotional intelligence theory (Goleman, 1995), transformational leadership (Burns, 1978) and trauma-informed leadership (Esaki, 2019). Nevertheless, the impact of leaders' interpersonal factors on effective collaborative leadership remained unclear. Additionally, research has highlighted that children going into care is on the rise (Thomas, 2018), and leaders working in collaboration to enhance the effectiveness of systemic EBIs to reduce out-of-home placements is essential.

Empirical Study Methodological Considerations

The ES adopted reflexive thematic analysis (TA) (Braun & Clarke, 2006) to uncover underlying and implicit meanings in the data through an inductive and latent approach. This theoretical framework allowed for a deeper exploration of perspectives not overtly expressed by the participants, revealing new meanings through the researcher's views and interpretations. A critical realist position was assumed, allowing reality to be discovered while acknowledging that the sociocultural contexts of the participant and research shape reality. Critical realism was chosen for its ability to provide rich explanations of social phenomena and to inform practice policy recommendations to address social issues (Fletcher, 2017; Fryer, 2022; Maxwell, 2012).

Data saturation has been encapsulated in numerous formulae and statistical models for qualitative research to support estimating sample size (Constantinou et al., 2017; Fugard & Potts,

2015). *Data saturation* has been defined as the point in data collection and analysis where no new codes are discovered from the data (Guest et al., 2020). Although data saturation has been the gold standard approach to determining sample size, several problems exist with this outlook, including its lack of alignment with the values and assumptions of reflexive TA (Braun & Clarke, 2022). Instead, recent research has moved towards concepts of information power, which encourages researchers to consider the richness, depth, and complexity of dataset information and how it conforms with the study's goals and needs (Braun & Clarke, 2021; Malterud, 2016). The ES's approach supported the researcher sitting with uncertainty and acknowledging that meaning is generated through data interpretation. This approach allowed submersion in the data to obtain a complex, rich, and interpretive meaning of leaders' experiences.

Recruitment

Participant recruitment took a snowball sampling and purposive sampling approach. The external supervisor identified leaders from the different organisations within the project (e.g., Bridges Outcomes Partnership, Family Action), and all participants were invited to participate. Additionally, once interviews started, leaders would kindly recommend other leaders to contact. While these sampling methods allowed for the inclusion of multiple perspectives from the different organisations, they posed a risk of sampling bias. Participants may have proposed interviewing colleagues they knew well and had established relationships with (Parker et al., 2019).

Recruiting leaders from a small sample may have made some participants apprehensive about their anonymity and potential identification, impacting their answers in the interview. On reflection, I could have spent more time explicitly explaining what anonymising interview quotes would consist of. For example, explaining that identifiable characteristics such as occupation, organisation, ethnicity, or age would not be disclosed when disseminating the findings to enhance participants' understanding that anonymity is a priority. This could have supported their sense of safety, potentially leading to different information being obtained.

Expert by Experience Involvement

Facilitating expert-by-experience (EBE) involvement supports user activism, which is vital to good health and social care research if carried out non-tokenistic (Romsland et al., 2019). When contemplating EBE involvement for the ES, considering the eight forms of participation aided reflection to ensure involvement remained meaningful and ethical (Arnstein, 1969; Owen et al., 2022). The EBE, an experienced leader who had worked on comparable collaborative leadership projects, was approached to pilot the interview schedule's content, structure, and wording. Feedback on the wording helped with adjustments to minimise psychology jargon to better engage leaders from a non-psychology background. Co-production could have been enhanced by collaborating on developing materials (e.g., information sheet, consent form) and obtaining feedback from more than one EBE.

Reflections on the Interview Process

All participants interviewed were Pan-London Positive Families Partnership (PFP) project leaders. Interviewing leaders embodied an interesting dynamic during the interviews. At times, I felt the power sat with the participant, leaving me feeling powerless. I recognised that it was occasionally challenging to interrupt interviewees and ask questions regarding emotional processes, resulting in more silence on my part. Personal disclosures and authenticity are recommended to address power imbalances in qualitative research (Karnieli-Miller et al., 2009). Therefore, I discussed my career background and aspirations for the findings, which helped establish a positive rapport. On reflection, my sense of powerlessness could have stemmed from internal expectations of myself within the process of becoming a qualified clinical psychologist and not having confidence in my research skills. Additionally, the lack of opportunities to interact with experienced leaders of this calibre during my training contributed to my sense of inadequacy. These beliefs underpinned my desire to ensure that the interviews were of high quality to obtain rich data to make valuable clinical impacts.

Balancing adhering to the interview schedule and being open to exploring new avenues participants brought for discussion was challenging. The more interviews I conducted and the more I reflected on my interview style within thesis supervision, the more confident I became in managing this balance. Over time, I adopted a more flexible approach to responding to participants' digressions while holding the research aims in mind, ensuring the conversation remained pertinent to the study.

Typically, there is an opportunity to build a therapeutic rapport in a clinical environment before broaching sensitive topics involving emotions and potential conflict. Conducting remote interviews may not have fully established that sense of safety, possibly limiting the extent to which participants felt comfortable disclosing information. Nevertheless, my understanding of therapeutic skills and scholarly exploration enabled me to apply principles of trauma-informed practice to the interview process (Alessi & Khan, 2023). This involved prioritising participant safety and promoting resilience through active listening, expressing empathy and curiosity, and gradually transitioning towards more challenging and emotionally driven questions as the interview progressed.

Self-Reflection

Reflexive TA emphasises the requisite of researcher subjectivity, as the process recognises that knowledge is situated and shaped by the processes and practices of knowledge production, including researcher practices (Braun & Clarke, 2022; Gough, 2017). I approached this research from the perspective of someone who identifies as White-British, of working-class, but now mobilised to a middle-class background. Differences were visible between participants in age, ethnicity, and background. Using journaling and supervision to reflect on the research content and processes was helpful. By incorporating reflexive research practice, I remained aware of my biases and balanced my interpretations of experiences that I over- or under-identified with, ultimately leading to a more accurate analysis.

Recognising the significance of self-reflection in monitoring my reactions to participants' experiences allowed me to identify biases that emerged during the initial interviews, particularly

concerning the project's financial aspect. It became apparent that discussing finances was challenging for me, as a belief surrounding the importance of children having the right to access therapeutic interventions regardless of finances was present. Through self-reflection, I recognised I was somewhat disengaged from financial narrative threads. This realisation prompted me to acknowledge the need to express curiosity when these topics arose in subsequent interviews.

Conversely, the interviews provided insight into my alignment with the shared vision that prioritised children from being placed in care. Despite efforts to mitigate bias and actively identify my blind spots, my positive bias stemming from this alignment may have unintentionally resulted in less focus on conflicts and more on positive aspects. Therefore, another researcher with a different epistemology and alignment with the project's narrative could have generated different findings. As the primary researcher, it was crucial to consider the situatedness of children on the edge of care and acknowledge my privilege and safe context. Following the interview, the interviewee and I, to my knowledge, could disengage from the experience of discussing trauma, instability, and lack of safety. However, the children involved in the project could not.

During training, my placement in a child-looked-after team within social care involved direct work with birth parents, foster carers, and children in care. This experience afforded me a first-hand understanding of the potential impacts on children entering care. These experiences could have biased my interpretations during analysis, causing me to focus on the negative implications of entering care and thus highlight the positives of the project.

Impact

Clinical Impact

Despite the SR and ES limitations, both have clinical implications. Leaders can facilitate or impede EBI implementation and, when considered, could impact the likelihood of children and adolescents receiving the favourable outcomes demonstrated in research. Increasing leaders

understanding of how their leadership approach influences implementation is paramount. The SR findings suggest that EBIs have the potential to be implemented effectively by leaders, and successful implementation is more likely when a shared vision and staff buy-in are developed alongside leaders showing commitment. Continued monitoring of communication, collaboration and holistic support is then needed throughout implementation for sustainment.

Recent research corroborated how the themes derived from the SR link to resilience. Research suggests that resilience enables recognition and preparation of challenges, the ability to withstand setbacks, implement restorative action, and shape the post-organisation consequences (McEwen, 2022). Resilient leaders can increase job satisfaction, reduce burnout rates, and increase the ability to self-manage demands, thereby fostering resilient teams (McEwen, 2022). Therefore, it is within organisations' interests to develop systemic resilience. Despite leadership needing staff buy-in, consideration is owed to how it is not the sole responsibility of leaders within organisations to ensure that EBI implementation is adopted and sustained. Instead, it is all individuals' obligation, as the entire context needs to adopt and work towards implementation alongside leaders for it to be successful. Nevertheless, leadership teams can promote the implementation and sustainment of EBIs.

The preliminary findings from the ES indicate that effective collaborative leadership entails considering various components. Participants shared that 'establishing a secure foundation' was vital to 'navigating the complex context' of social care and working with multiple organisations. These themes accentuated the importance of recognising the trauma experienced by the families and within the system. Leaders also adopted a relational approach to collaboration, inadvertently integrating aspects of trauma-informed leadership. It is, therefore, recommended that future collaborative leadership endeavours consider incorporating trauma-informed leadership. Further, the study revealed that psychological safety was essential for collaboration. Studies have begun looking at enablers of psychological safety (O'Donovan & Mcauliffe, 2020), and this is something services

should consider establishing, particularly regarding leaders working in collaboration to implement EBIs.

Open communication aided collaboration. Organisations should establish clear communication channels to ensure all leaders remain informed and engaged in addressing challenges. Ascertaining if leaders' reluctance to share information with different organisations is due to policy restrictions or a lack of willingness to collaborate is problematic. Future policies should assess how they can consistently promote collaboration while addressing potential obstacles that could inhibit achieving this.

Bridges Outcomes Partnership's contribution to the data within the project was essential and supported the project adhering to its aims and working towards optimal outcomes. Therefore, it is recommended that space for reflection and recalibration on the components of collaborative leadership is carried out throughout all implementation stages to consider factors actively affecting implementation. Consideration regarding how fidelity monitoring and data can be integrated into services to aid this process is required.

It would be clinically beneficial for policymakers to consider the role of collaboration as a facilitator of implementation. Organisations must invest in leadership teams to ensure they are aware and actively working towards mitigating barriers while promoting facilitators to collaborative leadership and implementation. While these findings may apply to leaders who collaborate within the social care setting, services employing a collaborative approach to leadership may also benefit from increased knowledge of the interpersonal underpinnings that can facilitate or hinder the EBI implementation.

Academic Impact

Given the potential benefits of leadership to aid collaboration and implementation, research is encouraged to explore leadership in the context of the implementation of EBIs, whilst addressing these methodological criticisms. Future studies should consider longitudinal studies, follow-up

periods, differing contexts (e.g., custody-based settings), and analytic approaches to ensure leaders feel confident regarding their anonymity.

The ES discovered how effective collaborative leadership is facilitated when applying elements of trauma-informed leadership, despite a complex organisational structure implementing two EBIs. Researchers interested in trauma-informed leadership may build upon these findings by theorising a trauma-informed leadership model explicitly linked to collaboration. This could go beyond the present trauma-informed services and move towards trauma-responsive practice within organisations (Mahon & Jeawon, 2022). To this end, more studies are required, specifically looking at collaboration-based organisations or projects, with more representative samples from outside this project.

Dissemination

An online presentation delivered research findings to fellow trainee clinical psychologists and course staff at Royal Holloway, University of London, in May 2023. Fellow trainees gained insights into practical elements of undertaking research, potentially informing their thesis projects. Moreover, trainees will become leaders in the NHS and other organisations upon qualifying, and having access to this information may influence their future practice.

A lay summary of the findings has been produced and will be shared with the EBE who participated in co-production. A summary of the findings will also be disseminated to participants who indicated this on the consent form. PFP was linked to the ES and will be invited to a meeting where the findings will be presented. To address team members potentially being unable to attend this meeting, the presentation will be distributed electronically. Attendees will receive an anonymous feedback form querying the findings' usefulness, applicability, and relevance. Due to the project ending, those attending this meeting may be working on similar projects within the field. Therefore,

professionals who attend the meeting and are sent the findings will be invited to share the presentation with colleagues they believe would benefit from this knowledge.

PFP delivered MST and FFT within the project. Key findings will be summarised and shared with the MST research consultant and the FFT clinical and research director. They will be asked to share this with their respective MST and FFT colleagues. The findings intend to be presented at the biennial European MST Research Collaboration Conference, attracting MST-focused researchers from across Europe. These dissemination efforts will enhance the finding's reach to MST and FFT's academic and clinical communities.

The SR and ES intend to be published in peer-reviewed academic journals to facilitate further dissemination to researchers and professionals. The SR and ES will be prepared as two distinct papers to maximise the finding's impact. Consideration is being given to international and national journals with a wide readership among relevant professionals and those that will have the maximum impact on the intended audience. The impact factors of journals were assessed using The Scimago Journal and Country Rank website (https://www.scimagojr.com) to compare citation quantity by articles in each journal during 2022. Journals will be approached based on their impact factor, prioritising higher impact factor journals. Current consideration, in order, is the Journal of Child and Family Studies, Administration and Policy in Mental Health and Mental Health Services Research, and Children and Youth Services Review.

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Appendices

Appendix A

Systematic Review Full Search Strategy

This appendix displays the full search strategy for the systematic review. This search strategy was utilised for all three databases, Scopus, Web of Science and PsycINFO. The terms have been broken down initially, with the full search strategy minimised to demonstrate the specific database input.

Search Terms:

"Leader*"

AND

"implement*"

AND

"evidence base* pract*" OR "evidence-base* pract*" OR therap* OR program* OR interven* OR model"

AND

"chil* OR juvenile* OR "young pe*" OR minor* OR teen* OR youth* OR adolescen* OR "young offend*"

AND

"experience" OR "qualitative" OR "thematic analysis" OR "grounded theory" OR "interpretive phenomenological analysis" OR IPA OR "phenomenological model" OR "discourse analysis" OR "focus group" OR "semi-structured interview" OR "interview" OR "narrative analysis" OR "narrative model" OR "content analysis" OR "ethnography" OR "ethnographic model" OR "case study" OR "case study model" OR "historical model"

Scopus, PsycINFO, and Web of Science Input

((leader*) AND (implement*) AND ("evidence base* pract*" OR "evidence-base* pract*" OR therap* OR program* OR interven* OR model) AND (chil* OR juvenile* OR "young pe*" OR minor* OR teen* OR youth* OR adolescen* OR "young offend*") AND ("experience" OR "qualitative" OR "thematic analysis" OR "grounded theory" OR "interpretive phenomenological analysis" OR IPA OR "phenomenological model" OR "discourse analysis" OR "focus group" OR "semi-structured interview" OR "interview" OR "narrative analysis" OR "narrative model" OR "content analysis" OR "ethnography" OR "ethnographic model" OR "case study" OR "case study model" OR "historical model"))

Appendix B

Quality Appraisal Tool for Included Studies

This appendix consists of The Critical Appraisal Skills Programme (2018), the quality appraisal tool utilised to assess the quality of the 23 included studies in the systematic review.

Section A: Are the results valid?		
1. Was there a clear statement of the aims of the research?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • what was the goal of the research • why it was thought important • its relevance
2. Is a qualitative methodology appropriate?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • Is qualitative research the right methodology for addressing the research goal
Is it worth continuing?		
3. Was the research design appropriate to address the aims of the research?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)
4. Was the recruitment strategy appropriate to the aims of the research?	Yes ☐ Can't Tell ☐ No ☐	HINT: Consider • If the researcher has explained how the participants were selected • If they explained why the participantsthey selected were the most appropriate to provide access to the type of knowledge sought by the study • If there are any discussions around

recruitment (e.g. why some people chose not to take part)

5. Was the data collected in a way that addressed the research issue?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the setting for the data collection was justified
- If it is clear how data were collected (e.g.focus group, semi-structured interview etc.)
- If the researcher has justified the methods chosen
- If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
- If methods were modified during the study. If so, has the researcher explained how and why
- If the form of data is clear (e.g. tape recordings, video material, notes etc.)
- If the researcher has discussed saturation of data

6. Has the relationship between researcher and participants been adequately considered?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If the researcher criticallyexamined their own role, potential bias and influence during (a) formulation of theresearch questions (b) data collection, including sample recruitment and choice of location
- How the researcher responded to events during the study and whether they considered the implications of any changes in the research design

Section B: What are the results?

7. Have ethical issues been taken into consideration?

Yes ☐
Can't Tell ☐
No ☐

HINT: Consider
- If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
- If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled effects of the study on the participants during/after the study)
- If approval has been sought from the ethics committee

8. Was the data analysis sufficiently rigorous?

Yes	
Can't Tell	
No	

HINT: Consider

- If there is an in-depth description of the analysis process
- If thematic analysis is used. If so, is it clearhow the categories/themes were derived from the data
- Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
- If sufficient data are presented to support the findings
- To what extent contradictory data are taken into account
- Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

9. Is there a clear statement of findings?

Yes	
Can't Tell	
No	

HINT: Consider whether

- If the findings are explicit
- If there is adequate discussion of the evidence both for and against the researcher's arguments
- If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
- If the findings are discussed in relation to the original research question

Section C: Will the results help locally?

10. How valuable is the research?

HINT: Consider

- If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature
- If they identify new areas where research is necessary
- If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Appendix C

Ethical Approval From Research Ethics Committee at Royal Holloway, University of London

This email outlines the ethical approval granted from Royal Holloway, University of London Research and Ethics Committee, following proposal submission.

Result of your application to the Research Ethics Committee (application ID 3164)

EA

Ethics Application System <ethics@rhul.ac.uk>

Wednesday, 8 June 2022 at 10:15

To: Rose, Charlotte (2019); Harvey, Joel; Ethics

This message is flagged for follow-up.

PI: Dr Joel Harvey
Project title: Systemic Evidence-Based Practices for Children on the Edge-of-Care: A Qualitative Exploration of Leadership in Collaborative Implementation

REC ProjectID: 3164

Your application has been approved by the Research Ethics Committee.
Please report any subsequent changes that affect the ethics of the project to the University Research Ethics Committee
ethics@rhul.ac.uk

Appendix D

Participant Information Sheet

Participant Information
Royal Holloway, University of London

Study Title: Systemic Evidence-Based Practices for Children on the Edge-of-Care: A Qualitative Exploration of Leadership in Collaborative Implementation

My name is Charlotte Rose, and I am a Trainee Clinical Psychologist undergoing a doctorate in clinical psychology at Royal Holloway, University of London. I am carrying out a study which is interested in asking people about their experiences of leadership and implementation when delivering systemic evidence-based practices.

Summary
It is important for you to read this information sheet to understand why the study is being done and what will be involved if you choose to take part. Please take your time to read this and ask Charlotte any questions you might have about the research.

This study hopes to understand interpersonal factors that supported or hindered your leadership when working with other professionals to implement systemic evidence-based interventions, specifically in the Pan-London Positive Families Partnership.

What will I have to do if I take part?
If you agree to take part in this study, we would like to talk to you about your personal experiences of working on the Pan-London Positive Families Partnership and what supported you to work effectively with others on this project. This will entail an online discussion which should last about an hour and will be tape recorded with your permission. We also ask that participants speak enough English to participate in the interview, as interviews are unable to be conducted in other languages. After the interview, you will be invited to debrief with Charlotte. This will involve an informal conversation about how you found the interview and give you the opportunity to ask any questions you might have following your participation.

Do I have to take part?
No. Participating in this study is completely voluntary. If you do not want to take part, you do not have to give any reason, and no pressure will be placed on you to try and change your mind. If you decide to take part, you have the right to withdraw from the discussion at any time. If you do choose to withdraw at any point, consent forms, questionnaires, as well as interview data will be destroyed. If your interview data has been anonymised, the research team will do her best to remove your data from the research. However, this may not always be possible because participants' data will be amalgamated during analysis and information will not be identifiable as belonging to you once interviews have been transcribed and anonymised.

If I agree to take part what happens to what I say?
All the information you give us is confidential. The audio-taped recording of our discussion will be stored securely and will only be listened to by the researchers involved in this study.
How is this project funded?
Royal Holloway, University of London is the sponsor for this study and is based in the UK. We will be using information from you to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Any data provided during the completion of the study will be stored securely on password protected local servers.

What will happen to the information I give?
With your consent, the interview will be audio-recorded to ensure no information is missed. A transcript of the interview will be produced by myself as the researcher. People in the research team who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. Your name and contact details will be kept separately from the transcript and any details that could be used to identify you will be removed from the transcript. Only myself and my research supervisors will have access to the anonymised interview transcripts and interview recordings. Any extracts from what you say that are quoted in written work will be entirely anonymous. Please note however, that the project name will be identifiable within the write-up and publications, and it will be made clear that participants involved in the research are leaders within the project.

All electronic and personal data will be stored on a password protected computer. All digital recordings will be destroyed after completion of the project. Once the study is completed, transcripts will be stored securely on a password protected and encrypted memory stick for 10 years.

Royal Holloway is designated as a public authority and in accordance with the Royal Holloway and Bedford New College Act 1985 and the Statutes which govern the College, we conduct research for the public benefit and in the public interest. Royal Holloway has put in place appropriate technical and organisational security measures to prevent personal data from being accidentally lost, used, or accessed in any unauthorised way or altered or disclosed. Royal Holloway has also put in place procedures to deal with any suspected personal data security breach and will notify you and any applicable regulator of a suspected breach where legally required to do so.

To safeguard your rights, we will use the minimum personally identifiable information possible that is linked to their data (i.e., age, ethnicity). The lead researcher will keep the anonymous data gathered from the study for 10 years after the study has finished. Qualified individuals, with an approved purpose (e.g., data quality and analyses checking) may be permitted to view the anonymised data file. If the study is published in a relevant peer-reviewed journal, the anonymised data may be made available to third parties to allow other researchers to evaluate the conclusions drawn from the data. The people who analyse the information will not be able to identify you.

You can find out more about your rights under the GDPR and Data Protection Act 2018 by visiting https://www.royalholloway.ac.uk/about-us/more/governance-and- strategy/data-protection/ and if you wish to exercise your rights, please contact dataprotection@royalholloway.ac.uk.

Please keep this part of the sheet yourself for reference. Please feel free to ask any questions. You may wish to print a copy of the consent form or may contact the researchers for a word version of this information. This study has been approved by the Royal Holloway Research Ethics Committee.

What will happen to the results of the study?
A report will be written about the findings of this study. In that report the results will be presented in such a way that no one can identify anyone who participated. In other words, we can guarantee that information about you will be anonymous because we will talk about groups not individuals.

Conclusions
We hope that what we learn in this study may be used to help future leaders within the field of systemic therapies to deliver interventions effectively. It is not anticipated that you will experience any psychological distress because of our discussions. If, however, you become uncomfortable when we talk, we will of course stop discussion and think about any possible support you may need. We also provide you with a debrief sheet which will have links to support after this interview if it is needed.

Please contact me if you have any further questions about your participation and the study. You can contact me via the number below.

Next steps:
If you decide to take part in this research after reading this information sheet, you can contact Charlotte via email on charlotte.rose.2019@live.rhul.ac.uk.

Researcher
Charlotte Rose
Psychology Department
Royal Holloway, University of London
Egham
Surrey
TW20 0EX
Charlotte.rose.2019@live.rhul.ac.uk

Internal Research Supervisor
Dr Joel Harvey
Department of Law and Criminology - MSc Forensic Psychology Programme Director
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External Research Supervisor
Dr Tom Jefford
Family Psychology Mutual Community Interest Company
Appin House - 1 Ferrars Road
Huntingdon
Cambridgeshire
PE29 3DH
tom.jefford@fpmcic.com

Appendix E

Consent Form

Consent Form
Royal Holloway University of London

Project Title: Systemic Evidence-Based Practices for Children on the Edge-of-Care: A Qualitative Exploration of Leadership in Collaborative Implementation

Researcher Name: Charlotte Rose

Please complete the following: (Please circle your answer)

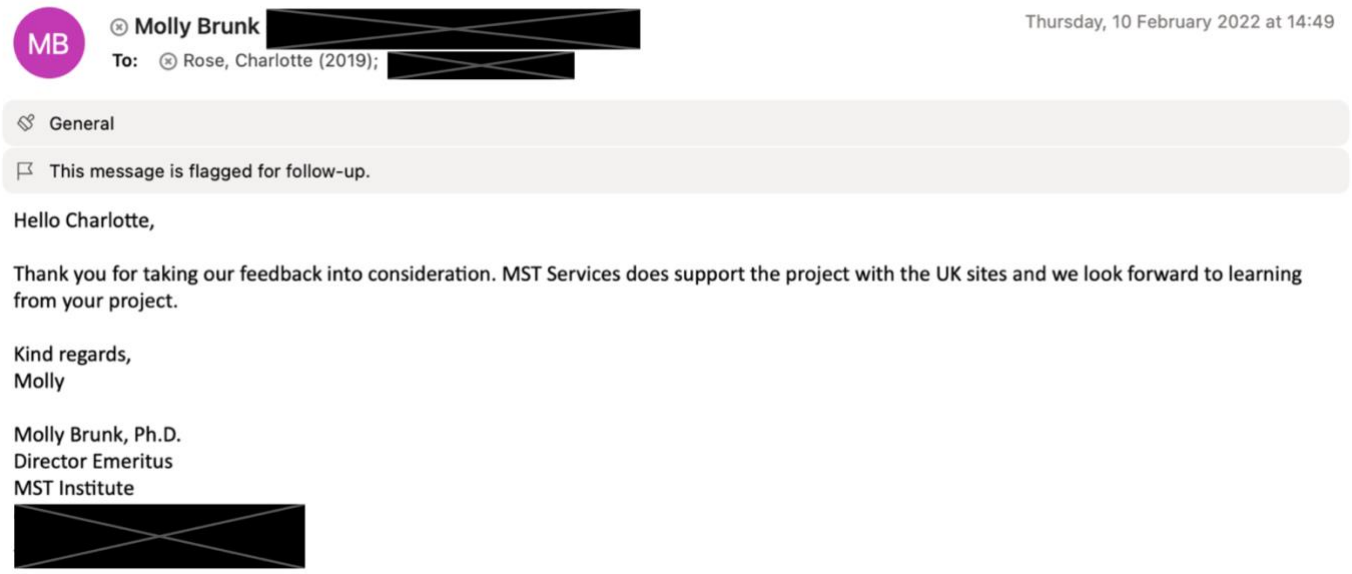
1.	I confirm that I have read the information sheet which describes this study.	**YES**	**NO**
2.	I have had an opportunity to ask questions and discuss this study and have received satisfactory answers to all my questions.	**YES**	**NO**
3.	I understand that my participation in this study is voluntary, and I am free to withdraw at any time without giving a reason.	**YES**	**NO**
4.	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 (2018).	**YES**	**NO**
5.	I agree for the interview to be recorded.	**YES**	**NO**
6.	I agree for anonymised quotes from my interview to be used in publications.	**YES**	**NO**
7.	I agree to being contacted for my comments on the findings of the study	**YES**	**NO**
8.	I would like a summary of the study findings	**YES**	**NO**
9.	Do you agree to take part in the above study?	**YES**	**NO**

Name of Participant	Date	Signature
Name of Person taking consent	Date	Signature

Appendix F

Study Approval From Multisystemic Therapy

This appendix shows the approval for the empirical study from multisystemic therapy personnel, an evidence-based intervention heavily involved in the project under exploration. Parts of the email have been redacted for confidentiality purposes.



MB

Molly Brunk [redacted]

To: Rose, Charlotte (2019); [redacted]

Thursday, 10 February 2022 at 14:49

General

This message is flagged for follow-up.

Hello Charlotte,

Thank you for taking our feedback into consideration. MST Services does support the project with the UK sites and we look forward to learning from your project.

Kind regards,
Molly

Molly Brunk, Ph.D.
Director Emeritus
MST Institute
[redacted]

Appendix G

Study Approval From Functional Family Therapy

This appendix shows the approval for the empirical study from functional family therapy personnel, an evidence-based intervention heavily involved in the project under exploration. Parts of the email have been redacted for confidentiality purposes.

MS

Michael S. Robbins [redacted]

To: Rose, Charlotte (2019); Tom Jefford; [redacted]

Sunday, 30 January 2022 at 16:16

On 21/01/2022, 1:38 pm, "Michael S. Robbins" [redacted]

Thank you Tom. This looks great and it is a nice addition to work that is being done side by side with MST around the world. We look forward to meeting you Charlotte and supporting this work in any way possible.

All the best

Mike

Michael S. Robbins, Ph.D
Clinical and Research Director, FFT LLC

[redacted]

On Jan 20, 2022, at 4:31 AM, Tom Jefford [redacted]

External Sender

[redacted]

As mentioned to you in our recent call I would like to introduce you to Charlotte Rose who is making the attached proposal for her doctoral thesis at Royal Holloway University London in Clinical Psychology. Her Supervisor is Dr Joel Harvey whom [redacted] have worked with in the past. I have agreed to be the external supervisor [redacted]

I hope that the outline meets with your approval as Charlotte begins to prepare a much more detailed outline in accordance with the university guidelines and in anticipation of ethical approval at a later stage.

Yours

Tom

Dr Tom Jefford
Business Development Director
Family Psychology Mutual Community Interest Company

Appendix H

Demographic Questionnaure

Demographic Questionnaire
Royal Holloway University of London

Please answer the following questions:

1. What is your age? (Please highlight accordingly)
- 18 - 24
- 25 - 34
- 35 - 44
- 45 - 54
- 55 - 64
- 65 and over

2. How would you best describe your gender? (Circle as appropriate): Male / Female / Other
- If other, please specify: _____

3. Which of these bests describe your ethnic group? (Please tick as appropriate):

White	
English/Welsh/Scottish/Northern Irish/British	
Irish	
Gipsy or Irish Traveller	
Other white	
Mixed/Multiple ethnic groups	
White and Black Caribbean	
White and Black African	
White and Asian	
Other mixed	
Asian/Asian British	
Indian	
Pakistani	
Bangladeshi	
Chinese	
Other Asian	
Black/African/Caribbean/Black British	
African	

Caribbean	
Other Black	
Other ethnic group (please specify):	
Arab	

4. What was your job title in the Pan-London project? _____

5. How long did you work in this role for? _____

6. What is the highest level of education you have completed?

☐ No qualifications ☐ GCSE's (or equivalent) ☐ A-Levels (or equivalent)
☐ Bachelor's Degree ☐ Master's degree ☐ Doctoral Degree
☐ Prefer not to say

Appendix I

Interview Schedule

This appendix shows the semi-structured interview schedule used with all 12 participants in the empirical study. The italicised text represents the prompts.

Introduction

- How did you become involved in PAN-London?
- Thinking about your leadership position, what role did you take on?
    - *What was your role going to include?*
    - *How did you enact your role? What were your main tasks? Were these what you expected? How did you develop this role? Did it change overtime?*
- What were your thoughts about the scale and scope of the project?

Individual

- What were the aims of the project?
    - *How did you get others on board with these?*
    - *Did these sit with your values? What are your values? – what matters to you? What drives you to what matters for you as a leader?*
    - *How did you manage with them not sitting/ aligning with your values?*
- Could you give me an idea about the challenging parts? Was anything difficult to implement?
    - *What surprised you? What made you act the way you did?*

Interpersonal

- Tell me about your relationships with others in leadership roles?
- How did you find leadership of others you were working with?
    - *Did you like working with your colleagues (energising, enthusing, frustrating etc.)?*
- What helped develop these relationships? What do you think helped work alongside other leaders?
    - *Can you tell me about what you think supports building good relationships with other leaders?*
- What was challenging when working with other leaders? What hindered developing these relationships?
- How did you manage working with other leaders with different perspectives and from different organisations?
    - *How did you and other leaders support one another when values, beliefs and thoughts differed? What helped/hindered during these times? How did you manage disagreements with other leaders?*
- What was your experience of when people disagreed? How did you manage these disagreements?
    - *Did you find it easy or challenging? Did it get easier, or harder?*
    - *After a disagreement, what allowed you to continue working collaboratively with one another?*
- On reflection, what qualities do you feel are important for effective leadership?
- How often do you feel individual beliefs/thoughts/feelings at the forefront of decision making?
    - More of a spur of the moment
    - Or more of a way of thinking

    - Aware of what they are doing?
    - Sense that they have thought it through from a particular position?
- What would you change about other's leadership you saw? Why?
    - *Did anything surprise you? Where do you feel leadership was most powerful? On reflection, knowing what you know now, what would you do differently?*

Success

- What was explained to you about what would make this project successful?
    - *How did you measure success for yourself?*
- Do you feel the project was successful?
    - *What makes you think that? What contributed to success/lack of success? Why do you think this worked/didn't work in this context? How did leadership support/hinder you to achieve the desired outcomes for the project?*
- What impact do you think the project had on young people and their families?
    - *How important do you think it is for leaders to understand the stories of young people and families that their decisions impact?*

Risk

- What risks were you aware of in the project? How did you manage these?
- Could you tell me a bit about your incentives for the project being successful?
- What stood out to you as the motivation to achieve outcomes?
    - *What was your experience of motivating others to achieve outcomes?*
- How do you feel the financial risk impacted your decisions?

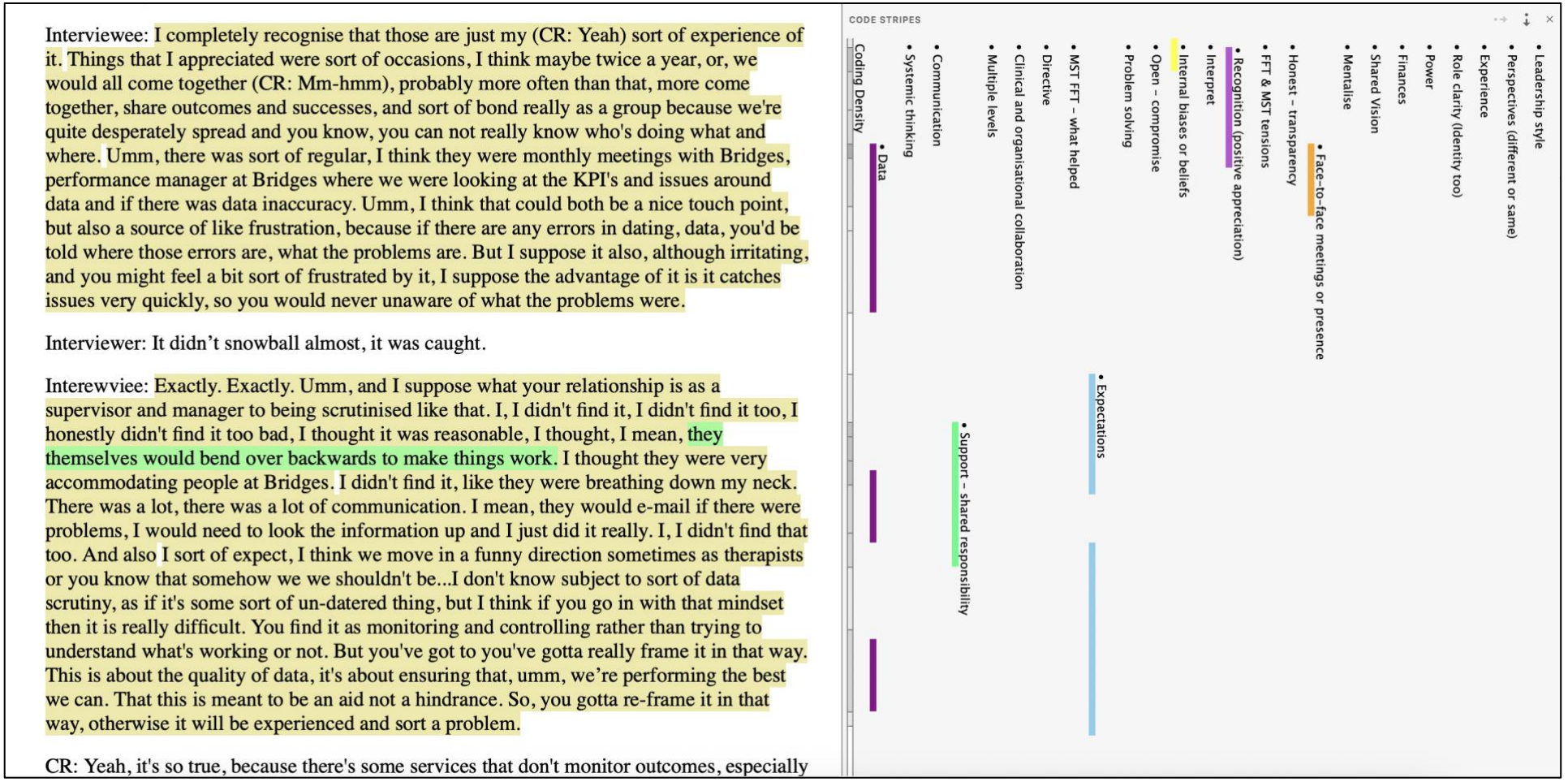
Closing

- Why do you think the project was not recommissioned?
    - Would you have like it to have been? Would you do a project like this again?
- What learning would you take from PAN-London if you were to do a project like this collaborative structure this again?
    - *If I were going away to set up a project with the same collaborative structure, what would be the key learnings you'd impart to me?*

Appendix J

Transcript and Coding Sample

This appendix demonstrates the individual analysis of the initial coding of the transcripts. This coding process has been screenshot from Nvivo, highlighting the initial coding on the right.



Interviewee: I completely recognise that those are just my (CR: Yeah) sort of experience of it. Things that I appreciated were sort of occasions, I think maybe twice a year, or, we would all come together (CR: Mm-hmm), probably more often than that, more come together, share outcomes and successes, and sort of bond really as a group because we're quite desperately spread and you know, you can not really know who's doing what and where. Umm, there was sort of regular, I think they were monthly meetings with Bridges, performance manager at Bridges where we were looking at the KPI's and issues around data and if there was data inaccuracy. Umm, I think that could both be a nice touch point, but also a source of like frustration, because if there are any errors in dating, data, you'd be told where those errors are, what the problems are. But I suppose it also, although irritating, and you might feel a bit sort of frustrated by it, I suppose the advantage of it is it catches issues very quickly, so you would never unaware of what the problems were.

Interviewer: It didn't snowball almost, it was caught.

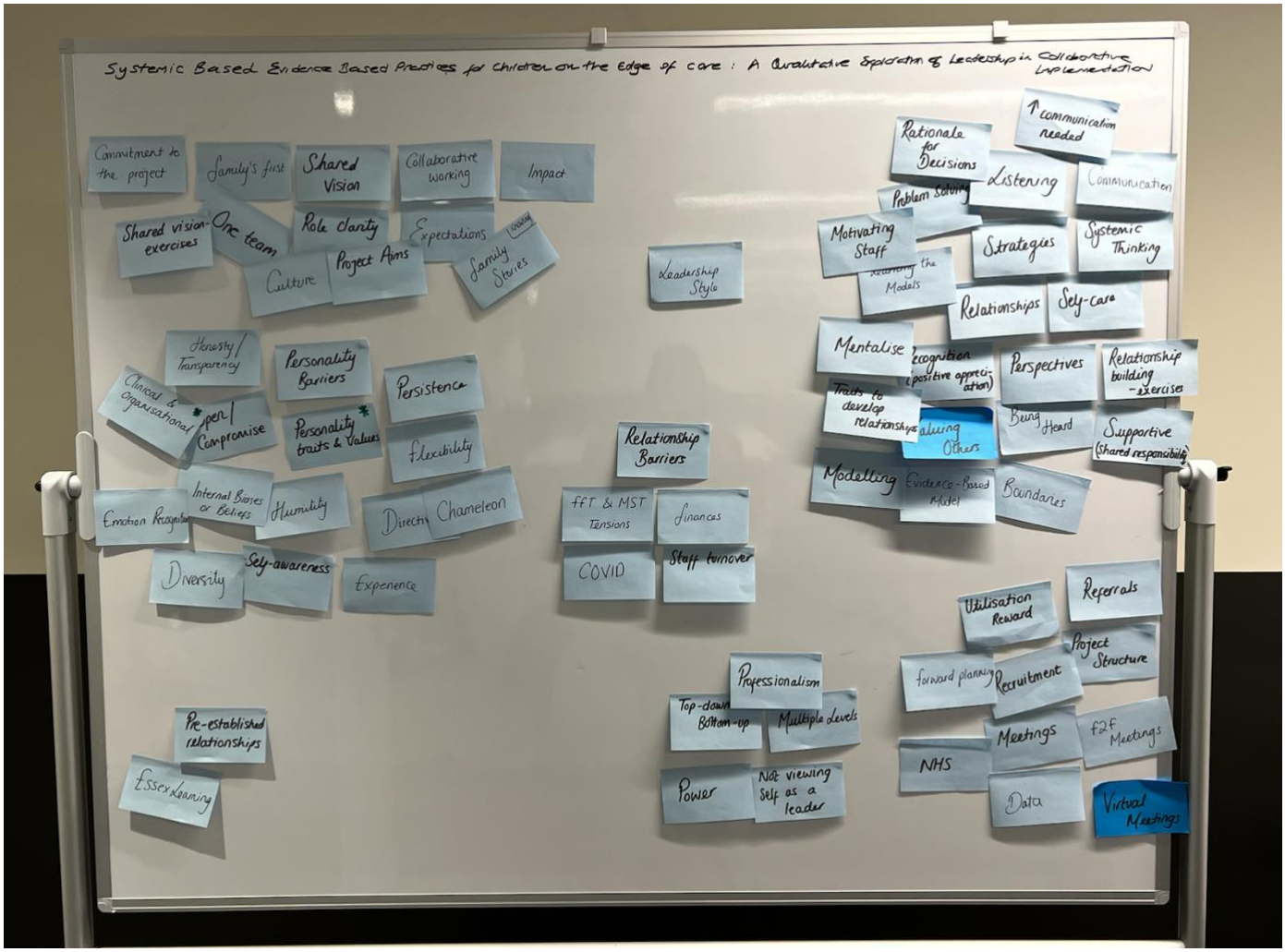
Interewviee: Exactly. Exactly. Umm, and I suppose what your relationship is as a supervisor and manager to being scrutinised like that. I, I didn't find it, I didn't find it too, I honestly didn't find it too bad, I thought it was reasonable, I thought, I mean, they themselves would bend over backwards to make things work. I thought they were very accommodating people at Bridges. I didn't find it, like they were breathing down my neck. There was a lot, there was a lot of communication. I mean, they would e-mail if there were problems, I would need to look the information up and I just did it really. I, I didn't find that too. And also I sort of expect, I think we move in a funny direction sometimes as therapists or you know that somehow we we shouldn't be...I don't know subject to sort of data scrutiny, as if it's some sort of un-datered thing, but I think if you go in with that mindset then it is really difficult. You find it as monitoring and controlling rather than trying to understand what's working or not. But you've got to you've gotta really frame it in that way. This is about the quality of data, it's about ensuring that, umm, we're performing the best we can. That this is meant to be an aid not a hindrance. So, you gotta re-frame it in that way, otherwise it will be experienced and sort a problem.

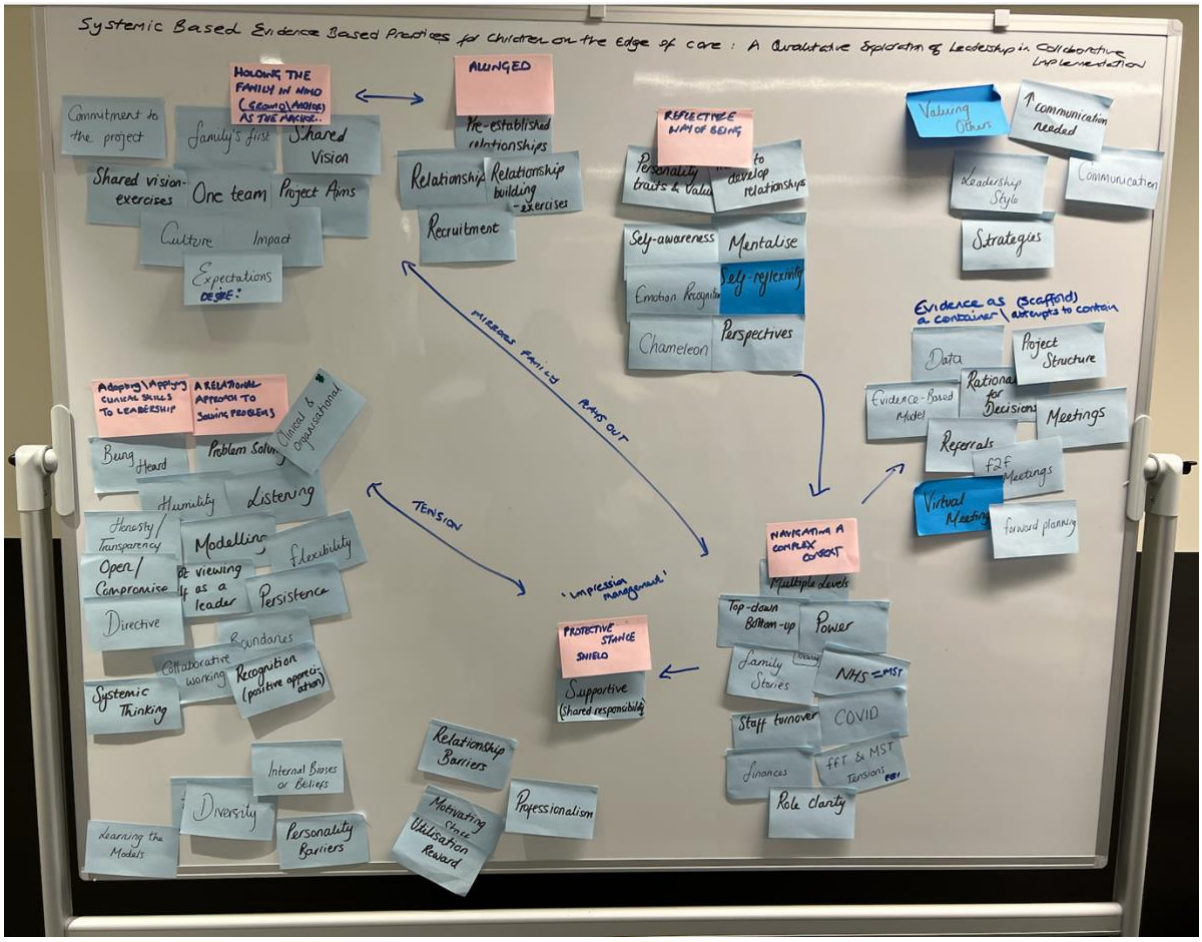
CR: Yeah, it's so true, because there's some services that don't monitor outcomes, especially

Appendix K

Photos of Developing Initial Codes Into Themes

This appendix consists of three photos demonstrating the creation of themes from initial codes. The photos show a developmental process as the narrative develops, represented by the arrows in the final photo.

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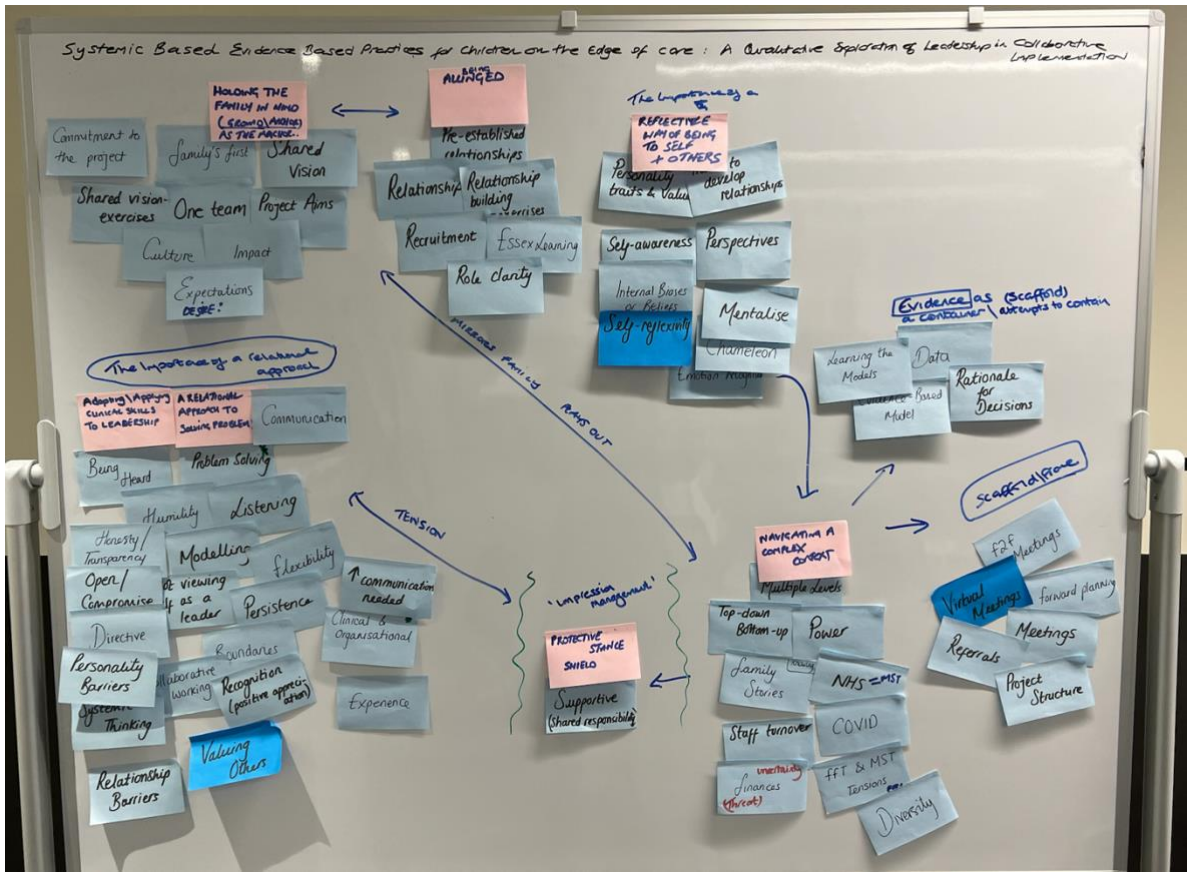
ALIGNED
Pre-established relationships
Relationship building -exercises
Recruitment
Commitment to the project
Family's first
Shared Vision
Shared vision-exercises
One team
Project Aims
Culture
Impact
Expectations
DESIRE:
REFLECTIVE MAP OF BEING
Personality traits & Values
to develop relationships
Self-awareness
Mentalise
Self-reflexivity
Emotion Recognition
Chameleon
Perspectives
Valuing Others
↑ communication needed
Leadership Style
Communication
Strategies
Evidence as a container
(scaffold) attempts to contain
Data
Project Structure
Evidence-Based Model
Rationale for Decisions
Meetings
Referrals
f2f Meetings
Virtual Meetings
forward planning
PULLING FAMILY APART OUT
TENSION
'Impression management'
NAVIGATING A COMPLEX CONTEXT
Multiple Levels
Top-down
Bottom-up
Power
Family Stories
NHS = MST
Staff turnover
COVID
finances
fFT & MST
Tensions re:
Role clarity
PROTECTIVE STANCE SHIELD
Supportive
(Shared responsibility)
ADOPTING/APPLYING CLINICAL SKILLS TO LEADERSHIP
A RELATIONAL APPROACH TO SOLVING PROBLEMS
Clinical & Organisational
Being Heard
Problem Solving
Humility
Listening
Honesty/ Transparency
Modelling
Flexibility
Open/ Compromise
Viewing self as a leader
Persistence
Directive
Boundaries
Collaborative working
Recognition (positive appreciation)
Systemic Thinking
Relationship Barriers
Internal Biases or Beliefs
Diversity
Motivating
Utilisation
Reward
Professionalism
Learning the Models
Personality Barriers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