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Programmes crossing borders: the international travelling of programmes in social work

Modeller krysser grenser—internasjonal flyt av kunnskap i sosialt arbeid

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The influence of evidence-based policy and practice is increasingly found in the field of social work. Using Multisystemic Therapy (MST) as a case, this article explores issues arising from the travelling of programmes to settings that are different and distant from those of their origin. While such travelling is often accompanied and facilitated by narratives of positive findings in effectiveness trials, it can be argued that effectiveness and efficiency are influenced by contextual conditions and therefore the informational value of such trials is limited. Accepting that there are epistemic and practical limits to the idea of a universal effectiveness of a certain programme, the travelling of programmes is not necessarily a case of the 'best ideas' being adopted and such travelling therefore requires critical examination. Decisions on programme adoption should be based not only on effectiveness trials, but also on knowledge about the generic elements of (alternative) programmes as well as on knowledge about contextual conditions including the needs of local service users and gaps in local service provision.

Keywords: evidence-based practice; international transfer of knowledge; transportability of manual-based programmes; Multisytemic Therapy

Profesjonelt sosialt arbeid er i økende grad påvirket av evidensbasert politikk og praksis. Artikkelen ser nærmere på noen av de utfordringene som kan oppstå når behandlingsmetoder overføres og tas i bruk andre steder enn der de ble utviklet, og den anvender multiystemisk terapi (MST) som et eksempel. Slike 'kunnskapsreiser' er ofte begrunnet ut fra positive resultater fra effektmålinger, men det kan reises spørsmål om verdien av disse målingene fordi de ikke alltid tar høyde for betydningen av kontekstuelle forhold. Forestillingen om at det finnes universelle effekter av enkelte behandlingsmetoder kan problematiseres, og derfor er det ikke nødvendigvis alltid de beste løsningene som tas i bruk. Av denne grunn er det viktig å ha et kritisk blikk på slike overføringsprosesser. Beslutninger om å adoptere behandlingsmetoder bør derfor ikke bare basere seg på evidensbaserte resultater, men også om kunnskap locale forhold som kan påvirke implementeringen av slike programmer.

Nøkkelord: evidensbasert praksis; internasjonal overføring av kunnskap; overføring av manualbaserte programmer; multisystemisk terapi

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Introduction

This article explores issues arising from the international travelling of programmes in social work.[1] A programme is defined as a consolidated body of knowledge, including theories, principles, values, methods and objectives that is organized in order to guide practice in achieving desired outcomes when addressing acknowledged social problems and meeting the needs of defined service user groups. Using the example of Multisystemic Therapy (MST), we focus on a distinct sub-type of international travelling programmes: The transportation of a manual-based and licensed programme to settings that are different and distant from those of their origin. MST is a family- and community-based programme for 'youth experiencing serious antisocial behaviour and their families' (Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 2009, p. 1) which was developed at the Medical University of South Carolina (MUSC) during the 1990s. Today it is delivered in 34 US states and 13 countries including Australia, Canada, Chile, New Zealand and eight European countries (Belgium, Denmark, Iceland, the Netherlands, Norway, Sweden, Switzerland, UK).

In the remainder of the article, first, we consider the international travelling of concepts and programmes in social work in general. Then we present MST as a case study of such a programme, examining its transportation strategy and using the experiences from Norway to illustrate how MST is adopted and implemented across national borders. We then discuss contextual influences on the measurement of effectiveness and challenges related to the travelling of programmes from one context and culture to another.

International travelling of concepts and programmes

The international travelling of concepts and programmes is nothing new in social work. The Hull House in Chicago was founded by Jane Adams in 1889 after she had visited Toynbee Hall in London. Case management was developed in the USA during the 1980s and since the 1990s has been adopted in the UK (as 'care management') and many other European countries. Family group conferences originated in Maori communities in New Zealand and have become established practice in children's and youth services in many states across all continents (Burford & Hudson, 2000; Heino, 2009). During the past three decades, exchange between social work professionals and academics from different national backgrounds has increased considerably. The channels and opportunities for the travelling of knowledge relevant to social work, such as ideas and concepts about how service users should be constructed, grouped and served and how social problems should be addressed, have multiplied and the travelling itself has accelerated, intensified and become a focus for research. Against this background, evidence-based policy and practice, which has been described as 'a new educational and practice and policy paradigm' (Gambrill, 2011, p. 31), could easily be regarded as one of these dynamic travelling concepts. However, rather than promoting a single programme, this discourse promotes ideas and premises about how knowledge relevant to human services, such as social work, should best be generated (through empirical research), formatted and disseminated (through systematic reviews of programmes/interventions/treatments, facilitated by retrieval systems) and, most important, utilized in processes of decision-making. Within this discourse, empirical knowledge related to the effectiveness of interventions and the evidential status of such knowledge is highly valued. Such knowledge is regarded as a core resource both in decisions related to individual service users (e.g. in decisions

about the appropriateness of services) and in decisions related to the selection of services and programmes that should be made available in a given territory of service provision (e.g. state, region, municipality).

The promotion of evidence-based policy and practice has not only contributed to the placing of 'an unwritten ethical imperative on human service practitioners to ensure, as far as possible, that interventions are informed by current best research evidence about the most effective interventions and outcomes' (Gray, Joy, Plath, & Webb, 2013, p. 157), it has also, intentionally or not but with more resounding success, contributed to a hitherto unparalleled heightening of attention to and demand for 'ready-to-use' programmes and interventions, especially for those carrying a label that identifies them as 'evidence-based'. At the present time, 'evidence-based' has become a marker that suggests a programme is research-based and has successfully demonstrated through empirical research (preferably Randomized Controlled Trials) the achievement of defined outcomes (for example, improvements in a service user's situation), as long as it is implemented and performed with strict adherence to the programme's stipulations. As evidence-based practice (EBP) is 'the goal of public services in many developed nations' (Nutley, Walter, & Davies, 2009, p. 552), the related discourse has established global market opportunities to disseminate and sell such programmes in human services. In the field of social work, this is a fairly new phenomenon that may have considerable impact on the distribution of resources and the composition of services at national, regional and local level.

It is interesting to note that a prominent protagonist of EBP has recently complained that the 'term "evidence-based" has become the latest mantra to market products including interventions (…)' (Gambrill, 2011, p. 39). However, the grounds and justifications for license-based marketing seem to be deeply embedded in the discourse of evidence-based policy and practice itself. It is not only the demand for a high level of predictability and accountability in programme outcomes, but also the intention to protect the well-proven and efficacious intervention against any distortion, that provide a common basis on which the interests of the owner/seller and the buyer of evidence-based programmes converge. What we term the 'manualization' of a programme, designed to facilitate programme adherence, enhances the transportability of a programme as it functions as a packaging of knowledge that ensures it is transported safely. The licensing allows for a profit-making dissemination of knowledge, provides legitimacy for administrators to purchase programmes and protects the licensing body from incidents of false application that may lead to undesirable outcomes with negative consequences for the programme's reputation and market opportunities.

Having considered these characteristics, it may be helpful to make a distinction between the adoption of a non-manualized programme (like the settlements, case management or family group conferences) and the transport of manual-based and licensed programmes. While both can be regarded as manifestations of travelling knowledge that include the crossing of borders, they seem to differ significantly in how they relate to the receiving context and how contextualization is conceptualized. Generally, in cases of the international adoption of a non-manualized programme, it is taken for granted that adjustment and transformation applies for both the programme and the context; efforts to prevent adjustment and transformation are not regarded as an essential feature. In contrast, with the transport of manual-based and licensed programmes, an adjustment and transformation of the programme is regarded as failure and considerable efforts are made to ensure programme fidelity. As it seems very doubtful that implementation of a manual-based and licensed programme on an international scale

can be achieved without any translation, adjustment or adaptation, it is reasonable to assume that attempts to disseminate such programmes are accompanied by imperatives to prepare and adjust the contextual conditions, instead of the programme. As we will see later, the 'transportation strategy' of MST provides strong support for such a proposition.

We have seen that there are close linkages between EBP and the travelling of knowledge relevant to social work. Previous research and debate within this discourse has primarily focused on the travelling of knowledge from research to practice and vice versa, as well as on the utilization of research-based knowledge in fields of practice, its preconditions and outcomes (Cnaan & Dichter, 2008; Gira, Kessler, & Poertner, 2004; Gray et al., 2013; Gredig & Sommerfeld, 2008; Johansson, 2009; Mullen, Bledsoe, & Bellamy, 2008; Osterling & Austin, 2008). Issues of international, cross-country and 'cross-context' exchange of knowledge have often been overlooked. Furthermore, the growing body of implementation research has paid little attention to implementation strategies on an international scale (Bhattacharyya, Reeves, & Zwarenstein, 2009; Brekke et al., 2009; Fixsen, Blase, Naoom, & Wallace, 2009). Thus only a few articles exist addressing the international travelling of programmes and a considerable number of them are related to MST (Gustle, Hansson, Sundell, & Andree-Löfholm, 2008; Schoenwald, 2008; Schoenwald, Heiblum, Saldana, & Henggeler, 2008; Schoenwald & Hoagwood, 2001; Sundell et al., 2008), or mention MST as an example or international dissemination and implementation (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005, pp. 13, 31 et passim).

MST—the programme

MST is a multifaceted home- and community-based intervention designed primarily for young people aged 12–17 with serious antisocial or disruptive behaviour problems. The MST model was developed in the USA during the 1990s from social-ecological theory (Bronfenbrenner, 1979), family systems theory and the extensive literature on the development and maintenance of behaviour problems in young people (Curtis, Ronan, & Borduin, 2004). MST is a family-based intervention targeting those factors in each young person's social ecology (family, peers, school, neighbourhood and community) that contribute to his or her antisocial behaviour (Schoenwald, Heiblum, et al., 2008). It follows a home-based model of service delivery with a therapist on call 24-hours a day, seven days a week. The duration and frequency of treatment sessions varies in accordance with changing circumstances, needs and treatment progress. Interventions are case-specific and based on comprehensive assessments of child development, family relations and peer relations; they draw from a range of techniques and treatment models (Henggeler & Borduin, 1995; Henggeler et al., 2009; Littell, Campbell, Green, & Toews, 2005). MST therapists operate in teams of no fewer than two and no more than four, and each therapist's caseload ranges between four and six families; the expected duration of a programme delivered to a family is three to five months. Therapists work with parents and caregivers to put them in a position of control, to improve parenting skills, family bonding, reduce the young person's association with antisocial peers, improve the young person's school achievements and engage the family's networks in order to support parents in their role and 'surround the youth with a context that now supports pro-social behaviour' (Henggeler et al., 2009, p. 5). The therapist works with the caregivers to keep the young person focused on school and gaining job skills. Given the adolescent's risk of placement outside the home, overarching treatment goals are often related to keeping the young person in the home and reducing antisocial behaviour.

MST is presented as an evidence-based intervention that has been proven to work, producing positive results such as, reducing out-of-home placements, keeping young people in school and/or out of trouble, reducing re-arrests, improving family relations and functioning, decreasing adolescent psychiatric symptoms and drug and alcohol abuse (MST Services, 2013a). Research grants for MST in the USA totalled $35 million by 2003; in 2004 another $20 million in research grants had been announced (Littell, 2006, p. 459). Most of this research has been conducted by researchers affiliated to the Family Services Research Center, MUSC (Littell, 2005, p. 448).

The MST transportation strategy

The local implementation of MST follows a particular transportation strategy developed by the originators of MST, based on considerable experience in transporting the programme to different settings and on the findings of its own MST-related 'transportability research' (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997; Schoenwald, Carter, Chapman, & Sheidow, 2008; Schoenwald & Hoagwood, 2001). Schoenwald (2008) captured the guiding vision of this enterprise as the 'evidence-based transport of evidence-based practice'. A critical step towards the building of a 'transport system' was the formation of MST Services Inc., a 'university-licensed technology transfer organization', which holds the exclusive rights to licensing the MST programme through agreements with the MUSC (Schoenwald, 2008, p. 72). MST Services Inc. provides assistance with all aspects of programme design, development and implementation, staff selection and training, quality assurance, record-keeping, marketing and public relations within the USA and worldwide (MST Services, 2013b, 2013c).

The rationale is that successful service user outcomes with MST depend on treatment adherence (Henggeler et al., 1997, pp. 296–300; Henggeler et al., 2009; Schoenwald, Carter, et al., 2008). As ineffective interventions can be implemented well, and effective interventions can be implemented poorly, choosing the right implementation strategy is regarded as being as important as choosing the right intervention (Fixsen et al., 2005; Schoenwald, 2008, p. 70). During the process of transportation, almost nothing is left to chance:

> Before clinical implementation begins, a systematic site assessment process is undertaken to assess the philosophical compatibility of MST with community agency and consumer groups; identify referral and funding incentives and disincentives that could impact long-term sustainability of the program; establish the interagency collaboration necessary for the MST program and client families to take the lead in clinical decision making; and align the structure, procedures, and culture of the service organization hosting the MST program to support therapist adherence to MST and provider accountability for family engagement and outcomes. That process, which can take up to one year to complete, culminates in the conjoint development by the site and MST Services or an MST Services Network Partner of a site-specific MST Program Goals and Guidelines Document (Schoenwald, 2008, p. 75).

The entire transportation strategy consists of three sub-programmes: (1) The MST Program Development Method (Trademark; MST Services, 2007), (2) Training and ongoing support through MST consultants and (3) The MST Quality Assurance/Quality Improvement Program (MST Services, n.d.), including initial and ongoing training at different levels, supervision, supervisor training, support and consultation, instruments for the ongoing measurement of programme adherence and outcomes and an ongoing

Program Implementation Review. All components of quality assurance/improvement are manual-based and obligatory. With respect to the USA, the total long-term costs for programme support and training have been estimated to be 'usually in the range of $400 to $550 per youth served' (Littell, 2006, p. 459; Strengthening Families America, 1999). Another key element of the transportation strategy is the development of a network of partner organizations committed to implement the MST model with full integrity and fidelity. MST Services Inc. maintains an ongoing working relationship with each MST Network Partner organization including staff development, quality improvement and quality assurance activities and retains accountability for quality assurance for all MST Network Partner organizations and all operating sites.

As the structured set of techniques and instruments demonstrates, the efforts of MST Services Inc. not only rely on staff-related strategies like selection, training and supervision, but also they cultivate the contextual conditions at implementation sites: 'proactive (i.e. pre-implementation and ongoing) alignment of organizational and service system policies and procedures with the demand characteristics of MST is built in to the transport strategy' (Schoenwald, 2008, p. 73). The extent of these expectations is illustrated in the following excerpt from MST's general information about implementation:

> The MST Provider organization with full support of all community stakeholders, must commit to provide the following resources: MST Therapists must be full-time employees assigned to the MST program solely. (…). MST Therapists must operate in teams of no fewer than 2 and no more than 4 therapists (…). MST Clinical Supervisors must be assigned to the MST program a minimum of 50% time per MST Team (…). MST case loads must not exceed 6 families per therapist with a normal range being 4 to 6 families per therapist. (…). MST Therapists must track progress and outcomes on each case weekly by completing case paperwork, and participating in team clinical supervision and MST consultation. (…). With the buy-in of other organizations and agencies, MST Therapists must be able to 'take the lead' for clinical decision making on each case. (…). Additional recommended program practices and characteristics [are]: MST Therapists should be Master level professionals. MST Clinical Supervisors should be Ph.D. level professionals. (…). Funding for MST cases should be in the form of case rates or annual program support funding in lieu of billing mechanisms that track contact hours, 'productivity' etc. (…) (MST Services, 2007, pp. 6–7).

These requirements of MST Services indicate that the transportation of manual-based programmes challenges the receiving context at multiple levels, including face-to-face practice, organization of service provision, interorganisational cooperation and institutional settings. The requirements are therefore likely to affect structures and cultures of service delivery at the receiving end. In the following, this is illustrated with regard to the importation of MST to Norway.

The importation of MST to Norway

The adoption and implementation of MST in Norway has been influenced by the evidence-based practice movement, but it also reflects a gradual acknowledgement that residential treatment for children and young people does not always provide the desired results (Andreassen, 2003). The coincidence of dissatisfaction with costs and outcomes of existing services on the one hand and the reception of narratives about more efficient programmes on the other, has certainly faciliated the importation of MST to the Nordic countries (cf. Gustle et al., 2008). To some extent, the importation process fits quite well into a four stages model of 'policy borrowing' in education (cross-national attraction,

decision, implementation, internalization/indigenization): impulses that 'spark-off cross-national attraction' are often rooted in 'internal satisfaction', leading to 'political and other imperatives' that may finally end up in decisions on implementation (Phillips & Ochs, 2004, p. 773, 778ff.). The Norwegian initiatives in support of MST and other evidence-based policy and practice originated in central government ministries and directorates. In 1997 the Norwegian Research Council arranged an expert conference on particularly troublesome children. With a view to developing effective interventions, scientists, clinicians and programme developers from the USA, Canada and Norway were invited to present research as well as interventions and programmes to a Norwegian audience of practitioners, policy-makers and researchers (Biglan & Ogden, 2008). The Ministry of Child and Family Affairs took an initiative to strengthen capacity and research related to children and young people with serious behaviour problems. It funded a research unit undertaking a five-year project at the University of Oslo, Institute of Psychology. Two evidence-based family and community programmes were given priority; Parent Management Training, Oregon (PMTO) and MST. Their implementation began in 1999. Ogden, Kärki, and Teigen (2010, p. 174) comment as follows:

> The decision to implement evidence-based treatment programmes like MST and PMTO on a large scale was taken before any Norwegian research evidence of the programmes' effectiveness had been produced. In the collaborative relationship between researchers and policy makers, the researchers might actually be more important than the research they produce.

Acoordingly, they state that researchers are often asked to express their 'expert opinions' instead of contributing with research results because political actors and bodies often regard the presentation of expert opinions as less expensive and time-consuming compared to the commissioning of relevant research. Furthermore, they argue that the implementation of MST has, to a large extent, 'depended on the enthusiasm of "gatekeepers" in the policy, practice and research communities' (Ogden et al., 2010, p. 174).

Once started, the initiative expanded quickly into a comprehensive and nationwide project designed to take the lead in the top-down implementation of MST programmes targetting antisocial behaviour in children and young people. In 2003 the project became permanent through the formation of the Norwegian Center for Child Behavioral Development (NCCBD), a subsidiary of UniRand Ltd., which is owned by the University of Oslo. The NCCBD is funded by the Ministry of Child and Family Affairs, the Directorate of Education and the Directorate of Health and it serves as the national centre for development and research on the implemention of several evidence-based programmes (Ogden, Amlund Hagen, Askeland, & Christensen, 2009). The Norwegian implementation strategy includes: (1) long-term state funding for programme implementation; (2) the establishing of a national centre designed to coordinate policy, practice and research, develop a therapist and practitioner recruitment strategy and provide comprehensive therapist training, supervision and maintenance programmes; and (3) state-funded research on services to children and adolescents and an extensive system of quality assurance (Biglan & Ogden, 2008). In addition, a national MST monitoring system was developed in which all cases are registered and for which parents provide information about their child's living circumstances, drug-related problems, criminal offences and acting out at 6, 12 and 18 months after termination of treatment.

The ministry integrated MST into the decentralized child welfare organizations and into operations of the specialist child welfare services in the 19 county authorities. These services provide expertise and services to the total number of 430 local authorities around the country. Later a child welfare reform in 2004 established five regional agencies responsible for the development of a unified state child welfare system. The purpose of the reform was, among other things, to reduce the continuous increase in costs by reducing the use and duration of placements in institutions; increase the use of foster homes and a variety of in-home assistance; strengthen the availabilty and use of evidence-based services; improve the quality of services rendered; and ensure equality in the services provided across regions and municipalities (Deloitte AS, 2011). The costs of using MST are split between the regional child welfare authorities and the municipalities. By 2007, 23 MST teams existed across Norway and today there are 20 teams. Prior to the reform, reports had stated that evidence-based services like MST were under-used (Econ, 2007). In 2006 the utilization rate of MST services was on average 57% (Econ, 2007). However, in 2010 the utilization rate increased to an average 85% of what had been expected (Deloitte AS, 2011).

At the practice level, decisions about appropriate interventions including MST are usually left to the child welfare practitioners in the local authorities. Professionals have reported difficulties with assigning cases to MST because case characteristics often fail to meet the inclusion crieria for MST. In addition, they perceive a weakness of MST in addressing properly the problems and needs of multi-problem children and adolescents with whom they are often confronted (Slettebø, Oterholm, & Stavrum, 2010). In Norway geographical distances can also make access to MST services difficult. One might say that the importation of MST in Norway at the national level went quite smoothly, but the implementation of the programme at the local level has been challenging owing to the regional and local organization and provision of child welfare services.

The MST implementation strategy does not only reflect low confidence in the competencies and capacities among the child welfare professionals at the local level. It also can be regarded as an example of how the state authorities try to overrule decision-making authorities at the local level, thereby threatening the principle of local autonomy, which at the same time is often praised as a cornerstone of Norwegian democracy in the rhetoric of political actors. Norway was the first non-English-speaking country to implement MST and the first to implement it nationwide (Ogden & Halliday-Boykins, 2004). The national implementation and research unit at the University of Oslo (NCCBD) conducted an empirical study 'to determine the degree to which favourable outcomes obtained in the US would be replicated in Norway' (Ogden & Halliday-Boykins, 2004). In a weighted randomisation procedure one hundred adolescents between 12 and 17 years were assigned randomly to MST (62 families) or Usual Child Welfare Services (CS; 38 families), including long-term institutional placement. The study found that 'MST was more effective than CS in reducing youth internalising and externalising behaviours and out-of-home placements, as well as increasing youth social competence and family satisfaction with treatment' (Ogden & Halliday-Boykins, 2004, p. 77). Results of another randomized controlled trial (RCT) across the first year of MST, second year of MST and CS (105 participants) supported conclusions on sustained effectiveness and programme maturity as clinical outcomes in the second year matched and surpassed those in the first year, and 'MST treatment delivered in the second year was more effective than regular child welfare services in preventing out-of-home placement and reducing internalising and externalising behaviour' (Ogden, Hagen, & Andersen, 2006, p. 4). The reported

studies have also been presented as the first trial of MST conducted by an independent team of researchers (research teams without the participation of MST developers). As a consequence, the Norwegian project has been considered 'the first fully independent replication of the favorable outcomes' that MST achieved in the US-based research and a strong recommendation for the international transportability of the programme (Henggeler et al., 2009, p. 275; Ogden & Halliday-Boykins, 2004). However, a careful look at the entire body of research on MST on an international level shows that results on outcomes are mixed and remain inconclusive. It is to this issue that we now turn.

The controversial effectiveness of MST across contexts and cultures

Reportedly favourable results of outcome studies have become a consistent theme in the stream of literature on MST, in reviews on 'effective interventions' and recommendations of expert bodies (see Gambrill, 2006). Such results have been woven into narratives that accompany and stimulate the travelling of the MST programme around the world. However, a systematic review, based on the rules and procedures of the Cochrane and Campbell collaborations (Littell et al., 2005), found that:

> Of 27 published reviews of research on effects of MST, only 7 had explicit inclusion/exclusion criteria, 5 used systematic searches of electronic databases, 8 included unpublished studies, and 6 included meta-analysis. (Littell, 2005, p. 449)

The systematic review included 8 out of 35 identified MST outcome studies. All included studies were randomized controlled trials which had been conducted between 1990 and 2004 in the USA, Canada and Norway. Results of the synthesis and meta-analysis of the included data led to the conclusion:

> Thus, available evidence does not support the hypothesis that MST is consistently more effective than usual services or other interventions for youth with social, emotional, or behavioral problems. However, it is not appropriate to conclude that MST has no effects. In sum, evidence about the effectiveness of MST is inconclusive. (Littell et al., 2005, p. 12)

A more recent study which investigated 'short-term outcomes of youths receiving MST as compared with youth receiving TAU [Treatment As Usual] in a Swedish context' in a multi-site intention-to-treat design demonstrated 'no significant differences in treatment effects between the two groups' (Sundell et al., 2008, pp. 550, 551). Two RCTs on MST that provide outcome data for the full sample (i.e. including dropouts)—the Canadian (Cunningham, 2002; Leschied & Cunningham, 2002) and the Swedish (Sundell et al., 2008) studies—failed to support assumptions on a higher effectiveness of MST compared to contrafactual conditions. A third one, conducted in the UK, showed that 'the MST model reduced significantly more the likelihood of non-violent offending during the follow-up period' when compared to 'the comprehensive and targeted usual services delivered by youth offending teams' (Butler, Baruch, Hickey, & Fonagy, 2011, pp. 1220, 1231). What can be learned from these results?

The developers of MST tend to explain the disappointing results of the Canadian and the Swedish study by low treatment adherence and as illustrating the importance of the quality improvement and quality assurance activities provided by MST Inc. (Henggeler et al., 2009, pp. 276–277; MST Services, 2007). However, a closer look at the measurement of treatment adherence in the Swedish study reveals 'a lack of significant

differences when comparing TAM [Treatment Adherence Measurement] scores with outcomes' and 'some effect sizes that disfavored the group in which TAM scores were relatively high' (Sundell et al., 2008, p. 558). It has to be mentioned that Henggeler et al. (2009) also suggest that the 'failure to attain MST effects might have been due to the relative strength of usual services (i.e. the comparison condition) in Sweden' (p. 277), which seems to be more interesting at a general level because it shifts the focus on the contextual conditions that may affect the measurement of the effectiveness of programmes such as MST.

The influence of contextual and cultural factors on MST's measured effectiveness is discussed explicitly in the Swedish study. Sundell et al. (2008) argue that differences in outcome results for the USA and Swedish settings could be caused by different traditions in responding to delinquency and to young people displaying antisocial behaviour. In contrast with the USA, MST in Norway and Sweden is carried out within similar social services: 'This makes the provision of in-home services quite frequent … and not exclusive to MST, as may be the case in the United States where youth offenders are processed within the juvenile justice system, a risk factor in itself …' (Sundell et al., 2008, p. 558).

Against this background, the inconsistent findings on effectiveness of MST in the Norwegian and Swedish contexts seem to be even more interesting. Sundell et al. offer two explanations. First, they point out that in Norway MST was implemented on a national scale by the Ministry of Child and Family Affairs, and the implementation process was supported and evaluated by a national research unit, while the Swedish implementation project was undertaken by local initiatives without a national supporting framework. Second, they report that 'fewer youths received residential care in the Swedish study (18%) when compared with (50%) in the Norwegian study. This might have disfavored the Norwegian TAU group' (Sundell et al., 2008, p. 558). In the UK study, MST is compared to a 'tailored range' of 'evidence-based interventions recommended by National Institute for Health and Clinical Excellence (NICE)' and delivered by youth offending teams (YOT; Butler et al., 2011, p. 1224). To a certain extent, this RCT studies the effectiveness of two different models of delivering different evidence-based interventions. Among the 'key differences between MST and YOT' highlighted by authors it is reported that in the YOT arm:

> interventions are not normally organized to be delivered in a family context by a single person. […]; rather interventions are offered on a 'as needed' basis by specialist agencies to which the young person is referred. […] Overall, young persons in YOT condition attended a significantly greater number of appointments. (Butler et al., 2011, p. 1224)

These considerations emphasize the relevance of contextual conditions in effectiveness trials: if effectiveness is measured by comparing the effects of a certain programme to the effects of TAU, what counts as TAU has an influence on the measured effectiveness.

If it is accepted that configurations of provided services as well as models of service delivery vary across countries, and commonalities in terms of service quality and accessibility are less likely than differences, the generalizability of effectiveness trials across countries is limited. This relationship also applies to cost-benefit comparisons of programmes because labour costs, contributions to social security systems and costs for infrastructure vary across countries: 'treatment effectiveness and cost effectiveness is always relative' (Olsson, 2010, p. 568). A two-treatment type (MST versus TAU) costs

and benefits analysis conducted in Sweden showed that MST was not found to reduce the use of or the cost associated with placement intervention (Olsson, 2010). An analysis in the UK found 'scope for cost savings' for MST in combination with other interventions when compared to the other interventions alone (Cary, Butler, Baruch, Hickey, & Byford, 2013).

Inadequate comparison of short-term and long-term outcomes may also cause bias in effectiveness trials. A study in one of the MST teams in Norway showed that 40% of all adolescents who received MST during 2001–2008 had been placed out-of-home after two years (Andersen & Hansen, 2011) as opposed to 20% in the Norwegian national randomized study (Ogden & Amlund Hagen, 2006). It may be that some evaluators are under pressure to report positive findings and under-communicate parts of the analysis that show no statistically significant effects or other bias in the reporting. Evaluators and recipients of evaluations have worried that a mixing of the roles of programme developers and programme evaluators may bias results reported in intervention studies in a positive direction (Petrosino & Soydan, 2005). In a meta-analysis of experimental and quasi-experimental research, Petrosino and Soydan (2005) found that effect size increased positively when evaluators were influential or involved in the treatment setting. MST is far more researched than most other programmes (Littell et al., 2005), but research on MST has to a large extent been carried out by people who are affiliated with the development and implementation of the programme or are even stockholders of MST Services (Littell, 2005, p. 448; Schoenwald, 2008). However, this may be justified by its advantages, for example, a deeper insight into the programme and added opportunities in using findings for the programme's further development.

The discussion shows that evidence-based programmes such as MST which are 'proven' to be 'more effective' in one place, will not necessarily prove to be 'more effective' in other places, because the objects of comparison (and sometimes the measures of effectiveness) vary across places.

Challenges to implementing evidence-based programmes such as MST

In the literature regarding MST much of the attention is focused on evidence-based transportation and the implementation of evidence-based practice in given care settings. Findings from transportability research indicate that the MST transportation strategy supports the cultivation of therapist, supervisor and consultant adherence; that adherence is understood as a consistent predictor of short- and long-term outcomes, and that clinical and organizational factors also affect adherence and outcomes (Schoenwald, 2008). In other words, if practitioners are not implementing the intervention correctly, local purveyors would be useful in the implementation process of evidence-based programmes. In addition, one should expect that the implementation of such programmes takes time.

On the basis of research that relates outcome to implementation quality, some authors conclude that there is a need to have more definitive quality requirements placed on the child welfare services provided (Sørlie, Ogden, Solholm, & Olseth, 2010). Practitioners in child welfare are criticized for their lack of accountability and lack of concern with outcomes of their interventions (Maher et al., 2009).

According to Ogden et al. (2010), evidence-based methods do not only challenge practitioners, but also universities and colleges responsible for their education. They claim that evidence-based methods are not included in academic training programmes.

A Swedish study showed that social workers, who sympathized with the ideology on which MST is based, who reported of a good work climate and good social support, referred clients to MST to a greater extent than others (Gustle et al., 2008). However, the social workers' support was related to the idea of family- and community-based interventions, but not necessarily the evidenced-based method. This suggests that when implementing evidence-based methods one needs to consider whether the method is consistent with the current treatment ideology of the unit. Working conditions should also be considered. Could ideology be of more importance than effectiveness when deciding whether to make a referral or not?

Moving programs from one welfare state to another

There are difficulties in moving programmes from the particular political and cultural environment within which they were developed to another. Welfare services are organized differently around the world because they are rooted in specific visions for children, families, communities and societies. Different countries have developed different welfare systems, protecting children and aiding families and to meet vulnerable families' needs. Often there is a difference in the overall ideology between the countries, from 'child protection systems' to 'family service systems', and other distinctions due to differences in ideology, cultural contexts and social policy orientations. MST's focus on the parents can be seen as inconsistent with the existing values within welfare regimes that emphasize children's needs for protection. Lack of children's participation in the decision-making process within the Nordic welfare model has resulted in recent calls for greater emphasis on the rights of the child. Inadequate children's involvement in assessment and decision-making processes has been identified as problematic and the extensive use of preventive measures can postpone necessary out-of-home placements. Perhaps MST would have obtained more support among the social workers if the intervention had paid more attention to the participation and the evaluation of MST among the adolescents themselves, not only their parents. It is also important to bear in mind that child welfare services often work with families who are challenging to engage with and for whom permanency and continued child safety remain as core service objectives.

Perhaps there is also a need for a critical re-examination of the existing biases within MST and other evidence-based home and community programmes, for example, the current and often negative attitudes towards residential provision in any form. This is a bias that underpins current child welfare services planning in many countries.

Concluding comments

As we have seen, MST has been widely regarded as holding much promise, but its adoption into existing service systems requires addressing a series of complex implementation challenges. Implementing evidence-based practice in human services is not just a question about how to bridge gaps between knowledge and practice. The travelling of knowledge may also affect distribution and allocation of resources and therefore raises ethical and political questions (Fox & Ashmore, 2014; Littell, 2006; Littell & Shlonsky, 2010; Ruffolo, Thoburn, & Allen-Meares, 2010). In this article we have used MST as a case in discussing challenges found in the international travelling of programmes in social work, but other programmes could also have been used as

examples. Social work has a long tradition in moving programmes across borders and continents, but there has been a lack of consciousness around the pitfalls and challenges of programmes crossing borders. Actors who are responsible for the adoption and implementation of new programmes in social work at different levels and in different roles—politicians, administrators, researchers, academic experts/teachers and practitioners—need to reflect critically and carefully about the contingencies of outcomes when knowledge in the shape of programmes and interventions travels from one context to another. Instead of regarding this as a neutral process, where knowledge is transferred from A to B, we need to look at power issues and the particular interests embedded in such processes. How does a programme fit with local organizational structures? Are local actors prepared to change the context to accommodate programme implementation? At what costs? On what grounds can it be argued that a promising programme will meet the needs of local service user populations and represents best practice in a local configuration of resources, needs and available services?

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