Responsiveness, permission-seeking and risk; three components of outreach family therapy services with marginalised families

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3 Themes

- Responsiveness
- Permission-Seeking
- Dialogue and Risk
Context: Newham, London, UK

- 80,000 under 18: the largest child population in East London
- Newham has very high levels of deprivation
- 85% of Newham residents from Black & Asian Minority groups
- Prevalence for mental health disorders 20%-30%
- The 2012 Olympics/Paralympics
The Clinic: a specialist psychiatric service for children, adolescents and their families

- Fragmented psychiatric services: apart from our clinic’s staff—about 20 others across Newham
- Clinic has about 43 clinicians including 10 systemic family therapists
- 1600+ referrals per year
- Assessment → Treatment Model
- Funded by central and local government
Strengths

- Comprehensive emergency services
- Single building with ‘outreach’
- Short waits for routine assessments & brief treatment
- Teams for ADHD, Psychosis, Learning Difficulties, Under-5’s, Paediatric illness, children in public care
- Large training/learning-partnership programme to community workers
Challenges: clinical

- The most at risk were falling through the network of agencies, between the cracks....the access problem
- Interactive links between parental & child self-esteem, parenting, child behaviour, learning & school exclusion, and poverty...need intervention at all levels
- Co-morbidity of psychiatric problems
- These marginalised client groups face multiple social exclusions, at risk for offending profile, partner violence, adult psychiatric problems, housing problems, multiple deprivation
- Local research shows that top excluded groups are white working class boys in specific localities and african-carribean boys
- Tensions between the service mandates: the government wants us to see all referrals quickly but these are often not the most marginalised families, who tend not to come to appointments...we often spent our time seeing families with moderate problems rather than the most marginalised children and families
Challenges: training & knowledge

- Fragmentary
- Dependent on clinicians interests
- No co-ordination
- Many different treatments, ideologies and languages in psychology
- Specialist clinicians get more training & resources
- Institutes of learning removed from contexts of practice
- Therapy discourses usually uni-problem, euro-centric, trialled in low deprivation areas, non-complex and minimise the problem of access/compliance
CLINIC ← COMMUNITY →
BARRIERS TO RESPONSIVENESS
Barriers between clinic and community

- Inferences about motivation
- Allocation bias
- Thin/competing theorising
- Complex proliferating, confused networks
- Action as opposed to therapy
- Mainstream as opposed to local
- Team acculturation dynamics
- The ‘ivory tower’
- Client powerlessness
- Expectations of chronicity
- Catastrophisation
Social Exclusion

“A short-hand term for what can happen when people or areas suffer from a combination of problems such as unemployment, poor skills, low incomes, poor housing, high crime environment, bad health and family breakdown”

UK Government Cabinet Office, 2001
Multiple Voices & Discourses

GOVERNANCE
SERVICE USERS
PROFESSIONAL ASSOCIATIONS
INSPECTORS
DISCIPLINES
SCHOOLS
CRITICAL PSYCHIATRY
WAIT TIMES
PRACTICE-BASED EVIDENCE
POOR SERVICE TAKE-UP
FUNDING PROBLEMS & CUTS
LOCAL KNOWLEDGE
EQUALITY/ACCESS ISSUES
THE HOSPITALS
PATIENT ADVOCACY GROUPS
COMMUNITY GROUPS
CHILD SAFEGUARDING SERVICES
SERVICE COMMISSIONERS
LOCAL SERVICE PARTNERS
EVIDENCE BASED PRACTICE
TREATMENT SPECIFICITY
PCT
CENTRAL GOVERNMENT POLICIES
EXPLANATORY PARADIGMS
RESEARCH

HOW CAN WE POSITION OURSELVES TO PROVIDE THE BEST SERVICE?
‘Too often, we invite clients to enter our world without asking for an invitation to enter theirs’
3 core learning/s: differences that makes a difference in outreach family therapy

1. Individual and team responsiveness
2. Permission-seeking practice
3. Dialogic approaches to risk: developing ‘benign invigilation’
Individual & Clinical Team Responsiveness (1)

- Theorized in constructionist discourses (Shotter and Katz, 1998), philosophy (Levinas, 1998), and recent neurobiology (Stern, 2004)
- Connects individual action with the group, and with notions of personal responsibility
- Links to components of effective personal and team collaboration
- Challenges barriers posed by team acculturation
- Overrides differences in professional cultures and languages
- Acts as a unifying value challenging health inequalities (WHO, 2001)
- *In responsive practices the therapists & team managers oppose the colloquies restraining connection between clinic and community.*
Individual & Team Responsiveness (2)

- The importance of values (Williams & Fulford, 2007)
- We want what service users want: services which are...Clear, Relevant, Specific, Responsive, Consistent, Reliable, Efficient, Efficacious....ties up with Hubble, Miller, Duncan et al
- Push general Clinic service culture to change: don’t routinely ‘close’ families that don’t come to appointments if they are persistent/severe/complex
- Develop outreach family therapy services
- Modify team conversational style
- Develop simple/clear service standards
- Develop training/consultation/large sector workshops/community dialogue forums (Wenger, 1999)
Individual & Team Responsiveness (3)

- Working in homes, schools and other places
- Risk identification
- Clearer referral pathways
- Provide meetings where clinicians in different agencies can discuss clients with potentially severe beginning problems ('heavy-end prevention')...
- ...and for clients with multiple problems/non-engagement
The Newham ‘Responsiveness Days’
1 day workshop, “Developing personal and team responsiveness”
All agencies in the locality
Learning space which is generative
50 people
Value of bottom-up knowledge/quiet voices
Difference between post-box theory of communication and a complexity theory...communication changes with context
Taking turns in speaking and listening
Three organising themes, networks/responsiveness/complexity
Exercises and dialogue
Responsiveness...the value of curiosity & questions
Permission-Seeking Practices (1)

- PSP is an interviewing stance for hard-to-reach families
- Child psychiatric services were sometimes not targeting those most in need
- But: there are several meanings inherent in ‘increasing access’ policies...two government policy streams in the UK
- Stream 1 'Increasing Access to Psychological Therapies' and parenting programmes, brief therapies made available for the commonest disorders. Patient present and available, motivated, consents
- Stream 2 policy concerned with families not accessing services... 'Think Family’...poverty/refugees/multiple disadvantage/interactive loops...systemic therapy
- Outreach therapists work in a context of competing legal and governance frameworks-client entitlement to information privacy, and the need to share information for child protection reasons
- The therapist explores the experience of entering the client’s space, as well as inviting the client to enter the therapist’s space
- In permission-seeking practices the therapist builds bridges between the clinic and marginalised, socially withdrawn clients through careful attention to the initial conversation/connection
Permission-Seeking Practices (2)

- ‘Conduct Disorder’ in boys/context of violence/male therapists entering home
- Dilemma: how to find ways to engage with families who are not present available and consenting, particularly where there are issues of risk/violence
- Dilemma: need to deliver therapies to unwelcoming clients, and share information, safeguarding function
- History of disrupted relationships with helping agencies
- Poor or non existent attendance with psychiatric services
- Much of systemic literature is clinic-based
- There is a home-based literature: Aponte, Cottrell, Messent, Kosutic and Mcdowell, Jakob, Van Lawick & Bom, Somerset team, UK outreach in schools
Permission-Seeking Practices (3)

- ‘justice work’ (Waldegrave, 2009)
- Not the families that were hard to engage with, but the families experienced services as hard to engage with: how could we fit to the family rather than the family fitting to the clinic?
- Seeking permission usually of the mother challenges the embedded discourse of powerlessness
- Shifting authority back to mother
- Asking client’s permission at all stages to proceed, contrast to one off
- Therapy as talking, talk is a good thing, for these families talk may be a precursor to violence...they may see talk as part of the problem
- So how do we begin to negotiate contact?
Permission-Seeking Practices (4)

Building bridges.....
- From clinic to the home
- From simple to complex
- From withdrawal to agency
- From concealment to transparency
Dialogic Approaches To Risk (1)

- There had been a spate of government reports following homicides and suicides in East London
- Reports recommended clearer care pathways, agency restructure, clarity around leadership
- But...depressed morale
- Could we use an Appreciative Inquiry (Cooperider et al) ‘whole service’ approach to...
- Raise intra-personal and team responsiveness about clinical risk
- Reframe risk awareness as a positive attribute of the organisation
- Create a context where risks might be predicted
- Reduce fear
- *In dialogic risk practice, therapists & team leaders encourage a different sort of dialogue about risk: bringing forth inner dialogue and developing benign invigilation*
Dialogic Approaches To Risk (2)

- ‘what if’/scenario planning sessions for whole staff groups. Could focusing on the future, as well as the past, help re-position risk as something to be actively embraced & welcomed?
- Could clinical risk be re-contextualised as something to be welcomed?
- Could an Appreciative Inquiry model increase responsiveness between clinicians so that risk management is enhanced?
- Could an Appreciative Inquiry model create better conversational styles between clinicians in teams such that risk management is increased? And if so, would this enhance clinical decision-making?
- If we were to ‘think future’ what would we be looking back at now that from the vantage point of the future we would consider risky?
- Are there risky events brewing in our work in the present that are giving off very faint fumes?
- What kind of positive organisational culture supports good risk management and can that culture be modelled and described?
### Two Discourses in Risk Awareness

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<td>coming from below</td>
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<td>rational/scientific knowing</td>
<td>professional experience</td>
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Dialogic Approaches To Risk (4)

Whole service risk workshops
‘benign invigilation’
Inner/outer conversation
  o How long do I go on/when do I cut off?
  o Do I sit within the boundaries of conversation or move outside?
  o Do I follow head or heart?
  o Do I hold on to a case or pass on?
  o Do I write notes long or brief?
  o Do I offer myself in a care co-ordinating role or hang back?
  o Can I find a voice and challenge poor practice without giving offence?
  o Do I hold risk or pass it on?
Bridging clinic and community: systemic triangle

responsiveness (fuzzy)

Permission-seeking (sharp)  Risk (scary)
Summary

- In responsiveness practice the therapists & team leaders oppose the colloquies restraining connection between clinic and community.
- In permission-seeking practice the therapist builds bridges between the clinic, networks and marginalised, socially withdrawn clients through careful attention to the initial conversation/connection.
- In dialogic risk practice, therapists & team leaders encourage a different sort of dialogue about risk: bringing forth inner dialogue and developing benign invigilation.
References

- Jakob, P. (2010) [www.partnershipprojectssuk.com](http://www.partnershipprojectssuk.com) retrieved 31/05/11
References