

What happens when systemic practice  
is transferred from clinical settings to  
family homes? A qualitative review



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Practitioner-led research 2008-2009

PLR0809/108



This report is part of CWDC's Practitioner-Led Research (PLR) programme. Now in its third year, the programme gives practitioners the opportunity to explore, describe and evaluate ways in which services are currently being delivered within the children's workforce.

Working alongside mentors from Making Research Count (MRC), practitioners design and conduct their own small-scale research and then produce a report which is centred around the delivery of Integrated Working.

The reports are used to improve ways of working, recognise success and provide examples of good practice.

This year, 41 teams of practitioners completed projects in a number of areas including:

- Adoption
- Bullying
- CAF
- Child trafficking
- Disability
- Early Years
- Education Support
- Parenting
- Participation
- Social care
- Social work
- Travellers
- Youth

The reports have provided valuable insights into the children and young people's workforce, and the issues and challenges practitioners and service users face when working in an integrated environment. This will help to further inform workforce development throughout England.

This practitioner-led research project builds on the views and experiences of the individual projects and should not be considered the opinions and policies of CWDC.

**What happens when systemic practice is transferred from clinical settings to family homes?  
A qualitative review**

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March 2009*

## **Abstract**

We aim to evaluate and critically assess the process and outcomes relating to the transfer of systemic practice from clinical environments into family homes. The emphasis will be on practice possibilities presented both for service users of and for practitioners in a multidisciplinary, integrated service for young people on the edge of care.

We are accepting the practice and policy challenge to 'think family' and deliver our services at the 'right place, right time'. In so doing we have had to reflect and rethink our position on outreach work and established modalities of practice particularly in relation to integrated work. In developing our collaborative approach both for workers and with families we have found that the working relationship is strengthened and engagement promoted by home based working and to facilitate the achievement of positive outcomes. We have been informed by social constructionist ideas and 'free talking' methods, using video as a key tool to promote both engagement and analysis. This will aid dissemination of our key learning points of the opportunities afforded by integrated working to shift practice modalities and develop a reflective space for practitioners.

## Introduction

This small-scale qualitative research is an exploration of the possibilities and opportunities offered by integrated working through an analysis of what happens when systemic practice is transferred from clinic-based practice into families' homes. Firstly, we have taken the opportunity to shift established modalities of clinical practice and so promote service user engagement and optimize the outcomes of our intervention. Secondly, we have grasped the possibility to create a reflective space for, and promote reflective practice by, social workers and front-line practitioners. Finally, we have the opportunity to construct and develop 'home grown' research and evidenced based practice at practitioner level and 'make research count'. This emphasis on focused time with service users and reflective practice is particularly resonant and valued in the current target focused, blame ridden climate for social work and safeguarding children<sup>1</sup>.

Like integrated or multidisciplinary working, the idea of bringing services into family homes is not new. Social workers, community nurses, occupational therapists, health visitors, and GPs all provide home based services to the community that they serve. However, the wealth of outcome research undertaken in home based family therapy has been mainly conducted in America like many other examples of evidence based practice<sup>2</sup>. Systemic therapists in the UK have not been as forthright or foresighted as their American counterparts in promoting this way of working. The clinic-based context has been the preferred method for offering family therapy in this country, and developing an evidence base has been fraught with many challenges particularly in terms of resources and support networks.

Over the last two years systemic therapists have been invited to rethink their position on outreach work. The government has come up with catchy phrases like 'Right place at the right time'<sup>3</sup> and 'Reaching out and think families'<sup>4</sup>. The rhetoric is an attempt to invite clinicians to reconsider how services are being offered to families who experience difficulties accessing family support services and being part of an integrated team with social workers has actively promoted this possibility. Family therapists are not just being asked to consider shifting their practice from clinic to community but are being encouraged to get involved in joint working with other professionals. The mantra of partnership and integration is the new language spoken by service commissioners in the 21st century but a shift in and the development of a collective mindset through a sharing of cultures and valuing of difference are essential to harness the potentiality of integrated working.

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<sup>1</sup> We are currently awaiting publication of the Laming Review 2009.

<sup>2</sup> Steve Aos ([www.wsipp.wa.gov](http://www.wsipp.wa.gov)); Biehal (2007).

<sup>3</sup> 'Reaching Out: think Families' (Cabinet Office, 2007). [www.cabinetoffice.gov.uk/social\\_exclusion\\_task\\_force/families\\_at\\_risk/](http://www.cabinetoffice.gov.uk/social_exclusion_task_force/families_at_risk/)

<sup>4</sup> *Right Time, Right Place – learning from Children's NSF development initiatives* (Massie, CSIP, 2008) .

## **Aims of the project**

We did plan to not only apply our research to those actively engaged in home based systemic practice but also attempt to evaluate and explore reasons for non-engagement or engagement in clinical provision but realized this was too big an undertaking. However, we wanted to develop a base from which we could return to this in future. The aims we identified in the proposal included:

- What type of relationship gets created and how might that impact on families' lives and their social world?
- How do families experience the process of home based systemic work and how can the life chances of young people be improved?
- How can home based systemic work reduce cost and address resource constraints?

As the findings will show, we were perhaps too ambitious in our aims but this research has established a framework for our future activity in this respect but also the necessity of this activity in itself. What we have identified are the possibilities offered by integrated working and practitioner-led research that we want to capture and take forward.

## **Methodology**

Our methodology was to undertake small-scale qualitative research that is action or session based using video as a recording and reflecting tool. This would enable us to triangulate the views and experiences of the worker, the family and the reflective or home based therapy team and to analyse process and identify outcomes. We were informed by a brief literature review relating to home base practice and diversionary interventions as referred to in the 'Context' section below.

We aimed to be as transparent as possible in our research and actively work in collaboration with stakeholders and service users. The research was consent based and we intended to work within appropriate requirements of confidentiality, especially as we used video recording and playback. We focused our original aims, as identified above, to emphasize the qualitative aspect of our research proposal. Moreover, we ensured we had approval in relation to the research and ethical governance from senior managers who have been referenced in each stage of this research.

The participants in this study were three families who had received home based systemic family work and four members of staff from the Family Solutions Team (FST) who participated in the delivery of home based systemic work with families. The data was collected in two parts. The three participating families were interviewed individually at the end of their involvement with our service. Using the technique of free talking, families were invited to give feedback of their experiences of the service received.

Following the feedback, families were asked to comment on the process of the interview.

The focus group interview involving staff from the team formed the second part of the data collection. Using the technique of free talk, the group was asked to give feedback of their experiences of home based systemic family work. A ten minute break was structured after the feedback was given. Group members were then asked to comment on the process of giving feedback, so the research interview was between one and one and half hours long. The focus group interview and family interviews were video recorded. The remaining two families chose not to have their interviews video/audio recorded, but their feedback was written down. The staff focus group interview was conducted in the building of Greenwich Social Care where the FST is situated while 'family feedback' interviews were held in the family home. The data analysed was influenced by the guidelines of Interpretative Phenomenology Analysis using the information that emerged from the reflective feedback given by the staff focus group and families' feedback interviews. Feedback given by participants was then used to identify and explore themes that emerged across interviews.

Interpretative Phenomenology Analysis (Smith and Osborn 2003; Willig 2001) and Social Constructionism (Burr 2003) offer the theoretical ground for the framing of this research. Social constructionism stresses the importance of an awareness and sensitivity to the use and power of language, history, cultural and social difference. It invites reflection on how these ideas shape our social world and suggests that knowledge emerges through relationships. This principle represents a shift from assumptions that places greater emphasis on objectivity, universality, truth, and the use of normative criteria; and so represents the difference, risk and uncertainty inherent in our work.

Interpretative Phenomenology Analysis provides a theoretical framework and practical tools for analysing how people make sense of their day-to-day lived experiences. It avoids any attempts to make objective descriptions but focuses on the uniqueness of an individual's ideas, experiences and perceptions. The approach relies on a researcher's ability to step into the social world of research participants. From the position of being an internalized other (Tomm 1989) the researcher co-creates their interpretation of the participant's experience. Drawing on social constructionism we can balance this lived experience with social and structural 'realities'.

We use the term 'free talking' to refer to enabling research participants to give meaning to their lived experience in a manner that fits their preferred way of talking. 'Free talking' does not subscribe to set questions, nor is it theory led. As such, the idea of free talking fits with principles of social constructionism and IPA principles in that it allows participants to have the space and freedom to tell their story as they wish. This builds on the ideas of oral tradition as represented in the work of Anderson (1987) and Bolas (2002).

The 'free talking' inquiry involved interviewing families and staff members about their experience of home based sessions. The free telling feedback

interviews took place at the end of the working involvement with families. Asking families for feedback fits with the current pattern of ending our work with families. Families are invited to fill in a structured questionnaire about their experience of the services received. For the research, instead of a structured questionnaire families were invited to give an account or testimony of their experiences. Research participants (families and staff team) were encouraged to negotiate and discuss the best way to give feedback that would fit with their experiences and their way of conveying their telling.

We adopted the research triangulation idea and invited two members of the focus group to review the data and identify themes and accounts. The triangulation method was adopted as it proved difficult to organize follow-up interviews with families to give feedback once they had ceased their involvement with the agency. In addition, time constraints meant that the triangulation fitted with our time frame.

## Context

This study analyses the impact and experiences of an integrated team situated in Greenwich Social Care in attempting to proactively engage families through collaborative, home based, practice. Some of these families may have found services 'hard to reach' in the past or had been discouraged by the connotations of 'clinical' intervention. As mentioned previously, the idea of home based work or systemic family therapy is not new. There is an abundance of outcome research that demonstrates home based family therapy works in a variety of contexts. However, there is a paucity of research that is grounded in a multidisciplinary, integrated and systemic practitioner-led approach.

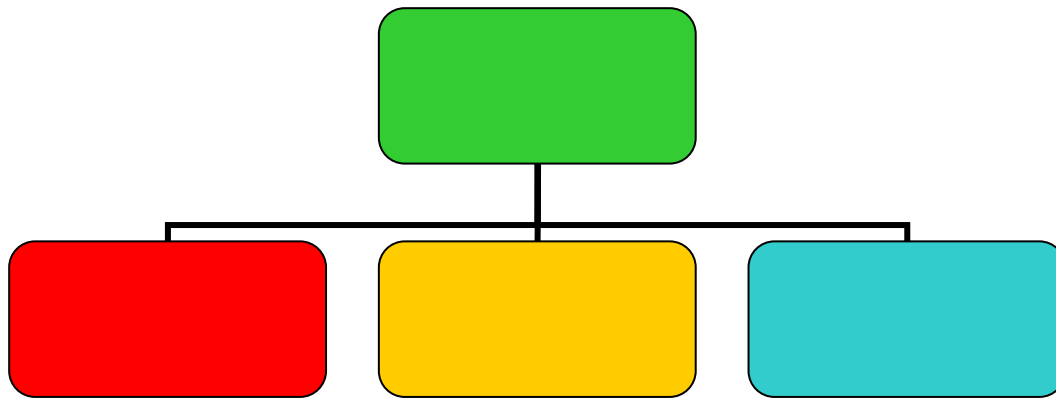
Working collaboratively is often seen as a 'poisoned chalice' that can be driven by the forces of rivalry, hierarchies of roles and inflexible institutional structures that often make it difficult for partnership and collaborative working to succeed. The model that we have evolved in our team reflects the skills and abilities of the partnership of the two disciplines: family therapy and social work. The approach described in this study is rooted in systemic ideas that integrate social work practices to deliver an imaginative and innovative service in the community.

The aim of the Family Solutions Team (FST) is to ensure that young people 'on the edge of care'<sup>5</sup> in Greenwich have a safe and stable home base from which to achieve the best possible outcomes. The team offers responsive, intensive, and integrated, multidisciplinary support, assessment and intervention to these young people and their families, this being the core of the service provided. The team is composed as shown in the diagram.

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<sup>5</sup> *Care Matters* (DfES 2007).





The FST is located in Children’s Safeguarding and Social Care and is essentially a diversionary, ‘invest to save’ initiative. In this task we have been effective and efficient in either reducing the numbers of teenagers looked after, minimizing their length or identifying community alternatives unless a period of accommodation is necessary to ensure safety and wellbeing<sup>6</sup>. However, we were keen to reflect on the quality of services provided, the nature of working relationships particularly with a view to the wellbeing of or outcomes for our service users and to ensure sustainability.

Massie (2008: 63) identifies that ‘multi-agency work does not just happen’ but ‘it frequently requires considerable attention in terms of planning, delivery and management’. However, she does note that the likelihood of success is much greater if the ‘project’ or task is new rather than bolted on to something else. In this case we were at an advantage in the Family Solutions Team. While working within established culture(s) and structures, we had the opportunity as a new ‘invest to save’ initiative to develop and negotiate our own culture and value base. Our role gives us a defined focus and clear expectations and so mitigates against competing claims and priorities and by establishing a protocol for our integrated working we were able to build on our learning and establish a constructive way forward.

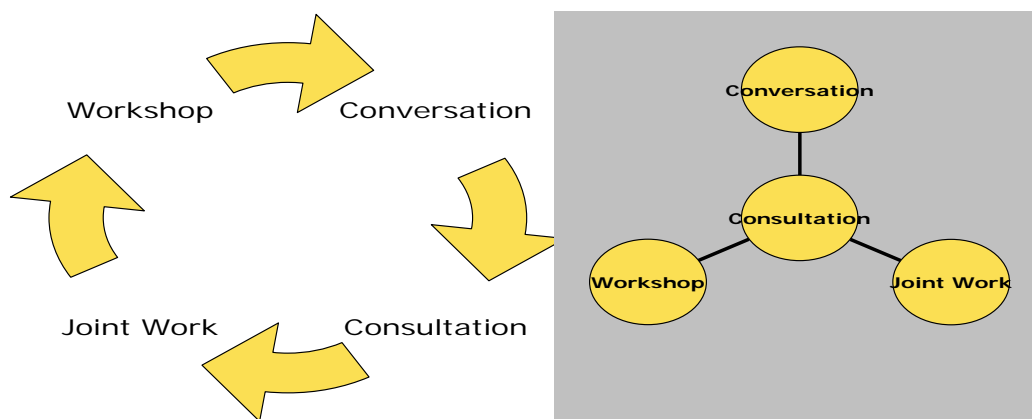
That is not to say, however, that we have not had to resolve significant challenges or that many issues associated with ‘interprofessional’ working need continuous revisiting and negotiating. Doel and Shardlow (2005: 51) suggest that, ‘effective interprofessional working requires each profession to value the contribution of the other, have respect for difference and understand how they might complement the other’. There are possibilities of considerable differences within the team regarding power, status, income, working conditions and requirements in terms of case responsibility and clinical responsibility, for example, or distinct and discrete recording systems.

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<sup>6</sup> Section 20 Admissions arising from a breakdown in family relationships and parental rejection of teenagers have reduced by a third in Greenwich. FST worked with 155 young people on the edge of care 2006–2008. At the end of our involvement 85 per cent were at home or in community alternatives. Of those that were LAC, 75 per cent were supported to return home or to alternatives to ‘care’.

In developing the protocols and understanding identified above we were enabled by a shared focus and clear vision to offer the right services to young people and their families at the right time in the right place for them. This was informed by a focus on outcomes led services that recognized that our strength was in our diversity and a shared interest in working constructively with families using a strengths based, systemic and solution focused approach<sup>7</sup>. The protocol and model of integrated work that we established to structure the fit between the workers within the team and the fit of the team with CSSC and CAMHS is represented below:

## Process / Protocols



The term 'home based family therapy' is defined as 'early interventions that are aimed at keeping children in their homes, keeping family members safe and strengthening the family unit'<sup>8</sup> and so strongly resonates with the work of the team. In terms of the process or protocols identified above, then the home based work could be either delivered through the 'workshop' or 'joint work'. Research literature demonstrates that home based family therapy has been identified as an 'effective alternative to residential placements' (Hinckley and Ellis 1985); as a treatment option in health care and mental health care systems' (Crane 2007); and as the 'most effective way of working with family members who have a diagnosis of schizophrenia'.

Boyd-Franklin and Bry (2000) identify the competencies, skills and abilities required by clinicians to work with African American families in their homes. Their work illustrates how the model of 'home based family therapy' can be used as an effective intervention for working with families in the context of race, culture, ethnicity and poverty. This contrasts with, and enables us to tackle, 'themes of racism and cultural incompetence in health and social care services' identified by Harrison (2008). She notes how a lack of resources and discriminatory practices in service delivery, staff training, and service

<sup>7</sup> See below; also Parton and O'Byrne (2005); White, Fook and Gardener (2006); Healy (2005).

<sup>8</sup> [www.Childwelfare.gov/pub/usersmanuals/crisis/crisis.cfm](http://www.Childwelfare.gov/pub/usersmanuals/crisis/crisis.cfm)

commissioning can thwart delivery of holistic and integrated practice. Due to the constraints of this study we summarize the ideas that have informed our home based systemic practice in the table below.

Concept	Summary	Sources
<b>Making self and relational reflexivity a lived experience</b>	Team members are encouraged to use felt experiences as a resource. The ability of the team to be aware of how their responses get generated in their interactions with families has proven to be an effective tool for understanding how we work with families and how families work with us.	
<b>Reflecting team</b>	In this way of working the therapist has a conversation with family members while members of the home base systemic team listen. At an agreed point in the conversation the team share their ideas and experiences with the therapist and family. The reflecting team approach allows for different and uncomfortable conversations to be voiced in a non-threatening manner.	Anderson (1987)
<b>The wider context:</b>	Using the ideas from The Coordinated Management of Meaning (CMM). We created conversations that helped families to develop an understanding of: <ol style="list-style-type: none"> <li>1. How they speak to each other</li> <li>2. How their understanding of the situation was created</li> <li>3. The importance of context in understanding relationships within their family network.</li> </ol>	Pearce (2001, 2004)
<b>Containment: An in hand co-ordinating experience</b>	Families arrive at our service feeling that they can no longer continue emotionally, socially and physically in the space that they find themselves in. At this stage of the referral social workers play an active role in de-escalating the crisis. This might mean liaising with school, health agencies, housing, social funding agencies, education and police. The intervention acts as a bridge for families to find a space to talk with each other and talk with us.	

<b>Solution focused</b>	This approach is time limited and goal focused. The emphasis is on the 'here and now' and problem-free talk. Families are invited to identify areas that they want to work with and exceptions to the rule.	De Shazer (1985); Berg et al. (1994)
<b>Creating hopefulness</b>	Boyd-Franklin and Bry state that 'families who find they are at the point of breakdown often feel a great sense of blame, ashamed and that they are failures'. <b>[run on]</b> As a team we actively look for areas where families have made change and use the information to strengthen families' beliefs and hopes about the possibility of developing and expanding on the gains they have made.	Boyd-Franklin and Bry (2000)
<b>Respect</b>	This approach demands that social workers and therapists appreciate that it is an honour to be allowed entry into families' homes. Boyd-Franklin and Bry (2000: 38) suggest 'family therapists can benefit greatly from the exercise of putting themselves in the family member's position and consider how they might feel if a stranger came into their home asking painful, difficult and sometimes intrusive questions'. As a team, we privilege the importance of being aware of and sensitive to issues of difference.	Boyd-Franklin and Bry (2000)
<b>Time</b>	The idea of time is about being mindful of going at the pace of the family. A session could take an hour, two or even three hours. The team respects and follows the family's rhythm of talking and allows the conversation to come to a natural end.	
<b>Understanding the legacies of family's past and implication to current issues:</b>	Foucault (1979) argues that in order to understand a situation, a response or a concern, one has to look back into the situated history of the concern. This approach emphasizes the importance of understanding the legacy of a family's history as a way of understanding the family's day-to-day lived experience.	Foucault (1979) Brandon et al. (2008)

<b>Compassion</b>	This is a most abused concept and one that is rarely used in psychotherapy. As practitioners we have developed sensitivity to seeing, hearing, listening, feeling and being in the presence of others in their own home. Families have reported the value and benefits of being heard and listened to by professionals. The concept of compassion is a key foundation in a relationship with families that can transform and generate change.	
<b>Appreciation of the power of words and the human voice</b>	Families who find themselves referred to our project are often in turmoil and at a loss as to what to do next. As a result, talking in a way that generates positive relationships between family members can seem difficult, particularly in the early stage of contact. An appreciation of the power of words requires practitioners to encourage families to talk in a way that invites other family members to listen.	
<b>Story-telling</b>	Haley (1980) has written about the impact of family breakdown, particularly in relation to adolescents. He suggests that they tend to be given a minimal voice by their families and professionals. In our work with young people we often experience Haley's concerns about the inaudibility of the young person's voice. To redress this imbalance, we might encourage the young person to tell their story about how they see their situation from their perspective. We then create a forum for the young person to tell their story to family/carers. This has been a useful technique to create opportunities for marginal voices to be heard.	Haley (1980)

We have identified seven stages of home based systemic work informed by the above concepts and the theory outlined in the methodology below.

Stage	Activity
1.	Meeting and joining the family
2.	Establishing relational cooperation: How the team and family are going to work together

	<p>Identifying what has worked for the family The family's ideas on what needs to happen now to alleviate the immediacy of their crisis?</p>
3.	Identify the family's strength and resources
4.	Understanding and reflecting on concerns
5.	Planning, cooperation and negotiating regarding what needs to be done by whom, how and when – persistence, curiosity and tenacity
6.	
7.	Time for talking
	End: Evaluation and feedback

## Findings and learning

The key themes that emerged from the reflective feedback will be used to illustrate our findings from the research before we conclude with key points of learning. These will be elaborated on further in the presentation using video clips. The shared themes across family participants in the research are outlined in the following table.

Theme	Summary
<b>Courage</b>	Families spoke about having the courage to stay with the uneasiness of entering a relationship with outsiders and not knowing whether they would be of any help.
<b>Dignity</b>	Conversation about dignity was around not feeling stupid, inadequate or blamed. Families felt that by working from home they were able to retain their self-esteem. With their identity and self-worth intact, families felt able to deal with the problem(s) they were struggling with.
<b>Fear of label</b>	The stigma of mental health raised concerns for families. The explanation given was linked to safety. The term 'mental health' in the CAMHS identity evoked feelings of coldness, a sense of not belonging and stories about ethnic groups in particular being labelled. There was uncertainty about whether their involvement with mental health services might have a negative impact on their children's future. Families talked about the artificialness of attending clinic-based sessions. This evoked experiences of talking with professionals in ways that did not make sense, having to sit in rooms that were like hospital wards, and feeling that they could not disagree to what was being said.

<b>Relationships</b>	Families reported that they found it easier to forge a relationship with the home based systemic team than they had with other professionals. Their explanation was rooted in the idea that at home they experienced themselves as being in control and this gave them a sense of empowerment. They also felt that the home based team responded and interacted with them in ways that made them feel respected. There was also an issue about perceived commonality. Families had a belief that professionals were not always welcoming in their use of language and engagement. These responses made them feel inadequate.
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Five main themes emerged from the focus group analysis. They were linked to the skills that clinicians needed when working in family homes.

1. The ability to manage movement in **home based** sessions. For example: sharing the talking space with the TV; managing moments when friends call round; pausing while parents attend to the preparation of meals; family members entering and leaving the room where the conversations are taking place; and engaging with family pets. The team felt that working in families' homes required an appreciation that movement was part of the territory.

2. **Interpersonal skills:** Suspending moments of judgement. Team members talked about the importance of practitioners having awareness of their values and beliefs to develop an understanding of how their ideas impact on their practice, responses and relationship with families.

3. **Safety:** The team talked about issues of safety from two levels:

**Personal safety** was an issue that the team felt was a concern for family therapists, who they perceived had an entitlement to withdraw from offering home based work on grounds of safety issues. Social workers were aware of the issues of keeping safe and felt that they had the experience and skills to make the necessary risk assessment. However, at a wider level they did not feel that they were entitled to make a fuss because the nature of their work could not guarantee their safety.

**Safety in relation to families:** The team felt that practitioners needed to be mindful of managing difficult conversations in families' homes so that families are not left to pick up the pieces when sessions come to an end. The group talked about the skills used to end sessions positively.

4. The outcome of our conversations was that it was important to give **choices** to ensure effective engagement with, and ownership of, the process by the family.

5. **Humility in co-learning;** The benefits of working collaboratively were appreciated. The different skills that each clinician brought into the work context was felt to enrich the quality of the services offered. It was felt that the sharing of knowledge and learning created a sense of community, transparency and relational risk taking.

## Conclusion – key points of learning

We recognize the need to grow our own localized research and evidence base for practice that can engage with broader developments. We have demonstrated the value of a reflective space and the opportunity to change established practice to best meet the needs of service users and optimize outcomes. There is a paucity of research on home based systemic work in the UK. This small-scale study has shown us that families are better able to engage in home based systemic work and therefore have a greater chance of accessing a therapeutic service, as suggested by Boyd-Franklin and Bry's work (2000).

The CAMHS review (2008) identified that children and young people say that services are not as well known, accessible, responsive or child-centred as they should be. As such, those who access specialist services do not always have the opportunity to develop trusting relationships with staff for the length of time they need so an individualized, integrated and holistic package of support<sup>9</sup>, such as home based therapy, should and has been made available. During the life of the study the team witnessed a reduction in 'Did not Attends' and as such we have seen improvements in the life chances of young people and their families. As a consequence, these families have been able to re-engage with outside systems. Last but not least, young people at the 'edge of care' have been supported to remain in their families and in their local communities through the provision of services at the right place and at the right time. Delays in referrals to other agencies and professionals are avoided, for example.

In order to develop our practice and implement such work we need to encourage a culture in which practitioners have the confidence to research and evaluate their practice and contribute to a developing research and evidence base for practice. Clinicians and practitioners sharing their experiences may help to showcase innovative practice and motivate others to embark on this way of working. The value of reflective space for social workers in the current context of increased 'managerialism' and target focused practice has also been reinforced. Moreover, our emphasis on critical

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<sup>9</sup> CAMHS Review (2008) *Children and young people in mind: the final report of the National CAMHS Review*



thinking and social history taking is consistent with the ecological approach advocated by Brandon et al. (2008) in their analysis of serious case reviews 2003–2005.

The renewed vitality that has been given to this area of work is exciting. It challenges the idea that families are to blame for not accessing services and invites practitioners to take responsibility for the way services are offered. Home based systemic family work has the potential to foster imaginative and inventive practice. As an approach, the evidence appears to demonstrate that it is beneficial for families and is an effective additional tool for practitioners and clinicians. As a developing team we hope to continue testing and expanding the knowledge we have gained to transform our practice.

## Action plan

In order to mobilize, expand on, and sustain the momentum and learning from our research we need to undertake the following action<sup>10</sup>.

Goal	Task	How	Who
Discover	Further information in relation to outcomes, outputs (eg LAC status) and inputs (appointments offered/ attended).	Audit of all work by therapist in team. Revisiting the aims identified in the proposal.	Identify external resources (staff/ funding) or within team.
Deepen	Raise profile of work and value added.  Ongoing commitment to researching and research in practice.	Disseminate reports, feedback and findings of practitioner-led research into work of team. Audit.	Huw/Julia with CWDC; CAMHS awaydays; CSSC consultation process
Develop	Enhance our model of home based family therapy but also integrated practice and the reflective team.	Team meetings, supervision and reflective team processes.	Team, supervision.
Deliver	Put themes and models identified into practice.  Constructive contribution to organization.	Supervision and reflective team processes.  Continue to offer effective integrated and holistic services.	Team.

<sup>10</sup> GOL/TDA – change management framework

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