Early contact family meetings in psychiatric services

Kevin Hawkes and Alex Reed

Together with colleagues, we have been involved in developing and delivering family therapy services in adult psychiatric-hospital and community settings over a number of years. Inspired by open dialogue as well as earlier family therapy literature about psychiatric crisis work (Scott & Starr, 1981), we have focused on the implementation of 'early contact' family meetings. Our aim is for these family meetings to be offered routinely at the first contact with services so that a collaborative ethos is created from the outset.

In working towards a service culture where family work is routine, another aim is for the meetings to be facilitated by staff from the clinical teams with our support, so that family work isn't viewed as a specialist, 'bolt on' service that only a small number of people are referred to. Rather, we wish to promote the message that family meetings are a vehicle for dialogue and can be helpful to all who come in contact with services.

In this article, we discuss the potential benefits of these early meetings in an early intervention in psychosis service and offer some reflections on the opportunities and challenges faced in developing dialogical family work in UK psychiatric services.

Why early contact family meetings?

In an early article describing the development of open dialogue in the Western Lapland region of Finland, Seikkula and Sutela (1990) discuss the shift from a traditional psychiatric service to their network-based approach. A first step in this service change was to offer family-staff network meetings at the point of hospital admission. The Finnish team soon took the step of offering these meetings even more quickly, prior to admission. Often, the family and team would find ways of talking about and responding to the crisis that would help mobilise the family's healing capacities. This new dialogical approach brought startlingly improved outcomes, with a dramatic reduction in the need for hospitalisation of people experiencing psychosis, and also a marked decrease in the use of neuroleptic medication (see Seikkula, this issue).

Similarly, Dennis Scott, an early pioneer of family-based crisis intervention in the UK, found that, when staff responded quickly to a referral using a team approach and maintaining a relational perspective, the need for hospitalisation was often averted (Scott & Starr, 1981). Scott argued that a destructive breach of the relationship between the person in crisis and other family members, which he termed 'closure', could also be prevented through this approach. In a period of emotional crisis, the beliefs of family members are often in flux as they attempt to make sense of what is going on. When the behaviour of the person who is the focus of concern is inexplicable and alarming to the family, they are likely to draw upon dominant cultural beliefs about mental illness as an explanatory framework. The arrival of psychiatric professionals into a crisis situation may reinforce this view by confirming that the person is 'ill', particularly if the outcome is hospital admission (Whittle, 1996). In this process of 'closure', problems are located 'inside' the person in crisis, rather than in relational or socio-cultural contexts.

Both Seikkula and Scott pointed to the idea that meanings are created 'on the boundary', at this crucial meeting-point between families and staff. Indeed, there is a rich tradition within systemic therapy of focusing upon initial interactions between families and staff to enhance opportunities for therapeutic change (see for instance, Bruggen 1987). In an early intervention in psychosis context, this initial meeting-point is often a family's first encounter with mental health professionals, and the service culture can seem mysterious. Families may also be fearful that they will be blamed for their relative's difficulties. We are therefore keen to communicate that 'first contact' family meetings are a routine part of our work and that families are a crucial resource towards recovery.

Aims of the early family meetings

- Family and staff getting to know one another
- Engaging with each person's point of view
- Providing an opportunity to discuss each person's experience of the crisis
- Experiencing and understanding the emotional climate of the household
- Reducing or containing anxieties (family and staff)
- Beginning to explore how people are getting along
- Inquiring about family composition and transitions
- Understanding family culture
- Taking account of material circumstances
- Providing opportunities for reflection
- Informing and being informed.

Practice scenario

As you read the following practice vignette concerning initial contact between a person in crisis, his family and mental health professionals, we invite you to hold these questions in mind:

- *Whose voice do you feel most and least drawn towards?*
- *What emotional responses arise for you?*
- *Is a hypothesis beginning to form? If so, does this hypothesis and your emotional responses invite you into any particular kind of action?*
- *Do you hear echoes of colleagues' voices as you consider this scenario?*

Marcus, a 25-year-old man, was referred by his general practitioner to an early intervention service in the north of England. His parents, John and Charlotte, contacted the GP expressing concerns that Marcus is "paranoid" and has felt unable to work since leaving university two years ago. The family is white Scottish.

Marcus was initially met by two care coordinators (who were both community psychiatric nurses). He expresses fears that a

criminal gang is targeting the family and that neighbours have been recruited to keep them under surveillance. Marcus also says he has heard people whispering about him in public places, and that secret messages are being conveyed via Facebook.

The care coordinators are also concerned for the family. John is confrontational towards Marcus during the assessment, and Charlotte is tearful throughout. An 'early contact family meeting' is arranged with other members of the team. The family therapist and a care coordinator, who has foundation-level systemic training, arrange to visit the family soon after.

This meeting begins with the staff asking the family what is important to be talked about. John thinks that Marcus is worrying too much, and "just needs to get on with it". He says the problem is that Marcus "has nothing to do". John also demands to know from the staff, "what you will do to help my son". Marcus himself states he "isn't sure how talking will help" and fears the staff "will just try to persuade me that I am mad". Charlotte becomes tearful and describes, "feeling awful that this has happened to Marcus". She also worries about "what others will think about us".

Early family meetings are often characterised by anxiety for both family and professionals. Family members may feel desperate for professional help, but also fearful of intrusion, labeling and stigma. Cultural, familial and individual narratives about 'mental illness' and the role of psychiatry may come into play, powerfully shaping interactions in the meeting. If staff anxieties are raised or they feel under pressure to 'do something useful' they might find themselves speaking and acting from stereotypical professional positions, moving quickly to diagnostic talk or becoming prematurely 'interventive'.

The early intervention team members identified several 'orientating principles' that guide them in initial family meetings and support a more curious, exploratory position. These orientating principles are:

- Respect
- Flexibility
- Being strengths-focused
- Where possible, meeting in the family home, helping us understand the context of people's lives
- A gender balance within the staff team
- Approaching discussions about confidentiality as opportunities for opening up (rather than closing down) conversations.
- With family agreement, ensuring that the family meetings are integrated into an overall care-plan.

We would add that creating a dialogical ethos in the meetings requires of staff a 'negative capability'; a capacity to 'be still' and attentive to what is going on in the present moment, listening and seeing with a quality of 'beginner's mind' (Reed 2014). This kind of 'still' listening includes attentiveness to the 'outer' voices of all present, as well as our own 'inner' voices. These inner voices are interwoven with multiple personal and professional contexts; a tapestry that includes voices from our own families, of families we have previously met, of our colleagues, trainers and supervisors, and also from the rich diversity of family therapy models.

Colleagues have commented to us that the dialogical nature of these meetings has allowed them to enter into a different kind of talk with families, liberated for a time from prescribed technologies of assessment.

Innovation in an austere climate

The government's 'austerity measures' to reduce public sector expenditure present organisations with powerful economic drivers for change. Also, new commissioning processes have led to increased pressure on services to demonstrate 'quality' and 'efficacy'. This service context creates opportunities and challenges for the development of dialogical family work. There is increased organisational interest in shifting towards more 'effective' ways of working, leading to greater acceptance from managers and senior clinicians of the need to provide training in family interventions and to develop models of delivery that will make family work routine, in line with *NICE Guidelines for Psychosis and Schizophrenia*.

Despite this increasing focus on family work, individualistic biological and psychological narratives continue to be powerfully influential within services and, when teams are under pressure, they may quickly revert to a more traditional, biomedical 'default position'. Also, tightened budgets have led to staff shortages and increased caseloads which can make attending training, supervision and participating in family meetings difficult for colleagues. An emphasis on risk management can create additional pressure for staff to move quickly to an understanding of the situation and to uncover the 'true story'. There is an obvious tension here with dialogical approaches that entail a capacity to tolerate uncertainty and engage with polyphony.

We found weekly supervision groups where staff can reflect upon their work with families, alongside opportunities for less experienced staff to co-work with colleagues with more advanced family therapy training, invaluable in maintaining a relationally-focused service-culture (Reed & Hawkes, 2007). Co-working also enhances reflective and creative practice. Complex psychosocial processes are often in play in family meetings, and co-working is one way of helping 'contain' staff anxieties.

We have also found it's crucial to engage managers and lead clinicians in an ongoing dialogue about the value of family work, at all levels of the system. Even in service areas where family work appears well established, 'constant gardening' is needed to maintain this activity when services are struggling with multiple (sometimes conflicting) priorities.

Concluding reflection

Harlene Anderson (2002, p. 281) raised the following question regarding the Finnish open-dialogue approach, *"How can therapists translate the approach, which evolved in such a unique cultural context near the icy tip of the world to other cultural, organisational and political contexts?"* This question has also occupied us for a number of years, as we have witnessed the culture of UK services shifting in response to changing political and socio-economic circumstances and evolving discourses about 'good practice'. Often, we have felt encouraged, occasionally disheartened. One of the strategies we adopted in trying to introduce dialogical approaches in this fluctuating climate was to concentrate on embedding relatively small-scale developments, such as the early family meetings described here. A disadvantage of this strategy is that family work often remains something of an adjunct to a more traditional service. However, to quote Frank Zappa, *"it's a matter of infiltration"*. We have found focusing on small steps helped us remain persistent on occasions when things didn't 'go our way' and, over time, the organisation has warmed to this way of working and became supportive of these developments.

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Peer-supported open dialogue

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In October 2014, a number of NHS trusts initiated a foundation diploma course 'peer-supported open dialogue, social network and relationship skills'. This article sketches the development of the course and describes the initial work being done to implement this approach within the participating trusts.

The Norwegian context

During the past ten years at Gjøvik University College, Norway, I have been the director of a post-graduate programme in network meetings and relational competence, based primarily on open dialogue. The history of network approaches to mental health care in Norway goes back almost thirty years. Much of the initial impetus was based on the work of Tom Andersen, who helped establish a training programme in relationship and network interventions in 1987. Jaakko Seikkula and his colleagues, who were developing the open-dialogue approach in Western Lapland, visited Andersen for the first time in 1988. This became the start of an intense collaboration between the Norwegian and the Finnish groups during the 1990s. The Western Lapland project also paralleled work in Oslo under the guidance of Live Fyrand who had introduced social-network therapy in Norway. Both the Norwegian and the Finnish groups had visited the Nordic Network Project in Stockholm. This group had worked closely with the American psychologist, David Trimble, who in turn had studied under Ross Speck and Carolyn Attneave. Speck and Attneave are (together with Uri Rueveni) considered the originators of social-network therapy and had in 1973, published *Family Networks* describing their approach. In it, they state their most fundamental principle is *"Any help, to be useful, must be part of the social context of the person in distress"*.

This was the background and inspiration for a number of clinical groups in Norway to establish open-dialogue projects in the late 1990s. In 2002, the project group in Valdres, central Norway, with representatives from the regional trust, the municipal mental health care-services and national service-user and carer associations, contacted Gjøvik University College regarding the possibility of collaborating on a post-graduate programme. The first group of students started in January 2005 and we have been further developing the programme since, in the past five years in cooperation with Akershus University Hospital Trust.

After the first ten years of the Valdres project, it was evaluated by the Norwegian Institute for Public Health and the results showed that service users, carers and staff reported that the method had contributed positively towards involving clients actively in shaping their own treatment programme; encouraging open communication between patients, network members and professionals; increasing insight into clients' problems; promoting social support; enhancing the ability to cope; and contributing to the improved cooperation between professionals from primary and secondary care (Holloway *et al.*, 2009).

Despite this relatively long Norwegian and Nordic tradition, and the positive evaluation, the spread of the open-dialogue approach has been slow. I was therefore very excited when I was contacted in January of 2014 by psychiatrist, Russell Razzaque, associate medical director at North East London NHS Foundation Trust, regarding training for a national multi-centre open-dialogue pilot that would seek to transform the model of healthcare provision for persons with major mental health problems in the UK. Razzaque, together with family therapist and trainer, Val Jackson, and I, started work on adapting the Norwegian model and syllabus for use in the UK.

The model

The Valdres model that I have worked with was based on continuous service-user and carer involvement, community integration and peer-support and we therefore chose to name our approach 'peer-supported open dialogue'. The model