Referrer Engagement

In Family Therapy

In The Context Of Child Protection,

A Process Study

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1. Abstract

This study aimed to identify the significant processes involved in a systemic approach in which the referrer is involved in family therapy when working with families that have safeguarding concerns and who are known to the social care system (Tier 3). The Referrer Engagement Method, is a collaborative approach to work with both the family and referrer. The overall aim of the research study is to show whether this approach improves their therapeutic alliance and the family's motivation for change.

I conducted a focus group with five experienced referrers and seven semi-structured individual interviews with four new referrers. All referrers were from Children's Social Care, one from the voluntary team (Early Help) and the others from the statutory. Grounded theory was used to analyse the individual interviews and thematic analysis to analyse the focus group. The codes were combined.

The analysis of the referrers' accounts identified four significant processes in the approach: Naming power, Opening dialogues, Engaging the system in the room, and Working collaboratively. The referrers saw the families start to take ownership of their changes. Observing and participating in a systemic interview influenced the referrers to expand their practice with families. Some referrers noticed their relationship with the family improved. Referrers found some aspects of the approach challenging in balancing risk and engagement.

Working collaboratively was found to create an important space for reflection

The study raises implications for the further development of the approach and its application in other contexts, and contributes to ideas about the challenges for social workers working in child protection.

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3. Acknowledgements

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4. Introduction

When consulting with a group of social workers in 2010, one team member suddenly asked me:

> *"Do you really think we, social workers, can have a good relationship with our clients?"*

I was surprised because, for me, the answer was "yes". And it was this comment that inspired my Doctorate research.

Since 2009 I have run the Parenting Project providing systemic family therapy to Tier 3 clients involved with the child protection system. This service was aligned with the Think Family (2009) agenda which recognises and promotes the importance of a whole family approach. Social workers refer families to the Parenting Project and, unlike other therapeutic services working with social services, our service pathway involves the referrer within the therapeutic process, an approach we call the Referrer Engagement Method.

The Referrer Engagement Method has a number of underlying assumptions. Like all systemic therapists, the family therapists of the Parenting project see the referrers as part of the family system. The first assumption is that, to become effective agents of change, the referrers must view themselves as part of the system of change. Secondly, their relationship with the families impacts the families' engagement level. Third, this in turn is assumed to influence the family's motivation for change. Fourth, the method influences the referrer's practice. Lastly the method assumes the family therapist can facilitate this process.

I wanted to explore these assumptions and other aspects of the referrer's experience of the Referrer Engagement Method with the aim of identifying significant processes of the approach, the effect on the referrer's practice, and

the impact on the families. I was interested to find ways to develop the method further.

5. The Referrer Engagement Method

My first job at the NHS was in a family therapy service for families affected by substance misuse – the Meanwhile Family Therapy Service (Meanwhile). The system around these individuals and their families was usually large. Each part of the system viewed the issues through different lenses and the communication between the different services, and at times between the services and the family, was difficult, contradictory, and confusing, and the voice of the family was diluted. In substance misuse the majority of the services follow medical models, which focuses on the individual with the addiction problem and treats it as an illness with less or nonexistence emphasis on the impact on the family and significant others.

In Meanwhile, when we worked with families with young children, we involved the system around the family, mostly when their relationship became conflictual or difficult. We called a 3-way meeting with the family and the other service, providing a platform/space to discuss their difficulties (more in the form of mediation between them), chaired by the family therapist. Moving from a two-person system to a three-person system, helps in moving away from a polarized relationship , widening the feedback loop and interactions which results with more space for constructing new ideas and meanings (Campbell, Draper & Huffington, 1989a). In the 3-way we would interview the professional about their experience of working with the family, using strength based questions, and looked at the challenges and hopes for change. The Meanwhile Family Therapy Service was heavily influenced by the solution focused model (De Shazer & Berg, 1997). In the core of the 3-way meeting then, it was important to present and connect with the client/s as a person and

not only with their problems (Sharry, Madden & Darmody, 2001), focussing on strengths and hopes. A 3-way usually allowed an open discussion between the family and the professionals. Families could voice their views, wish for change, and usually left the meeting feeling clearer about what was expected of them. In addition, solution focused therapists also listen to the client's story and allow the client to engage in problem talk and express their feelings, which helps clients in feeling heard, understood and important to the process. We did not use a 3-way routinely; we used it when children services were involved or when the professionals and/or family felt stuck.

In 2009 Meanwhile Family Therapy Service was approached by a CAMHS commissioner to provide family therapy to families with safeguarding concerns and who are known to the social care system (Tier 3). Despite being the 'children commissioner' she decided to commission an Adult service, arguing that it would be able to offer parents a less judgmental and blaming service, and produce a better level of engagement with the parents. This was aligned with the Think Family (2009) agenda that recognises and promotes the importance of a whole family approach. The Parenting Project was initially based in Meanwhile within the adult addiction directorate although it was not specifically for parents with addiction difficulties. The rationale for creating the service within the addiction directorate was due to the experience of the service in working with parents who had gone through challenges in parenting their children. The Parenting Project is based in a borough in London and works closely with the local Children's Social Care. The Parenting Project initially provided both family therapy interventions and a psychoeducation parenting programme (Triple P) to families in the borough who are supported by Children's Social Care due to safeguarding concerns regarding their children and suffer from mental health, substance misuse, or domestic violence difficulties. Both the parents and the young persons usually require multi-agency (Rider, 1986) intensive input to address their needs and are mandated (Snyder & Anderson, 2009) to engage. The families are usually

receiving support as part of a Child Protection Plan, Child in Need Plans, Looked After Children Plan or prevention support from the localities teams, who are the voluntary branch of Children's Services.

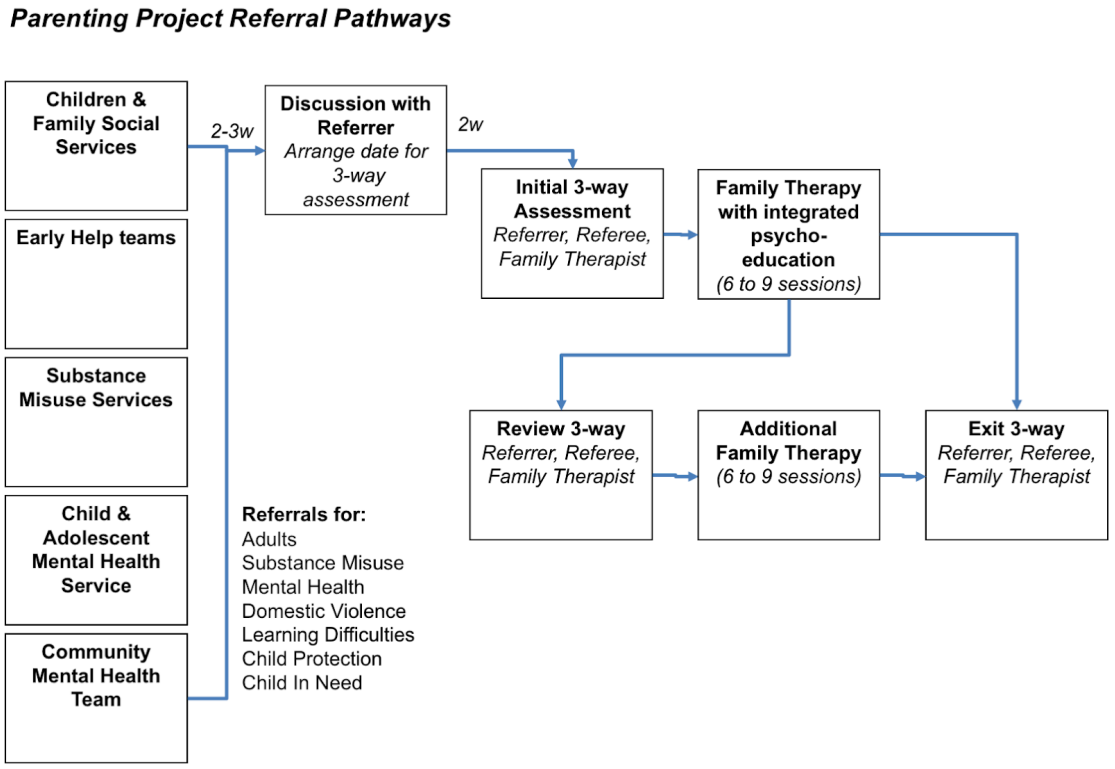

Figure 1: Parenting Project Service Pathway

I was responsible for creating and managing the Parenting Project. Knowing that the family therapists would need to work closely with the Children's Social Care practitioners (which were in most cases the referrer to the service), while the family is engaged in family therapy, made me think about using the idea of the 3-way meeting. I created a method which included the collaborative referral form for referrers to complete with the families (see Appendix 12); pathway to the service (see Figure 1) which included the Initial 3-way meeting, Review 3-way meeting and Exit 3-way meeting. Each 3-way meeting was with the referrer, the family and the family therapist. The family therapist

also attended all multi professional safeguarding meetings such as child protection conferences and core group meetings.

Following a phone conversation with the service, the referrer has to fill in a referral form jointly with the family. The form includes both of their views and asks for their hopes for changes by both the family and the referrer.

During the initial 3-way meeting the family therapist interviews the referrer in the presence of the family asking about their experience and involvement with the family, the strengths of the family, the challenges in working with the family and their hopes for the family by attending family therapy. Following up from the interview of the referrer the family therapist opens the discussion to include the family's view before agreeing on the aims for therapy. In my experience clients in the context of child protection are often confused, angry and do not voice their needs. The conversation facilitated by the 3-way is an opportunity to give space to the client's voice and to establish a shared and achievable therapeutic contract and goals. The setting is also an opportunity for the referrer to hear new information and possibly get a different perspective on their clients. Family members can feel anxious prior to attending the meeting so starting the meeting with a focus on the referrer is a way to ease the family way into family therapy.

The mid term 3-way is after 6-9 sessions of work with the family and the exit 3-way meeting happens when the family's involvement with our service ends. Both meetings are used to assess progress towards the originally agreed therapeutic goals and review the direction of the work. In this research study I referred to both as a Review Meeting.

The 3-way meetings with the referrer, the family and the family therapist creates a dynamic where more relationship/interactions are possible and the presence of the third person puts the other two or three participants in a different context of being observed and being a witness. It also offers possibilities for the participants to develop systemic awareness of themselves

in the context of the others. The presence of the third person highlights, challenges and disrupts the patterns of their interactions, beliefs and actions and brings about new conversations (Campbell, Draper & Huffington,1989a).

The idea of involving the referrer in the 3-way meeting was supported by the Milan paper by Selvini-Palazzoli et al. (1980).They aimed, in the context of mental health work, to bring the referrer's views and experience with the family closer to the system around the family by inviting the referrer to the first session with the family. They aimed to gather information about the relationship between the family and referrers in order to understand the mutual influence between the different parts of the system and the dilemma of change, no change. Selvini-Palazzoli and colleagues believed that addressing and handling the dynamic between the family and referrer was a precondition for starting work with the family. These ideas fit well with my work with families and the helping system around them, and I have adapted them to the context of child protection.

Throughout the work with families in the Parenting Project the family therapist moves back and forth from a position of 'not knowing' to 'expert' and back (Anderson and Goolishian, 1988), following a constant reflection and assessment of risk in the family. A more directive approach is used when focussing on behavioural changes in the family, for example, directing parents to work together as a unified team to facilitate change in the child's behaviour. In addition, using some of the principles from the 'Triple P' positive parenting programme (Sanders, 2008) fits well with some of the Structural (Minuchin,1974) and Strategic (Madanes & Haley, 1977) ideas and techniques. Families that are told to attend therapy hold an expectation to be told what to do and ironically the lack of directive tasks is perceived as ineffective.

Alongside the use of behavioural approaches, the family therapist focuses on creating a safe environment for parents to engage in therapeutic work and

explore the challenges they experience in their families, the unique outcomes when they overcome or deal differently with the challenges, their perceived strengths, their beliefs and ideas about their family members - using strength based questions inspired by solution focused (De Shazer & Berg, 1997) and circular questions. Circular questions are questions which are characterized by a general curiosity and exploration of connections of events (Tomm, 1988). They are formulated to bring forth the 'patterns that connect' people, beliefs and actions (Campbell, Draper & Huffington,1989a).The family therapist usually uses circular questions with the family members in the meeting and less with the referrer, as a way to explore their understanding of their parenting difficulties in the context of their family dynamics.

Mandatory, non voluntary clients do not usually put their hands up and request intervention (Furlong, 1996). Due to the statutory nature of the contract between the referrer and the family, their relationship can often suffer and be antagonistic. Both the family and the referrer tend to perceive the problems that they are focussing on as down to the personal qualities of the individuals involved, rather than informed by the context and the respective roles. Different families need different styles of engagement, and the clients' experience of us (and vice versa) is always mediated by the interlinking of the wider context, class, culture, age and gender. From my experience, one of the most common complaints from families about their social worker, was related to the social worker's age and whether they were a parent. Families tend to feel better understood by a more mature social worker who is also a parent. This criteria also applies to myself, when working with these families I am often asked by parents whether I have children. Realising the importance of this to families and to their engagement, I have occasionally used my own personal experiences as a mother with my families, as part of 'use of self' (Anderson & Levin,1998).

Smith, Osman and Godings (1990) argue that "parallel processes" take place in the relationship between the social worker and the family (also known as

isomorphism within the systemic field). The contradictions found in the social worker role between caring and assessing risk, uncannily mirror the antagonistic forces in family life as to nurture and to control, the need to care and to discipline. The conflictual aspects of family life can evoke both transference and countertransference, responses by both family and the social worker (Furlong,1996). Because I trained psychodynamically prior to my systemic training, these ideas, and the importance of the therapeutic relationship, are part of the method. Conducting a 3-way meeting is viewed as an opportunity to explore the relationship between the referrer and the family prior to the referral and also invite them to reflect on their work relationship, with the hope for improvement. The 3-way is also an opportunity for the family therapist to form a relationship with the referrer and the family and introduce a collaborative way of interacting with both. The premise underlying the Referrer Engagement Method is that keeping the referrer closely involved in the therapeutic engagement will impact the referrer-family relationship (Sveaass & Reichelt, 2001a, 2001b), the referrer's work practices (Carpenter & Treacher, 1983), and also ensure a better engagement in therapy for the families . A desirable outcome is to help mandatory clients to engage in a more voluntary way. This was achieved with some of the clients, who came to the initial meeting reluctantly and ended up stating that they would like to continue their work with the service after completing their work with Social Care.

The family therapist moves between a position of 'not knowing' using curiosity and listening carefully to the family's narrative and a position of expert when assessing safeguarding issues. In either position the family therapy will act respectfully to families and encourage dialogue and collaboration with the family.

6. Literature Review

This literature review will provide an overview of the literature in a number of related areas. The first area is the context of the Parenting Project. This includes the context of Social Care and child protection, including multi-agency families, and also the contribution of systemic thinking to the social work field. Second is the literature related to the development of the Referrer Engagement Method. This includes how multi-agency families interact with the helping system, and the work with the referrers and ways to include them. I will also explore the related concepts of engagement and therapeutic alliance before looking at collaboration in the context of child protection. Finally I outline the literature related to researching the Referrer Engagement Method. The concept of power is central to the research project as is dialogue.

6.1. Literature related to the context of the Parenting Project

The Referrer Engagement Method aims to create a collaboration between the referrer (usually a child protection social worker), multi-agency families, and the family psychotherapist. In this section I will review relevant literature on the context in which the method was developed: social work in the context of safeguarding children, multi-agency families, and systemic thinking and social work.

6.1.1. Social work in the context of safeguarding Children

Social work is an established profession with a role in safeguarding children within a framework of legislation and government policy. The British government set the legal framework for protecting children with the Children Act (1989, 2004). Local authorities, on the other hand, have a direct

safeguarding responsibility to keep children safe, in collaboration with other agencies.

Social workers work within a context of high levels of uncertainty, stress, conflict of interest, complexity, and risk. Lord Laming (2009) recognised the demanding task social workers face and the need for the ability to cope with anxiety, stress and conflict in order to fulfil their safeguarding duties well. The Munro Report (Munro, 2011; Cooper & Whittaker, 2014) also emphasised how child protection work is characterised by complexity and uncertainty and, as a result, put professional judgement at the centre of the child protection profession in England. Munro suggested reducing the bureaucratic framework that attempted to address risk with administrative processes (Ferguson, 2004; Whittaker, 2018).

Definitions of role and responsibilities is widely open to interpretation. Boodhoo (2010, p. 96) said: “Role may be reviewed as one’s task or function and responsibility as the area for which one is answerable for one’s action”. However, child protection social workers are often challenged with negotiating and balancing the rights and responsibilities of the state and family (Boodhoo, 2010). Social workers have statutory responsibilities for child protection which puts a demand on their role to find a balance between caring and controlling.

In the caring part of their role, which is rooted in their professional ideology, social workers focus on engagement with clients. This puts the workers in an uncomfortable position when legal orders demand the removal of children (Birchall & Hallett, 1995). “The constructive use of authority is an important but problematic strand in social workers’ professional training and orientation” (Boodhoo, 2010, p.105). Social workers are faced with role conflict due to having to carry out more than one role at the same time (Handy, 1993), even if the expectations from these roles are clear.

Fargion (2012) is not alone in recommending that a balance of care and control is ideal. According to Alfandari (2017) and Munro (2011) doing the

combination of care and control well improves child protection more than not doing one or the other very well. The degree to which child care systems balance child protection and family support, safety and prevention is regarded as a critical overall issue in the design and delivery of services (Ferguson, 2001).

There are many critiques showing how child care systems have usually failed to meet this balance due to the dominance of child protection and advocating the need to 'refocus' on family support (Dep. of Health, 1995). Remarkably little has been written on how a healthier balance can be found (Farmer, 1997).

6.1.2. 'Multi-Agency' Families

Some families in crisis are involved with more than one professional helping service. These families typically face multiple and long-term challenges including lack of education, violence, chronic long term poverty and lack of resources, and substance misuse (Colapinto, 1995). Parental mental health and/or substance misuse are common risk factors associated with families in contact with the child protection system (Bromfeld, et al., 2010; Swenson & Chaffin, 2006; Wood, 2008).

The literature refers to families in this client group by different names including 'disorganized pathological' (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967), 'disorganized' (Reder, 1983), 'underorganized' (Jenkins, 1983), 'multi problem' (Imber-Black, 1991), 'neglectful' (Colapinto, 1995), 'involuntary' or 'mandated' (Snyder & Anderson, 2009), 'resistant' (Barlow & Scott, 2010), and 'multi-agency' (Reder, 1986).

Reder (1986) argues the term 'multi-agency' is useful for several reasons:

- Emphasises process rather than state.
- Emphasises the system we work with clinically is the family and its network of helping services.

- Less labelling and blaming for the families as the problems are shared with the larger system.

In his work within a secondary care agency providing assessment and treatment of emotional problems by children Reder (1986) observed that some multi-agency' families had very weak relationships with their extended families, fluid family composition, and inconsistent relationships with services. These professional services are often 'involuntary' or 'mandated' (forced to attend by a legal body) (Snyder & Anderson, 2009). These attributes can impact the therapeutic relationship with the family. The multi-agency system results from a sequence of multiple agency contacts, each with a short period of closeness with a professional. In the process of involving more professionals in their life, a possible outcome can be a dilution of the family relational life within the larger system (Colapinto, 1995). A multi-agency system can be uncoordinated. The agencies can work at cross purposes and at times give the family confused messages.

6.1.3. Systemic Thinking and Social Work

The Referrer Engagement Method came out of the 'Think Family' agenda. It is a systemic way of working with families who are on the child protection register and were referred by a social care practitioner to the Parenting Project. The systemic thinking and way of working is introduced to the referrer by both modelling by the family therapist and by their participation in a collaborative dialogue in the 3-way meeting. The method is based on the underlying belief that systemic thinking, of focussing on the relational impact between referrer and the family, can be significant to the family's level of engagement in the therapeutic work. This section reviews the literature where systemic thinking has been applied to a social work context.

During the 2000s a number of young children died in England, despite the involvement of child protection social workers (Laird, Morris, Archard, & Clawson, 2017). The government introduced tightened national performance management targets to address the concerns raised by these incidents. Although well meaning, this managerial approach brought a greater demand for paperwork with an associated negative impact on social worker practice. This in turn led to a greater interest in practice theory to improve child protection performance (Broadhurst, Wastell, White, Hall, Peckover, Thompson, Pithouse, & Davey, 2010; Munro, 2011). Some English local authorities added a systems approach to their child protection practice which was guided by a theoretically informed systems approach to families (Dep. of Education, 2016; Goodman & Trowler, 2012).

The influence of systemic and relational thinking in the field of child protection in the UK has been increasingly evident since the publication of the Framework for the Assessment of Children in Need and Their Families (Department of Health, 2000). The framework introduced a relational frame to child protection assessment. The emphasis is on practitioners exploring the interrelated domains of the child's developmental needs, parenting capacity and family and environmental factors. 'Think Family' approaches promoted by the government encouraged support provided by children's, adult and family services to join up and to consider how individual problems affect the whole family. One approach that has developed in this context is 'Reclaiming Social Work' (Pendry, 2012) which, at its core, is an integration of systemic thinking and practice into children's social care.

Traditionally Social Care has focused on a single causative factor, to explain child abuse, typically blaming an individual and often a parent (Jack, 1997). The belief in a single causative factor led social workers to focus on what actions parents or carers must take to effect change. This approach ignored

the wider system and has led to the social worker becoming part of the problem system (Bowman & Jeffcoat, 1990).

Child protection social workers have been criticised for the overall emphasis in their work on the mother-child dyad, to the detriment of direct work with fathers and wider family members (Morris, White, Doherty, & Warwick,, 2015; Featherstone, White, & Morris, 2014b). Their practice usually includes child-centred interventions, largely based on Bowlby parent-child attachment work, that enhances the focus on the mother-child dyad (Featherstone, 2009).

A position, at times taken by social workers, ‘that I am only here for the child’ underplays the relational understanding of children, with their parents, and runs the risk of decontextualising the children by, for example, removing them from their parents (Featherstone, White & Morris, 2014b).

The lack of engagement with the complexity of family comes at a time when the family unit is changing - parental separation is on the rise, single parenthood is increasingly becoming common, and large numbers of reconstituted families are created (Laird, et al., 2017; Gorell-Barnes, 2004). Home visits used to be the best way to meet all the family but are becoming an inadequate format to engage all the family members. Social worker practice needs to be more mobile to get an insight of family dynamics. Laird and colleagues (2017) recommend a couple of practices in order to develop depth and consistency of interaction with families. Firstly, they suggested having meetings outside the family home which offer privacy not always possible at home. Secondly, acknowledging the fragmented nature of modern families, they suggested using social media to keep contact with family members. Traditionally social workers focus on the mother-child dyad yet it is increasingly recognised that multi-agency families benefit from interventions which include the whole family (Diamond, 2014; Ryan & Schuerman, 2004). Ferguson (2001) calls out the need for father-focused work. Child protection social workers need knowledge of systemic practice theory to enable them to

work with the whole family. In addition, workers need support from their organisation in the form of reduced administrative and case burden. The 'Hackney Model' is an example where both structural changes within the organisation and systemic thinking were involved, in integrating systemic thinking in the social care system. (Goodman & Trowler, 2012).

Using systemic thinking, and forming a good client relationship, can encourage reflection by the social worker on their position in their relationship with the family and to help to reduce the fragmentation of services and families (Colapinta, 1995). In the systemic approach causation is viewed as a circular process involving the family system (Dallos & Draper, 2010). Problems are understood as interpersonal and embedded within relationships and not as a result of individual deficit. This approach can have a 'liberating' effect on children and their families, as it is less blaming. O'Gorman (2013) offered a second order framework to use in child protection, to assist workers in making difficult decisions in regard to a child placement. It uses both attachment theory and family system theory. To achieve relationship safety, the child's needs should be assessed in the context of their larger system. Practitioners are encouraged to assess the system (family, wider system) that they are operating in, including themselves, whilst also assessing the direction they should all move to.

6.2. Literature related to the development of the Referrer Engagement Method

In this section I review literature which informed the development of the Referrer Engagement Method. A number of ideas influenced the method: the concept of referrer engagement in the family therapy literature, multi-agency families and their work with the system, the concept of engagement in both social work and family therapy, and collaboration. I also explore the literature

on the concepts of power, in both the context of social work and family therapy, and dialogue.

6.2.1. 'Multi-Agency' families and the helping system

The families referred to the Parenting Project are multi-agency families. In this section I explore the relationship between these families and the professionals with whom they interact, including both social workers and therapists.

Imber-Black (1991) described challenges when the informal family system meets the formal system of the helping agency. Problems can arise even if neither system is 'dysfunctional'. The capacity of the child protection system has to be considered when looking at the progress of the family (O'Gorman, 2013). Therapists find working with mandated clients challenging, particularly around limitation of confidentiality (Honea-Boles and Griffin, 2001). Bennett, Plint, and Clifford (2005) looked at the impact of child protection tasks on the emotional wellbeing of social workers. Child protection social workers exhibit high levels of stress, burnout and anxiety. One way of trying to cope with that is depersonalisation where the social worker attempts to distance themselves from their client, as a way to cope with work demands (Rumgay & Munro, 2001). This, however, can impact the social worker's assessment of the needs of the multi-agency families. This increases risk to all parties.

Authority overshadows the relationship between social worker and mandated families (Horwitz & Marshall, 2015). Mandated families perceive the child protection system as leading on the change (Snyder & Anderson, 2009). Typically relationships are antagonistic, with the social worker in a position to judge the parents, and the family's ideas canvassed. In this situation, genuine engagement is not possible, the family is likely to resist treatment and have a low motivation for change. Sotero, Major, Escudero, and Relvas

(2016) recommended that practitioners “resist the temptation to be scandalized when involuntary clients do not want to take part in therapy and...construe the negative reactions of clients as an expectable initial reaction” (p. 53).

When working with multi-agency families, social workers have to deal with the dilemma of either being too remote from families or getting too close (Kettle, 2018). When too remote there is a risk of creating ineffective engagement in the process of change. Being too close runs the risk of becoming enmeshed with the family. Being too remote or too close risks leaving the children unprotected.

Social workers and families manage distance, using different strategies (Kettle, 2018). An extreme mechanism to ensure distance is when families display hostility and aggressiveness toward the social worker (Kettle, 2018). Social workers view such hostility and aggressiveness as part of their job, normalise it. Families also refuse to engage, being dishonest, or give different accounts to different professionals, which impact the multi system work.

Sometimes families want to get social worker closer (Kettle, 2018). The family seeks help and this usually results in cooperation. Social workers can also feel hostility and used in this situation, when they feel manipulated by the family to keep supporting them. He recommended the use of reflection as a strategy to manage distance.

A number of factors contribute to the complexity of child protection social work when working with multi-agency families (Stevens & Cox, 2008; Hood, 2014). Children with multiple problems, the challenges of collaborating with professionals from other disciplines and agencies, appointments, paperwork, and the actions arising from meetings. Child protection social workers are challenged by their multiple tasks, roles, concerns, and the need to make decisions in an uncertain context (Jansen, 2018). To cope with the complex systems they face, Jansen recommended abandoning traditional linear

thinking, and use the with straightforward cause-and-effect explanations. Jansen points out that complexity theory can help deal with the uncertainties and unpredictability in child protection practice. 'Complexity theory demands that attention be paid to the ever-changing nature of the system and asks for an intuitive approach as the practitioners comes to understand that they, too, are part of the complex adaptive system' (Stevens & Cox, 2008, p. 1323).

O'Gorman (2013) suggested that changes in the child protection system or the family, impact the other in a circular way and lead to further changes. The quality of the interaction between client and practitioner or the practitioner's ability to help the family increases the client's level of motivation (Rooney, 1992). Honest communication can allow the social worker and family to find ways to work together effectively (Horwitz & Marshall, 2015). This can change the mandated process into a voluntary and more productive one.

6.2.2. Referrer involvement in Systemic / Family Psychotherapy

Referrer involvement is a core part of the Referrer Engagement Method. This section looks at the origin of the idea within family therapy, how it was used, and the benefit for the system.

The subject of involving the referrer in systemic and family psychotherapy within the context of child protection has received very little attention. Most of the literature on referrer involvement and the professional network are from the early stage of family therapy (Milan approach). More literature has been written in systemic and family psychotherapy on the involvement of the larger system when working with 'multi-agency' families (Reder, 1986) and in particular within the context of social services (Holt, Grundon & Paxton, 1998; Imber-Black, 1991; Dimmock & Dungworth, 1983).

Systemic family psychotherapists need to look for the strengths of each system and determine whether the meaningful system is the family alone or the family and its helpers, the family-larger-system (Reder, 1986). This helps

to avoid replicating previous mistakes in forming relationships between the family and their helpers, i.e. enmeshed relationship with the family or the helping system joining the system and retaining the problem (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980).

Reder (1986) emphasises the importance, before starting work with the family, of clarifying the different roles, goals and expectations of the various agencies. Dimmock and Dungworth (1985) believe a network meeting is essential to get that clarity. This clarity can help the family therapist in engaging the family in the process of change (Teismann, 1980).

In addressing the challenges in working with multi-agency families and their system, the Milan model in systemic therapy has looked at the role of the referrer in the therapeutic process and suggested to involve him or her in the family engagement process. Selvini-Palazzoli et al. (1980) believed that the first question when working with a family should be “who referred the family?” During their clinical work (in a mental health context) they had observed that some families were difficult to engage. On analysing these cases they believe the therapist had undervalued the relationship between the referrer and the family and the referrer’s place within the family dynamic. The referrer can occupy a homeostatic position as a member of the family and can be viewed as a ‘supplementing figure’. The authors recommend assessing the role and position the referrer has in the family and then deciding the degree to which the referrer is involved. Selvini-Palazzoli and colleagues suggested inviting the referrer to the first session with the family with the aim of gathering information about the relationship the family members have with the referrer, the reasons the family was referred to family therapy, in some cases asses when the referrer play a role in the family system and became a homeostatic member of the family, and when the referrer became exasperated by the lack of change on the part of the family. Selvini-Palazzoli and colleagues believed

that addressing and handling the dynamic between the family and referrer is a precondition for starting work with the family.

Carpenter and Treacher (1983) assumed the referrer is “burdened” by the family and will respond positively to strategies that helped the family become less burdensome. They suggested convening an initial meeting with the referrer followed by a meeting with both the referrer and the family to renegotiate the referrer’s role. Carpenter and Treacher suggested continuing the referrer’s involvement throughout the work with the family so any issues arising from an enmeshed relationship can be resolved.

Involving referrers at the initial session (creating a 3-way meeting) also allows the family therapist, who is the new worker in the system, to position themselves as a resource to the family rather than as an extension of the existing system that might be associated with the family problem (Colapinto, 1995; Carpenter & Treacher, 1983). Teismann (1980) adds that the referrer can also help in exerting pressure on the family to attend, while allowing the therapist to remain supportive, which can help in the engagement stage.

Sveaass and Reichelt (2001a, 2001b) studied 50 refugee families referred for family therapy. This work highlighted the possible discrepancy between the referring problem as perceived by the referring professional and the problem experienced by the family. Involving the referrer at the initial session can help clarify misunderstanding, explore the different opinions and views on the family matter and to formulate an agreement between the family and referrer regarding goals for therapy. This approach encourages collaboration between families and the helping system, and families and therapist, including reaching an agreement regarding the division of roles and responsibilities among the professional and family.

In the context of Social Care the referrer is usually the key worker. Humphreys (1995) identified the key worker as crucial to ensuring that the therapist received accurate information about the family. This information helps the

family to be the subject of a personalised intervention and not an object of referral.

6.2.3. Engagement and therapeutic alliance

To quote Marzillier (2004, p. 394) “the personal exchange defines psychotherapies. All else flows from it”. Engagement is an important vehicle for change to take place in a therapeutic context. I will explore the literature on engagement in the context of helping professions in general. Then, as this study is concerned with two different professional groups (social worker, family therapist), I will look at engagement as understood by each of these groups, and how they achieve it. Engaging mandated clients poses challenges for practitioners so I explore the literature on developing and maintaining engagement with these clients.

> *"Engagement is a complex, reciprocal process concerning the relationship between the therapist and family. It refers to the specific adjustments the therapist makes to him/herself over time to accommodate to the particular family" (Jackson & Chable, 1985, p. 65).*

Engagement is a process of forming and holding a ‘good enough’ relationship between therapist and family so that the therapeutic work can take place (Flaskas, 1997). Different families need different styles of engagement and client’s experience of us, as professionals, (and vice versa) is always mediated by the interlinking of the wider context class, culture, age and gender.

The therapeutic alliance between client and therapist refers to the quality and strength of the collaborative relationship during the course of therapy (Bachelor, 2011; Horvath & Bedi, 2002). Therapeutic alliance includes both positive affective bonds (mutual trust, respect, caring, and liking) and cognitive aspects of the relationship (consensus and commitment to the therapy goals).

Therapeutic alliance is a key factor in successful therapeutic outcomes (Friedlander, Escudero, Heatherington, & Diamond, 2011). It is considered as 'common factors' (Sprenkle & Blow, 2004), which account for a desirable change in the therapy processes. Therapeutic alliance is two way and a joint effort by both the therapist and client (Sprenkle, Davis, & Lebow, 2009). Bordin (1979), in an effort to understanding the components of therapeutic alliance, developed a conceptual model outlining three elements: bonds; tasks and goals. Bonds are the quality of the relationship including trust and engagement. Tasks is the agreement on what to focus on in therapy. Goals are what therapist and client are working together towards.

In the following subsections I elaborate on various aspects of engagement. The first two subsections look at engagement in the context of social work, firstly at engagement in general, and then specifically at how engagement is formed. The remaining two subsections look at therapeutic alliance in the context of family therapy, and therapeutic alliance with mandated clients.

6.2.3.1. Social work and engagement

English social workers have always aspired to a collaborative approach with families (Whittington, 2007) as the single most effective child protection practice is to create a strong constructive working relationship (Turnell & Edwards, 1997; Munro, 2011; Kettle, 2018; Horwitz & Marshall, 2015; Yatchmenoff, 2005). A constructive relationship with parents means the care plan will integrate the family's needs and preferences (Alfandari, 2017) and helps ensuring the safety and wellbeing of children (Farmer & Owen, 1995; Saint-Jacques, Drapeau, Lessard, & Beaudoin, 2006). This has tangible outcomes, for example, partnership with parents decreased the length of time a child was in care.

Other practices are less effective, for example, no matter how good the assessment tools, they are not a replacement for relationship building (Ruch, Turney & Ward, 2010) and effective communication (Koprowska 2014). Even

if the focus is assessment the practitioners-client interaction, especially the worker's approach and language, is an essential part of child protection assessment (Toros, LaSala, & Medar, 2016).

Although the importance and value of family engagement in child protection social work is clear, such engagement is often lacking (Horwitz & Marshall, 2015). Partnership in the context of child protection is not easy. According to the Scottish Children Act (1995), working in partnership with parents is one of the most difficult and sensitive tasks for all agencies. Child protection work is inherently conflictual and is embedded in the power inequality between families and professional (Healy & Darlington, 2009).

Child protection professionals also have a tendency to engage almost exclusively with mothers and leave fathers marginalised (Bell, 2002).

6.2.3.2. Forming engagement in social work

Evidence of a well engaged family is when the family voluntarily reaches out to the child protection social worker for help (Horwitz & Marshall, 2015).

Social workers can enhance engagement of parents through their ways of working (Horwitz & Marshall, 2015). Examples are establishing a good relationship with parents (Buckley, Carr & Whelan, 2011), treating the family with respect and dignity, eliciting family views (Mckay & Nudelman, 1996), being attentive to issues that are important to the parents, only asking parents to do things that are understood and helpful for them (Gladstone, Dumbrill, Leslie, Koster, Young, & Ismailia, 2014), and enable them to influence the process and impact of the decisions made (Alfandari, 2017).

Yatchmenoff (2005) found that engaged child protection relationships are characterised by the family accepting the intervention and seeing it as right and useful for them, positive working relationship and lack of mistrust. Atman

(2008) added that developing shared goals, growing a sense of hopefulness, respect of cultural issues, honest communication and worker persistence in completing tasks, were all found to support a good family engagement in the child protection system.

Horwitz and Marshall (2015) gave two main barriers to successful family engagement in the context of child protection. The first barrier is the tension between authority and engagement in the work. The second is misalliance between casework (direct work with the family) and case management (paperwork) goals and method in social work practice.

Social workers face the challenge of balancing casework and case management (Horwitz & Marshall, 2015). Casework focuses on building relationships and providing support. In contrast, case management focuses on using assessment tools, monitoring compliance and making referrals.

Contemporary child protection practice is increasingly driven by risk management, which may not work alongside the relational approach (Murphy, Duggan, & Joseph, 2013). Child protection social workers tend to engage in risk led practice (Houston, 2014) and usually focus on deficits and failure at the expense of assessing resources and capacity (Toros, 2012, 2014). Case management reduces the time social workers can spend with families and works against the focus on engagement. The tension between these key elements of a social worker's job - relationship and risk - can be a barrier to successful family engagement.

Authority in the family-social worker relationship can be useful to the family in helping them to make changes and give the social worker access to monitor the change (Oliver & Charles, 2015). However, authority also undercuts the social worker's ability to work and engage the family from a strength-based lens which helps in engaging and empowering the family.

Parents trying to voice their family's needs and conditions can be classified as 'non-cooperative' by social workers, and can be the subject of judgement (Alfandari, 2017). The social worker's interpretation of the parents' position as resistant had a negative effect on the social worker - family working relationship. This is a reinforcement of the social worker position of power.

Engagement can lead to a positive feedback loop. A higher family engagement can motivate the social worker to be more effective in family engagement (Horwitz & Marshall, 2015).

One of the factors explaining the lack of engagement by parents with parenting programmes is how they will be perceived, with the worry of being labelled as bad parents (Butt, 2009) or through feeling shame and as a result feeling blame and stigma (Kemp, Marcenko, Hoagwood, & Vesneski, 2009). Holt (2010) found parents experienced shame through a 'spoiled identity' when they had to attend mandatory parenting programmes. This was also true when their engagement was voluntary, as their behaviour was still monitored for signs of risk and harm with a view to identifying potential further intervention (Pinkerton, 2000). This shame has a negative impact on parent's engagement.

"For many social workers, participatory practice may seem an unachievable goal, particularly in child protection" (Wilkins & Whittaker, 2018, p. 2003). Wilkins and Whittaker argue that truly participatory child protection social work needs more than tools for engagement, "but an innovation in the value base of children's services" (p. 2003).

Research about voluntary work with services showed that clear roles and developing a collaborative relationship with parents contributed to the success of social worker interventions (Horwitz & Marshall, 2015; Mckay & Nudelman, 1996). But involuntary clients frequently comply with tasks while not truly engaging or collaborating with the work. Engaging clients in child protection is challenging (Barber, 1991). Howe, Brandon, Hinings, and Schofield (1999)

suggested this was due to the way the system/service is structured and delivered, or the client blocking the relationship due to psychological and developmental problems.

6.2.3.3. Family therapy and therapeutic alliance

The literature presents a wide spectrum of research that explores the connection between therapeutic alliance and outcomes in therapy (Flückiger et al., 2012). Family therapy has not always focussed on engagement and/or therapeutic alliance. For the first 40 years of its history, family therapy literature, but not practice, neglected therapeutic relationship as a response against psychoanalysis (Roy-Chowdhury, 2006). Treacher (1992) argued that the major schools of family therapy prioritised technical expertise as they were predominantly scientific and anti-humanist. Therapists of this period cared about how the client felt about being in family therapy. Early strategic and structural family therapy put emphasis on application of techniques by an active, directive therapist. The Milan group proposed that the therapist should strive for a position of neutrality (Selvini-Palazoli, et al., 1980).

During the 80s and 90s neutrality was reframed as 'state of activity', where the therapist's curiosity helped to keep respectful engagement and allowed for new types of conversations (Cecchin, 1992). More attention towards the position of the therapist was paid.

Anderson and Goolishian (1988) pushed therapists to take a 'not knowing' position to therapy, to foster respectful curiosity and to allow for new possibilities to develop in conversations. Therapist reflexivity began to be encouraged, to be aware of our own prejudices and biases, which we bring into therapeutic conversations. This brought the challenge to the therapist of developing awareness of their views and allowing space in therapy conversations for the effects on clients (Cecchin, 1994).

In recent years, more interest in the therapeutic relationship has developed and psychoanalytic ideas have been reconsidered. The Flaskas papers (1996, 1997) highlighted the poverty of systemic thinking on the therapeutic relationship and brought in the ideas of transference, countertransference and projective identification. Flaskas states “engagement in the systemic context can thus be thought of as the process of forming and holding a good-enough therapeutic relationship so that the work of a particular therapy can occur. The engagement is ‘good enough’ in the sense of the therapist and family finding some ‘fit’ between them, and in the sense of ‘fit’ developing between the demands of the therapeutic work and the attachment and intimacy of the therapeutic relationship. Engagement provides ‘environment’ or ‘frame’ of the therapeutic work!” (1997, p. 270).

Frosh (1997, 1999) and Pocock (1997, 1999) wrote about systemic theory and psychoanalysis and have contributed to the construction of a theoretical framework for locating therapeutic relationship in systemic practice. Hardham (1996) argued that therapists are always ‘embodied’ in their work with families and simultaneously are ‘embedded’ in the context of the therapeutic relationship.

In the process of therapy, the therapeutic relationship is central to the experience of both therapist and clients (Flaskas, 1997). The therapist has to form a good relationship with the individual and family as a whole (Sprenkle & Blow, 2004). Escudero (2016) focussed on the ‘expanded therapeutic alliance’ in family therapy practice, where the therapist has cope with the challenging situation of multiple, simultaneous relationships.

Friedlander et al. (2011) believed therapeutic alliance should also consider the connection and relationship between family members. With more family members in the therapeutic environment comes a greater concern about safety between family members. This can result in a possibility of family

members dropping out of therapy due to risk (Beck, Friedlander, & Escudero, 2006).

6.2.3.4. Therapeutic alliance with mandated clients

Very little research in family therapy has touched on the issue of the development and maintenance of therapeutic alliance with mandated clients (Snyder & Anderson, 2009). The literature on involuntary intervention highlights difficulties in creating and maintaining a good therapeutic alliance with mandated clients (Friedlander, et. al, 2006; Snyder & Anderson, 2009).

Sotero, Major, Escudero, and Relvas (2014) aimed to compare involuntary and voluntary clients in creating the therapeutic alliance in the context of family therapy. Their study found a big difference in the therapeutic alliance of voluntary and involuntary clients after the first session. Involuntary clients were less engaged, less emotionally connected to the therapist and felt less safe in the therapy context. They established a significantly weaker alliance than voluntary clients. Therefore concluding that mandated families can have conflicting motives and feel ambivalent about taking part in therapy.

Sotero and colleagues showed that involuntary self-perception status is not static and can change over a course of therapy. The differences between these two groups faded through the process of therapy (session 4). 'We can assume that engagement may evolve positively along the therapy" (p. 18).

Involuntary clients, and particularly mandated clients, often come from poor multi stressed families (Madsen, 2007). Cultural, social factors and family patterns of these clients (Imber-Black, 1988) may sometimes be misunderstood by therapists who do not share their context. This might itself contribute to aspects of feeling forced to attend therapy, especially when it is mandated by services that are seen to be negative and represent the state

(Honea-Boles & Griffin, 2001). It is likely that these clients will perceive the therapist as an extension of that agency (Friedlander, et. al, 2006).

Therapeutic interventions with involuntary clients can be a challenge for both therapist and clients due to motivational issues, ethical dilemmas and alliance issues (Sotero, et al., 2014). Psychotherapeutic work with mandated clients is commonly described as complex or, more emotionally, as frustrating (Tohn & Oshlag, 1996). Some therapists can sometimes feel reluctant to work with mandated clients. Rooney (1992) described those who do as the 'involuntary practitioners' (p. 6).

6.2.4. Collaboration

The Referrer Engagement Method is a collaborative approach between three parties. Collaboration is particularly relevant in the context of this study as the families affected have large systems around them. In this section I explore the benefits and challenges of collaboration, and how to develop and maintain a collaborative relationship.

The term 'collaborate' is from the Latin *'com'*, meaning 'together', and *'laborare'* meaning 'to work' (Boodhoo, 2010). In the literature collaboration is sometimes referred to as partnership (Armistead & Pettigrew, 2004), and alliance (Kale, Dryer, & Singh, 2001). Collaboration has also been defined in terms of process or a set of processes. Following this definition Gray (1989) saw collaboration as a process through which parties who hold different aspects of a problem, explore the problem from their different lenses, and construct a solution which expands beyond their individual vision. Huxham and Vangen (2005) saw collaboration as people working together across organisational boundaries towards a desirable outcome. Homby and Atkin (2000, p. 12) echoed this definition: "a relationship between two or more people, groups organisations working together to define and achieve a

common purpose". This definition is a goal-oriented relationship that may be formed between different participants.

UK policy has addressed partnership and collaborative working between health and social care (Dep. for Education and Skills, 2003). This partnership / collaboration is seen as a requirement (Dowling, Powell, & Glendinning, 2004) for providing optimal care (Boodhoo, 2010).

The literature describes a different arrangement for collaborative working in social care and health: partnership working, joint-working, inter-agency working, multi-agency working, multi-professional working, and collaborative working (Percy-Smith, 2005). For my research I use the general term 'collaborative working'.

Sloper (2004) differentiates between 'interdisciplinary' working and 'trans-disciplinary' working. Interdisciplinary working is where individual agencies from different services separately conduct assessments of the needs of a child and their family and then come together to share and discuss their views and agree a work plan. In contrast trans-disciplinary describes a multi-agency service, where all professionals work jointly at the operational level. Everything is share in this mode of collaboration, including aims, information, tasks and responsibilities.

San Martin-Rodriguez, Beaulieu, D'amour, and Ferrada-Videla (2005) suggested that professionals coming together from different organisations can better respond to the complex issues involving safeguarding dilemmas than those from a single organisation. This is because the professionals bring their competencies, experience and judgement of both themselves and their organisations.

Reder, Duncan and Gray (1993) investigated conflict and tension in inter-agency work. Inter-agency cooperation was hindered by failure to facilitate mutual responses between the different roles, and deficits in the

transmission of information between members of the professional network. Reder, Duncan and Gray recommended that professionals in the support system discuss their different goals and how to achieve them.

6.2.4.1. Collaboration in the context of child protection

Integrated working is a key concept in the Children Act (2004). Fish, Munro and Bairstow (2009) presented a systems model for organisation and working jointly (multi-agency system) in the context of safeguarding children . The model originated with accident investigation methods in the field of aviation and engineering but was applied to human sciences by Senge (1990). Senge described systems thinking as an interrelationship framework and a way to see the whole. The aim is not limited to understanding the cause but to look broadly and study the whole system and learn about its holistic functions (Vincent, 2004). Fish and colleagues adapted the systems approach to safeguarding work, including both the individuals and the context in which they work. Whole systems working was seen as a radical way of thinking about change in complex situations such as safeguarding (Pratt, Gordon, & Plamping, 2000). The approach shifted the focus from parts or individual organisations to the whole, focussing on how these connect and relate to each other.

An effective protection of children is more likely to take place through a good collaboration between the professionals around them and between the family and the professional (Kettle, 2018). In the last few years there has been an increase in the evaluation of collaborative practice, which supports the assumption that collaborative working does bring about positive change, increased effectiveness of practice, and leads to better outcomes. Research on professional perceptions of the benefit of collaboration report improved assessment of needs, support to the client, understanding of the issues

discussed, and understanding of the others professional role (O'Brien, Bachmann, Jones, Reading, Thoburn, Husbands, Shreeve, & Watson, 2009).

In practice, achieving collaborative working can be a complicated and challenging process at all levels - policy, organization and individual (Boodhoo, 2010).

The collaborating parties (professional with professional and professionals and families) also face challenges, tensions, conflicts and dilemmas (Hudson, 2000; Ehrle, Scarella, & Green, 2004), down to differences in values and frameworks. Achieving integration can challenge the individual's role and organisational identity, and disagreements can lead to division rather than unity. Social workers should consider the challenges and the differences in the process of looking for commonalities. Taking part in the Referrer Engagement Method provides the referrers with a space to both experience and reflect on their part in the collaboration with both the families and the family therapist.

6.2.4.2. Interprofessional collaboration

> *"The emotional impact of safeguarding work affects the ability of professions to achieve a collaborative way of working" (Boodhoo, 2010, p. iv).*

Social workers in child protection deal with high levels of responsibility and anxiety about children (Reder & Duncan, 2003; Morrison, 1997). Hughes (2009) says that the anxiety affects both the organisation and the individual. Social workers in child protection depend highly on their relationship with other professionals (Kettle, 2018) because they share information and responsibility. Social workers in the context of child protection perceive that they carry the anxiety of other professionals around risk. Minimal sharing of information, due to issues of confidentiality, also increases anxiety for the social worker. Similarly professionals communicating in a vague manner

(without detail) increases anxiety and does not help the organisation or the families.

Increasingly the government is recognising the systemic, interconnected nature of child welfare issues, which leads to cross commissioning of adults and children's services (Milbourne, Macrae, & Maguire, 2003). This shows a recognition at a government level of the value of adopting a whole systems approach. In the Green Papers, Every Child Matters (Dep. for Education and Skills, 2003) acknowledged that children's needs are complex and need to be addressed in a multi-professional manner.

Turner applied social identity theory to social issues and organisational studies to enhance professional understanding of the relational difficulties encountered between health and social workers when working together in the context of child protection (Turner, 1991; Tafjel & Turner, 1986). According to Hogg and Abrams (1999) the individuals entering a partnership tend to focus on how they identify and compare themselves with others in the partnership. This leads to forming stereotypical descriptions of others and favouritism of what is familiar and coming from their professional identity. This can bring conflicts to the work. Having to complete joint tasks like home visits can help in reducing the conflict.

NHS workers also feel anxious when working jointly with 'children's social care' in the context of child protection (Davies & Ward, 2012). The NHS workers worry about the effect on their relationship with the family when the family is also being seen by social services. Service priorities and practice differ between the services, so NHS workers are concerned about sharing information with the social workers and including the social workers in decision making. This anxiety is also transferred and felt by families when considering whether to seek help or not (Hawkes, 2012).

6.2.4.3. Social worker and family collaboration

Social work in England always aspired to a collaborative approach between families and social workers (Whittington, 2007), however, this is found to be challenging. Research about the position of social workers found a fundamental tension between their powerful role as gatekeepers of resources and advocating and supporting families (Murphy, Duggan, & Joseph, 2013; Duffy, 2010). McLeod described social workers trying to support a family at the same time doing a risk assessment as a conflict of interest (McLeod, 2007). Symonds, Williams, Miles, Steel, and Porter (2018) confirmed in their research there is tension in the social worker's role between professional judgement and the role of nurturing autonomy and control in the client.

When the multi agency partnership includes the service users within the whole system around the family, the collaboration will be stronger and more likely to create change (Billis & Harris, 1996). The system needs to be inclusive of all stakeholders and share a commitment to rise to the challenge of managing the different perceptions, ideas and experiences of the participants. The parents and children's views and knowledge about their personal relationship, and what they perceive as important for them, needs to be voiced in the partnership (Willumsen & Skivenes, 2005). Workers must be mindful of the balance of power among the different participants.

The social worker's role is often portrayed as an interface between client and system, a position where their allegiances face both ways, towards clients and representing the system (Symonds, et al., 2018). This can make them feel powerless within a bureaucracy that shaped their practice.

Roose and colleagues used the terms 'user led' and 'service driven' social work (Roose, Mottart, Dejonckheer, Van Nijnatten, De Bie, 2009). Where social work is 'user led' participation of families is at the centre of the work.

Fargion (2012) identified two approaches for assessment in child protection. The child welfare model, where the social worker protects children through collaboration with the Family. The child protection model where the worker concentrates on protecting children hence has a focus on deficits.

6.2.4.4. Solution focused approach

Child welfare systems are increasingly using a solution focused approach (Hughes, 2014) and child protection interventions that focus on collaboration between clients and workers usually include some solution focused aspects (Lohrbach, Sawyer, Saugen, Astolfi, Schmitt, Worden, & Xaaji, 2005). The solution focused approach focuses on strengths and people's resilience and can help in the process of change (Cowger, 1994; De Shazer & Berg, 1997). Rather than emphasizing the problem, the deficit, a solution focused approach shifts the discourse to positive coping and solutions (Berg & De Jong, 1996). This approach works by building supportive relationships, and having clients feel listened to, respected and their strengths acknowledged (Beyebach, 2014). The solution focused approach helps practitioners to learn from clients and give greater priority to their perspectives, which is useful for both improving communication and enhancing collaboration (Bliss & Bray, 2009; Smith, 2011).

Language is very important in solution focused work as solutions are jointly constructed (De Jong & Berg, 2001; Miller, 1997; Strong, 2009). The language of solution focused therapy is positive in nature, non-judgemental and strength focussed (Jordan, 2014; Lan & Yuen, 2008). Questions should encourage motivation and increase the client's ability to achieve their own goals for change. The approach helps both the practitioner and client gain a better understanding of the situation and collaboratively create a plan.

Several evidence-based practice models in child protection include solution focused ideas. For example Signs of Safety (Turnell & Edwards, 1997, 1999) helps workers achieve a balanced assessment, considering both risk and safety.

Some authorities caution that too great a focus on solution and strength based approaches can result in insufficient focus on risk to the child (Brandon , Bailey, Belderson, Gardner, Sidehotham, Dodsworth, Warren, & Black, 2009; Walsh, 1997). De Shazer and Berg (1997) called professionals not to divide solution focused work from assessment of risk to the child, but combine them to achieve effective outcomes. This ensures the safety of the child is protected, yet also focuses on the family's strengths, which helps in building a positive working relationship between social worker and parents, and increases the motivation to change (Toros, LaSala, & Medar, 2016).

Solution focus contributed a strength based perspective to the Referrer Engagement Method.

6.2.5. Concept of Power

Foucault said "power is everywhere" and influences the way we relate with others (Foucault & Hurley, 1984, p. 93). In this section I look at both systemic perspectives on power and the concept of power in social work practices, the two professional groups which interact in the Referrer Engagement Method. I start by presenting a brief history of the conceptualisation of power as this influenced later thinking.

> *Power is "the probability that one actor within a social relationship will be in a position to carry out his own will despite resistance, regardless of the basis on which this probability rests" (Weber, 1978, p.53).*

I chose to start with the definition of power offered by Max Weber, a German political economist and social scientist. Weber's definition emphasises the social interaction context where power dynamic takes place.

Michael Foucault, 1926-1984, is highly influential in systemic psychotherapy work when considering issues of power. Foucault believed power was "a total structure of actions brought to bear upon possible actions: it incites, it induces, it seduces" (Foucault, 1980, p. 220). Foucault also stated:

> *"Power is everywhere: not because it embraces everything, but because it comes from everywhere … power is not an institution, nor a structure, not a possession. It is the name we give to a complex strategic situation in a particular society" (Foucault & Hurley, 1984, p. 93)*

Foucault looked at the connection between power and knowledge, and how they link together through language using the term 'discourse' (Foucault, 1991). In his view, language, which is the expression of knowledge, defined and described people. Foucault observed that people distinguish between 'normal' and 'abnormal' presentation, and society creates institutions such as prisons and mental health hospitals to deal with the 'abnormal' presentations. This categorisation is part of the power of control. Foucault saw the individual's agency to resist as part of the power relationship and structure. Resistance to imposed control by institutions (such as Social Care / social workers) would not be seen as a resistance against misuse of power. Instead, any such resistance would be considered as 'abnormal', as the institution with the power defines what is 'normal'.

Foucault influenced a number of family therapy models including the Narrative Model. Michael White and David Epston (1990) were influenced by Foucault's ideas about defining power of language and the power of institutions. Foucault's idea of discourse is at the core of Narrative Therapy. One of the key concepts in Narrative Therapy is 'externalising the problem', where the problem is seen as internalisation of an oppressive discourse. In White and Epston's therapeutic work they deconstructed meanings through language, which is culturally driven. The Referrer Engagement Method is influenced by some Narrative Therapy ideas. Hacking (2002) took the idea of constructing power through language (Foucault, 1991) and the idea of 'open systems' from cybernetics to form the concept of the looping effect of human kinds. In this concept classifications affect the people classified, and they mutually construct each other.

In the following subsections I look at power in social work practice and the systemic perspective on power.

6.2.5.1. Concept of power in social work practice

The issue of power is always present in child protection work, particularly at the initial stage when contact is established with the families (Kettle, 2018). Power is partly inherent in the social worker's role. The social worker's task in child protection is to help the family to improve their ability to cope with parenting challenges and feel empowered, despite the power that has been taken from them in the process (Horwitz & Marshall, 2015). Power is dynamic and changes with the level of the social workers' experience. The level of the social worker's reflection in their work affects the way they use their power.

Social workers have been exploring different ways of how to use their statutory powers to benefit their clients. Dumbrill looked at the overlap between child welfare and anti-oppressive practice in Britain and Canada

(Dumbrill, 2006, 2010, 2011). He looked at parents' perspectives on social worker interventions and the practitioner-parent relationship and found that parents find it difficult to know how to respond to social workers interventions and were worried about making mistakes. A father explained, "They've got power, scary power" (Dumbrill, 2010, p.197). The social workers, in the study, perceived their power as pervasive and were not sure if they are able to benefit parents with their advice, "they hoped for ideas about how parents could develop alliance with workers were interrupted by preoccupation with the considerable power imbalance in the child protection casework relationship" (Dumbrill, 2010, p.197).

The fear of losing their children into care forces parents in child protection to comply with plans (Corby, et al., 1996; Reich, 2005). The 'anti-oppressive practice' movement was trying to understand how social differences such as race and class, create imbalances in power and promote clients' empowerment with the recognition of statutory powers (Danso, 2015; Tew, 2006). The anti-oppressive movement focused on issues of social worker power but only considered the social identity of the social worker (the power which is located in their professional domination) and not other aspects of their personhood that could play a part in the power dynamic.

Critical social work, which is preoccupied with social justice, questioned and addressed power differences in social work practices and encouraged reflective practices (Fook & Askeland, 2007).

Use of self has a long history in the field of social work, in both training and supervision. It used to be a core concept in establishing social work as a relationship centered field (Ramsay, 2003), which was mostly rooted in psychoanalytic theory introducing countertransference. The use of self concept focuses on interactional response by the therapist's unconscious to a trigger from a client. (Hanna, 1993). The issues of power were neglected in psychoanalytic work including by Dewane (2006) who categorised the

dimensions of use of self: personality, belief system, relational dynamics, anxiety, and self disclosure. Dewane's categorisation makes no mention of the worker's identity and power. However, Mandell (2008) looked at the importance of 'use of self' by child protection social workers in addressing power issues. Mandell argued that in the relationship between the social worker and the family, an imbalance between the use of power by the worker and client vulnerability, is looked at and is understood, especially in its impact on the delivery of care alongside authority.

Both Rossiter (2001) and Margolin (1997) saw issues with the concept of 'use of self'(establishing rapport and trust, warmth, relationship building, etc) in the helping professions. Rossiter found a direct link from using the identity of helpers and helped in positioning helpers in a relationship of power. Margolin looked at social work, and specifically child protection, and considered use of self as an 'insidious tool'. The concern is the use of self allows professionals to gain trust of their client and then use their mandated power, to abuse this trust. This raises the question of whether social workers, when operating under 'social control', role are reproducing social injustice.

Social work has been influenced by feminist and postmodern thinking (Mandell, 2008). Social workers are increasingly including their client's voice. Their awareness of diversity - values, beliefs, assumptions, power - and directly addressing issues of oppression and privilege (Laszloffy & Hardy, 2000), is more visible in their practice . Professionals are moving away from a stance of expertise, and associated pre-judgment, to a stance of curiousity or 'informed not knowing' (Anderson & Goolishian, 1992). They are also attempting to work more collaboratively with clients (Dyche & Zayas, 1995).

Kettle (2018) encouraged social workers to consider the complexity of power in their role in the context of child protection. Kettle drew on Tew's (2003) typology of power (not from a child protection context), looking at social workers exercising power over families and exercising power in collaboration

with families. Kettle referred to it as *power over* and *power together*. 'Power over' is protective power, safeguarding. 'Power together' is cooperative power, collaboration. Kettle was interested in how social workers can achieve a balance between power over and power together. Social workers experience a growing sense of authority alongside the realisation of how limited the power associated with their role really is. Social workers reported that they felt their power is coming through the court and not from their role. However, the families perceived the social worker as having a lot more power than them. The concept of power over and power together is relevant to the 3-way meetings of my study, where both types of power were practiced, following up from the context of the work, by both the social worker and the family therapist.

6.2.5.2. Systemic perspective on power

Power is a key concept in systemic psychotherapy and developed in parallel to the development of the field (Dallos & Draper, 2010). The concept of power was influenced by the journey of moving away from positivist thinking, through constructivism, to social constructionism, and is still evolving. The early cybernetic paradigm did not explicitly mention power, but descriptions of the relational interaction saw power as influencing subjugation and discrimination (Guddemi, 2010). Bateson (1972) saw power as part of an ecosystem, a system based on living biology with patterns of communication and feedback. Haley (1963) spoke about the power struggle with which the families were involved.

Feminist critiques of gendered power (Falicov, 2003; Goldner, 1985; McGoldrick, 1994) started a process in the development of the concept of power within family therapy. Practitioners, when being mindful of power, should consider not only issues of cultural, societal and interpersonal subjugation but also look at the therapeutic relationship. The social graces

(Burnham, 1992; Roper-Hall, 1998) focussed attention on : gender (Burck & Daniel, 1995), culture (Krause, 1998), and race (Singh & Dutta, 2010; Hardly & Laszloffy, 1995; McGoldrick, 1994; Pendry, 2011). In comparison to the early years of systemic theory, this led to a significant increase in interest in therapeutic relationship in family therapy. Despite an increased understanding and awareness of discrimination and power, some therapy models did not incorporate this into their practices. In the early systemic models, such Structural, Strategic and early Milan, therapists were clearly using their power in influencing the family. The later models, social constructionist oriented, late and post Milan, Narrative, and Solution Focused, acknowledged power through reflexive process.

Therapists who adopted a more collaborative and dialogical approach and followed the 'not knowing' position (Anderson & Goolishian, 1988), emphasised the overt power dynamics in relationships. This required a conscious attempt to address the issues of power through dialogic conversations. These therapists aimed to move away from a position of hierarchy to collaboration. Andersen (1987) introduced the reflecting team approach. Anderson and Goolishian (1988, 1990) introduced the collaborative language oriented therapy to systemic therapies. Seikkula (2008) further developed the dialogic approach. These approaches "invite participants to both influence and be influenced to shape and be shaped by the interaction, and to be mutually involved in meaning construction" (Guilfoyle, 2003). Shotter (1993, 2008) uses the term 'joint action' to bring the reciprocity into dialogic conversations. New meanings emerge 'between' speakers and not by the intentions of individual speakers. They are seen as interactively or dialogically created.

A few studies, using discourse analysis, addressed the issue of power in systemic psychotherapy. Roy-Chowdhury (2006) and Guilfoyle (2003) criticised the 'not knowing' collaborative position of Anderson and Goolishian (1988). They argued that by using a less clear structured therapeutic

relationship to achieve collaboration, therapists do not remove power, but merely conceal it. Guilfoyle believed that power is a significant aspect of the therapeutic relationship. He described how we might disregard new ideas from our clients which are not congruent with the one we chose to use in our work with them, to the detriment of the relationship, or the power we have in interpreting the client responding with a “no” to our intervention as resistance. Guilfoyle concluded that “the concept of dialogue may require expansion to include, rather than exclude, considerations of power” (p. 340).

Mason (1993), in his paper, “Towards Positions of Safe Uncertainty” also critiqued the ‘not knowing’ position (Anderson & Goolishian, 1988). Mason argued that ‘not knowing’ downplayed the expertise of the therapist:

> *"one of the reasons that clients come to see people for help is because they feel the therapist has some expertise that can be useful for them. Rather than be disingenuous I suggest we can aim to hold a belief of authoritative doubt one that encompasses both expertise and uncertainty" (p. 191).*

Mason’s suggested position is commonly used when working with mandated clients in social care.

The studies described above can be seen as indicative of a turning point in systemic psychotherapy, moving to a position where power is acknowledged and visible, and where therapists consciously bring their prejudices and biases to the therapeutic work. Watson (2017) argued that this position in relation to power has become generally accepted. Power is now a significant aspect of therapeutic engagements (Guilfoyle, 2003).

Krause (2012) sees reflexivity as the ‘process of ethics’. She argues that the process the therapist is engaged with, in order to position themselves in their role and power, is very important and significant to their practice. Davies, Harré and Langenhøve (Harré & Langenhøve, 1991) developed positioning

theory, which explained the way people understand and talk about things that are important to them, are influenced by their position. Role, stance, interest and hierarchy are all influencing people's position, both consciously and unconsciously in every setting.

Watson (2018b) described how the family therapists who work in the context of child protection also face the challenges of balancing both their ethical positions in prioritizing safeguarding children, while ensuring the wellbeing of the parents. This complex balancing act includes both balancing their different positions, power imbalance, moving between these positions, and following different ethical postures in different moments of therapy. This requires a constant use of reflexivity to decide which position to take in their work with the family and the system.

The therapists position and power shapes the construction of dialogue with their clients. The next section explores the concept of dialogue.

6.2.6. Dialogue

Dialogue is at the core of family therapy and hence central to the Referrer Engagement Method. In this section I explore how dialogue enables the exchange of ideas and the creation of new meaning.

Quoting Bakhtin (1984):

> *"Life by its very nature is dialogic. To live means to participate in dialogue: to ask questions, to heed, to respond, to agree, and so forth. In this dialogue a person participates wholly and throughout his whole life: with his eyes, lips, hands, soul, spirit, with his whole body and deeds. He invests his entire self in discourses, and this discourse enters into the dialogic fabric of human life, into the world symposium" (p. 293).*

Under the umbrella of social constructionism, new therapies have emerged that focus on the role of language in creating and resolving personal difficulties (Anderson & Goolishian, 1988). 'Dialogical Therapy' focuses on dialogue within therapy and distinction between dialogue and monologue (Guilfoyle, 2003). Monologue is exclusive, and the speaker refuses to shift in response to others. The aim of a monologue in a professional setting is to change the client without impacting the therapist. In contrast dialogue is inclusive. All participants are invited to influence and be influenced.

A dialogue involves the mutual construction of meaning (Anderson, 1997; Seikkula, 2002). Ideas are co-created as people talk about them, changing, and being shaped by the process of telling and listening (Anderson, 2008; Bagge, 2012). A person's ideas change in the process of being listened to and hearing other people's reflections.

> *"Feeling understood is more than just useful knowledge; more too than a better story. It is an experience of being more known to and appreciated by others and, through them, to a greater appreciation of oneself. It is a celebration of both our common humanity and of our differences." (Pocock, 1997, p. 298).*

Dialogue is the vehicle to achieve this greater knowledge and appreciation.

Rober (2005) believes dialogue is more complex than the simple split between dialogue and monologue. In his paper Rober introduced Bakhtin

(1981, 1984) and Shotter's (Shotter, 1993, 1994, 2000) ideas and work about the concept of dialogue. He emphasised that "therapy is a meeting of living persons,searching to find ways to share life together for a while" (p.385). He also points that monologue is part of any dialogue and that in every conversation there is a tension between the modes (Shotter, 1993).

Krause (2012) explains that dialogue is a process "which creates new meanings, but there is much knowledge before and behind these new meanings" (Krause, 2012, p. 13). Krause claims that we focus on language in the therapy field, which can lead us to minimize some of the local and specific differences between the therapist and the family. This can lead to us obscuring and missing the signs for potential misunderstanding and conflict between the therapist and the client.

Professionals must think differently about how they work when they are trying to build worker-family partnerships (Turnell & Edwards, 1999). The professionals must leave the expert role aside and engage clients with genuine respect.

Therapists engaging in dialogue take a position of not knowing, joint action and unfinalizability of meaning (Guilfoyle, 2003). Not knowing enables the collaborative emergence of new ideas (Anderson & Goolishian, 1988) in which the client narrative leads the way (Seikkula, 2002). Unfinalizability of meaning is an effort to focus on the mutual search for meaning in which the therapist is tentative about offering their own knowledge (Anderson, 1987). The 'not knowing' position requires the therapist to adopt respectful listening which involves listening in an active and responsive way (Anderson, 2008). Careful listening was an established practice within psychoanalysis, however was adopted by family therapists in the 1980s. A listening therapist gives the floor to the family, gives them space to think, go at their own pace (Box, Copley, Magagna, & Moustaki, 1994) and creates an opportunity for the family

members to hear each other. Joint action is used to emphasise the mutuality of therapeutic conversation (Shotter, 1993).

Fredman (2004, p. 68) sees “the body as communicator of feelings not as container of feelings”. Verbal and non-verbal communication come together. Cronen and Pearce (1985) coined the term ‘speech acts’ to describe the combination of speaking and acting elements of communication. According to Griffith and Elliot Griffith (1994) we experience and show our own ‘emotional postures’ and are affected by the postures of others. These postures influence the quality of conversations we can have. Every expressions of our own, including emotional postures, demands a response. We cannot ‘not-express’ and cannot ‘not respond’ (Watzlawick, Bavelas, & Jackson, 1967). In addition to being heard or received, words also move the talker.

We have some control of the emotional posture we adopt. Fredman (2007) recommends “aiming to enter a meeting and join the relationship in a posture which invites the client into a relationship marked by curiosity, mutual listening and respect where touching each other with words and actions is mutually enjoyable and attention is focussed on connecting with each other and on reflecting” (p. 50). Tom Andersen (1995) suggests that we touch each other and ourselves by the way we express and use words, in the presence of others. We influence both our own position and others.

Strong and Sutherland (Sutherland, 2007) saw language in dialogue as intersecting forces, influencing each other continuously, and relying on each other for their continued existence. The exercise of power by one party, for example, requires collaboration of the other party in the form of conformity or resistance. To develop their thoughts on power further Strong and Sutherland used Conversation Analysis to examine collaboration with clients within family therapy practice. In particular they looked at Karl Tomm’s collaborative practice (Tomm, 1987a, 1987b, 1988), Michael White’s narrative practice (White, 2012) and de Shazer’s solution focused practice (de Shazer et al.,

2007). Strong and Sutherland argued for 'power-with' and 'power-over' as two dialogical 'forces' (Starhawk, 1987). 'Power-with' was seen as desirable and necessary to create change. They also saw therapy as a negotiation between therapists and clients, with active contribution by the client (Rober, 2005).

A study reported by Hill, Corbett, Kanitz, Rios, Loghtsey, and Gomez (1992) showed that clients initially resisted the very therapist behaviours they found most helpful. This means the presence of client resistance or initial reluctance to consider or accept the proposals of the therapists does not necessarily demonstrate poor therapist practice, nor necessarily lead to negative outcomes. Building on these findings Sutherland and colleagues developed the concept of Responsive Persistence (Sutherland, Turner, & Dienhart, 2013, Sutherland, Dienhart, & Turner, 2013). They defined persistence as "therapists staying the course they have chosen, despite facing conversational 'obstacles' that could thwart their intention" (Sutherland, Turner, & Dienhart. 2013, p. 471). Therapists applying Responsive Persistence persist in their desired direction, for example, to use their knowledge to benefit the client.At the same time the therapists remain responsive to client feedback and adjust their own responses accordingly. The responsive nature of this approach avoids the risk of abusing their own power which persistence alone would bring. Therapists' demonstrate patterns of behaviours including "providing detailed descriptions, self-disclosing to provide information, adapting lessons to clients' interests, and changing the format or structure of task or activity" (Sutherland, Turner, & Dienhart, 2013, p. 2). It is a sustained effort that distinguishes persistence:

> *"Therapists merely proposing an alternative understanding or course of action in a tentative, one-off conversational turn may be insufficient for the clients to experience change. What may be required is a therapist sustained focus, or persistence, when introducing new ideas or exploring new possibilities with the client. The course of action that therapists pursue may involve one of the following: maintaining the focus on a particular issue or topic; advancing a particular agenda or perspective in interaction (whether their own or of specific family members); holding a particular therapeutic posture for a period of the conversation; or guiding the conversation toward a particular therapeutic goal" (Sutherland, Turner, & Dienhart, 2013, p. 3).*

Recently Flaskas (2016) has focussed on 'open dialogue' which emphasises the therapist's humaneness and openness. Amongst other things, this leads to careful listening, invitations to reflection, witnessing, and use of inner and outer dialogues, and an interest in how power manifests itself and can be dealt with (Seikkula, 2008; Rober, 2005; Wilson, 2015; Shotter, 2015; Watson, 2017). Flaskas has the concept of 'space between' people in the work. Flaskas describes what she calls "responsive relating in the present that creates the relational conditions for dialogue to emerge in the space between...[enabling] difficult conversations ... to come to the fore, and uncertainty may be more easily tolerated and lived with" (Flaskas, 2016, p. 163). Flaskas sees it as an 'ethical obligation' of the therapist to pay attention to the "richness of the push and pull of our involvement (Flaskas, 2016, p.157). Flaskas describes "anti-therapeutic sequences" where the "therapist unwittingly begins to relate in ways which close down rather than open up space for the therapy to progress...and [so]..reinforce stuckness" (Flaskas, 2016, p. 155).

Dialogue is not in isolation. Modern society is diverse yet there is still a dominant culture that impacts discourse around how we should live our lives

and parent our children (Bagge, 2012). A therapist also brings their own knowledge and beliefs into meetings with a client. Drawing from 'second order cybernetics', the therapist is included in the system (Campbell, Draper, & Huffington, 1989b). Therapists should reflect and be aware of their prejudices to help move from linear thinking towards a circular, curious, non-judgmental stance (Cecchin, 1987). Rather than a limitation, therapists aim use their own beliefs and prejudices as a resource to inform hypotheses.

"Reflective processes encourage, and lay the groundwork for, polyphony, and a liberation from rigid ideas and actions" (Bagge, 2012, p. 183).

I have discussed power earlier (see Concept of Power section) however power and dialogue are interrelated. According to Anderson and Goolishian (1988), power in therapy arises through the therapist's use of 'expert' language and its imposition on the client's experience. Guilfoyle (2003) suggested that "the concept of dialogue may require expansion to include, rather than exclude, considerations of power" (p. 340). The recent perspective on collaboration as negotiation, inherent in approaches such as Responsive Persistence (Sutherland, Turner, & Dienhart, 2013), point to a shift in the field from static conceptions of power, with power in the therapist and not in the client, to seeing power as the result of complex joint actions between client and therapist.

Some writers have argued that dialogue is only possible in relationships where there is equality, otherwise those with more power have greater influence. Petrie and Corby (2002) highlighted that child protection system functions push for dual demands of both 'care and control'. Munro (2011) portrayed the social worker as both an agent of social control and one who provides social welfare. This dual responsibility can be hard for workers. Parents, on the other hand, hold fear of having their children removed from home, which can inhibit free communication (Dumbrill, 2006).

6.3. Summary of the Literature Review

I have reviewed literature relevant to the wider context of the Parenting Project in which this research took place. I examined literature on social work theory, the multi-agency client group, and the integration of systemic thinking into the field of social work. The relationship between multi-agency families and the systems around them comes with challenges, and the review looked at possible approaches to address these. The idea of referrer involvement in systemic practice was outlined. Literature on engagement / therapeutic alliance and collaboration were explored as were power and dialogue relevant to the referrer engagement method and thus to this research.

White, Essex and O'Reilly (1994) argued that systemic thinking provides a means to understanding the complexity of child protection. Wilkins and Whittaker (2018) found that one of the barriers for collaborative work between child protection social workers and the family was the social workers prioritising the child over the parents. The social workers had a fear that reversing this priority would mean they lose sight of the child's needs. I was interested in this view and wanted to explore it further as part of this study. I believe in order to have safe children you must work with the parents.

In developing the Referrer Engagement Method I aimed to include all 'elements' around the family, which helps in widening our perspectives and allows us to gain a better understanding of the multi-agency families and the system dynamic around them (Hingley-Jones & Mandin, 2007). Selvini-Palazzoli et al (1980) believed that the referrers can occupy a role in the family dynamic and this can influence their engagement in a new service and that addressing the dynamic between the family and referrer is a precondition for starting work with the family.

I wanted to explore the impact of referrer involvement in the context of child protection. The literature suggests there are challenges involved. “For many social workers, participatory practice may seem an unachievable goal, particularly in child protection” (Wilkins & Whittaker, 2018, p. 2003). Child protection social workers are faced with the challenging tasks of balancing care and control, building relationships and managing risk. In addition the role of authority in the relationship between the social workers and the families, undercuts their ability to empower and engage the family (Oliver & Charles, 2015). Wilkins and Whittaker (2018) found that, given their authority, social workers were concerned that an empathic and collaborative working relationship with the parents would be experienced by the parents as disingenuous. These challenges are barriers to establishing a good engagement with the family (Horwitz & Marshall, 2015). The desire to learn more about these challenges, and how to address them, has influenced the design of my study, and shaped my research questions.

7. Research Questions

My research questions:

> Question 1: What does the referrer perceive as significant processes within the referrer engagement method?
>
> Question 2: How did the referrer experience the effect of the referrer engagement method on themselves and their practice?
>
> Question 3: How did the referrers think the method impacted on families?
>
> Question 4: What can be learnt from the referrer’s experience to develop the referrer engagement method?

8. Methodology

The study is an exploratory qualitative process research using both a focus group and semi-structured individual interviews. The data was analysed using grounded theory and thematic analysis methods.

8.1. Setting

The setting for the research was in NHS Parenting Project - Tier 3. I formulated the service pathway which included the Referrer Engagement Method, an approach to therapy involving the referrer within the therapeutic process. The service pathway includes a 3-way meeting at three points in a course of 18 sessions (Initial Meeting, Review Meeting, Exit Meeting). Each 3-way meeting includes the referrer, client and therapist.

Two family therapists, a colleague (Alicia) and myself, followed the Referrer Engagement Method when working with clients. My colleague and I also co-moderated the focus group. Unfortunately Alicia was not with me for the duration of the research study as she was made redundant during the data collection stage.

The method is discussed in greater depth in the section on Development of the Referrer Engagement Method section.

8.2. Epistemological stance

As a systemic psychotherapist I hold a social constructionist stance (Charmaz, 2006; Dallos & Draper, 2010). I believe that realities are co-created through dialogue and the experience that one has with others, all within their

social and cultural context. These realities are not fixed but continue to evolve and develop.

Choosing to conduct a qualitative research study fits well with this stance as a qualitative researcher who views the creation of knowledge through interaction between researchers and participants, and sometimes between participants (Elliott, Fischer & Rennie, 1999; Dallos & Vetere, 2005; Willig, 2008). Qualitative approaches are applicable and commonly used in family therapy research (Burck, 2005). Qualitative researchers emphasise the uniqueness of phenomena rather than seeking universal generalisation (Charmaz, 2006).

My philosophy fits well with the constructivist approach to grounded theory (Charmaz, 2006). This approach takes a reflexive stance towards the research process and outcomes. In this approach both researchers and participants interpret meanings and outcomes. Burck (2005) outlined some advantages in using grounded theory method of analysis from a systemic perspective as offering a clear framework, step-by-step guidelines for analysing data which help in bypassing researcher hypotheses and prior assumptions and to avoid a discovery of what the researcher knew or hoped to find. This is very relevant to my research, as I'm researching my own service and practice. I'm an insider researcher and have a very close relationship with the data.

Due to my own position in this research, as both a researcher and a clinician, it was important for me to explore the perspectives of referrers who had experienced the approach with families they had referred, prior to the interviews with the new referrers, as a way of identifying some themes which could be further explored. I decided to run a focus group with these referrers. I choose to analyse the focus group data using thematic analysis (Braun & Clarke, 2006). Thematic analysis was the most commonly used method of analysis in analysing focus groups (Wiggin, 2004). In addition, thematic

analysis, as described by Braun and Clarke has a lot in common in its implementation with grounded theory, without conducting a line by line analysis.

8.3. Sample

Five referrers participated in the focus group and I conducted individual interviews with four other referrers. The participants were from Children's Social Care including both:

- Social Workers, Child Protection Teams (statutory)
- Parenting Practitioners, Localities Team (voluntary)

All referrer participants had referred a case to the Parenting Project in their role as care coordinator in a child protection system.

The difference between statutory and voluntary clients is the nature of the relationship with social services. Statutory clients must engage with social care whereas voluntary elect to engage.

A focus group with six to eight participants enables sufficient interaction, but is still manageable and can be transcribed with relative clarity (Kruegar & Casey, 2000; Stewart & Shamatsani, 1990). Hurworth (1996) recommends over-recruiting for a focus group by two participants to ensure a suitable number attend even with dropout. I approached nine social workers and of these five agreed to take part in the focus group. All of these participants had referred a number of families to to the service, and had a range of experience and outcomes. This diversity helped to elicit a range of opinions and views from the group.

Name	Role	Team	Notes
Adam	Senior Social Worker	Child Protection Team	
Dana	Newly qualified Social Worker	Child Protection Team	
Gary	Newly qualified Social Worker	Child Protection Team	
Shelly	Senior Social Worker	Child Protection Team	
Yvonne	Senior Social Worker	CAMHS Team	Also trained as a counsellor

Table 1: Focus group participants (names are pseudonyms)

The individual interviews were with new referrers. These participants had recently referred a case to the Parenting Project for the first time but had not started the engagement. Some of these participants dropped out during the research and had to be replaced. It might have been helpful to interview all of the referrers of the families that dropped out as this could have contributed to the further development of the method. However, at the time, I decided not to interview referrers after their family dropped out. I was looking for the referrer's view of change as they moved from the initial 3-way to the second, so I focused on those referrers whose families continued. I was interested in the conversation, and wider perspective, that the 3-way can bring (Campbell, Draper & Huffington, 1989a). Specifically I was interested in understanding the process of change in both the family system and the referrer's practice.

I originally intended to individually interview three new referrers. Recruiting and retaining participants throughout the therapeutic process proved to be challenging. Both families and referrers could and did drop out. In practice I interviewed four new referrers. The family of the one referrer (David) dropped out of therapy after the initial research interviews so we never conducted the Review Meeting or the second interview. As a result, I added a fourth new

referrer to the participant group. This meant I interviewed four referrers after the initial 3-way but only three of these referrers after the Review Meeting.

Name	**Role**	**Team**	**Interview 1**	**Interview 2**	**Notes**
David	Experienced Social Worker	Child Protection Team	✓ delayed	×	Family dropped out
Jez	Principal Social Worker	Child Protection Team	✓ delayed	✓	
Ana	Newly qualified Social Worker	Child Protection Team	✓	✓	Familiar with service as a trainee
Pam	Experienced Family Practitioner	Localities Team	✓	✓	Two clients

Table 2: Individual interview participants (names are pseudonyms)

Given the challenges I was facing finding and retaining participants I decided to include a social worker (Ana) who, although a new referrer, was not entirely naive about the Referrer Engagement Method. As a student she had attended an initial 3-way with her supervisor. A few months later she joined the research study as a newly qualified social worker referring a new family to the service. I decided to interview her as she was inexperienced as a social worker despite having some exposure to the service. This prior exposure influenced the initial interview data from this participant.

Pam was the only referrer who was not a social worker. At the time she worked for the Localities Service as a family practitioner. This is the voluntary branch of Social Care.

The participating systemic psychotherapists were my colleague Alicia and myself. During the research study my colleague Alicia was made redundant,

which left me as the only systemic psychotherapist in the service. In this study I was an active participant as a clinician, a researcher and the service manager for the Parenting Project, and also the clinical lead for the systemic psychotherapists within the service.

A full picture of the impact and perception of the service would have required involving the user-families. I did not embark on such a study due to the complex nature of their issues and their level of vulnerability.

8.4. Design

The study was an exploratory process research, using both semi-structured interviews with individuals and a focus group, all within a qualitative paradigm. There were four major steps in the design: interview with myself as Service Manager and insider researcher; focus group; first interview and second interview with new referrers (see Figure 2).

The Referrer Engagement Method existed before this research study so I arranged for another family therapist to interview me as the first step in the research process. The interview gave me an opportunity to reflect, clarify the hypotheses I held, and reveal my preconceived ideas and assumptions (Burck, 2005). This helped in freeing my mind and allowed me to be open to hear and adopt different ideas from my participants. The interview also helped to create an initial protocol for the focus group.

The second step was a focus group with referrers who were familiar with the Parenting Project and the Referrer Engagement Method. This helped expand ideas about the method, and to inform the semi-structured interview questions for the new referrers..

Following the focus group I interviewed new referrers. I interviewed the four new referrers after their initial 3-way meeting (Step 3) and interviewed three of them again after their Review Meeting (Step 4).

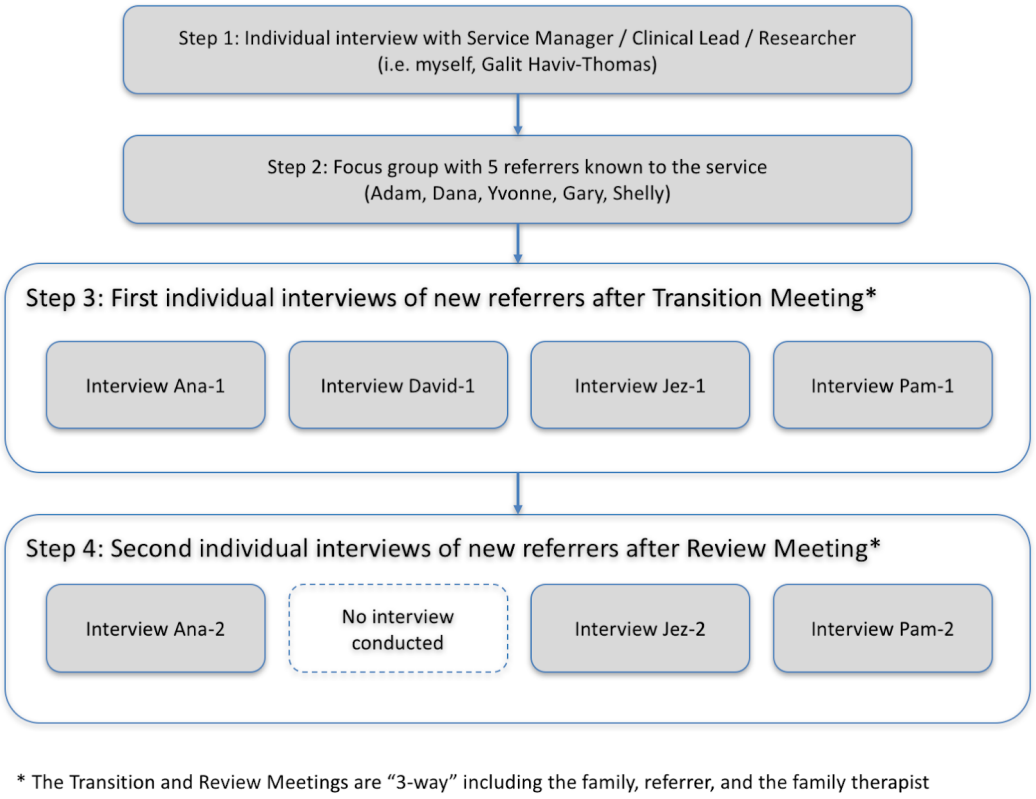

Figure 2: Research Design

Subsequent sections elaborate on these research steps.

8.4.1. Process Research

In spite of having a lot of psychological (systemic) theory about what brings change, we still know relatively little about how change happens in psychological interventions (Elliott, 2012). Originally research of psychotherapy was either outcome research, which focuses on the extent to which the client changed over the course of treatment, or process research, which looks into what happens within treatment sessions. Greenberg (1986) proposed change process research (CPR) to bridge the gap between these two types of research and addressing the need to study the processes that bring about change. Change process research tries to answer the questions

of how and why change occurs (Elliott, 2010). For example, how change is facilitated? How does family therapy work?

According to Friedlander, Heatherington and Escudero (2016) there are fewer change process studies in couple and family therapy than of process studies in individual psychotherapy. Friedlander, Heatherington and Escudero attributes this to the 'complex nature' of a conjoint therapy format and the fact we cannot generalise from what 'works' in individual psychotherapy to family therapy. Several aspects of family work make tracking change 'complex'. Assessing multiple family members with their own thoughts, feelings, and reactions to the therapist. Different members of the family might join therapy at different times making it harder to track what is said in a session, by the therapist or family member, to whom, and the systemic impact it might have. Therapeutic alliances are more complex and vary between family members - for example, see Friedlander, Escudero, and Heatherington (2006).

In investigating change process in therapeutic work, the researcher can learn from the therapy process by analysing the sessions to explore what happens in therapy and the change in the session, usually using discourse analysis and/or narrative analysis. For example Burck et al (1998) looked at how the therapist interventions contribute to the emergence of alternative and new meanings in family therapy sessions.

The other way to learn about change process is through asking about the different perspectives in the therapeutic process by interviewing professionals or clients after the intervention. The researcher learns about significant process that facilitate change from the participant's experiences of therapy. For example, Sundet (2011) examined how a group of families and their therapists described helpful therapy.

In my study I was exploring the referrer's experience of the Referrer Engagement Method with the aim to develop the method further and to identify their view of significant changes and significant change processes. I

elicited the referrer's experience through individual interviews and a focus group. I used semi-structured interviews to identify what had changed for the referrers and their clients, how they thought those changes came about, and what interfered with the change process. In the interviews I probed for both negative changes as well as positive or helpful factors. The interviews offered the referrers a chance to explain any changes in their own words, through their experiences, which also provided an opportunity to reflect on the changes (Elliott, 2002).

My choice to use grounded theory to analyse the individual interviews fits well with change process research. In both of these two research methods the researcher nominally starts from a position of "not knowing", but usually has some background knowledge (Elliott, Slatick, & Urman, 2001). The researcher, learning from the client's experiences of change, moves gradually towards an understanding which is embedded in the data.

According to Elliott (2012) what makes a 'good qualitative change process research' is the ability to answer the questions: does this study give us a better understanding of how it works? Does it help us to do a better job with our clients? In my study I aimed to learn from the referrer's experience of the method in order to develop the approach further. I hoped to learn about any changes they themselves experienced and gain their perspective on the changes their clients experienced.

8.4.2. Action Research

I originally considered an action research design. Action research is an approach to research involving the researcher and participant collaboratively, solving problems while simultaneously generating new knowledge (Coghlan & Brannick, 2001). This includes a process of planning, taking action, evaluating the action, which leads to more planning (Coghlan & Brannick, 2005).

Unfortunately, due to logistical and organisational issues, I was not able to complete the action research elements of my original design. The process of data collection took longer than expected due to families dropping out of family therapy treatment (see Sample section), and changes in staff within social services (referrers leaving). During the extended data collection period the Parenting Project underwent a major restructure and suffered cuts. As a result of these changes I lost my colleagues Alicia as co-researcher and the possibility of continuing the action and reflection learning set.

The revised design was an insider process research.

8.4.3. Individual interview of Self as Service Manager and Researcher

An external colleague interviewed me about the systemic approach including the Referrer Engagement Method as the first step in data collection. The interview provided me with both a reflective space to identify and clarify my own pre assumptions and hypotheses and to outline an initial protocol for the Referrer Engagement Method. Although I had developed this approach to working with families and their referrers, this had not been previously described or elaborated.

The interviewer was a systemic psychotherapist from a different NHS Trust who had previously worked in the Parenting Project, but was not part of the service at the time of the interview. These attributes meant the interviewer had an appropriate background to ask probing questions but could still offer something of an outside perspective.

The interview covered these areas:

- Reasons for developing the method
- Main elements of the method
- How and why the method has evolved over time

- What difference it has made to my practice with both the clients and the system
- What challenges were faced in developing it
- What other outcomes I am hoping for

The interview was digitally recorded and used as a basis for my description of the service and its theoretical underpinnings. It was an opportunity for me to elaborate the approach as well as to make explicit my ideas and beliefs about it to take into account before conducting the focus group and interviews. My interview enabled me to gain some distance from the method and helped gain a different perspective (Burck, 2005).

I found it interesting how at the beginning of my research project I was very focused on trying to influence the referrer and in particular, the social worker's view on the importance of the therapeutic relationship. I even aimed to "bring back therapeutic relationship into the social work profession". I started from a position of seeing the referrer as my client together with their profession, believing that they needed to change their ways with their clients by listening to them. I also wanted to encourage them to prioritize the relationship to create better engagement. Being interviewed helped me to keep opened to other aspects which are significant to the referrers and the development of the method.

8.4.4. Focus Group

In order to explore and identify significant processes within the Referrer Engagement Method, I wanted to include the referrer's voice.. Five participants with experience of the Referrer Engagement Method from prior interaction with the Parenting Project attended a one off focus group. These participants were familiar with the service pathway and the systemic approach

of working closely with the systemic psychotherapist and the referred family. The focus group took place at Social Care to accommodate their busy schedule.
I invited social workers from the child protection teams in Social Services. All participants knew each other but were from different child protection teams in the service.

My focus group participants all shared professional values and worked within the context of safeguarding children. They all referred to, and had previously worked with, the Parenting Project. The participants differed in their experience as social workers and in their training. Two were senior social workers, two were relatively new to the profession, and one was a senior social worker but was working alongside the CAMHS team and was training as a counsellor. The participants also had different working relationships with their clients prior to referring and had different experiences of referring families to the service.

Focus group discussion is a qualitative research method, a form of group data collection that uniquely combines interviewing, group interaction and participant observation, which are moderated towards a specific topic (Nyamathi & Shuler, 1990; Barker & Rich, 1992). Focus groups offer a unique advantage in allowing participants to hear and respond to one another (Stewart & Shamdasami, 1990) and build upon each other's responses (Kitzinger, 1995). The group is 'focussed' around a collective activity which can include discussing a set of questions around a particular topic (Kitzinger, 1994). Focus groups are distinguished from group interviews by using the group interaction as research data (Morgan, 1988). Focus groups aim to explore diversity and discover a range of views – they do not set out to form a consensus (Plummer-D'Amato, 2008). This makes focus groups a good fit to examine how practitioners and clinicians think and talk about specific issues. This process generates a very rich conversation and data.

Morgan (1992) recommended a homogeneous group of participants, who share similar experiences and backgrounds with each other. This helps participants feel more comfortable in sharing their views in a group setting and bypasses issues of status differences within the group.

Despite the need for a focus group to be homogenous, Krueger and Casey (2000) thought having a level of variation among the participants allow for some contrasting opinions.

Hurworth (1996) claimed that acquaintanceship can disrupt the group dynamics and can potentially inhibit responses. However, as my study was about a particular experience through their work, from a specific service (Social Care), it required a specialised group recruitment. My sample was a 'naturally occurring' group (Kitzinger, 1995).

Morgan (1995) recommends segmentation based on level of experience and status at the workplace. Segmentation creates more homogenous groups based on the level of experience. The aim is to address inhibition in expressing views freely in the focus group. I decided not to use segmentation in my study for two reasons: because of the small numbers of participants (5), and to encourage a richer conversation. The participants may have differed in their professional experience but they all shared the experience of working with the Parenting Project.

The atmosphere during the focus group was very open and positive. I did not notice any domineering voices. The participants appeared very honest when sharing their experiences with the Parenting Project, as indicated by the level of sharing and also sharing difficult and challenging experiences with their clients. The rich responses and variety of comments suggest the environment enabled a free and open discussion. Although there may always be an element of participants wanting to be seen by colleagues and the researchers as competent professionals.

In focus groups the group discussion is moderated towards a specific topic. Focus groups are considered to have high levels of validity due to the credibility of responses and comments from the participants (Njamathi & Shuler, 1990). This depends on how well the focus group is moderated to elicit honest information and ensure anonymity and confidentiality.

The moderator is a non-participant whose role is to facilitate the group processes and ensure the discussion covers the topics of interest (Chestnutt & Robson, 2001). It is the moderator's role to set group rules and create an environment which encourages participants to share their views (Hurworth, 1996; Krueger & Casey, 2000). The moderator should establish good rapport, be non-judgemental, probe effectively, and be empathic.

A family therapist colleague and I jointly moderated the focus group. My colleague and I had worked together for many years and were comfortable with reflecting on issues and difficulties together. As family therapists we were in a good position to moderate the focus group. The family therapy skill set includes enabling a variety of voices to be heard freely, and encouraging in-depth conversations with feedback.

Both moderators knew the participants through work and had a good working relationship with each other. We were both having to deal with the challenge of how our relationship can impact the level of openness in the discussion. As the participants were working with us on their cases they may have found it difficult to share disagreements or criticism of our work and the service pathway. Having two moderators helped in having the presence of one moderator who was not directly involved in any particular case being discussed, it also helped in watching each other and reflecting on the process when needed. However, I am aware that being insider researchers, and also the moderators, had an impact on the data collection and encouraged the participants to elaborate on their responses (Kruger & Casey, 2000).

At the beginning of the focus group we explained the importance of their view in improving and shaping our way of working. We also asked a variety of questions which included both positive and challenging experiences with the Parenting Project.

As moderators we faced the challenge to sit and listen to the conversation without sharing our professional point of view (Krueger & Casey, 2000; Sim, 1998). We had to restrict our involvement to directing the conversation.

Hurworth (1996) recommended having prepared questions to ensure the focus group answers the central topic. I prepared a set of semi-structured, open ended questions (see Appendix 4). The discussion was organised by the pre-prepared questions and also by new questions that were generated within the focus group. This created a richer discussion, which expanded from the initial moderator's prepared questions.

The semi-structured interview for the focus group covered:

- What the referrers liked about the method
- What the referrers disliked and what they would like to be different
- Difference it made to their perception of the family and the referring problem
- Difference it made to their practice, both general and with the specific clients

The focus group was audio recorded and transcribed before the next step in the research. Some general themes were highlighted before the individual interviews started. This helped inform and refine the semi-structured interviews of the next step.

8.4.5. Individual interviews of new referrers

I interviewed four new referrers, i.e. who referred families to the Parenting Project for the first time and had no previous experience of the Referrer Engagement Method.

My original intention was to conduct the initial interview immediately after attending the initial 3-way meeting (Transition Meeting). This timing offered several advantages, the experience would be fresh in the referrer's mind, it would be less time consuming for the referrer, and the referrer's experience of the Referrer Engagement Method would be limited to the referral process and the initial 3-way. There would be no opportunity for the referrer to meet the family between the 3-way and the interview, and no opportunity for the referrer to refer a second family and attend another 3-way meeting.

In practice, I was only able to interview two referrers immediately after the initial 3-way meeting (Ana, Pam). The other two (David, Jez) were interviewed a few weeks after the initial 3-way. This delay increased their exposure to the Referrer Engagement Method and this was reflected in the responses to the first interview. For example, between his first Transition Meeting and the research interview, Jez had referred two more clients.

The second individual interviews were planned to immediately follow the Review Meeting. For Pam, however, the Review Meeting was for a new client. Pam had been off work for six months due to health reasons and upon her return brought a new client to the service. This meant Pam's second interview covered both of her client families. Pam talked about her previous and overall experience of working with the service but the interview also had elements of an initial interview.

By the time of the Review Meeting the families were familiar with the service and the family therapist they were working with.

The semi-structured interviews focussed on the participant's experience of the Referrer Engagement Method and covered:

- What the referrer liked about the method
- What the referrer disliked and what they would like to be different
- Difference it made to the family and their perception of the family and the referring problem
- Difference it made to their practice, both general and with the specific clients

Because the sample of referrers was small I did not differentiate in relation to gender, culture, or sexuality. However, there was a variety of backgrounds of the participants.

8.5. Insider researcher and reflexivity

Practice based research is increasingly gaining popularity in qualitative research methods. "Practice based research involves exploring naturally occurring practice" (Helps, 2017, p. 351). Practice based research has a good fit within responsive, collaborative and dialogue nature of social constructivist systemic psychotherapy.

In postmodern qualitative research, researchers are invited to be visible and involved (Simon, 2014). Researchers are not expected to be neutral or objective. Researchers are instead expected to own their biases and assumptions and work openingly with them. These biases and assumptions are expected to impact the interpretation of data, which is contextual (Laitila, 2016).

In conducting this research study I had multiple roles. I managed the service, I was a clinician within the service, I created the Referrer Engagement Method and associated pathway, and I was the researcher of this aspect of the service. I was an insider researcher. I was researching my own method and

at times my own practice in conducting the 3-way meetings. This brought some advantages to the research process and also created challenges. I used different mechanisms to address the challenges of being an insider researcher and the most important was self reflexivity.

8.5.1. Advantages of being an insider researcher

One advantage of insider researchers is the knowledge and familiarity that researchers bring to their study (Chavez, 2008). An insider researcher has valuable knowledge about the organisation and context and this can lead to richer data (Coghlan & Brannick, 2001).

Recruiting participants for the interviews was a straightforward process and I had an existing relationship with some. The current study took place in my own service, so I had relatively easy access to my participants, the referrers. After booking the initial 3-way meeting with the referrer, I asked them over the phone whether they would be happy to participate in a research study. Where possible the research interview was conducted immediately after the 3-way, so it would be less time consuming for the participants. I conducted the latter two interviews at the participants' offices for convenience..

When a participant dropped out (due to the family dropping out), it was relatively easy to recover and recruit a different referrer. The process of recruiting was more challenging for the focus group. I had to approach referrers who would agree to participate at a time separate from any 3-way meetings they may have, which was more time consuming. As I had a prior relationship with some of the participants in the focus group and they knew each other through work, I believe it helped in establishing a comfortable, open environment for their discussion - easy rapport.

According to Dallos and Vetere (2005):

"the benefits of researching our own therapy and in our own organisation can be profound: they can contribute to learning both ourselves, our practice and our organisations, when we try to understand and confront our own and other's assumptions and lived experience, grounded in our day-to-day interactions. Thus we can be said to be working in learning organisations." (p. 174)

8.5.2. Challenges of being an insider researcher

Having a greater knowledge before the research means biases and assumptions inevitably follow (Chavez, 2008). These can influence data collection by assuming knowledge or a lack of curiosity during the interview and data analysis. It is more difficult to identify patterns due to familiarity with the subject.

Insider knowledge makes it difficult to stand back to enable analysis (Coghlan & Brannick, 2001). Insider knowledge can block alternative reframing. To facilitate theory building researchers need to set aside pre-existing ideas and views (Creswell, 2007). Researchers, looking at a situation from a theoretical stance, have to detach from the context being researched.

My multiple roles meant that, although I understood the goals of the research, I also brought a belief that the Referrer Engagement Method is beneficial for both referrers and clients. The assumption, one I hold dearly, is that therapeutic engagement provides a solid foundation for change. The Referrer Engagement Method extends this concept and comes with an assumption that the method enables an improved referrer-family relationship and that itself would lead to positive outcomes for the client. These beliefs influenced the questions I asked, how I moderated the focus group, and my interaction with the interview participants.

Researchers with an interest in the subject, whether professional or academic, must endeavour to give the spotlight to the participants during data collection. Such researcher must listen carefully and concentrate on the participant's view without unduly interjecting their own (Krueger, 1993; Sim, 1998; Krueger & Casey, 2000). Being an insider researcher it would have been impossible to prevent my views coming out in the focus group or interviews yet it was vital that the findings reflect the product of the discussion rather than reflect my own ideas and biases.

Another challenge of researching one's own practice is the researcher beginning to filter the data in the perhaps unconscious desire to find validation for the expected outcome. This can result in asking leading questions or blocking views that are not expected or different to the researcher's. Researchers need to fight this trend "so that one does not discover what one already knew or hoped to find!" (Burck, 2005, p.245).

As an insider researcher I needed some detachment although detachment could negatively impact my professional role. I could not set aside my pre-existing ideas completely as they informed the way I approached referrer engagement. I addressed this in both my clinical and academic supervision, and this helped me to make sense of my own experience.

As a family therapist within the service and the service manager, I had an existing relationship with the focus group participants. I also built up a relationship with participants of the individual interviews, through the on-going therapeutic work and the research interviews.

Families are the main clients of my service but the referrers are also, in a sense, clients. When they realised they need help in their work with a family, the social workers referred the family to the service. This placed me in a position of power as I provided a service they needed. Being in a position of power can negatively affect both the recruiting process and the data collection process (Smyth & Holian, 2008). This power differential can lead participants

to make an assumption about what they think the researcher wants to hear and can lead them to filter their responses (Hockey, 1993). It can also interfere with creating a collaborative approach to the research (Burck, 2005).

Insider research can lead to conflicting agendas between the researcher and the organisation. However, as this research study was supported by both my organisation and the commissioner of the service, there were no conflicting agendas.

8.5.3. Addressing the challenges of being an insider researcher

I did a number of things to address the challenges of researching my own practice and method. Firstly, I chose a qualitative method of analysis which fits within the social constructionist paradigm (Guba & Lincoln, 1994) and has reflexivity as a core practice.

I asked open questions in order to give sufficient space to participants and allow different views to emerge.
Using my supervisors, attending data analysis sessions, presenting part of my research to an academic seminar, were all ways to challenge my own voice and invitations for more reflection.

“The mutual dyad of (a) reflection on one’s own practice and (b) the use of supervision and professional development, helps” (Helps, 2017, p. 362).

As part of my research design I arranged to be interviewed by an external colleague, who is familiar with the service but did not work in the service at the time. The interview was about my reflections, prior assumptions, and ideas about the Referrer Engagement Method. All before starting to collect data. The idea was to clarify my own hypothesis. This interview helped me to gain a good understanding of my position and helped in freeing me up to hear different ideas from the participants.

I shared my reflections with the other family therapist using this approach. This at times challenged my ideas and position.

When I found data different from my expectations during data analysis, I shared my bias with my research supervisor and my colleague Alicia. This helped me to stay open to the data and challenge my thinking, for example, it was difficult, at first, to see the helpfulness of one referrer's account who was less obviously positive about the effect of the approach on him. I was very close to the data and at times found it overwhelming or lacked curiosity and took too much for granted (Hanson, 2013). Both my supervisor and colleague questioned me, highlighted the unique or relevant, I was slowly able to develop a stronger reflexive voice.

From my reflexive journal (17 July 2017) following a session with my supervisor:

> *Insider knowledge - being so familiar with the way it is, or the way I think it is, gets in the way. I am at risk of seeking validation for what is working for me as a clinician. This is a cloud on my role as a researcher. I need to keep open. Be critical. This is hard. I keep looking for what I want to find. I struggle to see the contribution of the difference, those who have a different view.*

Researching your own practice is ethically more complex than research 'about' others (Tullis, 2013). The process of reflexivity can help address this challenge.

I wrote a research memos and notes about my thoughts and ideas, during the process of collecting data and the analysis of it. I also kept a reflexive diary (McNiff, Whitehead & Lomax, 1996) of my own experience at work when using the Referrer Engagement Method and when analysing the data. This was particularly important for my study as I was an insider researcher. It was

a tool in helping to promote thoughtful reflection on the process of research and the collected data to which I was extremely close. I am very passionate about the value in working collaboratively. When some of the participants spoke about how challenging they found it and even responding in 'shock' to being interviewed in the 3-way meeting in front of the family, I was very surprised and initially found it hard to understand their position. I started to develop a critical voice instead of keeping my curiosity in exploring their experience. It is only after putting these in my reflexive diary and through my discussions with my supervisors that I realised my difficulties in hearing new and unexpected views on my method. It helped me to avoid the danger of searching for what I already knew.

Self reflexivity is a constructionist process, which aims to explore what is happening within and between individuals. It helped me in thinking about the relationship between not only myself and the researched topic (self-reflexivity) but also between the participants and myself (relational reflexivity). This invited me to bring doubt and invoke a responsibility to act and position myself in an ethical manner. In addition critical reflexivity which is aiming to explore multiple meanings and interpretations, responses and our moral responsibility to others and also how we constitute our social experiences and identities in every interaction (Cunliffe, 2014). This has been useful to my critical analysis of the literature and the data.

8.6. Data transcription

The focus group and individual interviews were audio recorded and transcribed by a commercial transcription service.

8.7. Methods of Analysis

I used thematic analysis to analyse the focus group and grounded theory to analyse the individual interviews.

8.7.1. Thematic analysis

Thematic analysis is a common interpretive data analytic process (Peterson, 2017). It involves immersing oneself in the data to identify common ideas or themes that emerge based on researched phenomenon and the research questions. Thematic analysis "is a method for identifying, analysing and reporting patterns (themes) within data" (Braun & Clarke, 2006, p.6). Braun and Clarke argue that thematic analysis should be seen as an independent and reliable qualitative method of analysis.

Thematic analysis can be conducted within both the realist and constructivist paradigms. It can both report experiences, meanings and participant's reality and to examine the way meanings and experiences are constructed within society (Vaismoradi, Turunen & Bondas, 2013; Braun & Clarke, 2006).

This theoretical framework fit my research well. I wanted to discover how my participants experienced and made sense of the Referrer Engagement Method. However, I was also aware that my own position as an insider researcher and the knowledge I have about my own method would affect the process of analysis, and that "data are not coded in an epistemological vacuum" (Braun & Clarke, 2006, p.84).

Although there is no agreed or recommended method for analysing focus group data (Jackson, 1998), thematic analysis was highlighted in reviews of published focus group research as the most commonly used (Wiggin, 2004). Vaismoradi, Turunen and Bondas (2013) stated that thematic analysis can be used for a large complex data such as a focus group discussion with multiple participants. Thematic analysis highlights similarities and differences, and generates interpretations from both social and psychological perspectives.

I chose to analyse my focus group data using thematic analysis. The focus group was conducted prior to the individual interviews. Drawing themes from

the focus group also helped me, as an insider researcher, to reflect on my own position and challenge my preconceptions I brought to this study.

I carried out both deductive and inductive coding to bring forth meaningful themes and categories (Hsieh & Shannon, 2005). Deductive coding is driven by a philosophical or theoretical framework. In contrast inductive coding comes directly from the text data and the participants discussions. Using thematic analysis in my study enabled for both inductive and deductive analysis of the data (Im & Rosenberg, 2016). The inductive analysis was useful for coding the semi-structured discussion and disjointed conversation from the focus group (disjointed due to people speaking over each other) . My aim was to learn from the participants experience and produce rich data which inductive research can create (Braun & Clarke, 2006).

I brought my knowledge and experience to the study from my insider researcher position. This would colour the research process and the analysis of data (produce some deductive codes). The deductive analysis allowed applying theory-driven concepts to the codes, for example, ideas about therapeutic alliance. In addition to gathering of knowledge about the meaning of the research focus, thematic analysis provides a highly systematic and transparent form of qualitative analysis (Joffe, 2012).

Braun and Clarke (2006) came up with a six phase guide,which provides clarity on both process and practice (see Figure 3).

Braun and Clarke (2006) advised to consider both latent (underlying ideas, assumptions) and manifest (something directly observable) content in data analysis. The latent content tends to come from a constructionist paradigm (Burr, 1995). In this form thematic analysis overlaps with grounded theory. The analysis process is recursive and results in a story which the researcher tells about the data in relation to the research question (Braun & Clarke, 2006).

The story can also be presented in a visual way with a thematic map (see Appendix 5).

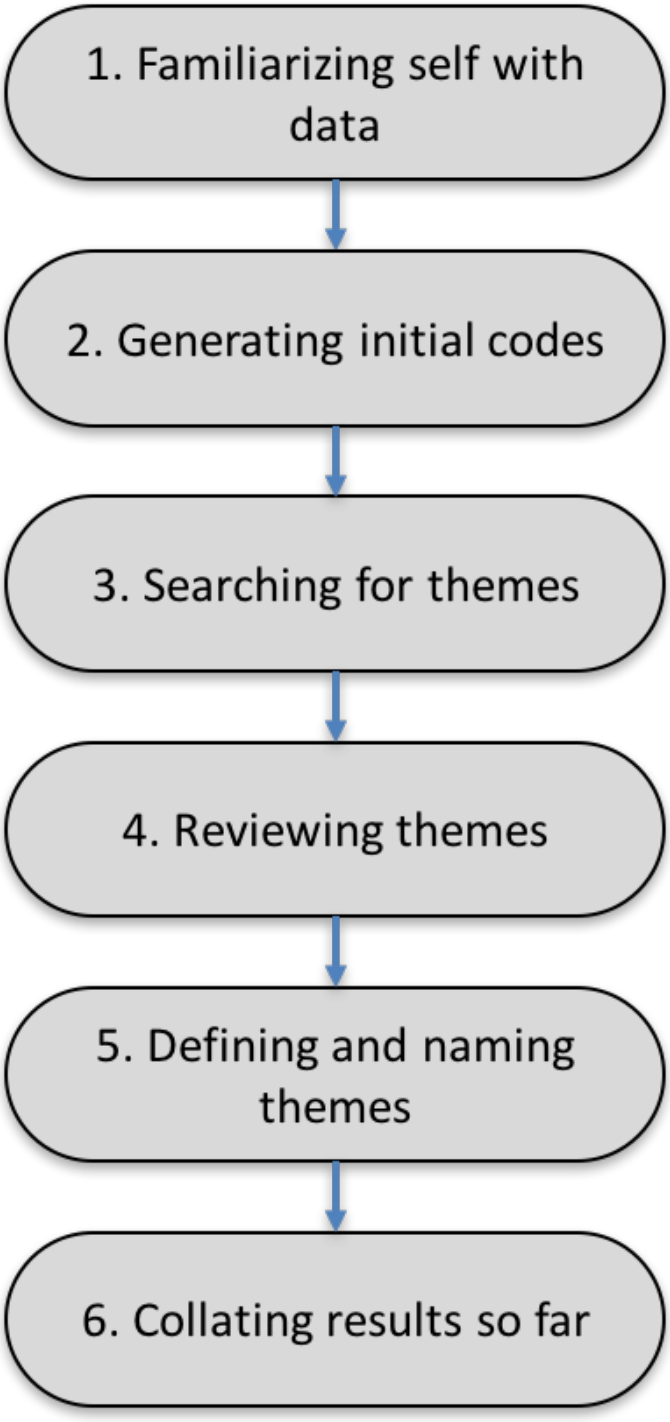

Figure 3: Six phases of thematic analysis

8.7.2. Grounded theory

I chose to use grounded theory method as the method for data analysis for the semi- structured individual interviews. The grounded theory method is a systematic, inductive and comparative approach for constructing theory (Charmaz, 2006). It is a qualitative research design in which the researcher aims to generate a theory (general explanation) of a process, action or interaction shaped by the participant's views or experience (Strauss & Corbin, 1998). The main researcher assumption is that theories should be "grounded" in data from the field, which includes actions and interactions (Creswell, 2007).

Glaser and Strauss developed grounded theory when researching the social processes of death and dying in hospital in the United States in the mid-1960s (Glaser & Strauss, 1967). They came up with a set of inductive strategies to proceed systematically from observations of people's views, actions and experiences within their lived context to general conclusions or theory.

Kathy Charmaz and Antony Bryant (Bryant, 2003; Bryant & Charmaz, 2007; Charmaz, 2003, 2006) were the first researchers to name their work constructivist grounded theory (CGT). They placed more emphasis on reflexivity, the researcher's views, values, beliefs and assumptions, which impact the relationship between the participants and the researcher.

Clarke (2005) added the importance of the research context and how knowledge and production of knowledge is occurring within its context. Grounded theory becomes grounded in the context. The focus on social processes enables grounded theory to investigate how social structures are influenced by relationships, interpretations and patterns. The parallels between researcher reflexivity and the self-reflection of therapists, psychotherapists have also influenced the suitability of grounded theory method for psychotherapy research including systemic therapy (Burck, 2005).

Researchers nowadays view grounded theory's epistemological position as operating on a continuum (Tweed & Charmaz, 2012) from the more original positivist form (Glaser, 1992) through post-positivist (Strauss & Corbin, 1998) to constructivist (Charmaz, 2006)

Constructivist grounded theory aims to generate co-constructed theory and not discover one (Charmaz, 2006). This suggests that 'theory' is not necessarily about final truth but is about offering a 'dynamic framework' to explain what we understand from the study (Silverman, 2000).

In this study I decided to use constructivist grounded theory as it fits well with both my social constructivist stance and the nature of the research questions. The research questions focus on processes in the Referrer Engagement Method within the context of my work place. In addition, according to Henwood and Pidgeon (2003), grounded theory can be used where existing theories or areas of research are under-researched. Being an insider researcher, researching in my own service and researching some of my own work, required a robust process of reflexivity. Grounded theory accepts the interplay and connectivity between the researched, the researchers, and the interpretations made.

Grounded theory can be used to investigate a broad range of open-ended research questions that focus on processes and patterns and research their meanings within their context. Grounded theory helps researchers examine the subjectivity of experience and leads them to start their research from their participants' point of view (Tweed & Charmaz, 2012). From a constructivist and epistemological stance, the data will have been constructed for a specific purpose and outcome, so needs to be recognised as such (Charmaz, 2006).

Grounded theory uses coding as the main tool for data analysis. "Coding means naming segments of data with a label that simultaneously categorizes, summarises and accounts for each piece of data" (Charmaz, 2006, p.43).

Charmaz recommends grounded theory researchers make their codes short, active, and specific.

As grounded theory emphasises the analysis of processes, highlighting what people are doing, the codes use gerunds. A gerund is the noun form of a verb and in English ends in "-ing" e.g. "asking". Using gerunds in codes puts the focus on the action taking place.

Grounded theory calls for an initial coding, line by line, which aims to help keep the coding process close to the data, define directions for exploration, identify gaps in the data, and compare data to codes. The data can be seen from multiple perspectives which lead to circular revision of the research questions in light of the data. This is in keeping with a systemic enquiry in which "feedback informs and shapes further enquiry" (Burck, 2005, p.244). After studying the initial codes researchers treat their most compelling and frequent codes as focussed codes .

Throughout the coding process researchers write memos. Memo writing and keeping a research diary through the research process help keep researcher reflexivity (Burck, 2005). Memo writing is the most important stage between coding and writing the first draft. Memos help in keeping the analysis process transparent which support self reflexivity in the research process. Memo writing helps with comparing analysed units i.e. data with code, code with code. Memos also help in challenging pre-existed hypothese (Charmaz, 2006). This was particularly important for my research due to my position as an insider researcher. I wrote memos and comments while analysing in addition to diary keeping after my discussions with my colleague and from my ongoing practice at the service. See Appendix 9 for samples of memos.

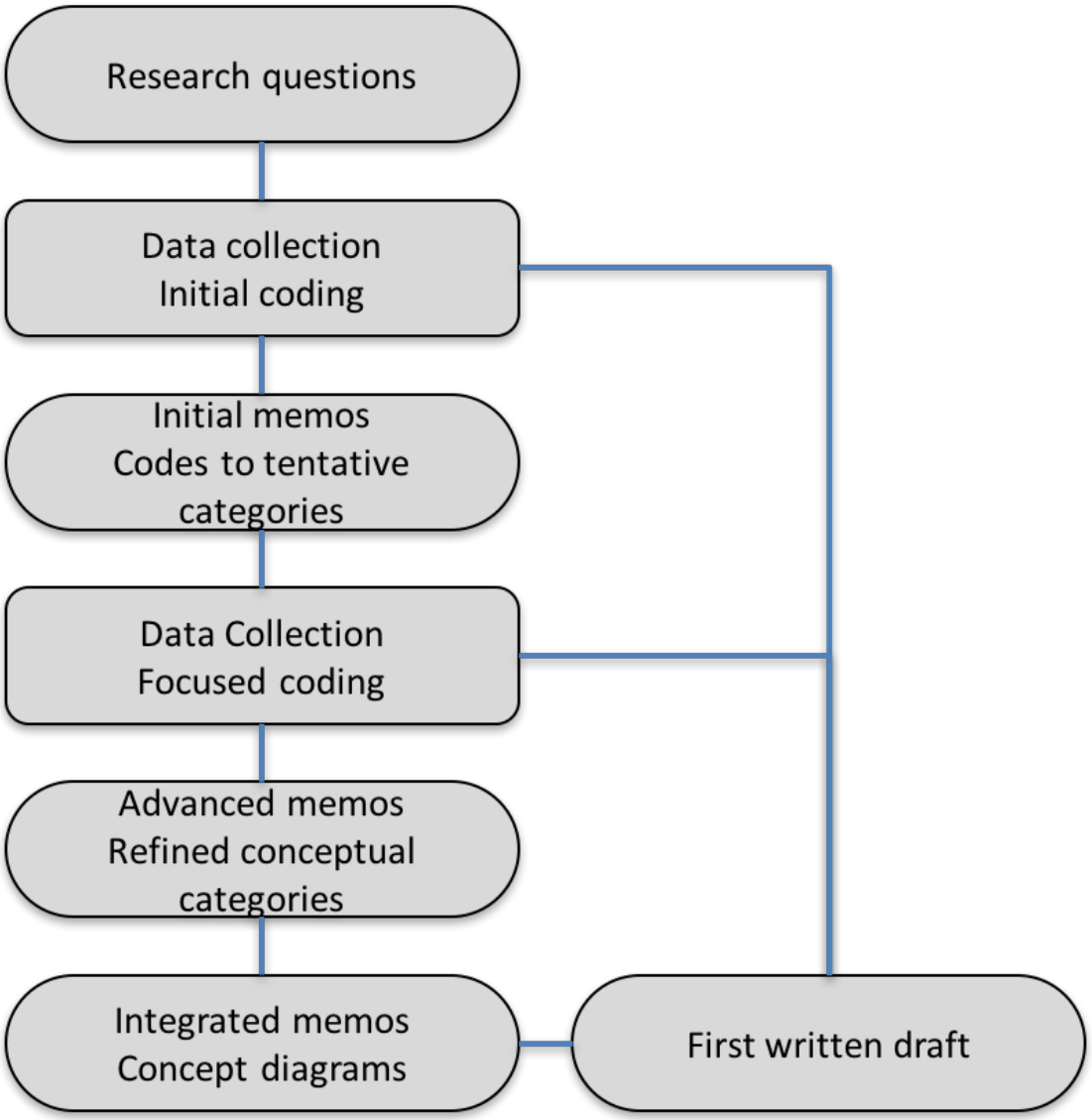

Figure 4: Grounded theory process (adapted from Charmaz, 2006)

Charmaz (2006) recommended an iterative process of data analysis, i.e. analysing the data from each interview before conducting the next interview. This is to help with the process of refining the research questions and to ensure the research is an active, reflexive process that continues to develop and change based on the experience of the participants and the researcher's reflection. Figure 4 shows the grounded theory process, adapted from Charmaz (2006).

I was only partially able to conduct iterative data analysis within my study. Where possible I undertook initial coding of the transcripts between data collection sessions. However, restructuring in the service meant I was anxious about completing the data collection so I prioritised conducting the interviews over analysis. This meant I was under time constraints so I was not always able to complete analysis prior to the next interview. At a minimum I read the transcript before the next interview to familiarise myself with the prior interview. This sparked some thinking and helped me refine my semi-structured interview.

Generally, in grounded theory, data saturation is seen as the point where no new categories are emerging and data collection can end. In constructivist grounded theory saturation of data is more open. O'Connor, Netting, and Thomas (2008) stated that saturation occurs when no new information emerges to add to meaning. This is still difficult as, through a constructivist lens, new meaning is assumed to be always created. I agree with Lizette Nolte (2014) that saturation should be seen as where the themes/categories reach a point of coherence and are able to account for most of the data. This stance takes into consideration the co-construction of data which is influenced by both researchers and context.

The literature review is a contested area in grounded theory. Glaser and Strauss (1967) initially advocated conducting the literature review after analysis to avoid the literature influencing the data. Charmaz (2006) and Clarke (2005) criticised this position, pointing out that researchers do not come to their research without knowledge and awareness of research topics into their field. Charmaz (2014, p.307) says "any researcher should tailor the final version of the literature review to fit the specific purpose and argument of his or her research report".

In my own study prior knowledge is very significant as I researched my own method in the Parenting Project I work within. Following Charmaz (2006,

2014) I wrote an initial literature review to inform my initial thinking and for the research proposal Further literature was drawn on in the light of my data analysis.

8.7.3. Combining thematic analysis and grounded theory

As a final step of my data analysis, I compared the codes from the grounded theory analysis from the individual interviews and the themes from the thematic analysis from the focus group. Despite using different methods of data gathering and data analysis, similar concepts were generated. I therefore presented the themes from the focus group and the categories from the grounded theory analysis of the interview which were similar together, and identified the differences (this is discussed in more detail in Appendix 10). Combining the analysis from thematic analysis and grounded theory raises a terminology issue as they use different terms. Thematic analysis is concerned with themes (and perhaps sub-themes). Grounded theory with categories and axial codes. Given this is a process research study I have elected to talk about significant processes and sub-processes.

Using different data collection and data analysis methods and finding such similarities through the analyses helped to increase the study's credibility (Patton, 2002).

8.8. Quality: Contribution, credibility and rigour

How to assess the quality of qualitative research is much debated in the literature. Lincoln and Guba (1985) argued that the language of positivistic research – such as validity and reliability – is not congruent with or adequate to qualitative work.

Lincoln and Guba developed a parallel set of criteria to replace validity and reliability of quantitative research. They suggested achieving 'trustworthiness' for establishing credibility, transferability and reliability in qualitative research. Trustworthiness is evaluated through the criteria of dependability, credibility,

transferability and confirmability. Polit and Beck (2014) suggested trustworthiness, or rigour, ensures the quality of a qualitative study, where trustworthiness looks at the degree of confidence in data, interpretation, and method used.

Spencer and Ritchie (2012) described an alternative scheme for assessing the quality of a qualitative research study. They offered three guiding principles: contribution, credibility and rigour. Contribution is about the value and relevance of the study. Credibility is about whether the claims of the study are defensible and plausible. Rigour demands appropriate decision making and thoroughness of research conduct. The authors suggested a number of questions, in each of these guiding principles, to assess the quality of a study. Appendix 6 goes into greater detail on how the current study addresses the Spencer and Ritchie's guiding principles and associated questions.

I have opted to follow the three guiding principles of Spencer and Ritchie (2012) because their scheme clearly separates underlying elements of quality and trustworthiness. Subsequent sections expand on each principle.

8.8.1. Contribution

Contribution is "the extent to which the study has contributed to wider knowledge and understanding or had some utility within the original context" (Spencer and Ritchie, 2012, p. 233). The study may update theory, inform policy, change practice, identify processes, formulate concepts, generate hypotheses, extend methodology, or transform the lives of individuals involved.

To be credible research should be transferable beyond the confines of the specific study. The transferability, also called wider inference or external validity, of qualitative research is much debated.

Postmodernist researchers believe qualitative researchers should not attempt to infer meaning beyond the context being studied as the meaning found in a specific context is a product of time and space (Schwandt, 1997). Feminist researchers point out that, given qualitative research has to take into consideration the relationship between the researchers and the researched, it is misguided to aim for neutrality (Bowles & Klein, 1983). Qualitative researchers seek rich data and "the contradictions and conflicts in the responses of participants are anticipated and welcomed, not sidestepped or minimized" (Wren, 2004, p. 475).

Despite the reservations of the post-modernists there is a clear consensus that generalisation is possible for qualitative research and that the basis of any such generalisation is assertional logic rather than probabilistic (Kvale, 1996; Stake, 2000). There are different approaches to generalisation. In inferential generalisation the findings from one setting are generalised to other settings or contexts (Lincoln & Guba, 1985). Theoretical generalisation allows analytical concepts to be applied more widely to theory (Strauss & Corbin, 1998), possibly starting from a case (Seale, 1999). Representational generalisation is where the conceptual analysis of the study population are applied to the parent population (Lewis & Ritchie, 2003).

This study is a process research, with the aim to identify processes which will influence practice. In choosing grounded theory the findings are generalised to theory, and with conducting thematic analysis the 'elements of broader social thinking are contained in individual accounts' (Lewis & Ritchie, 2012, p.233)

8.8.2. Credibility

Credibility is "the extent to which findings are believable and well-founded" (Spencer and Ritchie, 2012, p. 234). Credibility relates to interpretive validity and is concerned with how convincing the claim is, how strongly the data backs up the claim, how well the claim is presented (Seale, 2007; Whittemore

et al., 2001). Interpretive research is a chain of interpretations that must be documented for others to judge the trustworthiness of the resulting meanings (Creswell, 2007). There are a number of ways to increase the credibility (and interpretive validity) of a research study.

In my thesis I have included some ‘raw data’, extracts, from my interviews to enable the reader to judge whether my analysis is persuasive. Extract of the focus group and one interview are included in Appendix 7.

Having my colleague for part of my data collection process, gave me a platform to share my thinking and use her as a peer review. Using multiple data collection, and/or data analysis methods, or different samples, is also a way to check or extend the analytic interpretations and increase credibility. However, authors disagree whether this is to validate the claim or to help form a more sophisticated account (Greene, 1994; Patton, 2002). In my study I used two different methods of analysis, grounded theory and thematic analysis, which I have compared and merged the analysed data for my final findings. I also collected data through both a focus group and individual interviews. I shared my codes with both supervisors, which we read and discussed and also coded parts of the interviews together (an activity we did separately and then compared). Furthermore, I attended data analysis sessions, where analysis and data were discussed with peer researchers and the tutor. Part of my interviews were coded by my peers and I was able to compare with my own codes. This was to use it as a critical theoretical sounding boards, to encourage my own reflection and explore alternative interpretations and perspectives in relation to data (Guba & Lincoln, 1994).

8.8.3. Rigour

Rigour is synonymous with methodological validity and is shown by “the transparency of the research process, the defensibility of design decisions and the thoroughness of conduct” (Spencer and Ritchie, 2012, p. 235).

Qualitative researchers suggest reliability is demonstrated by auditability, dependability or reflexivity (Spencer & Ritchie, 2012). Wren (2004) called for researchers to go beyond the “orthodox assurances about reliability and validity to a more critical exploration of their constructions of empirical material” (p. 476) and adopt a reflexive stance. Reflexivity is the researcher making explicit their values and theoretical orientations, and also explicitly assessing the impact of their role and presence in the research context. In my research I adopted a ‘reflexive stance’. Reflexivity is the main concern within the social constructivist framework (Charmaz, 2006). I addressed reflexivity by having myself interviewed (Burck, 2005), moderating the focus group with a peer, conducted the individual interviews of new referrers, and kept a reflexive journal. Feedback from these different processes allowed me to explore my views, beliefs, assumptions, biases, and knowledge gained from experience, all in relation to the topic of the study. Wren (2004) encourages us, as researchers, to acknowledge our subjectivity and accept that data does not verify researcher claims but instead enables interpretations.

Auditability is achieved by the researcher providing a documented audit trail of their reflective practice e.g values, theoretical orientations, roles, impacts (Lincoln & Guba, 1985; Carcary, 2009). In addition the audit trail has to document key decisions made through the research process. It is unusual and unnecessary to publish the full audit trail. A particular research report will only include the relevant portion of the audit trail that is sufficient to fulfil the needs of the report. (See Appendix 8.)

Defensibility is concerned with the soundness of the research approach and design. The two primary concerns are having a clear logic of inquiry (Fournier

& Smith, 1993) and an appropriate sample composition (Mitchell & Bernauer, 1998; Strauss & Corbin, 1998). Both the logic of inquiry and sample composition must lead to answering the research questions.

8.9. Ethics

As part of conducting this research study I attended to ethical issues. Following the acceptance of the research proposal by the examining board, I submitted a request for approval to the Ethical Committee at the Tavistock and Portman. The research project commenced upon approval. Please find the ethical approval in Appendix 1 and Appendix 12.

Multiple roles (as a clinician, researcher and manager) can create ethical issues, in particular the potential power differences in the team and the threat to confidentiality (Coghlan & Brannick, 2001). These issues could have operated against the study findings being substantial and trustworthy. I explored these issues early on with my colleague and acknowledged and worked on any anxieties and reservations the team member had . We worked together for many years and had a good working relationship. I encouraged feedback in our meetings throughout the research project.

Robust self and relational reflexivity was important at all stages of the research process to address the multiple roles and the relationship with the participants.

All research participants were given a written explanation of their involvement (see Appendix 2). It covered the process and purpose of research and the limits of confidentiality. They were informed that they can withdraw from the research at any time.

Participant anonymity, and the anonymity of any families mentioned in the clinical work, was assured in the transcription of data (the consent form used

for participants is included in Appendix 3). I informed the participants about how I intended to publish and use their material. I also informed the participants of what would happen the audio recordings, journals and notes taken. I will destroy all of these at the end of the Doctoral degree. (See Appendix 7 for a sample of the transcript).

Confidentiality and protection are the major ethical concerns when conducting focus groups (Plummer-D'Amato, 2008a, 2008b). The focus group participants knew each other from their work setting, and some of the participants also worked directly with me, so there are additional privacy concerns that had to be addressed. In addition they might also feel obliged to participate. I explored this possibility with them in our case consultation and reiterated that they can leave the research at any time. As the moderator I ensured that ground rules were set at the outset, and emphasised that anything that the participants were privy to during the focus group was to be kept confidential (Parsons & Greenwood, 2000).

My subject matter, discussing a method of working closely with referrers, appeared relatively safe compared to more socially emotive subjects. However, there was no guarantee that some unexpected disclosure would not take place, or that experiences in the group might affect working relationships following the group. This meant I offered the participants a debrief session and if necessary advice on where they could seek further help; none of the focus group participants took up the offer. During the reflective discussion within the focus group, a couple of participants shared how surprised they were when their position with their client family, and presumably beliefs, was challenged. As all the participants knew each other in a professional capacity, a space for reflection was created and respected by the others. As the moderator I offered the affected referrers a space after the meeting for support. This was not taken up as the individuals reported that they felt comfortable and heard in the group.

At the start of the focus group I outline the aim was to explore diversity and a range of views rather than to find a consensus (Kitzinger, 1995). To reduce anxieties regarding their level of knowledge or previous experience, I stressed the point that there is no such thing as a right answer (Plummer, 2008).

I sought and obtained written consent for the audio recording, taping and transcription of the interviews (group and individual) and the publication of their anonymous material.

9. Findings

In this chapter I present the analysis of the individual interviews and focus group, focussed on the experience of referrers. Although I used grounded theory to analyse the interviews and thematic analysis to analyse the focus group both methods of analysis generated very similar codes. There were differences but these were minor. Given this is a process research study I have elected to talk about significant processes and sub-processes, rather than the themes of thematic analysis or the categories and axial codes of grounded theory.

The themes from the focus group informed the categories and axial codes of the grounded theory. Appendix 10 details how I synthesised the focus group themes with the grounded theory categories.

The combined analysis enabled me to identify four significant processes: Naming power, Opening Dialogues, Engaging the system in the room, and Working Collaboratively. Each significant process has 4 to 6 sub-processes.

Table 3 shows where the data supported each sub-process.

Significant process	Sub-process	FG	I1	I2
Naming power	Oppressing the client	✓	✓	✓
	Dealing with the court	✓	✓	×
	Taking sides	×	✓	✓
	Seeking help	✓	✓	×
	Moving to a both/and position	✓	✓	×
Opening dialogues	Expanding ideas about confidentiality	✓	✓	✓
	Working transparently	✓	✓	✓
	Balancing and interweaving voices	✓	✓	✓
	Developing a different view of the family	✓	✓	✓
	Feeling uncomfortable	✓	✓	✓
Engaging the system in the room	Creating connection	✓	✓	×
	Watching the family therapist intervening	✓	✓	✓
	Seeing the family change	✓	✓	✓
	Improving the referrer-family relationship	✓	✓	✓
	Reflecting on own work	✓	✓	✓

	Building up engagement skills	✓	✓	×
Working collaboratively	Joining forces	✓	✓	✓
	Collaborating professionally	✓	✓	×
	Family owning change	✓	✓	×
	Evaluating the 3 Way Meeting	✓	×	✓

Table 3: Significant processes and sub-processes

Notes:

- FG = Focus Group
- I1 = First Interview
- I2 = Second Interview

9.1. Naming power

A significant process uncovered in the Referrer Engagement Method was 'Naming Power'. The referrers acknowledged their power over the client and its oppressive nature. Referrers also took sides between the parents effectively sidelining one of the parents. Where the court was actively involved, both the family and the referrer were disempowered. But in the mere act of referral referrers acknowledged they needed help with the family and approached the family therapist for support. The referrers noticed the family therapists taking a different approach to power.

9.1.1. Oppressing the client (Naming power)

The majority of referrers were social workers working in child protection teams. Some of the families were on a child protection plan and for some the

court was involved. In response to questions about their relationship with the families, and engagement with the Parenting Project, they brought in the issue of 'being statutory'. Their own role is 'statutory' and, in their view, 'oppressive'. 'Being statutory' had an impact on their relationship with the families and kept them in a position of unequal power. The social workers viewed their role as managing risk and, as the parents represented a potential risk, the referrers were in a position to judge their clients. The referrers were working from the domain of production (Lang, Little, & Cronen, 1990) and they considered their responsibility was to 'fix' the problem which the family presented with. The referrers consistently contrasted their own approach with that of the family therapist. The social workers viewed the family therapist role as different, focusing more on listening to the family's narrative (Domain of Explanation) and paying attention to engaging the family as a response to their representations in the meeting (Domain of Aesthetics). According to the referrers a professional was either statutory or voluntary, and the different domains did not overlap. The referrers focussed on what the family needs to change, 'or else', pushing the change desired by Social Services without the family having a say in the plan.

> *David-1 (p.11) I would say you need to change this or this is what happens; whereas actually she [family therapist] focused more on their motivation, what is it, what would be the positive effects of you changing the situation and what would it be like if things didn't change. ... I kind of say well you need to change or else. I think that was more helpful.*

The referrer's position, trying to impose change, negatively impacted the family's view of self. He thought the family felt 'less important', lacking voice and being 'suppressed'. Although he wished to, the referrer felt he was not able to give the family the time or space to express themselves.

David-1 (p.8) Whereas in my meetings I guess they are slightly more suppressed and I'm here under a statutory role and I need to discuss these things and I'm not going to give them the space to argue, this is not where this happens.

'Being statutory', the referrer's saw themselves as focussed on risk and risk management. The focus on risk interfered with the process of engagement with the families, meaning they engaged the families in a less sensitive way (compared to the family therapist) and lacked the capacity to address issues sensitively.

Adam (01:09:15, p.30) so even if you were concerned the way you guys asked questions I think it gets around things quite nicely. I think for us -- I bet we want to do things like that, but sometimes because of the pressure we're under it's like you go all right f-ing I'm just going to -- especially if you've got a parent where you've almost lost your rack, you've lost your patience.

'Being statutory' also meant the referrers believed their relationship with the families would always be 'uneven'. Whether or not the relationship is difficult with the family, the family needs the referrer's help and the referrer has the power to help.

Adam (01:06:55, p.29) The best way I can put it is that it's always going to be an uneven relationship ...but they do want some support with housing, so you become their social worker... Although not officially part of their role, referrers can make judgements about the families.

Yvonne (01:11:35, p.32) its part of our job not to judge them, but we do make judgements. We have read all over the report about them

The referrers saw a tension in their role between wanting to provide the family with sympathy. This was sympathy and not empathy, feeling sorry for them but can not feel their feelings, keeping an emotional distance. At the same time they had to talk about the risk the parents pose for the children. They perceived being warm and showing 'sympathy' as a 'luxury', not an essential part of their work, in contrast to assessing risk, which viewed as 'realities'. This tension impacted the relationship with their families.

Yvonne (00:56:47, p.25-26) I think is the difficult thing with our job that we do have to speak out some realities and that's hard for them and it is painful for them. The problem is we don't have the luxury to say, oh poor you, we try our best to be sympathetic.

The referral to family therapy itself can be an expression of power. A social worker can mandate attendance. For example, Shelly talked about the power of making recommendations that the family had to follow, of the ability to influence families' decisions, not through her relationship with the client, but through representation of the state. Shelly said that when the relationship with families is difficult, having the family therapy referral as part of their child protection plan reinforced the family's engagement to therapy.

Shelly (00:25:16, p.11) If it's not built into the plan, I don't think they're willing to go

The power dynamic between the family and the referrer extended into the 3 way. The families are mostly attending the 3 way following the referrer recommendation; the families are following the lead of the referrers. The referrers have an advantage by having more information about the process and by bringing them along.

Shelly (01:27:44, p.38) We've got the advantage of having prepared our case because we've done a written referral, so that power dynamic is still there and you can't get away from that.

Pam's situation demonstrates and supports the split the referrers made between statutory and voluntary, as she operated from a voluntary service . In contrast to the other referrers, Pam was a family practitioner working in the voluntary wing of Social Care. She used language of choice with her families when referring to the Parenting Project. Families had more say when working with voluntary services. This seemed to require more focus and emphasis on engaging by the referrer.

Pam (p.8-9) I feel that if they want to have therapy say yes or no

Despite being the only referrer with a voluntary contract with her family, Pam was aware of the power she held in the relationship with her client. Pam was preoccupied by ensuring the family had a voice and did not feel dictated to and wanted her client to have a choice on the engagement with the service. Pam believed that the family would disengage and the work would be less productive, if the family did not express their needs and opinions.

Pam-2 (00:23:54, p.18) 'Cause I don't want them to feel, 'oh, Pam says that I need therapy and then at the end of it think, I don't really need it, but I just did it because Pam said'.

In contrast to their own position, the referrers viewed the family therapist to be both voluntary and 'therapeutic'. They saw these positions as allowing the family therapist to give families more space to share their stories about their family, use a language of choice and focus on their motivation for change. This meant the family therapist was able to engage the family in the process of change and helped them to be an active participant.

David-1 (p.10) So I think a lot of the things that we call voluntary are kind of we force the parents into them. There is no voluntary aspect really about it. But I like the idea of this is what you're willing to put into it

Ana-1 (00:25:17, p.8-9) It changes the scene. It becomes something different when you're involved. It doesn't become about social work, it becomes therapeutic which is probably what, you know, most social workers want to be doing something more like that ... But the role doesn't, although it kind of lets some of it in.

Due to their role, representing Social Care, the referrers did not expect the family to share 'sensitive' information either with them or in front of them. I found it significant that workers from both the statutory and the voluntary part of Social Care shared this view - that the family would share different information with them and with the family therapist. They saw their role as defining the relationship with the client, communication, and the level of information shared.

Ana-2 (00:12:17, p.9) In terms of being a social worker and you know, he's probably…he probably feels really differently about you and what he can tell you and how he can express himself and what he needs to tell me, it might be something different

The referrers assumed the family would distinguish between Social Care and family therapy in the same way they did, i.e. very different with no overlap. From the social worker's perspective the family therapist can create a neutral space and they cannot. As Ana put it the family therapist can provide "a more kind of neutral territory" as opposed to us, and the family was only expected to open up in a neutral space.

9.1.2. Dealing with the court (Naming power)

In cases where the court was involved or the family was on a Child Protection Plan, the higher context changed the dynamic between social worker and family. The effects were positive or negative for the referrer but generally difficult for the family.

A social worker can feel protected by the court when working with families that are difficult to engage. The court reinforces the social worker's own power when working with the family, meaning the families are more likely to follow directives.

Yvonne (00:24:32, p.11) …but even if the relationship is difficult or the dynamics are very difficult, the parent doesn't engage at the time with the social worker, if you have the CP context of the court board, you are a little bit protected

Attending, however, is not the same as engaging, and some referrers noticed that having the court involved can interfere with the family's engagement in therapy. Families can be more hostile and display negative behaviour, which

can slow down their ability to engage in reflection. This situation changed when the family started to trust the family therapy space – away from the court and Social Care.

> *Adam (00:21:45, p.10) she was quite hostile and there was a court order in place, so I think that was the context of that, but I think that she was aware that after that it was her time and place and she used that.*

When the family is on a Child Protection Plan, with a court involved, there is additional pressure on both the social worker and the family. Both referrer and family can feel powerless in the higher context, which results in a more rigid interaction between them, having to follow up procedures and particular structure. This 'ruins' any positive relationship they had before.

> *Ana-1 (00:20:05, p.16) Whereas in court she probably felt… They were forcing her to do a lot.*

> *Ana-1 (00:22:41, p.18) As much as you try… you're having these connections with these families outside of that the second you go in there. All of that structure is in place, it kind of ruins it… So, it's quite difficult… And because of the language you use when you write reports… And you worry about the court.*

So, perhaps not surprisingly, when the court is no longer involved, the referrer experienced the client as engaging better and being more open about problems.

> *Adam (01:24:01, p.36) I mean if I go back to this end case with the mother who has a drug problem, she's actually been more open about her problem and going to seek help. Something she couldn't do when we were in court*

9.1.3. Taking sides (Naming power)

The referrer saw their main duty as safeguarding the children. This influenced their process of engaging the parents. Most of the referred families were comprised of separated parents. For the referrers the meaningful subsystem was the children and their main carer. This priority led to a more difficult relationship with the other parent - the marginalised subsystem who was viewed as less safe. The referrers did not hold a systemic perspective when working with families and did not aim for neutrality in the process.

All interviewed referrers described a split relationship within the parental couple they dealt with. All referrers had a good relationship with one of the parents, the main carer of the children or the parent they thought should be the main carer. The referrer had conflictual and difficult relationship with the second parent, if they were in the picture at all, and this other parent was considered 'less safe' for the children.

> *David-1 (p.2-3) My relationship with dad was quite good because we were both on the same page. Dad was asking for the children to live with him permanently. And myself from the local authority was supporting that, so I think because of that we agreed on most things. My relationship with mum was more difficult because I was suggesting that her children lived elsewhere and she obviously wanted her children to live with her. … She often felt blamed and myself from the local authority was against her. So my and mum's relationship I think at this point was quite difficult and she felt very blamed, very accused and like all the pressure was on her.*

Jez reported a "reasonable working relationship" with the main carer of the children, but in this case the client was a single mother and the father was not involved. Dealing with a solo parent meant Jez did not have to choose

between the parents, and this meant the relationship was more positive overall.

> *Jez-1 (00:26:23, p.15) I suppose being consistent and responding to them. I've always, you know, the telephone calls that come to me, I tried to respond to them pretty quickly … And also just try to…I listen to what they're actually looking to achieve themselves and if there's a change they'd like to make in their lives. Sort of working together how we're best going to do that.*

Ana also spoke about 'taking sides' in a later stage of our work with the family (Review meeting). This may reflect her context of work, as the parents were in a difficult process of divorce. At that stage the work, more changes had taken place in the family through engagement in therapy, which had an impact on their work with their referrer. A positive change in one part of the system created a new challenge for the referrer. The referrer's position on any change, and how they deal with it in their work, can have a significant impact on the outcome of the family's work.

As with most of the referrers, Ana's significant subsystem was the main carer (mother) and the children. The father was outside this subsystem but had contact with the children. As the therapeutic work progressed with the father, and he made positive change, Ana found it harder to stay in her one sided position. Siding with one subsystem compromised the relationship with the other subsystem. This imbalance challenges the social worker's position. Their position needs to evolve and reflect the acknowledgement of the change the family had made. This can challenge the existing relationship. Concern about retaining the positive relationship with the meaningful subsystem challenges the referrer to move to a more balanced position while working to retain the positive relationship.

> *Ana-2 (00:13:05, p.9) I have to be mindful going back to her that I'm not overly positive about him, do you know what I mean? But I still have to remain really neutral otherwise it ends up really difficult.*

For Ana, the change in the marginalised subsystem pushed for a change in the way she was relating to family. The social worker had a choice in how to respond to this imperative, either embracing the change or protecting the meaningful subsystem. Protecting the meaningful subsystem involved delivering a compromised version of the change and minimising acknowledgement of the change. This approach perpetuates the referrer's position of taking sides.

> *Ana-2 (00:13:59, p.10) I'm not going to go back to relay this with her but you know, I do sort of give her a little bit of feedback to try and make her feel better about the fact that contact is probably really positive because he's putting all this work in which you know, I want her to take on board. But I have to be mindful that if I'm too positive, that compromises my position with her.*

By responding to the change in different subsystems in the family, the social worker works hard to take up a more neutral position in their work with the family. This approach would enable and invite for more changes in both marginalised and meaningful subsystems. As a result of the positive change the father was making, Ana started giving the father more voice in their work but not equal to the main carer. This helped her work more inclusively with the family and have all voices represented in the process. Ana no longer side lined the father as she had done previously.

Ana-2 (00:17:35, p.12) it's a really helpful one with dad and getting to know dad. Otherwise, he would be…to be honest, if you weren't involved he really would be quite side-lined. He would come to the meetings, I wouldn't be able to…yeah, I don't think his voice would be part of the process really.

It helped the referrer to expand their views about the family dynamic.

9.1.4. Seeking help (Naming power)

In the process of assessing the need to refer a family to a therapy service, the referrers reflected on their own work with the family - how it is progressing, whether they can help, who else can help the family, and what the family needs. The referrers were seeking support with their own work with the family.

The intent behind the referral was for the family to make more changes following their work with the referrer. When a referral was made at the end of the social worker involvement, the social worker's position was less influenced by working with the service and attending the meetings. The referrer viewed the 3-way meeting as a handover meeting to a new service, which would follow up from their work. They viewed their position as external to the family work.

All referrers assessed the needs of the families and shared a hope for change by referring to family therapy. However, for these families any further change was expected to happen in therapy, away from the referrer and their associated position of power.

> *Jez-1 (00:00:44, p.1-2) I felt that they were people who could really benefit from some kind of sort of therapeutic intervention. That they would have sort of their own space to sort of somewhat away from perhaps my role as a social worker.*

Referring to another service, and having to attend a Transition Meeting with the family, challenged the power dynamic between the referrer and the family. They were both seeking help. Both the family and their referrer were recognising a need for help in the process of change.

The specific reasons for referral differed. Jez saw his work as a social worker was completed and sought to hand over to another service to complete an 'in depth ' work focussed on the family relationship. Yvonne and Gary referred to get similar relational work but earlier in the process, i.e. not at the point of completing their work with the family. Pam was worried about giving the family the 'wrong advice'. Pam and Adam both spoke about limitations in their role and lacking some skills to deal with complex emotional needs. Ana wanted help in building and improving her relationship with her clients. David and Shelly spoke about feeling 'stuck' in their work with the family. For Shelly referral was reinforced by being a recommendation on the Child Protection Plan.

> *David-1 (p.2) It's the progress of the work wasn't really going anywhere, so I referred to your service*

Shelly talked about referring to family therapy at a low point in her own relationship with a family. A time when she felt stuck in her work with the family.

> *Shelly (00:100:27, p.5) I've been at quite a low point in my relationship. It's where I felt stuck.*

> *Shelly (00:30:56, p.14) We're stuck here. One of us isn't getting it, it's either the parent or it's me. We are stuck, let's bring someone else in.*

Adam referred at the point of needing help. He had a positive working relationship with the family, but believed the presenting issues were beyond his capacity and he “could not resolve them”.

Yvonne described referring a family that had difficulty with communication. Looking at the historical pattern in the families of origin, Yvonne thought engagement with family therapy would help the family to untangle the patterns of communication.

> *Yvonne (00:07:15, p.4) Because of the complexities in this particular family's communication I think communication was the key.*

Gary referred families experiencing substance misuse, mental health problems, and that presented difficult relationships within the family.-complex needs.

> *Gary (00:15:42, p.7) there were concerns with alcohol, potential drug use ... And then there were clear problems with the relationship between mum and daughter.*

Shelly described a case where referring was part of the Child Protection Plan. In this situation the referrer was following recommendations.

> *Shelly (00:08:13, p.4) For my family … I think it was a planned intervention that was on the child protection plan and the mother agreed*

In this case the relationship with the family was difficult and she was doing it to show ‘good will’ to the family. The potential need for a specialist service was present but secondary to their difficult relationship. Upon reflection, in the focus group, Shelly identified a potential need for herself as well, she would benefit from expanding her perspective with this family, which could help with the referrer – family relationship.

> *Shelly (00:100:50, p.5) I just needed to show them some good will by offering this specialist service and saying okay, we're not communicating well, let's try someone else, but maybe they do need a more specialized service and I perhaps need to see a different perspective as well.*

Ana spoke about the need to build up good relationships with the family. She expected to achieve this by referring to a service she experienced as positively able to build a good relationship with families. Ana had some previous experience of the Parenting Project, which raises the question whether her focus on the relationship was influenced by this previous exposure.

> *Ana-1 (00:00:42, p.1) having worked with you before I know how you work and in terms of the way you interact with me and the really good relationships you build up with what can be some complex cases, I decided to refer this case to you.*

Due to his long involvement with the family, Jez saw the referral to family therapy as ‘almost’ voluntary, as far as the family was concerned.

> *Jez-1 (00:04:52, p.3-4) I know the clients well enough that I'm working with to sort of assess whether they are A, ready for it, B, I've quite clearly talked to them what the role would be for yourselves and with the beneficiaries and it's almost to the point where they arrive at a definite yes or they're almost asking me to make the referral anyway for an identified service.*

The social worker was still holding the power in referring the family to family therapy, but the long term relationship and transparency in the process of referring, seemed to change the family's relationship with their social worker and the way they worked became more collaborative.

9.1.5. Moving to a both/and position (Naming power)

The statutory referrers initially worked solely in the production domain (Lang, Little, & Cronen, 1990). They were trying to mandate change on the family. The Referrer Engagement Method exposed them to a way of working where a professional balances risk management and client engagement.

Ana emphasised how seeing the family therapist both having good relationships with clients and keeping open communication with the referrers around risk, was an unexpected ways of working.

> *Ana-1 (00:12:36, p.10-11) the fact that you communicate with us more than other therapists might, is really useful … And still build a really strong relationship with the clients*

Dana liked the idea of fostering good working relationships with clients but expressed some concern about how she would manage boundaries when doing so. She found it challenging to do both, with the fear of having to compromise on her ability to do her work. It was challenging to move from an either/or to a both/and way of working and relating with families.

> *Dana (01:20:19, p.35) And I think if we can work on removing that, obviously you have to have your boundaries where you can foster a much better relationship, working relationship.*

Dana appreciated the importance and the benefit of learning new information from the family but worried that this would compromise her own position when working with the family. She saw it as two separate skills which she found challenging to integrate together in her work. She was worried that any emotional engagement would possibly interfere with her work and that she saw a need to grow 'thicker skin'. This point seemed to be highlight Dana was not sure how to respond to these disclosures nor how to process them for herself. These disclosures seemed to be beyond Dana's professional capacity.

> *Dana (00:47:23, p.21) when she started describing some of things that had happened to her, you know, I was like woo. It was helpful and you have to try and grow and develop a thicker skin.*

Following taking part in the 3-way meetings, and having observed the family therapist, some social workers reported that they were able to hold both positions, managing risk and putting focus on listening to the family narrative and needs. Crossing domains enabled a better working relationship between the family and the social worker. The family felt less oppressed and more listened to. David addressed the effect of the transition meetings on his own practice.

David-1 (p.14) I've changed the questions and language I use and I guess the work I do with her now is less oppressive and it's more how can I help you rather than you need to do this and this and this. Which has an element of that because that's partly why I'm involved.

Despite the constraint of their statutory role, the change of position extended beyond the Transition Meeting making the social worker's engagement more 'therapeutic'.

Ana-1 (00:25:17, p.8-9) you're involved. It doesn't become about social work, it becomes therapeutic which is probably what, you know, most social workers want to be doing something more like that ... But the role doesn't, although it kind of lets some of it in.

Adam spoke about how holding a both/and position got easier and found a way to share information in a transparent way which was not 'condescending' or 'oppressive'. When Adam was able to hold a 'both/and' position – transparent and keeping a positive relationship – he found the meeting useful for both himself and the family. Adam spoke about 'bring(ing) about shared responsibility'. This applied to working collaboratively with the family in a session, which possibly brought more of a sense of mutuality into the context.

Adam (00:11:31, p.6) I found it quite useful, you know because it sort of brings about some shared responsibility.... And I think as a worker, you try and find a way that's not too condescending and not too oppressive for that parent to hear so you find a balance of how you present those difficulties.

The referrers reported that the family therapist collaborated well with the referrers without compromising their relationship with the family. By doing this the family therapist demonstrated an integrated way of working from all three domains, production, explanation, aesthetic (Lang, Little, & Cronen, 1990).

The production domain by assessing and managing risk and collaborating with the referrer. The explanation domain by listening and understanding why the family are going through some experiences in their family. The aesthetics domain by looking at how to engage the family and being mindful of their emotional state, which can contribute to their patterns of interaction with all professionals.

9.1.6. Naming power

Referrers viewed their contract with the family as one of mandating change. Mandating change put the referrer into a powerful position relative to the family. As a result they thought the families felt oppressed, lacking voice, and not important. The active involvement of the court contributed to there being a more difficult dynamic.

In these separated families the two parents were not equal in the eyes of the referrer. At the point of referral the interviewed referrers had a split relationship with the parents. The referrer took sides and the relationship with one parent was significantly worse. This split reflected the referrer's assessment of the safeguarding of the children and created a meaningful subsystem with a hierarchy of stakeholders. The referrer is primarily concerned with engaging the children and their main carer. The parent considered less safe was not their priority in engagement and may not be engaged at all. This demonstrates a linear view of causality from problems to solutions (removing the children from the less safe parent). This bias made one of the parents even more powerless in an already challenging relationship - they became a marginalised subsystem.

At the point of referral, the work with the families had stalled and the referrer saw a need for external help. The process of seeking help shifted some power away from the referrer.

The referrers observed that the contract with the family therapist enabled them to help families to feel empowered, have a say, become active participants in change, and include all members of the family. They witnessed the family therapists doing this whilst also acknowledging the importance of risk management and safeguarding for children - holding a both/and position. However, referrers struggled to do this. Initially social workers saw an unbridgeable differentiation between their own role ("statutory") and that of the family therapist (voluntary / "therapeutic"). Following their involvement in the systemic approach, some referrers discussed beginning to adapt a more integrated position. They reported a change in their position of power moving to more of a both/and position, which enabled some positive shift in their relationship with the client.

9.2. Opening dialogues

The interaction in the 3-ways were more open and transparent than the referrers expected or had experienced previously. This expanded their ideas about confidentiality. The referrers observed the family therapists actively encouraging transparent working and attempting to balance and interweave the three voices in the room (referrer, family and family therapist). This process helped the referrers to develop a different view of the family, although the process could be uncomfortable. I have chosen to call this significant process, Opening dialogues.

9.2.1. Expanding ideas about confidentiality (Opening dialogues)

When they referred their clients to the Parenting Project, the referrers had an expectation around confidentiality and sharing information. The social workers (statutory) generally had very low expectations about being part of an open dialogue with therapeutic services. They viewed the therapy space as

separate from social services. This was seen as a space where different work could be achieved with the family. The referrers saw themselves as unwelcome in the therapeutic setting. They considered themselves unwelcome by both therapist and family members. This position lowered the referrer's expectation of having an open dialogue about the family work. Despite the fact that they expected little information, their preference was a more open sharing communication - a type of communication they reported experiencing with the Parenting Project.

Information sharing and open communication between the referrer and family therapist, following the confidentiality policy, enhances collaboration about the family.

Referrers expected limited communication with the family therapist to protect their client's space. Expecting an overview, they did not expect the "gory details".

> *Ana-1 (00:28:25, p.22) ...I think it's useful because you don't, yeah, you don't give me like, the deep, you know, gory details … It's more a perception of an overview of how they're doing if that makes sense.*

Given the family therapy space was for the family, the referrers expected their own active engagement in the therapeutic process to stop after transferring the family to the Parenting Project, briefing the family therapist on difficulties, and possibly some initial support.

Jez-1 (00:09:03, p.6) I think it's quite important for them to realise that it is their space, it's very much about them looking at themselves and them looking at their own needs, their own difficulties and actually as a social worker, yes, I'm there for perhaps the initial meeting just to turn around and talk about some of the difficulties, but it isn't about me, it isn't about the department, but moving forwards.

Referrers saw their role in the engagement with family therapy as administrative, promoting attendance and managing the family's appointments.

Pam-2 (00:17:32, p.13) 'Cause I think that's their space … Yeah, unless they wanna tell me. But I'll just check up and make sure they're going and… Yeah. 'Cause I don't really wanna delve into…that's their little… separate space.

With the exception of safeguarding, the referrers viewed any future discussion about the family as outside their remit.

Pam-1 (00:08:56, p.15) I think with mum, that'd be confidential between the two of you unless like you said any safeguarding concerns.

The referrers found the Parenting Project different from other therapeutic services. They thought the family therapists were open to discuss more about their families. They began to see a more inclusive way of working between adults services (like the Parenting Project) and children's services – holding a more systemic perspective.

From their experience, other therapeutic services did not share information about the progress of therapy. Referrers found this frustrating. They did not

know how the family were progressing and were looking for evidence of change. In the absence of information they made assumptions.

> *Gary (00:38:57, p.18) ...when families are going off and having counselling. It's feeling that if they are going it's being effected and there's a good outcome. And you don't get anything back and you can work on that assumption without any evidence to show it.*

Although referrers expected therapists not to share information, they were aware that they needed the information when working with their families. Referrers wanted more insight from the therapeutic process. They wanted to know how change took place for the family. The referrers did not feel in a position to challenge their confidentiality expectations, even if they had the need for the information and felt frustrated with the process. Shelly said this was particularly important when her view contradicted the therapist's view and more evidence for change was needed. When discussing the Parenting Project (called "Meanwhile" here):

> *Shelly (00:41:49, p.19) It's like showing your workings, isn't it, because Meanwhile [i.e. Parenting Project] if you're going to come back to us and say actually this parent is functioning very well. They're taking care of the children's needs, I would want to know how have you reached that conclusion because that's not my observation.*
>
> *And I would be thinking what's going on in that room because I can't imagine that conversation. It's about knowing how you got there.*

Ana thought other therapeutic services hesitated to share with social workers in order to protect the client's confidentiality. She also thought they might be scared of Social Care and the court, and these institutions' ability to interfere with the therapeutic relationship with the family.

Ana-1 (00:27:38, p.22) [other services] wouldn't ever speak to you after that three way, do you know what I mean? They wouldn't really give you a – they wouldn't give you any updates or have an open conversation about the case or anything like that … So, they're protecting, you know, confidentiality which I understand but yeah, I think they're scared of social services, they're scared of court work or the mention of court work even though we don't ask them to do anything like that

One referrer, Yvonne, was concerned that other therapeutic services, by not talking or sharing information, were insufficiently child focussed. This could create different views of the family by the adults and young people services involved, with split views between the two services.

Yvonne (00:40:27, p.18-19) I have to say they are quite open compared to other services ….in some situations you are very, very concerned about what this work is doing because it's split, they don't want to even have an open communication with you about, you know, they are struggling to be more child focused

The confidentiality expectations of two referrers, Yvonne and Pam, differed from other referrers. Both expected a level of information sharing from the therapy services and a sensitive and protective way of using the information about and with the family. Yvonne is a social worker who had trained as a counsellor. She spoke about her expectation of confidentiality from a more integrated position of respecting the client's privacy, and not using the information in a statutory document, and as case coordinator still expecting to learn from the therapist about the direction of their work.

Yvonne (00:40:27, p.18) it's not all about finding out problems or trying to get information that you're going to use for your superior reports … we need to have some respect that these people, you know, say very personal things. But just getting a flavour that this work is moving and there is change in the dynamics.

Pam, from a voluntary sector, also expected a degree of collaboration and information sharing between the two services about issues that might rise in the sessions. She saw this as a platform to work jointly to support the family.

Pam-2 (00:06:01, p.4) Because, I mean, if anything happens in-between us and the parent, I can let you know or if anything's come up for you during your sessions, you can let me know. And maybe we can work on that in-between. If there's anything that they need to work on, let them work on it together.

9.2.2. Working transparently (Opening dialogue)

The referrers experienced the engagement with the Parenting Project as involving greater transparency. Transparency came with both benefits and challenges for the referrer.

The referrers were accustomed to one way communications, from Social Care to the family. Having an open conversation between the referrer and the family in the 3-way meetings, with the family therapist as a facilitator/witness, created a contextual change in the referrer-family relationship that led to different interactions.

The referrers talked about sharing difficult information with the family in the Social Care context. They shared information with the family from a position of power without giving them a chance to influence it. This imposed challenges on the referrer in relation to transparency.

> *Ana-1 (00:23:08, p.19) I don't know because you still have to be really honest about what's not working … which comes across in a certain way to families. And then it's difficult to, I mean, we do, like the strength based stuff , sign of safety and write about our strengths and then sometimes, I think we even avoid writing about the negative things because it's too hard sometimes.*

The referral process encouraged transparent conversations between family and referrer and collaboration on the referral itself. Transparency was introduced from the initial conversation, between the referrer and the family, about a possible referral to family therapy, especially for the referrer from the voluntary sector.

> *Pam-2 (00:02:07, p.2) I spoke to mom about the service and, you know, asked her if it's something that she felt that she wanted.*

Transparency continued as the referrer and family wrote the referral form together.

> *Pam-2 (00:02:33, p.2) Get mom to give her views as well and then just send it off.*

Given the transparency, the referrer had to pay better attention to language, use of words and clarity, so the family would understand the aims of referring and feel welcomed to participate. Having the space to explain this to the family was a new experience.This in turn can impact the family's agreement to participate in therapy and engage in the process.

> *David-1 (p.1-2) it wasn't just me writing down something on a piece of paper and then reading it, I was able to explain and make sure that they understood why I was referring the family and also what I wanted from them.*

The Transition Meeting was a place to share family history and safeguarding concerns with the family therapist, who was going to 'take over' the case. The meeting was seen to be about reporting 'facts'. Jez thought his involvement ended at that point, and was not expecting a discussion, but thought it 'very useful' to be present.

> *Jez-1 (00:05:49, p.4) But as far as my voice and my side of things, I think it's really good process meaning for you as a service to sort of get a bit of a background and my perspective.*

The referrers reported benefits from the transparency process. The open transparent conversation with the family expanded the referrer's knowledge about the family history. The referrer viewed the family as expert about their life.

> *Ana-1 (00:13:29, p.11-12) I suppose just being open with them and saying, actually, I need your input because, I mean, I don't know that far back in your history … I need them … Yeah.*

Discussing the family and their life openly, and including the family's voice in the discussion, empowered the family and enhanced the referrer's knowledge of their family which could influence their interaction. For David it was also the first time the couple were present together in a meeting with him. This created a new context, and possibly influenced the conversation, and what and how the participants both heard and introduced their views. It was also a new experience for the couple, which introduced an opportunity for transparency between them too.

> *David-1 (p.16) I think it's [the relationship] improved since then. I think because the final meeting the parents had heard me say why I said -- I think it was good for them to hear it again in front of a professional to both of them after they've heard me either speak to one or the other*

Transparency contributed to more trust in the referrer-family relationship, and the referrer was able to communicate their concerns openly with the family.

> *Pam-1 (00:00:15, p.2) I feel that this worked really well. I like the way that we can introduce the parent to the therapist straight away. And I like where the therapist wants my opinion or the reasons for why I've made the referral. And it's also transparent if the parent is here so that they know what I'm thinking, so there's not any secrets. So they're aware of what I'm thinking and why I've made the referral. And it's good to hear if they feel that they agree with why I've made the referral and sort of actions that we want to come out of it in the end.*

For one of the referrers, David, transparency is a form of 'professional' accountability. He cannot hide behind written words.

> *David-1 (p.2) I've never done with the family present and I think that worked well in terms of like professional accountability. But I think often it's very easy to write things about a family in an e-mail but you wouldn't necessarily say it to them face-to-face. I think it was good for them to hear the reasons why we're all together.*

For Adam transparency was useful as it brought a shared responsibility between all participants.

Adam (00:11:31, p.6) over the years I think I found it quite useful, you know because it sort of brings about some shared responsibility, you know.

Unlike the other referrers, Jez saw his relationship with the family prior to referral as very open and good. Jez felt the Transition Meeting revealed little new information for him. He saw the family therapist as the main beneficiary of the transparent communication in the Transition Meeting. This can possibly be explained by Jez's focus on risk management.

Jez-1 (00:32:44, p.19) talking to them in your sessions I found there would be nothing new, particularly, to them. And there wouldn't be any great alarm because we've either gone through it all today or spent many weeks trying to sort of think about how we can move forward.

Ultimately transparency, during the Transition Meeting, contributed to each referrer being able to co-create a mutually agreed plan for the therapeutic work.

Jez-1 (00:11:20, p.7) the target areas have been accurately communicated and we've been able to sort of draw together a plan and work from there.

David-1 (p.5) And we came up with some agreements of what the next meeting would look like.

Transparency enhanced joint work between the family and referrer.

Jez-2 (00:10:33, p.6) I've always been quite used to having these kind of review meetings and I think they're always really, really beneficial and really useful. I think they're important for the family, I think they're important for us as transparency and we're working together.

The referrers reported how being transparent with the client challenges their power over their clients. They noted that clients feel vulnerable, exposed, and anxious about the family's reaction to what they share in the meeting.

David-1 (p.5-6) I guess I felt a little bit vulnerable because I was with the family -- I'm trying to explain -- vulnerable in the sense that I was saying these are the reasons that I think they need help. And being aware that they might not necessarily be things that they would agree with

Shelly (00:53:54, p.24) Yeah, so I think in terms of trust maybe that does help because they know that we're putting our neck on the line as well. I think that particular mother did.

It was important and beneficial to hear the family's views but it also could highlight their polarized position which was challenging for both the referrer and the family. It helped in having an open dialogue between the referrer and the family-having to find a way of saying things that are difficult and having a space to listen to the other.

Shelly (00:53:00, p.23-24) it was difficult to find any common ground, but I think it needed to be said. And I think I needed to hear what she was saying as well.

Transparency also existed between the referrer and family therapist. Hearing new information from both the family and family therapist encouraged the referrers to reflect on their work with their clients.

Ana-2 (00:01:18, p.2) being able to go over everything with him clearly in terms of what our plans are. I think your questions were really good because they…because maybe I haven't really thought about exactly what the goals are and what our plans are in terms of your therapeutic input and in terms of what we want.

Shelly asked for feedback from the family therapist which opened up different views and provided a place for her to express her own perspective
. This can challenge hypotheses and influence our lenses.

Shelly (00:38:19, p.17) I think you gave honest feedback and gave a different perspective when you saw the mother with the children. And I thought, mm.

Keeping a feedback loop of transparent conversation influences all parties.

Pam-2 (00:19:03, p.14)if they told you something and then you give me a little snippet of it then it automatically will make me shift, I don't know if that's a good thing or a bad thing, but it will…it will definitely make me think differently about… how I (am) with them

9.2.3. Balancing and interweaving voices (Opening dialogues)

The referrers bring the family to family therapy to have a different, new conversation. The referrers commented on how during 3-way meetings, where all parties are present, the facilitation of the family therapist gave both the referrer and the family space to express themselves. All referrers thought the family therapist managed to achieve a balanced representation of voices during the Transition Meeting and the Review Meeting, including both the family and referrer.

The meeting had different sections that invited different participants to talk. David described a situation where the family therapist was asking each party for their view in turn.

> *David-1 (p.5) Alicia [Family Therapist] I think made a few comments on what she was observing and then asked me to say what the situation was and why they were here and what I'd like them to get out of it. And then Alicia spoke to mum and dad and asked them what they thought about what I had said. And then she asked them what they were hoping to get out of it and what they were willing to put into it. And we came up with some agreements of what the next meeting would look like.*

The referrers felt they had the opportunity to clearly express their position.

> *Ana-2 (00:04:53, p.4) I feel like I was able to express our position quite clearly and that was heard*

And the referrers also saw that the family got a chance to share their views.

> *Shelly (01:04:27, p.35) But you're right, there is a reason why you've come here and I've just had the social workers referral, you're going to have a different perspective, so let's hear that.*

The referrers noticed the family therapist allocated special space for the family's voice and highlighted the voice the family had in the therapeutic process. This voice can be marginalised in meetings between the family and referrer. The invitation to participate, and curiosity from the family therapist to hear their story, gave the family permission to open up. The family could tell their family story, comment on what was said by both referrer and family therapist, and influence the plan of their therapeutic work.

David-1 (p.8) I think also for the family to be given space to express themselves as full as they want really.

Several referrers mentioned being surprised how families opened up including talking about sensitive issues.

Jez-1 (00:15:37) it was quite interesting and I suppose some of the things she talked about I found that she was very quick to open up. …very quick to talk about the difficulties she has and the difficulties…some of the difficulties she'd experienced in her life. Some of the things that were very personal to her and that was something, really, that she hadn't ever done before.

Adam saw the family opening up as a gradual process in the meeting, which gave the space and time for people to talk.

Adam (00:33:53, p.15) What I draw up from these meetings, because they come in sections, and I sort of liked the way it runs, the way you get people to talk and the questions that you ask. The same as Dana was saying, some people might never have said anything, but they just start talking. Some of them are able to attach feelings to that and I'm actually amazed by that and that's what I take from those meetings.

The referrer voice was also present in the Transition Meeting. All referrers were happy for the family to have a space to express themselves, but also needed space to represent their view and that of their agency. The family therapist asked the referrer's about the family's situation. This gave the referrer the space to share with both the family therapist and the family their perspective, which is about representing children's services. The referrers consistently focused on safeguarding concerns and risk assessment. The referrers felt they added some important information, which they would present very differently from the family.

Ana-1 (00:07:26, p.6-7) it's quite a balanced way of looking at it and it has strength based stuff in it, makes it quite collaborative, and the fact that he could just join in was helpful. I think it is really important having the social worker there for the first one? Because I don't know if, he would put it might be quite different from what I would say.

Shelly (00:20:36, p.28-29) I think that's a good question because actually although I didn't want the meeting, I think it was useful for me to be there. I mean, yeah, I would say that my input was very useful

The family therapist also had a voice. This was initially to explain the service

. Pam liked this as it gave the family knowledge about the service and also gave them insight into whether it was the right service for them. This was particularly important to Pam.

Pam-1 (00:02:48, p.8) You let them say what they've got to say, you give them a good introduction about the service. If they don't want it then they could tell you there and then…'

Some referrers spoke about challenges they experienced during the balancing and interweaving voices in the meeting. A few referrers were worried that giving a space for families to express themselves would lead to a series of complaints about the referrer and a split between the agencies.

Yvonne (00:20:53, p.9) You see, because that's what happened with this hostile family is they go to complain all about the other agency.

A perfect balance of participant voices is not always possible. Under representing one voice can easily lead to a 'more of the same' conversation, without new information and not experiencing a new dynamic. Imbalance can create frustration and generate less hope for change. Ana experienced this in

the Transition Meeting for one case, where the father was very talkative. Ana felt her voice was under-represented. Ana would have liked the family therapist to intervene more to give Ana more space in the discussion and keep the conversation focussed.

> *Ana-1 (00:03:28, p.3-4) I wasn't surprised that he kind of took over and talked a lot because that's kind of his nature. So, I wasn't really surprised and it's quite difficult to stop him talking as well sometimes. I find it really difficult.*
>
> *It's good that they step up and say actually, you know, this is my life, I want to talk about it, I think that's really positive. Having said that with him, I think it kind of tipped slightly too far the other way. So, maybe being brought back into it a bit more.*

Pam felt the mother's voice was underheard in the meeting, possibly due to the mother's emotional state, "being so upset".

> *Pam-2 (00:08:26, p.6) I think maybe 'cause she was so upset … that she didn't…maybe I spoke a bit more and maybe you spoke a bit more than she did*

In the Review Meeting Ana could see that the family therapist had formed a trusting relationship with the family. This helped the family therapist to interrupt the family if needed to allow for a balanced representation of voices and for following up on the meeting agenda. Ana noticed that the family therapist was able to do that without insulting the family.

Ana-2 (00:02:37, p.3) You know how to draw him out of… And he's responding well to that, you know? It's not an insult to him. It's just like, yeah, I need to hurry up.

Ana-2 (00:08:30, p.6) it's because it's about the trust that you've built up that enables these conversations to happen. Because in another context, these conversations could be really difficult and really stressful. I mean, I've tried … but they've been really stressful conversations that he couldn't have and he couldn't move past the list.

Ana put the success in having difficult conversations with her client in the meeting down to the trusting relationship between the family therapist and the family, which allowed for these conversations to take place.

9.2.4. Developing a different view of the family (Opening dialogues)

Given the transparency present during the 3-way Meetings, Transition and Review, the referrers have an opportunity to learn or see something new from the family, about the family and their history. In Ana's case she saw an emotional response from her clients in the Transition Meeting, which was a new experience for her.

Ana-1 (00:05:46, p.5) I kind of noticed a bit of emotion in him which I was quite surprised about because he's normally quite… he's kind of cut off and black and white – he just kind of processes information but you could see that actually there was a bit of emotion there when he's talking about things. Which I think was quite good.

Dana also spoke about how hearing new information from the family during the meetings helped her to get a better understanding of her client and her life. This influenced and broadered Dana's perspective about the family.

Dana (00:33:31, p.15) I probably got a better understanding of her and where she's coming from with the experiences that she's had. It kind of made me look at her a little bit differently.

New information can challenge previously held assumptions and hypotheses, have an impact on the referrer and family relationship, and influence the future plan and work with the family. In Pam's case she held a different assumption about her client's appearance which had an impact on the client's self esteem.

Pam-1 (00:07:41, p.5-6) She did bring up something that I didn't know about what she looked, her appearance and how she was when parents first met. So that surprised me quite a bit. Because I thought that the way she looked today was how she's always been …

Gaining a better understanding of their client's life can contribute to a change in the relationship between referrer and family and working practices. For example, Pam, on hearing new information about her client, reflected on her position with this couple and considered a new way of working with them.

> *Pam-1 (00:07:12, p.14) I need to like, not ignore what she's saying but have my own sort of thoughts on the thing and just try and work this out differently. So yeah, that was a good thing that came out. Yeah, different way of working with dad.*

For Jez the Review Meeting gave him a better insight into the work his client was doing with family therapy, which he then integrated into his future work plan with the family.

> *Jez-2 (00:09:12, p.6) I think it's important that we have the reviews, it sort of gives a bit of insight to what's going on. … I think they're important for the family, I think they're important for us as transparency and we're working together.*

Giving a voice to the marginalised subsystem also highlights the importance of all subsystems in the family. All subsystems contributed to the problem and all need to contribute to the solution. By listening to her client in the Review Meeting, Ana became conscious she had side-lined him. Listening to her client in the meeting and noticing the changes he had made changed her perspective of him.

> *Ana-2 (00:17:35, p.12) it's a really helpful one with dad and getting to know dad. Otherwise, he would be…to be honest, if you weren't involved he really would be quite side-lined.*

Yvonne spoke about how attending family therapy with one of her families had given her new information about the father in the family. His voice was always pushed aside, but he engaged well with family therapy and attended more sessions than the mother. The father was able to express his views about his family in the family therapy sessions. Yvonne had not heard his view before they engaged with family therapy as the mother's voice was dominating.

Yvonne (01:26:33) [The mother] didn't even give him a chance and the point is I've come to know that he's been attending more than her. So it's interesting to see that he was given a chance to

9.2.5. Feeling uncomfortable (Opening dialogues)

Despite acknowledging the benefit of the Transition Meeting, referrers recounted feeling uncomfortable about some aspects of the meeting. Some expressed shock. There were several causes of this discomfort: puzzlement at being involved at all, shock at being interviewed in front of the family, the challenge of managing a difficult conversation with a client in front of another professional, fear of being judged by the family or the therapist, or just hearing difficult information from the client.

Some referrers initially reported finding their attendance of the Transition Meeting puzzling. They saw the purpose of the meeting to share with the family therapist their knowledge of the family and their experience of working with the family. They had referred the family to family therapy and felt their work stopped there. They were not sure 'why on earth' they were expected to attend.

Shelly (00:17:43, p.8) I think my initial reaction was why on earth do you want me to come? I referred them … That was my initial reaction and then I called mum to tell her that we both come in and I'd arrange you to meet her because she was from the other side at the time … So I was like, gosh, this is quite time consuming, but you know, that was my initial reaction.

Shelly viewed the family as from the 'other side' and anticipated a difficult conversation when attending a meeting together. Coming together the anxiety about the conflict in their relationship.

Gary was worried that having their social worker in the room with them would reinforce the family's position in the process of having 'no say' or 'choice' and make the family reluctant to engage with family therapy.

Gary (00:21:13, p.10) One of the things that I worried about is that they feel forced to go to any service anyway, they might as well do this. By going along do we tempt it further? . . . but make it harder for them to be open to it.

Being interviewed in front of the family and talking about difficulties was also uncomfortable for referrers. Adam was 'shocked' the first time.

Adam (00:11:31, p.6) I was the one who came to the initial meeting and I was kind of shocked that I had to kind of talk about the parents there.

Referrers can feel anxious introducing the family and their work together. The concern is about 'getting it right' in front of the family given the family is the expert about their own history. This dynamic introduced a challenge to the referrer's position of power - it gave the family the power to judge the referrer.

> *Pam-2 (00:05:11, p.4) I suppose when I first came, I'd probably be thinking oh, God, what am I supposed to say? What am I supposed to say about the family? I don't want to miss anything out.*

Sensitive new information, 'new territory', can be difficult to hear. The referrer may find it inappropriate to hear this kind of material, may feel ill-equipped or lack sufficient capacity to deal with it.

> *Dana (00:32:50, p.15) I kind of found it a bit uncomfortable because she was just reeling it all off, like all the abused stuff that she suffered and I was thinking I'm probably not meant to be here.*

Referrer anxiety was not correlated to the quality of their relationship with the client. Referrers were conscious that 'getting it wrong' could have a negative impact on their relationship with the client. This raises their level of anxiety about either potentially ruining a good working relationship or make the relationship more difficult. A difficult relationship with the client, could increase anxiety when attending the Transition Meeting. Shelly, for example, was worried that the family would be hostile to her in the meeting.

Shelly (00:18:27, p.8-9) It's a challenge, isn't it because like I say, with each case, I've been at quite a low point and the idea of it being a three way meeting with an independent agency is --

Galit (00:18:42) It's now having the conversation in front of her.

Shelly (00:18:44) Exactly. I thought, don't need an audience for this, you know.

Shelly (00:19:16) . . . I was just a bit worried that the parent was going to be really hostile and it can be quite embarrassing to be honest.

A difficult couple dynamic can also cause anxiety for the referrer. David, for example, worried about his ability to manage the difficult dynamic in the Transition Meeting and hence felt exposed. He usually saw the couple separately.

David-1 (p.1) I guess I'm just a little bit anxious about the meeting in terms of particularly the mum and dad. They have quite an antagonistic relationship and therefore I thought it would be quite a difficult meeting to attend, so I wasn't looking forward to it because of that.

The referrers were aware of the family therapist witnessing their interaction and work with the family. Some felt exposed and at risk of embarrassment. These referrers were concerned that the family therapist would judge them for their relationship with the family, their knowledge of the family, and their ability to manage a difficult dynamic and the family's responses.

Shelly (00:26:40, p.12) It does expose you and you just think where have I gone wrong with this family. Because that was quite a difficult meeting. Yeah, that was a factor and I've never met Galit before and I thought just what is she thinking about this mother who just doesn't want to be in the same room as me.

On the other hand, David and Adam experienced having the family therapist present in the meeting as a support and this reduced his anxiety. Having the family therapist chairing the meeting, and hence having responsibility for the dynamic, freed David from his concern about not being able to manage the couple dynamic. Working transparently creates a platform for collaboration and shared responsibility which can help to reduce the referrer's level of anxiety.

David-1 (p.1) I liked the idea of the other professional being there and I guess knowing that they were chairing the meeting made me feel less anxious, but I felt less responsible for how the meeting would have gone.

Adam (00:11:31, p.6) Over the years I think I found it quite useful, you know because it sort of brings about some shared responsibility

Unlike the other referrers, Jez found the Transition Meeting easy to handle and without anxiety. It is possible the point in the work where the referral occurs can predict how the referrer will feel in the meeting. Jez referred families at a late stage in his work with them, when he had already established open communications after going through care proceeding

> *Jez-1 (00:05:49, p.4) But as far as my voice and my side of things, I think it's really good process meaning for you as a service to sort of get a bit of a background and my perspective.*

By the second research interview the referrers were familiar with the family therapist, the process of a 3-way meeting, and the type of questions / conversation they were likely to have. Generally the level of anxiety was lower than that felt going into the Transition Meeting. The second time around allowed the referrers to be calmer as they knew how to prepare themselves and their clients.

> *Pam-2 (00:04:31, p.3-4) Yeah. Fine, because, you know, I tell them beforehand that you're probably gonna ask me stuff about them so there's no, like, shock about what I'm gonna say. So, they more or less know what I'm gonna say … I know more about the families, what they're going through so it's a bit easier now to just roll off what's going on for them.*

Nonetheless one of the referrers (Ana) felt uncomfortable and anxious attending the Review Meeting. Feeling anxious going into the Review Meeting appeared to be related to how the social worker felt about their work with the family rather than a lack of familiarity with the process and any fear of engaging the family in a transparent way . Ana was familiar with the process and had had more contact with her client since the Transition Meeting but still felt ambivalent about attending the Review Meeting.

Ana-2 (00:01:00, p.1) I suppose I was thinking… it's be good to sit down … and go over everything, but at the same time, because of the historical meetings I've had with him…. I was probably thinking, "Oh, God. Maybe we're just going to be going over the same stuff again."

Ana felt 'stuck' in her work with her client and did not expect the Review Meeting to help or reveal anything new - she viewed the meeting as a waste of time.

Ana-2 (00:02:22) I'm thinking you know, what are we going to get from this?

9.2.6. Opening dialogues

The referrers were accustomed to one way communications, from social services to the family, and expected little information sharing with therapeutic services. Their experience with the Parenting Project challenged these expectations and established patterns of communication. The family therapist facilitated an open, transparent process with equal input from all parties - opening dialogues. The referrers saw the benefit of this, primarily learning information about the family to inform their own practice, but could feel exposed and uncomfortable.

9.3. Engaging the system in the room

The significant process Engaging the system in the room uses referrers' accounts of engagement during the 3-way meetings (Transition and Review). This includes what they noticed the family therapist did, how their families responded to it, and their own responses. Referrers could see the families

change and their relationship with the families improve. This changes invited reflection on their own work and encouraged experimenting with new skills.

9.3.1. Creating connection (Engaging the system in the room)

All referrers spoke about the welcoming space that the family therapist created for both themselves and the families. This started with the 'greeting' both 'nov-verbal' and verbal way of welcoming the family into the service.

> *Pam-1 (00:00:17, p.7) Parents that I've referred here liked the therapist yourself. Very happy, with your…the work that's being done and you seem to be able to relate to them pretty quickly. I mean this mum today, when she saw you downstairs and you just said "Hello" or something, and she's just like, she just said, "Oh. She's going to be nice. I can just see by her face and just her smile." So you don't even have to say anything to them. Because you felt the connection there already without even having to say anything.*

The referrers commented on the importance of the work of the family therapist to immediately establish a good alliance. The referrers saw this as unique to family therapy. Given their focus on risk and difficulties, they, at least initially, did not believe they could adopt this approach.

> *Ana-1 (00:10:42, p.9) you build really positive relationships quite instantly, you know what I mean? Relationship based way and sometimes people have difficulty with social workers because of the role, not necessarily in this case but sometimes that actually the atmosphere is quite a bonding one does that make sense. So, I know, in that way it's really good for building relationship*

The welcome made the referrer feel comfortable in the meeting as well. This comfort transferred into their relationship with the family as the 'atmosphere was bonding' in the meeting.

Yvonne found the systemic approach created a less threatening environment for the family and helped them to talk about their issues and vulnerabilities, which they would not do otherwise. Working systemically was seen as offering a less blaming, more inclusive way of looking at families and their challenges.

> *Yvonne (01:13:16, p.32) It's how you can learn to work better as a family. I think it's less threatening to them and they are more likely to like that because these people are going to hear about our family, they don't just sort me out because to do family therapy you really need to want it. And these families are not really going to go, yes I want to go to therapy. They are a little bit hesitant, they don't know what to expect. So I think there is a little bit of care from your side that we try to look after your family. … I felt it myself that you will think as a family, what is best for the family; not to just focus -- we know the parents have the issues, but we try to see it more systemically.*

The families were comfortable in the Transition Meeting. Referrers noticed how quickly they opened up and shared sensitive information in the meeting. The families felt safe to express themselves and to be themselves.

David-1 (p.5) I think they argued because they were themselves in front of Alicia and to me that was really important

Jez-1 (00:16:51, p.11) I did say that she has been very difficult to work with. Professionals have found it very, very hard. She seemed to instantly take to Alicia which was great.

Being comfortable, the families were 'themselves' in the meeting. David attributed this to the family therapist 'being fair', and giving the family space to express themselves.

David-1 (p.8) I think also for the family to be given space to express themselves as full as they want really.

David-1 (p.5) I felt that Alicia [family therapist] dealt with it very fairly and handled it very well.

Quite quickly the Transition Meeting was seen to become a safe space for both the family and the referrer. This enabled a better and quick engagement by the family.

9.3.2. Watching the family therapist intervening (Engaging the system in the room)

The referrers observed the family therapists conducting the Transition and Review Meetings and noticed them using certain interventions and techniques which helped to engage the family and themselves. The therapists really listened, spoke at the level of the client, asked effective questions, interrupted when necessary, and focussed on the relationship. The message to the family was of curiosity about their families and willingness to help and work with them.

For some referrers the engagement process had started even before the family came through the service door. Despite cancelled appointments, the

family therapist service gave the family a few chances to attend the initial meeting. The family therapist met the family when they were ready.

> *Pam-1 (00:00:17, p.6-7) And I think I like the way that you give parents quite a few chances. If they cancel appointments then you will be consistent in trying to make more appointments with them even though they're not turning up to them.*

The family therapists were observed to be 'really listening' to the family and gave the parents equal space to share their narrative with the professionals.

> *David-1 (p.6-7) I liked the way that she really listened to the parents and gave them space to say what they wanted to, so they were very comfortable... I think she gave both mum and dad equal time to speak.*

The family therapists used simple language and spoke 'on a level', both of which helped the family to engage and understand the process in the meeting.

> *Pam-1 (00:02:53, p.12) I suppose you talked on a level with mum so that she could understand. You didn't use any big words that she didn't understand that you had to explain to her.*

The referrers sometimes worried about interrupting their client in meetings. This could be due to culture or fear of escalating an already difficult relationship. Ana liked the way the family therapist outlined the plan for the meeting and then gave each participant space and time to share their views - interweaving the voices.

Ana-2 (00:04:14, p.4) I do struggle with that in a core group with him, how to draw him back to what we're talking about. But saying it out really clearly, saying like I'm going to ask questions to these people and then you'll get time to….

The referrers mentioned a few types of questions that they observed the family therapist using during the meetings, strength based questions; motivational focused questions and circular questions. These questions focussed the family to identify their desirable change, connect with their motivation to work towards it, and reconnect with their own ability and strength seen as important in the process of change.

David-1 (p.11) I think the questions Alicia asked were really good because … I don't think we really motivate the parents, look you really need to do this and if you don't this is how I'm going to act.

Strength based questions brought a more balanced view of the issues into the conversation and created an opportunity for a different interaction between all parties, moving from a problem focussed relationship to a more enabling and explorative relationship, bringing more collaboration to the process.

Ana-1 (00:07:26, p.6-7) it's quite a balanced way of looking at it and it has strength based stuff in it makes it quite collaborative and the fact that he could just join in was helpful.

Using circular questions (Tomm 1987, 1988) created a more inclusive and less blaming way of looking at the family issues, inviting the individual to reflect on their position in relation to the others. For Dana, being exposed to the Referrer Engagement Method had sparked her interest in the systemic model and the importance of a transparent, good working relationship with her client.

Dana (01:14:23, p.32-33) I think the way you kind of frame questions... you talk to the individual and you're asking him how their action might be affecting another person in the family. Obviously you won't say it so crude like that, but you might say what do you think Adam will feel when you do bla, bla, bla, and it's kind of making them think -- kind of putting them into that picture ... it's the way the system -- I'm very much interested in systemic, I think it's a good way of working with individuals.

Adam also commented that the style of questions were more sensitive. He noticed that, even when the family therapist was concerned with risk, she was asking and talking about it in a way that felt less confrontational, she 'gets around things quite nicely'.

Adam (01:09:15, p.30) The question of style, the line of questioning I think is very sensitive... so even if you were concerned the way you guys asked questions I think it gets around things quite nicely.

The referrers commented on the systemic/relational based way of working, which they observed the family therapist using in the meeting.

Ana spoke about observing what the family therapist was doing in the Review Meeting. Ana came to the meeting feeling 'stuck' with her client and was surprised to end up having different conversations with him. These conversations enabled movement. Ana saw how working in a more 'relationship-based' way enabled more trust between the family therapist and family.

Ana-2 (00:08:30, p.6) I like how relationship-based it is, always. And it's because it's about the trust that you've built up that enables these conversations to happen. Because in another context, these conversations could be really difficult and really stressful. The 'relationship-based' approach created a more neutral territory and, as the family were feeling comfortable, allowed difficult conversations to take place.

Dana noted how working systemically helped to create a more integrated and collaborative system around and with the family.

Dana (01:20:19, p.35) I think what I like about systemic way of offering approach is that it's less oppressive, it's anti-oppressive, because of the transparency it removes that kind of 'them and us,' and the barriers which we found they get offensive about because they feel that.

Moving away from "them and us" to more collaborative ways of working enabled a better working relationship. Dana felt the family therapist's approach was less oppressive than her own for the families and encourage a less aggressive response from their clients.

Yvonne said working systemically can 'inspire trust' with the families.

Yvonne (01:11:35, p.31-32) you can inspire some trust and that you have good intentions.

The referrers noticed the family therapists reflected back to the family what they heard and observed. This demonstrated respect to the parents but also influenced the family's awareness of their impact on others - created a systemic awareness. It challenged their position in their family and encouraged responsibility for his/her actions.

David-1 (p.7) She [family therapist] really reflected back and fed back to what she was hearing from the families for both mum and dad. And I think they felt really respected by that. And she was also able to challenge the parents and kind of say, well you know is this really what you mean?

The family therapist was modelling a 'both/and' way of communicating difficult messages in a soft way that the family can hear and work with – engage better. Adam felt that the family therapist was modelling this communication style and he was able to learn new skills from her as a result.

Adam (00:34:41, p.16) So you're modelling

9.3.3. Seeing the family change (Engaging the system in the room)

All referrers talked about a change in the family following their engagement with the therapeutic work and the service. The families learnt some new skills from watching how the family therapist worked / interacted with them. Benefits mentioned were being more empowered, using less blaming language, becoming active participants in the work, being less defensive, gaining ability to identify their own needs, and finding it easier to ask for help, and the ability to problem solve. The changes were attributed to both the overall therapeutic work and taking part in the 3-way meetings.

The social workers, whose families were mandated to attend therapy and initially expressed a degree of reluctance to come to the service, saw their families engage with the service and make the therapy their space. In a sense the families turned the mandatory obligation into a voluntary one. This was seen to have been enabled by giving the family more of a voice in the process and ownership in the therapeutic work. Engaging one subsystem encouraged engagement for the others.

David-1 (p.18) I think with this family particularly mum, she has a history of not engaging with things so I was also sceptical to how long mum and dad would engage for, particularly mum and I think if dad knew mum wasn't engaging he wouldn't have engaged either. So this, from what I can see, is the longest service that they've been engaging for and I think that's because they've taken ownership and they've said this is something that I've found helpful personally.

The families told the referrers about the benefits of attending the Parenting Project. The parents reported feeling more support, getting a better understanding of themselves, being "more confident", and being "a lot happier" .

Jez-1 (00:29:09, p.17) they feel as though it's beneficial. They've all felt that it's useful to them and they all felt that it gives them sort of that extra area of support and sort of areas of understanding themselves a bit more.

Families reported to their referrers how important having a space to reflect on their life and relationship was for them.

Shelly mentioned a client who liked having the therapeutic space, even if major changes did not take place. The client identified the importance of having space to reflect. This was a different experience for that mother compared to other professional services.

Shelly (01:21:06, p.35) I think she enjoyed the space, the therapeutic space, but that was where it ended for her.

Having the space in family therapy enabled the family to be more reflective and more open for help and change. One way this manifested was the family

gaining a stronger voice in their interactions with the social worker. They were able to express their needs more with the social worker and what they were less happy about. The referrer attributed this change to watching the family therapist work and for the way they have been engaged in therapy.

> *David-1 (p.13) I think after she had the meeting with Alicia she realised that she wasn't happy about the relationship she had with me. So she discussed that with me and said I want to change this and this, and this is what I would like ...almost she did what Alicia had done to her to me.*

More generally the referrers noticed their families were more open about their problems and more easily sought help. Having the space to reflect about their lives and needs, and being given the permission to express them in the therapeutic process, enabled the family to be more open about the need for support.

> *Adam (01:24:01, p.36) I mean if I go back to this end case with the mother who has a drug problem, she's actually been more open about her problem and going to seek help.*

Jez, for example, noticed his client becoming more proactive in her work with him. She was able to acknowledge and communicate difficulties to him.

> *Jez-2 (00:06:26, p.4) She seems a lot more proactive on trying to manage the issues. Now she's able to focus on, you know, she's able to acknowledge that she is having some difficulties within things going at home and her relationship with her son. Which a few months ago she was certainly unable to get to that point.*

Having a space to reflect about themselves and the improvement in the relationship within the family contributed to the overall process of change in the family.

David-1 (p.16) I think that the fact that his relationship with mum is more positive and there's no arguments is a massive step.

Referrers noticed their clients reflecting more about their past experiences and the impact these had on family dynamics and their parenting capacity. This lead to improving relationships within the family i.e. systemic change and how to address issues in a productive way..

Jez-2 (00:05:27, p.4) I think for her; it certainly seems to be she's giving a lot more reflection on her parenting. She's giving a lot more thought to how she approaches situations, she's giving a lot more thought about how to avoid certain conflicting situations.

Adam already had a good working relationship with his family, so felt that working with the Parenting Project did not benefit this relationship. However, the engagement helped the family by expanding their perception of their family members and seeing their realities differently. In this case one family member was able to widen their perception by gaining some knowledge about the process, when dealing with addiction. This may allow a more systemic response, which includes a circular causality in understanding problems in the family.

Adam (01:22:24, p.35-36) we had a grandmother that had very strong view about her daughter because she's got five children, they all went to uni, everyone if you like -- they've achieved apart from this one daughter -- and I think she had very strong views -- I think there was a sense of failure in her because her daughter messed up if you like. … She actually commented about seeing things a bit different now. Her daughter may never abstain from drugs. But there's an acceptance that there's a weakness; it's a journey, yeah, which I think a year ago grandmother wouldn't be there.

Several referrers observed that the parents having less arguments had a systemic impact on their children.

David-1 (p.13) So mum and dad have both said that when each other comes to pick up there is less arguments and they both seem to be taking personal responsibility… So they both talk about I have done this and this, I have done this; whereas before Alicia their conversation was like they did this, this did that, I'm not sure why they did this. So it's very blatant

Referrers noticed their families changed the language they used to talk about their issues and their family members, using less blaming language and more language of ownership. For example Ana's client changed his language after the Transition Meeting. He used a less stuck language, less blaming, and took more responsibility, was more future oriented, and could express himself more.

Ana-2 (00:06:24, p.5) And there has been quite a shift there because he's saying my ex, or sometimes he says my wife, he doesn't say my future ex-wife. There was something really stuck in terms of him….

Ana-2 (00:07:28, p.6) What's good about him I think is he doesn't sort of start saying negative things about her which is positive. You know, he doesn't start to relay stuff about her.

Gary also noticed that the family he referred changed their way of talking, both within the family and with himself as the referrer. Gary recognised the way the mother was speaking to her daughter was very different and connected it to the therapeutic work. The family gained new communication skills which they could apply in different parts of their system. The change in their way of communicating, allowed a responsive change from the system.

Gary (01:18:55, p.34) I mean sitting downstairs today with that client and listening to her talk to her daughter about how people perceive her and respond to her and how it would be if someone seeing her face and how she puts across; I mean it probably came out of your mouth.

Adam thought the therapeutic work helped his family to improve their own problem solving ability and to learn new skills. Problem solving by the family enabled less dependency in services and empowerment of the family – to be more equipped to deal with their challenges.

Adam (00:35:17, p.16) they appreciate the fact that, you know, able to problem solve now. They can save us a lot of time by the parents going out by themselves, little things that they can do as a couple. So for me it will be like skills more.

9.3.4. Improving the referrer-family relationship (Engaging the system in the room)

Many referrers noticed an improvement in their relationship with the family due to the therapeutic work the client was undertaking. The improvement was circular, in both directions, referrer to family and family to referrer. The improvement appears related to seeing change in the family (see Seeing the family change).

The starting point for change was better communications.

> *Jez-1 (00:22:07, p.13) I think communication is slightly better between us, but I'm not sure if that's particularly as a result. I mean, it certainly came after the referral I made to you*

Attendance of meetings increased and engagement in the meetings improved. The change was particularly true for the statutory social workers who initially reported some relational difficulties with their clients. It also became possible to have difficult conversations that previously were not possible. The change in their relationship was attributed to both the Referrer Engagement Method and to the family attending their family therapy sessions. The Referrer responded to the family changing, and changed their own way of relating and working with their client.

> *David-1 (p.4) Mum views my relationship with her better, she seems less defensive, less defiant, more open and therefore is allowing me to change more. I think I've changed my style to reflect kind of what mum needs.*

Both Jez and Ana made a connection between the client attending family therapy and the improvement in their relationship.

Ana-2 (00:11:36, p.8) I think you having sessions with him enhances our relationship for sure

Jez-2 (00:08:27, p.5) our relationship seemed to improve

Jez also saw an improvement in the client engagement with him and Social Care. The Client was more engaged in meetings and was less reluctant.

Jez-2 (00:06:13, p.4) I mean, yeah, the engagement has been genuinely really good since she's been working with this, … it just means she attends obviously meetings, she's engaged with this service, she seems a lot more proactive on trying to manage the issues.

Gary saw an impact on the relationship with one of the families he had referred. He saw an improvement in the mother-daughter relationship and also in the way this mother worked/engaged with social services. This demonstrates a systemic change - a change in one part of their system influenced other parts of the system. Gary was not sure what had enabled that change but he was relating it to the therapeutic process.

Gary (01:18:55, p.34-35) I mean sitting downstairs today with that client and listening to her talk to her daughter about how people perceive her and respond to her and how it would be if someone seeing her face and how she puts across; I mean it probably came out of your mouth. … So that sort of impact and the whole process, I think we're talking a year odd now, has shifted how she is with us. I don't know that I'd put that with me or maybe it's just -- it's only afterwards that it can sort of sink in.

Gary pointed out that the process of change is not immediate. Although initial benefits can be seen quickly it is a long-term process, “I think we're talking a year on now, has shifted how she is with us.”

The referrers recognised that both they and the family had to make changes to get a better working relationship between them. As the family gained more voice in their relationship with the social worker they were better able to communicate their difficulties and needs. Discussing issues openly with the family helped the social worker to be attentive and responsive. Ana and the family were able to have difficult conversations which were not possible prior to the family's engagement with family therapy. Family therapy provided a neutral, less judgemental, and safe place, and this made difficult conversations easier. This helped the family to talk about these issues in a different context to Social Care.

> *Ana-2 (00:08:30, p.6) I've tried to have them alone with him, and then we do and we talk about like him paying maintenance or anything but they've been really stressful conversations that he couldn't have and he couldn't move past the list. But the fact that we're able to kind of name this list thing and whether or not we could move past it is really, really good and that's because you've had those conversations with him before.*

When the social worker reacted positively to the way the family engaged with him, the relationship moved away from being experienced as 'oppressive' to one which was more collaborative and enabling.

> *David-1 (p.14) So I've changed the questions and language I use and I guess the work I do with her now is less oppressive and it's more how can I help you rather than you need to do this and this and this.*

The referrer-family relationship benefited from the family having a therapeutic space. As Ana said, "It doesn't become about social work, it becomes therapeutic", meaning their relationship is more therapeutic. The family had a voice in a therapeutic space and, over time, did not feel forced to attend. The

act of referring to family therapy made the social worker seem more supportive to the family.

> *Ana-1 (00:12:52, p.11) I think it was helpful for her, for us in our relationship because that was just after care proceedings but it was really – our relationship was ruined… It changed after that.*

Shelly shared that her client viewed her as 'being supportive' because they had attended the 3-way meetings together. This was the only positive experience that this particular client had experienced with social services involvement, as she had a very difficult relationship with her social worker and the service.

> *Shelly (00:25:16, p.11) I think for this particular mum I had I think she did find it supportive and you know, when we went to review conference she spoke about the support she got from children services and I guess that going to your appointment with her that probably was something that she found very supportive so that was quite successful, really.*

Even in cases where the referrer-family relationship did not change the referrer looks at the family differently. Dana, for example, did not think involvement with family therapy improved her relationship with the family, as she already had a good relationship, but she learnt new information and understood her client better.

Dana (00:33:31, p.15) I probably got a better understanding of her and where she's coming from with the experiences that she's had. It kind of made me look at her a little bit differently. In terms of the relationship, I think I was fortunate enough to already have a good working relationship.

9.3.5. Reflecting on own work (Engaging the system in the room)

The research interview encouraged the referrers to reflect on their professional practice. They used the research interview as a form of 'reflective practice' or consultation. Reflecting on their work enabled a more systemic, circular way of viewing difficulties and resolutions. It also encouraged referrers to look at their own part in the dynamic. They started to combine management of their cases' action plan with paying attention to their use of language and way of approaching the families. Referrers identified the Review Meeting as important in the process of change for all parties. The referrers learnt new information in the Review Meeting, usually regarding changes the family had made. This encouraged reflection by the referrer about their position with the client, and how their relationship and interaction needs to change to reflect the new changes and positions.

The process of being asked questions about their work and involvement with the family in the transition meeting invites them to reflect about their work and possibly served them as supervision/consultation.

Pam-1 (00:03:14, p.3) I suppose maybe because with therapy, it's sort of making parents think about what's going on for them. But I think also for the worker, it makes me think about, why have I referred them? What was the reason that I did it? Just making me think about maybe some things that I could do with the family when I maybe do a home visit. So maybe it's a bit of therapy for myself or making me think of different ways of working with the family also. So I suppose it would probably benefit parents and the worker.

In the Transition Meeting professionals acquired new information that led to changes to their interactions with the various subsystems. In Pam's case she reconsidered interaction with the father.

Pam-1 (00:04:10, p.4) I think maybe with just today when we're talking about mum's partner, I think even though their relationship is quite difficult and he can be quite defensive at times, it's made me think about maybe the way that I approach him and maybe the way that I talk to him to try and make him understand that we all want to work together, the best for their children and it's not about taking sides.

The experience of feeling exposed in the 3-way encouraged Shelly to reflect on her relationship with the family. She asked herself "where have I gone wrong with this family?" Listening to her family reflecting in the Transition Meeting, and learning new information about them, made Dana look at her client's differently and also reflect on her work and relationship with them.

> *Dana (00:33:31, p.15) I probably got a better understanding of her and where she's coming from with the experiences that she's had. It kind of made me look at her a little bit differently.*

Ana noticed that changes in her client had challenged her own position with the parents.

> *Ana-2 (00:07:16, p.5) I do feel really stuck in between these parents, I don't know, and I don't like it.*

Watching the family therapist interact and relate differently with their clients, encouraged the referrers to think about how their own ways of doing this. The referrers realised their role, representing Social Care, had an impact on how they relate to the family.

> *David-1 (p.11) I don't think they always feel important because I think the way we phrase it is you have to do this. And Alicia's work was less you have to, the more you want to.*

Adam described how, during the Transition Meeting, watching and listening to the family therapist acted as an invitation for him to reflect on his own ways of relating and interacting with the families. Adam assumed the family therapist's curiosity and ability to stay with the family to hear their history was due to working from a different domain. He liked this aspect of the therapist's interaction and would have liked to have done this as well. However, Adam thought the pressure he is under as a social worker had prevented him from having the patience to listen and explore what the families have to say. Here he starts to wonder whether he can incorporate something of this stance.

> *Adam (01:09:15, p.30) I bet we want to do things like that, but sometimes because of the pressure we're under it's like you go all right f-ing I'm just going to -- especially if you've got a parent where you've almost lost your rack, you've lost your patience.*

Seeing the family engaging well with therapeutic work challenged any doubt the referrer may have harboured about therapy.

Being engaged in a relationship based way, and seeing how well their family responded to this, invited the referrers to focus more on connection and their relationship with their families.

> *Ana-1 (00:20:44, p.17) Has it given me a different perspective about the family. Yes, I suppose for me it's more. Now, the more I think about – my job it's more about connections than anything else*

Jez was the only referrer who did not reflect on the effect on his practice. Jez saw himself as handing over his family to the family therapist.

> *Jez-1 (00:09:03, p.6) I'm there for perhaps the initial meeting just to turn around and talk about some of the difficulties, but it isn't about me, it isn't about the department, but moving forwards.*

However hearing his client talking about her experience in therapy and the impact this was having on her, enabled Jez to think about the next step. The client reflection invited the referrer to reflect on their work.

> *Jez-2 (00:02:23, p.2) Hearing how she felt about everything she'd experienced so far from the service and also how it had impacted on her experience of her child, her parenting. And it's sort of then enabled me to think about how we could further support her and the family in future*

The referrers considered how they could/should change their own practice, with different ways of working and engaging. One such outcome is taking a 'both/and' position, managing risk and at the same time enhancing a good working relationship with their clients, a position that was new for the referrers. Pam was considering engaging the father and giving him a voice, which was not part of her practice, as he was not part of the 'meaningful subsystem' in her work, and at the same time working with mum, not having to choose between them.

> *Pam-1 (00:07:12, p.14) But maybe I need to like, not ignore what she's saying but have my own sort of thoughts on the thing and just try and work this out differently. So yeah, that was a good thing that came out. Yeah, different way of working with dad.*

Pam reflected on one client who was very emotional in the Transition Meeting. For Pam this brought up a question about her assessment of her client's needs.

> *Pam (00:11:47, p.8) She was getting so emotional, I'm thinking, is this gonna be the right service for her?*

9.3.6. Building up engagement skills (Engaging the system in the room)

After exposure to the Referrer Engagement Method some referrers started making changes to their practice, experimenting and adding new skills to their professional toolbox. The changes were related to style of language and the types of questions they asked. Social workers retained their duty of safeguarding but put more emphasis on how to engage families.

Adam spoke about 'building up his skills'. He noticed that the family therapist asked questions differently which encouraged the family to reflect and 'problem solve'.

> *Adam (00:49:16, p.22) you guys always try to ask follow up questions, you try and dissect it a bit. It was quite useful for everyone, it's almost like a problem solving exercise from the get go; so I find that very useful. I mean like I said before, it's obviously foreign for me to build up more skills*

Ana, who had prior experience of the service from when she was a trainee, added strength based questions to her repertoire in order to change the conversation, improve the atmosphere, and expand her and her colleagues' perspective and narrative.

> *Ana-1 (00:11:43, p.10) I think something that I try and do although it doesn't always work, is in the core group rather than saying here's the panel let's go through it, sort of say, what's working well, what's not working? … Rather than let's go through the plan and some, for some networks that works well.*

David had also changed the style and language of his questions since the Transition Meeting. David was asking for his client's needs more than prescribing the desirable changes. Moving towards client focused intervention. The change helped his relationship with the client to be one which was more collaborative.

> *David-1 (p.14) So I've changed the questions and language I use and I guess the work I do with her now is less oppressive and it's more how can I help you rather than you need to do this and this and this.*

Adam saw the engagement with family therapy as a learning opportunity and inspiring. It influenced his way of working with families and this change was noticed by others. Adam's colleague Dana had noticed him relating and working differently with his families.

Dana (01:09:54, p.31) I think for you, Adam, had to recently see one of my mothers who decided to disengage and from your description on how you spoke to her, you know, to me sounds like you were very much adopting that kind of style;

Dana thought this new way of working helped Adam to re-engage a family who they found difficult to engage, and helped them to open up more and share information with them.

9.3.7. Engaging the system in the room

The referrers had observed the family therapists actively trying to engage the families. Their welcoming behaviour helped create a connection with the client/s. They noted the importance and effectiveness of the therapists really listening, speaking at the level of the client, asking effective questions, interrupting when necessary, and focussing on relationships.

According to the referrers, the families through their experiences of engaging and working with the family therapist, made some important changes. The families became more empowered, used less blaming language, became active participants in the work, were less defensive, gained ability to identify their own needs, found it easier to ask for help, and refined their problem solving ability. For many referrers the changes in the family led to an improvement in their relationship with the family.

Learning new information about their client, and watching them change due to the therapeutic work, encouraged the referrers to reflect about their own position, relationship and interaction with the client. Some referrers started making changes to their own practice, in particular their style of language and the types of questions they asked. More generally referrers began to hold a

more systemic, circular way of viewing difficulties and resolution. They could consider a more 'both/and' position with their families, retaining their duty of safeguarding but putting more emphasis on engagement.

9.4. Working collaboratively

Building on earlier significant processes the study highlighted how the referrer, family and family therapist joined forces. The referrers and family therapist collaborated professionally but more telling was the evidence for the family beginning to own their own change. The referrers also evaluated the 3-way meetings.

9.4.1. Joining forces (Working collaboratively)

The referrers noticed that, in the Referrer Engagement Method, the family therapist, referrer and family joined forces to make a smooth transition to therapy. A small number of factors were seen to contribute to joining forces. Responding in a timely fashion to the referral increased the chance to engage the family. The referrers viewed coming to the Transition Meeting together with the family as a way of supporting the family. It helped the family when coming to a new service by reducing anxiety and having a familiar face. All of the referrers also found the Review Meeting to be a way to collaborate and join forces with their clients to create a joint plan for the future.

Timing can be crucial for engagement with the family. According to the referrers the service responded quickly to referrals and allocated a worker for the cases (in contrast to other services). The referrals occurred at a point when the family had agreed for it and were ready, so responding quickly was important to engaging the family. Timing was also important for the referrer, as they had referred at a point when they were seeking help.

Jez-1 (00:02:42, p.2-3) I was very pleased with your response time, and very clearly had managed to sort of get the meeting set up and get things moving with the families and getting things moving with the parents. Because we talk to parents about interventions and what interventions we can put in place and if there's a delay from our side by a week or two, by the time there's processing from the other agency and it's all gone through and sometimes weeks and sometimes spill into two or three months and it's a huge amount of time from when we sat talking about it.

The Parenting Project was persistent in trying to engage families. Giving a few chances to attend, and not being quick to reject, was viewed as being significant in trying to engage the family. It reflected the Parenting Project's understanding of the difficulties in coming to a new service for families, which usually was initially mandated.

Pam-1 (00:00:17, p.6-7) And I think I like the way that you give parents quite a few chances. If they cancel appointments then you will be consistent in trying to make more appointments with them even though they're not turning up to them.

The referrers are conscious that collaboration began with filling in the referral form together. The family perspective was included from the outset.

The transition to the Parenting Project was helped by the referrer and family agreeing the identified need during the preparation for the referral and in the Transition meeting. This involves working closely with the family, listening to their needs, and being transparent about their difficulties.

Jez-1 (00:04:52, p.4) I like to think that in these particular kind of referrals which are therapeutic referrals, I know the clients well enough that I'm working with to sort of assess whether they are A, ready for it, B, I've quite clearly talked to them what the role would be for yourselves and with the beneficiaries and it's almost to the point where they arrive at a definite yes or they're almost asking me to make the referral anyway for an identified service.

Attending the Transition Meeting together, and being transparent on different views, helped create a collaborative action plan. For Pam this process helped create a strong alliance with her family.

Pam-1 (00:00:15, p.2) I feel that this worked really well. I like the way that we can introduce the parent to the therapist straight away. And I like where the therapist wants my opinion or the reasons for why I've made the referral. And it's also transparent if the parent is here so that they know what I'm thinking, so there's not any secrets. So they're aware of what I'm thinking and why I've made the referral. And it's good to hear if they feel that they agree with why I've made the referral and sort of actions that we want to come out of it in the end.

The Review Meeting was seen as an opportunity to go over things with the family, and reflect on the work.

Having looked at what happened and what has changed, the family and referrer worked together on a plan for the future.

> *Jez-2 (00:01:55, p.2) It's good for me to reflect on her experiences and… I suppose really hearing how she felt about everything she'd experienced so far from the service and also how it had impacted on her experience of her child, her parenting. And it's sort of then enabled me to think about how we could further support her and the family in future, really.*

The Review Meeting reflected a more balanced, in a comfortable place, where the family shared their views, experiences, and reflections. The family can add to the future plan from that perspective. The referrer, hearing about the change the family was making, reflected on their work with the family, what the family needs and how they might need to relate or do things differently with and for the family. This enhanced and enhances a collaborative, transparent way of working.

> *Jez-2 (00:10:33, p.6) I think they're [Review Meetings] always really, really beneficial and really useful. I think they're important for the family, I think they're important for us as transparency and we're working together.*

Shelly used the term 'marriage guidance counsellor' to describe her experience of being in the Transition Meeting together with the family and the work on the relationship between them by the family therapist. She said how therapeutic it was for her to go through the history of her relationship with the family. It gave an opportunity for both the referrer and the family to express their views.

Shelly (00:52:32, p.23-24) It's interesting this idea about the referral being part of the family network because just hearing -- well listening to what you were just saying, well actually I didn't reflect on it at the time but really you were like a marriage guidance counsellor I think with being with this mother (laughing). This kind of where are the two of you going wrong. It almost felt like a session for me as well, if I'm honest.

The meeting was an opportunity for her to look at her own position and work with the family and see what else she could have done. 'Where are the two of you going wrong'. Shelly and the mother were in a similar position in the meeting which illuminates that both play a part in this relationship , with a more mutuality. This challenged the power imbalance in their relationship.

9.4.2. Collaborating professionally (Working collaboratively)

The referrers spoke about their experience of having a third party, the family therapist, in the room during 3-Way meetings. A witness. Some referrers saw having a witness undermined the 'them and us' between the family and referrer. Others saw the family therapist as a support for themselves.

Adam said having the family therapist in the room is like "an independent eye". He felt this benefited both the family and the referrer. The family by having an independent listener to what they said, which defuses the 'them and us'. For the referrer the witness was another professional who saw the dynamic with the family, and witnessed the referrer's 'reality', and the tension between them.

> *Adam (00:28:00, p.12-13) It's interesting, it's like you have a little bit of an independent eye there, you know, because usually these people, they would constantly say, you know, they're not listening to me, I'm doing the right thing and you get a little bit of an independent view so where, you know, hopefully within a therapeutic context, but still saying, but that's the reality, you know? In some ways it's good that you see this. Yeah, you see this tension*

Adam felt having the family therapist observing their dynamic with the family, 'the tension', is useful for him. He touched on the issue of not being trusted by the families and being caught up in a symmetrical relationship, with competing perspectives. The family words against the social worker words.

David spoke about how supported he felt by having the family therapist in the room. David found the couple relationship very difficult to work with. Normally social workers coordinate the meetings about their family. Having the family therapist running the 3-way Meeting, thus changing his position in meetings with the client, helped David feel less anxious about having a transparent meeting with the couple. He was a 'visitor' and was less worried about how the meeting would unfold, which enabled him to reflect more on his work with the family.

> *David-1 (p.1) I liked the idea of the other professional being there and I guess knowing that they were chairing the meeting made me feel less anxious, but I felt less responsible for how the meeting would have gone.*

Working with the family therapist expanded the system around the family. The family therapy would help carry on the work started by the social worker.

David-1 (p.6) Yeah. It's actually just inviting another professional into what I'd already started.

9.4.3. Family owning change (Working collaboratively)

Referrers saw their family owning the process of change and becoming an active participant. The families became more empowered and more positive about change. They began to ask for help.

David saw the mother feeling empowered and realising she can make changes.

David-1 (p.16) It's coming out that she can make changes in her own life and she can affect the things around her.

Owning the process of change contributed to improving the family's internal working model - "I can do it", feeling empowered, having a voice, and influencing decisions about their family. The change in the family could lead to a change in the relationship with the referrer, and improve their working alliance - circularity in the process of change.

Adam gave an example of how in a conversation with one of his families, when discussing parenting challenges, the family were able to bring in the family therapist's voice. They had internalised the family therapist's voice and used it to address the issue. This helped the couple to problem solve. The family were able to utilise what they had worked on in family therapy. Being able to help themselves allowed the family greater independence from services. In this way, the family became more in charge of their own life.

Adam (00:35:17, p.16) Alicia told us that; that sort of thing, okay. … they appreciate the fact that, you know, able to problem solve now. They can save us a lot of time by the parents going out by themselves, little things that they can do as a couple

A positive and successful engagement in the therapy process can also change the family's engagement contract from mandatory to voluntary.

Ana-1 (00:31:40, p.24-25) I think the fact that she engaged with you was pretty amazing and then from that she was saying she was wanting to continue after we're gone…

The family began asking for help and commissioned the work. This might reflect their level of engagement and their owning the therapeutic space. .

9.4.4. Evaluating the 3-way Meetings (Working collaboratively)

All referrers found the 3-way meeting useful, including both the Transition Meeting and Review Meetings. 3-way meetings were a way to assess progress and look at future plans for their client. They also encouraged collaboration between the referrer and family. Having the family therapist facilitating the meeting helped the referrer focus on their work and reflect on their involvement, which also led to future planning. Finally the referrers seemed to use the 3-way Meeting as a form of consultation / supervision / reflective practice.

The referrers liked the format of the meeting and didn't suggest any changes to it.

Pam-2 (00:23:07 , p.17) Well, no, I don't think you should change anything because it seems to be working what you're doing

As the referrers were very respectful of their client's confidentiality during the process of therapy, the Review Meeting was an opportunity for them to learn

where the family was in their therapeutic work. It facilitated collaboration and helped the referrer to assess the next step. .

> *Jez-2 (00:09:12, p.6) I think it's important that we have the reviews, it sort of gives a bit of insight to what's going on. . . . I think they're always really, really beneficial and really useful. I think they're important for the family, I think they're important for us as transparency and we're working together.*

Shelly thought the outcome of the therapy and the level of engagement in therapy by the family validated her own assessment about the family.

> *Shelly (01:21:06, p.35) Well, the woman that we worked with she did talk positively about it and it was the only thing that helped her, which is praise indeed... I think it kind of helps my assessment of her because I think it reflected her, you know, her low ability to mentalise how other people were feeling.*

Shelly felt she needed an external validation of her own assessment of the family. Her relationship with this family was very difficult and confrontational. The mother's limited ability to benefit from therapy provided evidence that the problems were not down to Shelly herself, as a social worker, but due to the mother's 'low ability to mentalise'. Most professionals seek a level of validation to why they got 'stuck' in their work with a particular family. The experience of working with the family therapist and the family provided her with that validation she was looking for.

Unlike the other referrers, Ana had mixed feelings coming to the Review Meeting. She understood its benefit to her work but at the same time she felt stuck with her client. She expected 'more of the same'. Ana had a different experience in the Review Meeting. She was able to learn about some of the changes her client had made. Ana summarised her involvement as 'vital'.

Ana-2 (00:01:18, p.2) I was probably thinking, "Oh, god. Maybe we're just going to be going over the same stuff again." But actually, I feel…having done the follow up, I feel a bit differently about it because I think there has been some change in him in the way that he's able to express certain things. And actually, that was probably really positive, being able to go over everything with him clearly in terms of what our plans are. I think your questions were really good because they…because maybe I haven't really thought about exactly what the goals are and what our plans are in terms of your therapeutic input and in terms of what we want.

Some of the referrers found aspects of the 3 way meetings less helpful.

Shelly had no expectations that one meeting with the family and the family therapist would produce any changes due to the power dynamic between the family and the social worker which would interfere with the family's engagement in therapy.

Shelly (01:27:39, p.38) I think it's a tall order to expect any real change after that three-way meeting.

It's one meeting. We've got the advantage of having prepared our case because we've done a written referral, so that power dynamic is still there and you can't get away from that. I wouldn't expect an epiphany after that one meeting if I'm honest

Gary wondered if focussing on the referrer and family relationship during the meeting would be a distraction from the family's difficulties. It would allow the family to move away from what was possibly harder for them to talk about.

Gary (00:58:35, p.26) I do wonder though it sounds like I have my answer, but bringing the focus directly onto the problems with the relationship and the social worker brings the focus of the therapy on to that as opposed to any of the family issues or whether it does allow you to move through it.

Gary believed that asking about their relationship with the family slowed down the process of change for the family and side tracked them from what he felt were the 'real issues'. He also didn't feel that talking about their relationship made a difference to the relationship.

9.4.5. Working collaboratively

Shifting the power away from the referrer, opening dialogues, and engaging the system are all enablers for working collaboratively. Some other factors were also at play.

The referrers noticed that they joined forces with the family therapist and family to enable a smooth transition to therapy. The service was accommodating to both the family and the referrer. The referrers supported the family by attending 3-ways together.

The referrers spoke about their experience of having a witness, the family therapist, in the room during the 3-way meetings. Some referrers saw having a witness challenged / dissolved the 'them and us' between the family and referrer. Others saw the family therapist as a support for themselves.

Referrers saw their families owning the process of change and becoming an active participant. The families became more empowered and more positive about change. They began to ask for help.

All referrers found the 3-way meetings useful for a number of reasons. The meetings were to assess the family's status and plan accordingly. The

meetings were also the forum for collaboration between the referrer, family, and family therapist. The referrers also experienced the meetings as a form of consultation / supervision / reflective practice.

10. Discussion

On the whole**,** the referrers found that this systemic approach was effective for the families they had referred and also found that it had had an impact on themselves as professionals. This has been encouraging feedback, and what I was hoping for - as someone who has developed and used this method in practice.

In this chapter, I expand on the significant processes identified as a result of the referrer's experience of the Referrer Engagement Method, and link these to the literature and findings from other studies. I discuss the implications of this study for family therapy and for social work practice. This study has also highlighted some areas of development, growth and improvement for the Referrer Engagement Method, as well as pointing to areas for further research.

10.1. Significant processes

Analysis of the data highlighted four significant processes of the approach from the referrer's perspective: Naming power, Opening dialogues, Engaging the system in the room, and Working collaboratively. The significant processes are not therapist 'interventions', instead, the therapists 'invite' family members to engage in these processes (interactions between therapists, social workers and family members). These processes are interlinked and overlapping (see Figure 5). This relationship means the significant processes can have either a positive or negative influence on each other.

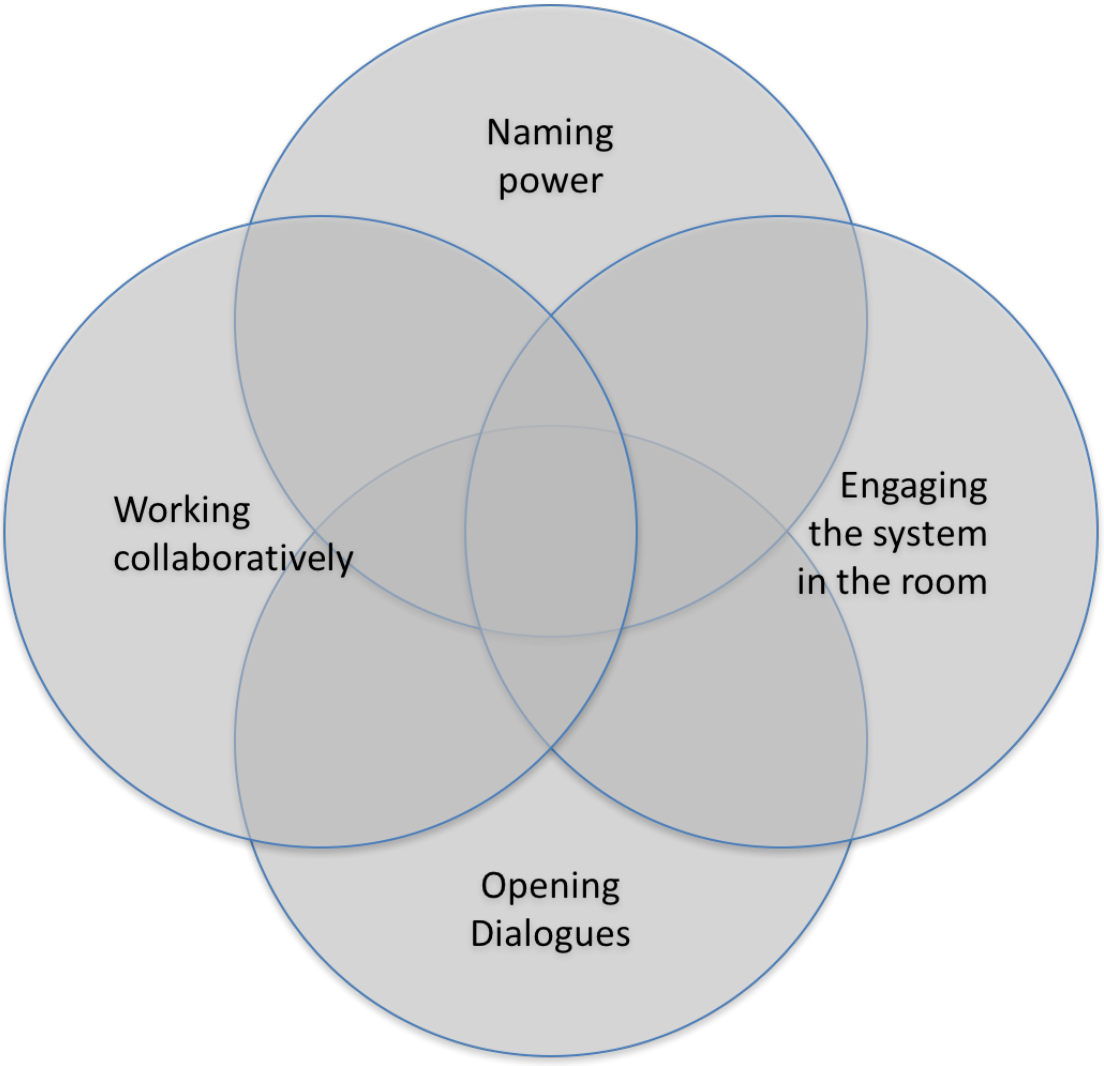

Figure 5: Significant processes in the Referrer Engagement Method

When a practitioner, whether a family therapist or social worker, positively engages with one of the significant processes, this will lead to a positive influence on the other three processes, with associated benefits. Family therapists in this study were able to include all four significant processes in their work with the families, benefiting from the relationship between them. The family therapists engaged families better using 'power together' (acknowledging power in the relationship) and gave more space to the family to share their views. This led to a better engagement in the process of change and greater collaboration, not only with family therapist but also with the referrer. These four significant processes are an integral part of systemic

training, and most family therapist would include them in their practice in no particular order of importance.

The inability to engage positively with one significant process will undermine (negatively influence) a practitioner's ability to benefit from all four of the processes. Social workers find it more challenging to use the significant processes in their practice. This is because they are working in a different context to family therapists, child protection, with statutory power and responsibility for safeguarding children. This means social workers are more likely to work with families from a position of power over, as a way of keeping them distant enough from the families to act on difficult decisions. This can result in them being less interested in their client's view, finding it more difficult to engage with their clients, and having fewer opportunities for collaboration. They are more inclined to tell clients what to do (which they experienced as 'oppressing the client'). Paradoxically this runs the risk of leaving the social workers powerless as change agents in their client's family life.

This situation can change when the practitioner attempts to include and use in their practice at least one of the significant processes in a positive way. Application of the significant processes is on a spectrum and is not all or nothing. Even with small steps a positive interaction of the significant processes can still take place and have a positive impact on the working relationship between the social worker and the family. For example, a social worker can take some steps in naming power in their relationship with a family by changing their language with the family and acknowledging the constraints in their relationship with the family. These small steps can lead to other significant processes becoming part of their practice e.g. better dialogue, better engagement, and more areas of collaboration.

Practitioners can start applying sub-processes from any of the significant processes depending on their professional experience and/or personal fit, for example, some would find attempting to open dialogue with families an easier

task while others aim to work in collaboration with the family.Working in child protection makes a positive approach to Naming power challenging for social workers. This challenge means Naming power is not the obvious place for social workers to start changing their working practices. Based on their own experience of the Referrer Engagement Method, social workers are more likely to experiment with sub-processes in Opening dialogues, Working collaboratively or Engaging the system in the room.

Watching the family therapist apply the significant processes seemed to inspire and influence the practice of the participants in this study.

10.1.1. Naming power

The starting position of the referrers in my study was one of ‘oppressing’ the client, and the belief that change would happen through giving the client a ‘to do’ list. Through the Referrer Engagement Method, the referrers realised there were alternatives available to them and that it was possible to balance both management of risk and engaging families when safeguarding children. This balance is one of the most challenging tasks for social workers and other practitioners in the context of child protection. The referrers of my study used their judgement in assessing the risk in families, which usually resulted in blaming a subsystem of the family or one of the parents. They reported poor relationships with their clients, usually with the parent that the child did not reside with, and felt powerless in influencing change in the family. The literature mentions this tension and the need for balance. Symonds, Williams, Miles, Steel, and Porter (2018) confirmed in their research there is tension in the social worker role between professional judgement and the role of nurturing autonomy and control in the client. Fargion (2012) added that what is needed is a good integration: “Workers must engage families in a positive manner while also ensuring the safety of their children” (p. 159).

The referrers of my study treated the two parents differently. They would work directly with the parent who was the main carer and marginalise the other parent. The marginalised parent was often the subject of the referrer's judgement in assessing the risk in the family and the resulting blame. This put the marginalised parent in a very weak position even relative to the main carer. After referral to the Parenting Project both parents would be invited to the 3-way meetings. For some referrers, being in the same space with both parents was a new experience, as is seeing the interaction between the parents, and how they communicate. This gave the marginalised parents a greater voice and created new opportunities for change.

The referrers observed the family therapist, using the Referrer Engagement Method, achieving that balance between engagement and ensuring safety (both/and) (see Figure 6). Although they did not use Maturana's (1985) language, the referrers in my study noticed that therapists practicing the Referrer Engagement Method were able to operate in all three of Maturana's domains simultaneously. The therapists operated from an ethical stance (aesthetic) and held risk in mind (production), all the while creating a positive therapeutic alliance with the families from a position of curiosity (explanation). This demonstrated to the referrers that a professional who also has to address safeguarding concerns can work from multiple domains. This is possible but challenging, as Lang, Little, and Cronen (1990), who brought Maturana's domains to the professional practice of systemic family therapy, stressed, when family therapists work in the domain of production (for example, in child protection), the therapist has to perform their task whilst creatively trying to keep and respect the client's autonomy, despite the fact that the client has not consented to be involved in the process.

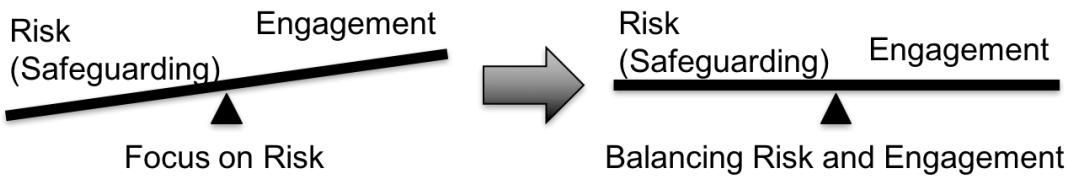

Figure 6: Balancing risk and engagement

The referrers in this study kept referring to their role as statutory, and felt this status constrained their options and prevented them forming a positive therapeutic alliance. Due to their statutory position, the referrers felt they could not act from multiple domains and roles. Yet the referrers also identified that working with families from only a single domain was limiting their ability to influence change in the families they worked with. They reported using more 'instructive interaction' as a way of managing risk and telling families what 'to do' without connecting with the family (Watson, 2018a, 2018b). Paradoxically, they spoke about working from a position of statutory power yet felt powerless to influence change. In my opinion, and from my clinical experience, changes are more likely to take place from within, when families understand and have a voice in influencing the change. Being an active participant in the process of change enhances families motivation and engagement in therapy. Alfandari (2017), in her research, supported claims that "for parents' participation in decision making is not to be merely a matter of being seen as playing fair, but rather allowing them decisional power to influence outcomes, a collective movement from the traditional all-knowing position towards an open, honest and humble organisational culture is required" (p. 1075).

The referrers felt that, given their statutory power, the families would attach a negative meaning to their actions, but attach different meanings when the family therapists performed the same action due to their voluntary contract. While the family therapist was able to freely intervene or stop parents from talking during the session, the referrer felt constrained by their power. The referrers believed that managing the conversation in a similar way to the

family therapist would be interpreted as disrespectful to the family's voice. This aligns with Dumbrill's (2006, 2010, 2011) findings that highlighted that parents found it difficult to relate to their social worker as families perceive social workers as powerful, and are wary of the social worker's power to remove their children. Dumbrill also found that social workers perceived their own statutory power as pervasive, yet hoped to find a way to create a therapeutic alliance within the presence of power imbalance. They found it hard to move to a more relational/collaborative way when working with families, due to the fear that it would lead them to compromise their statutory duty to safeguard.

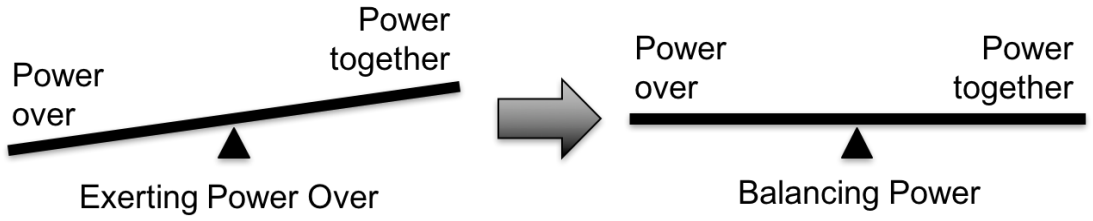

Figure 7: Balancing power

The referrers in my study were comfortably exerting 'power over' (protecting from risk) and uncomfortable with 'power together' (cooperative power-collaboration). These terms are from Kettle (2018) who also researched within the context of child protection. Kettle encouraged social workers to consider the complexity of power in their role and differentiate 'power over' from 'power together'. Kettle also highlighted the importance of acting from both positions of power - something the family therapist in my study found easier to operate from (see Figure 7).

The Referrer Engagement Method changes the power dynamic by naming power but can never equalise power. I agree with Zimmerman (2011), who when looking at collaboration in the therapeutic context, noted that aiming to achieve equal power is impossible:

"It would seem that much effort is misdirected in trying to equalize the therapist–client relationship by calling it collaborative and opportunities for a more frank evaluation of the relationship remain neglected. It may be more fruitful to acknowledge how one's experiences, degrees, age, gender, and so on contribute to each member's power. Ultimately, therapists ought to acknowledge power rather than to ignore it or to conceal their power simply by calling their therapy collaborative" (Zimmerman, 2011, p.221).

The referrers noticed that, by naming power, being transparent, open and 'honest' about their professional position, the family therapist was able to move between care and risk tasks, engaging and challenging, when needed. This matches the findings of Watson (2018b), who looked at power issues in child protection, and found that integrating systemic theory and techniques contribute to the work of safeguarding, together with the use of self and self reflexivity. Watson suggested that when therapists use reflexivity in their conversations with parents, they can address their emotional impact on families and on the family dynamic. By prioritising the parents emotional state and at the same time focus on safeguarding concerns, it enables the creation of ' joint authority', which is a position that the referrers in the study observed the family therapist using with families.

The family therapists of the Parenting Project are external to the Social Care system. This brings a different power dynamic to the relationship between the families and the family therapist, being more voluntary less statutory, more about collaboration and dialogue with the therapist explicitly moving between the position of 'expert' to 'not knowing', which allows for different conversations to emerge and bring about desirable changes for the family (see Figure 8).

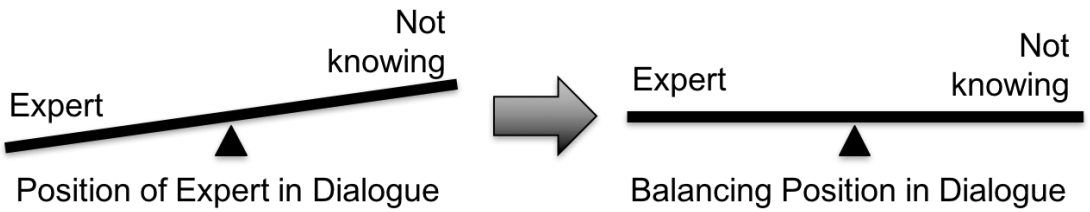

Figure 8: Position in Dialogue

It has been important to keep in mind the different power dynamics involved for family therapists and referrers with families where there are child protection concerns. Child protection social workers often feel so constrained by their sense of responsibility in making 'life/death' decisions about people's parenting, that it is hard for them to move away from taking an ‘expert’ position. Family therapists refer back to child protection social workers if serious concerns about children arise. Using systemic ideas about how to enable change family therapists take responsibility for processes, such as engaging the systems around the child and promoting a collaborative dialogue, alongside being more transparent about the power inequalities. Involvement in the Referrer Engagement Method introduced the referrers to systemic thinking and enabled them to consider other ways of working.

10.1.2. Opening dialogues

The referrers observed the family therapists of the Parenting Project opening dialogues. The family therapists used collaborative (inclusive) language in the 3-ways, inviting all participants in the meetings to both influence and be influenced by the dynamic and conversation. This allowed the participants in the 3-way to openly talk about risk, and also gave the parents the space to talk about the experiences which might have led to their choices and decisions. Therefore, the parents had a chance to influence the other members of the 3-way (see Figure 9). This transparent approach was based on Anderson and Goolishian’s (1990) observation that using collaborative

language creates a more transparent dialogue, which enhances collaboration in the work between the families and the professional system. Willumsen and Skivenes (2005) also looked at what will enable open communication in the field of child protection and found that working closely with families in meetings and deliberation are important components of a collaborative approach.

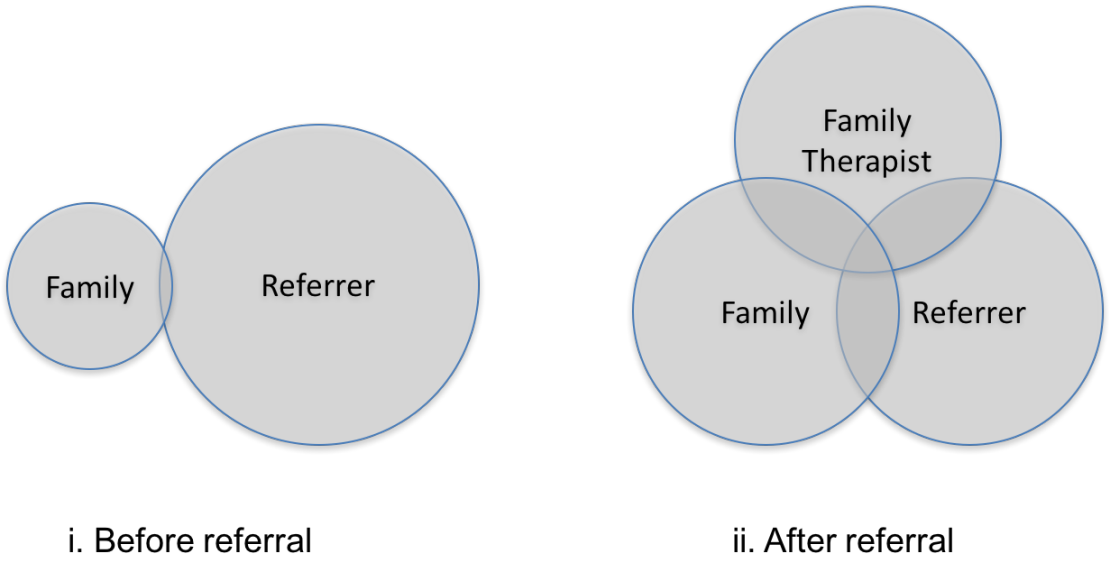

Figure 9: Views, Voice and Engagement

My study shows that referrers thought that the use of transparency challenges power relationships. Being transparent seemed to be a new experience for both the referrer and the family. Both felt vulnerable coming to a new service, attending a meeting facilitated by a new professional, and relating to each other from a different position. Both felt powerless, and this mutual vulnerability influenced their relationship and brought more trust and care. The referrers reported how the families viewed the family therapy service as 'being there for them'. Referrers found sharing more information with the families was uncomfortable but brought about reflection on their stance with families.

The referrer's power was challenged by this experience.They were surprised at the request to talk about their clients in their presence, and also by the

family's willingness to share sensitive information with them. The referrers were worried that learning new sensitive information about their clients would bring them too close to the clients and that this closeness would compromise their capacity to safeguard the children.

The referrers in my study respected the confidentiality of the therapeutic service. They did not expect to have information shared with them. I believe this position helped in maintaining their distance from the families, a distance they felt they needed in order to stay focused on their task of managing risk.

During the 3-way meetings, the referrers noticed that the family therapist was able to stay close to the family and listen to their narrative, which at times was difficult and painful, yet in the same meeting the family therapist was exploring and addressing issues of risk and safeguarding in the family. The premise behind the Referrer Engagement Method is that engagement (being closer) does not have to compromise on safeguarding children, and the referrer's saw the family therapists operating like this. Assessing the referrer-family relationship (how enmeshed or distant they are) is also part of the Referrer Engagement Method. Through the creation of a reflective space, the referrers were invited to assess the 'distance' between themselves and the family, and make changes or have a reflective conversation about it. Kettle (2015, 2018) stressed the importance of reflecting on one's own position when working with families to manage and regulate an appropriate distance between the social worker and the family. According to Kettle when social workers are too remote, there is a risk of creating ineffective engagement in the process of change. Being too close runs the risk of becoming enmeshed with the family. In either case, being too remote or too close, the children are at risk of being unprotected. He recommends social workers retain perspective and reflection as a strategy to manage distance. Kettle also explained how honesty is viewed as a strategy for regulating distance and keeps it at a level that allows for an effective working relationship.

The referrers were concerned that getting closer would be seen as ‘manipulation’ if followed by the exercise of their statutory power. Getting closer might have also been beyond their professional capacity to help or too difficult/challenging to hear sensitive information about the family. My referrer’s fear of seeming manipulative was echoed in an action research project by Wilkins & Whittaker (2018). They aimed to create a more participative model of child protection social work practice, known as Motivational Social Work (MSW). Parents view a number of behaviours as a prerequisite for collaboration: an empathic approach from the worker, taking part in decision making, and being listened to (Dale, 2004; Ghaffar, Race & Manby, 2012). Despite this, the MSW research found that one of the barriers to participatory child protection practice was that the social workers were concerned the parents would view an empathic approach as disingenuous, especially when their relationship results in a negative outcome.

The referrers noticed that the process in the 3-way meetings invited all participants to witness and listen to the conversation that was taking place near them. This encouraged a triangulated reflection (White, 2005), for the referrer to see their clients interacting with the family therapist, through different eyes, for the family seeing the social worker sharing their views and thoughts with the family therapist, by being interviewed and not interviewing, and for the family therapist to witness the dynamic and relationship between the family and the referrer. The witnessing process creates a context in which stories and views can be told and developed and new meaning can be emerged and shared by all participants. It enables different and wider conversations to take place between all participants. Freedman (2014) also describes this process: when one member in a session tells their story or shares their view, the others are positioned in a reflecting or witnessing position, to hear, listen and understand the story as it been told by the other member. This process encourages people to listen, rather than join in talking. This helps creating space for new stories and viewing others differently.

The referrers noted that giving parents space to voice their views, asking them about their desired changes and not telling them what to change (collaborating on change vs directing for change), brought a sense of ownership to the families and greater motivation for change. It enhanced collaboration and better engagement in therapy. In her study of social work in Israel, Alfandari (2017) too identified key ingredients for partnership with parents in child protection to be transparency, honesty, and allowing for parents to be part of the discussion about the problem, suggest solutions, and influence the process of decision making.

10.1.3. Engaging the system in the room

Engaging both the family and the referrer is an important part of the Referrer Engagement Method. Referrers thought the ability of the family therapists to building a good enough relationship with the family helped the family to become an active participant in the process and enhanced their motivation for change. This significant process is supported by many papers and studies. Therapeutic alliance is a key factor in successful therapeutic outcomes (Friedlander, Escudero, Heatherington, & Diamond, 2011). Ruch,Turney and Ward (2010) concluded that no matter how good the assessment tools are, they are not a replacement for relationship building in the context of child protection. Koprowska (2014) also discussed the importance of effective communication with families. Bentovim and colleagues' (Bentovim & Elliott, 2014) framework to empower practitioners who work in the front line recognized the therapeutic alliance, and the three elements that form the relationship ('common factors') - engagement, establishing hope, and goal setting (Laska et al., 2014) as key. These common factors are fundamental to an intervention's success (Bordin, 1979).

Similar to the Referrer Engagement Method, Bentovim and colleagues (Bentovim & Elliott, 2014) emphasised the importance of initial meetings and

the type of questions (socratic and circular questions) practitioners should ask to establish engagement.

The referrers were able to identify different ways the family therapist worked with the families in the 3-way meetings. The family therapist was seen to respect the families, gave space to families to tell their story, explored families' strengths and asked them for their desired changes. The referrers and the family members were able to learn from observing the ways the therapists interacted with them and started to use these kinds of questions and positions themselves - both referrers and families learned from their observations.

The referrers reported how their families shared their first impressions of the therapist and the service, which later was found to indicate their likelihood to engage with the service. Coulter (2007) and Symonds (2018) wrote about the importance of first impressions in therapy and how it can influence the parents' decision to engage with services.

Some of the referrers reported learning new skills, which surprised them. Some referrers tried to integrate and experiment with systemic techniques including circular questions, strength based questions, and to change their use of language to become more collaborative.

The literature is full of suggestions to help in the process of engagement like: respect and dignity, eliciting family views, delivering clear messages even when the message is negative, using strength based interventions to build a sense of empowerment, helping the family to identify their own needs and not only rely on psychological and relationship assessments (Mckay & Nudelman, 1996), being attentive to issues that are important to the parents, only asking parents to do things that are understood and helpful for them, finding useful services for the family, and reliably returning and making calls (Gladstone, Dumbrill, Leslie, Koster, Young, & Ismailia, 2014). Buckley, Carr and Whelan (2011) added the importance of workers interpersonal skills and ability to establish good relationship with parents. Practitioners are more likely to

engage parents if they have effective communication skills, relationship-building skills including the use of empathy, being honest and open and using ‘small talk’ (Axford, Lehtonen, Kaoukji, Tobin, & Berry, 2012; Barrett, 2009; Drake, 1994; Platt, 2008). However, reading about these suggestions on how to engage families may not help the referrers know how to apply them.The Referrer Engagement method offers a more experiential way of learning about a different way of approaching engagement with families.

Meeting the whole family in the initial 3-way helped create space for the voices of all the members of the family including those not engaged in the work with the referrers. The referrers identified engaging all the family members as a significant process in the approach. Watching the family therapist engaging with everyone, led the referrer to reflect on their own relationship with the family, their position of power, telling them what to do, and blaming them for the risk to their children.

Most of these referrers had maintained a split relationship, i.e. worked with only the ‘safe’ parent, with whom the child usually resides. Watching the family therapist engaging all the members, exploring how the family system functions (roles in the family, the family’s strategies to cope with difficulties), the relationship between different subsystems in the family and their impact on their children offered an understanding of problems as interpersonal and embedded within relationships and not as individual deficit. This approach was viewed as less blaming. Protecting children became keeping the child at the centre of the concerns, whilst understanding the complexity of the context in which they live.

Referrers noted that the families had changed their position from passive or resistant participants to active and motivated participants.

During the Review Meetings the referrers noticed that the families were initiating some of the change processes, in comparison to the initial 3-way

meeting. The follow up 3-way meeting, positioned the referrer as an outsider to the therapeutic alliance and shifted the conversation to a collaborative one between the family and their referrer. The referrers were able to move to work from a position of 'working with' rather than 'do to' families (Watson, 2018a).

The referrers where surprised that the family therapist explored the relationship between them and the family. Most of the relationships presented in the 3-ways meeting were difficult and at times conflictual. The referrers reported an improvement in their relationship with their families and that they found it easier to communicate with them more openly and clearly. The referrers reported changing their approach to a collaborative one. In turn, the family approached the referrer more when they needed help. This introduced a more voluntary interaction between them, despite the statutory nature of their involvement in the family's life. More engagement led to a positive feedback loop. Such mutual influence has been described in the literature (Horwitz & Marshall, 2015; O'Gorman, 2013). The quality of the interaction between clients and practitioner, and the practitioner's ability to help the family increases the client's level of motivation (Rooney, 1992). Honest communication can allow the social worker and family to find ways to work together effectively (Horwitz & Marshall, 2015). My research showed that improving the engagement can change the process from being experienced as entirely mandated into one experienced as more voluntary and more productive.

The desired outcome of a referral to the Parenting Project is the family making positive change. I was therefore surprised that some referrers found changes in the family challenging, especially in relation to their position. The referrers questioned their own position when families began to change. The second order (Dallos & Draper, 2010) way of working was introduced to the referrer through an invitation to reflect on their own position in relation to their clients on their part in the relationship.

10.1.4. Working collaboratively

Collaboration is at the heart of the Referrer Engagement Method. An effective protection of children is more likely to take place through a good collaboration between the professionals around them and between the family and the professional (Kettle, 2018).

The 3-ways meetings provided a platform for transparent conversations between the three parties. The Referrer Engagement Method assumes all parties bring different 'expertise' to the partnership; families know their family's needs and dynamic best, referrers carry the duty to safeguard children, and the family therapist brings the systemic lens in assessing and working with the system (see Figure 10), similar to Sutherland and Strong's (2011) description of a productive collaborative approach when working with 'multi-agencies' and families.

The dialogue during the 3-way meetings of my study created an opportunity for a reflective space for all participants. Having the family therapist chairing the meeting helped in reducing the level of the referrer's anxiety and brought a sense of sharing responsibility with another professional. The relational frame was found to 'liberate' the social worker from trying to fix a problem child, to working with the child's system. Bowman and Jeffcoat (1990) found that collaborative work can help to avoid enmeshment between the worker and the family as it involves pushing for role clarity when working with a wider system. Research about voluntary work with services showed that clear roles and developing a collaborative relationship with parents contributed to the success of social worker interventions (Horwitz & Marshall, 2015; Mckay & Nudelman, 1996).

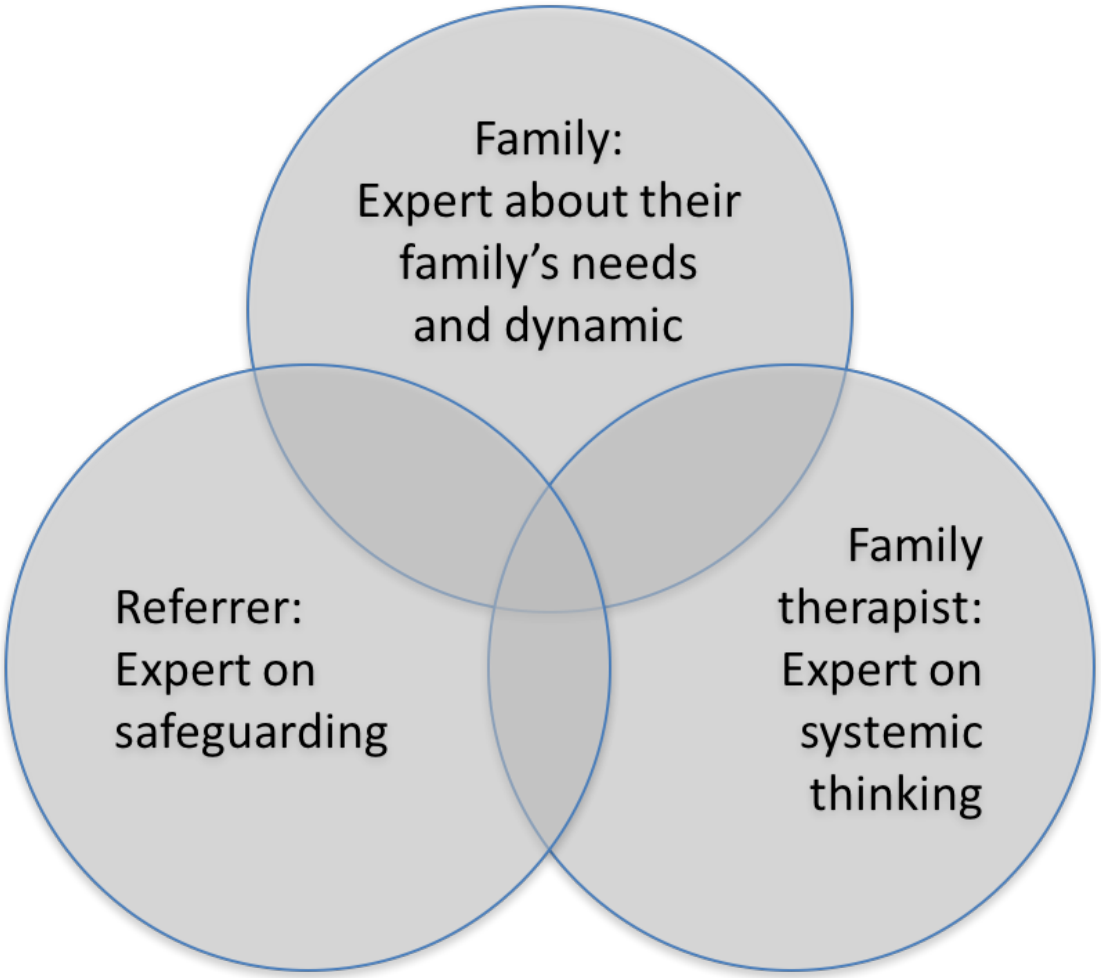

Figure 10: All parties bring different 'expertise' to the partnership

The Referrer Engagement Method helped to expand the system around the family and reduce the fragmentation of services.This professional collaboration helped the practitioners understand the complexity of the child protection system and associated work with families, the family therapist getting a better understanding of safeguarding issues, and for the referrer to be exposed to a systemic interventions with families. Social workers in child protection highly depend on their relationship with other professionals because they share information and responsibility (Kettle, 2018). The aim of collaboration between professionals and clients in a child protection context is to be able to make legitimate decisions for the best interest of the child (Willumsen & Skivenes, 2005) and for the relevant views and opinions to be

included in decision making. However, there are asymmetrical power issues and knowledge between professionals and clients. Sharing information with the client and giving the client a voice, that includes them more, reduces the power imbalance somewhat.

Establishing a participatory practice allowed for more transparent conversations to take place between all participants. The referrers commented that, to their surprise, this brought more trust and professional accountability to their relationship with their clients. A significant outcome in Alfandari's (2017) study is that parents expressed the need for clarity and honesty in the process of work by social workers.

Despite the benefits, working collaboratively did not always feel right and easy for the referrers. In my study, some referrers embraced collaborative working more than others. Interestingly, Wilkins & Whittaker (2018), in their action research study to enhance a collaborative approach between practitioners and families by introducing the Motivational Interviewing (MI) approach to social work, found four barriers to participatory child protection practice. Participation is not suitable for everyone and some social workers found it difficult to step back from a position of telling the parents what to do. Some social workers found engaging the parents more challenging, especially in cases of high risk, as they felt it reduced the focus on the child. Some social workers appreciated the collaborative approach but felt they lacked the skill to do it in practice. Wilkins and Whittaker (2018) found that social workers were able to integrate collaborative ways of working with some parents and exclude other parents from the process of making decisions and reduce their autonomy. This highlighted the need, to bring more collaboration into their practice, for a change to take place in the value base of children's services.

Using the Referrer Engagement Method to create a more participative/collaborative model between families, referrers and the family therapists, when working in the context of child protection, was found to

improve engagement with families. The message in the 3-ways meeting was that the parents and children's views and knowledge about their personal relationship are very important in the process of change and that the system needs to be inclusive of all stakeholders and share a commitment to rise to the challenge of managing the different perceptions, ideas and experiences of the families. Respect, being clear, upfront and mindful of the balance of power among the different participants were observed by the referrer when seeing the family therapist chairing the meeting. Billis and Harris (1996) support the idea of collaborating with the service users as part of the whole system around the family, and found that it made the partnership stronger.

The mandated clients in this study were motivated and engaged in the process of change. This is contrary to the findings of other studies where working with mandated clients was found to be challenging (Willumsen & Skivenes, 2005). Helping families to move to a voluntary engagement in therapy is an important and significant process and outcome. Improving the experiences of the family in the child protection system and reducing the need for statutory, non-consensual interventions into family life, will signal a positive engagement (Wilkins & Whittaker, 2018).

From attending Child Protection conferences and core group meetings I learnt that a lot of the families experienced confusion about what was expected of them in the presented action plan. Having the referrer involved in the initial 3-way meeting, gives voice to both the referrer and the family members, is a way to create a mutual plan for the therapeutic work, which is clear and agreed by all participants. Attending the Review Meetings provided a space to reassess the family needs and rewrite the plan accordingly.This approach encouraged collaboration between families and the helping system, and families and therapist, including reaching an agreement regarding the division of roles and responsibilities among the professionals and family. This avoids the problem noticed by Sveaass and Reichelt (2001a, 2001b), in their study about working with refugees, where a discrepancy existed between the

referring problem as perceived by the referring professional and the problem experienced by the family. Involving the referrer at the initial session offered a platform to discuss any misunderstanding, explore the different opinions and views on the family matter and to formulate an agreement between the family and referrer regarding goals for therapy. This information helped the families in the study to be the subject of a personalised intervention and not an object of referral. Humphreys (1995) identified the key worker as crucial to ensuring that the therapist received accurate information about the family.

Research on professional perceptions of the benefit of collaboration with families report improved assessment of needs, support to the client, understanding of the issues discussed, and understanding of the others professional role (O'Brien, Bachmann, Jones, Reading, Thoburn, Husbands, Shreeve, & Watson, 2009).

10.2. Implications for social work practice

My findings show embedding systemic approaches into the Social Care system will benefit social workers and the families they work with. This aligns with Watson (2018a), who introduced systemic values and techniques while conducting joint work between family therapists and social workers to enhance and embed relational practice and introduced social workers to different ways of thinking and working with families.

Family therapy and a systemic approach can help in addressing some of the challenges social workers are facing in their work with families. Systemic ideas help professionals gain a wider and deeper understanding of the complexity of multi agency family life (Hingley-Jones & Mandin, 2007).

The Referrer Engagement Method introduced and modeled a way of working with families, in which the professional moved in between positions of power and expertise and positions of collaboration and demonstrated a way to both

assess risk and keep families engaged.The family therapists explicitly named power and its effects in their work with the families.

To maintain a balanced positioning in the work with families, the referrers need to keep reflecting on their decisions and relationships with the families. It is an important part of their work to make a space to consider how they work with the family and their impact on the family.

I am conscious that social workers find a participatory approach challenging and practitioners were more familiar with a more directive approach. They were pushing for changes in the family by applying an' instructive interaction' and telling them what 'to do'. This approach did not lead to the desirable changes. The Referrer Engagement Method helps address this and move practitioners away from a directive approach by focussing on engagement and collaboration with families, where the participants feel more connected and open to hear and work on changes jointly.

A question remains for social workers, are these changes sustainable? Repeat referrals brought the same social workers back to the Parenting Project. With a second referral they understood their role better, are familiar with the language and the method. However, it is not clear how much the referrers have been able to apply and adapt some of the ways of working they have observed in their everyday practice. The Referrer Engagement Method is not sufficient on its own to sustain social workers' changes. I suspect Wilkins and Whittaker were correct when they concluded that, to bring more participatory practices into child protection, 'an innovation in the valuebase of children's service' is required (Wilkins & Whittaker, 2018, p. 2003).

10.3. Implications for family therapy practice

The study reaffirmed the importance of engaging the referrer in the therapeutic work and hearing what they have to say with the family present.

The Referrer Engagement Method helps the family therapist to learn about the context of the referral, the relationship between the social worker and family, and creates a platform to ask questions to clarify information. It allows the family therapist to start their therapeutic work with the family with an integrated, clear and agreed plan for work, which can help in achieving the desired changes. Having the referrer in the meeting also helps to explain the therapist role clearly and gives the family therapist the opportunity to introduce and position themselves as part of the professional system around the family (with both the differences and similarities).

Keeping the referrer engaged is where the long term benefit arises. The family therapist must keep involving the referrer, inviting them to meetings, and keeping them informed. The Review Meetings are key to the ongoing process of change. This is where the referrer can observe change in the family and reflect on their own practice.

Involving the referrer when working with families should be considered more widely within family therapy. This research shows that such involvement benefits all of the system - families, referrers and family therapists. The Referrer Engagement Method has been effective in the context of child protection, however, a more tailored way of conducting the method could be considered in each specific field/context. This would have to take into account power issues, system constraints, integrating systemic thinking,and creating a space of collaborative dialogue which brings about influencing and being influenced by the other participants.

The Referrer Engagement Method differs from the ‘Reclaiming Social work’ (Goodman & Trowler, 2012) approaches, where family therapists are part of the Social Care system. In the Parenting Project the family therapist is external to the referrers system, and the family therapist can not conduct joint sessions with the families and their social worker, apart from the 3-way meetings. Both approaches share the passion in bringing the systemic values

and techniques to the Social Care system when working with families. The Referrer Engagement Method is an individualistic approach in introducing the individual referrer to systemic thinking.

10.4. Further development of the Referrer Engagement Method

Based on the analysis of the accounts of referrers' experience ideas have emerged for further development of the Referrer Engagement Method.

The family therapist always explains, prior to the initial 3-way meeting, that the referrer will be interviewed about their work with the family, their hopes, challenges and the strengths they experienced with the family. Despite this some referrers were still surprised and felt anxious about the transparent interview. I am now considering a more detailed referral conversation. This could incorporate the importance of the referrer's presence, to have their perspective included openly in the engagement of the family with the service, that referrers have a place in the family dynamic, and that it is useful to understand their relationship with the family as a precondition for starting work with the family (Selvini-Palazzoli et al., 1980). Most importantly that, paradoxically, their presence is not taking time away from the family but rather accelerating the process of engagement and the likelihood of achieving the desired changes. I would also share the questions that family therapist would ask, specifically how they would describe their relationship with the family. It may also be useful to share what other referrers found challenging and invite discussion about their own anxieties. Hopefully this conversation would help reduce the level of anxiety and give the referrer the opportunity to share their concerns, particularly if their relationship with the family is difficult. It would be interesting to explore/research whether adding such a detailed briefing prior to the initial 3-way contributes to an improved relationship between the referrer and family, and/or benefits the family.

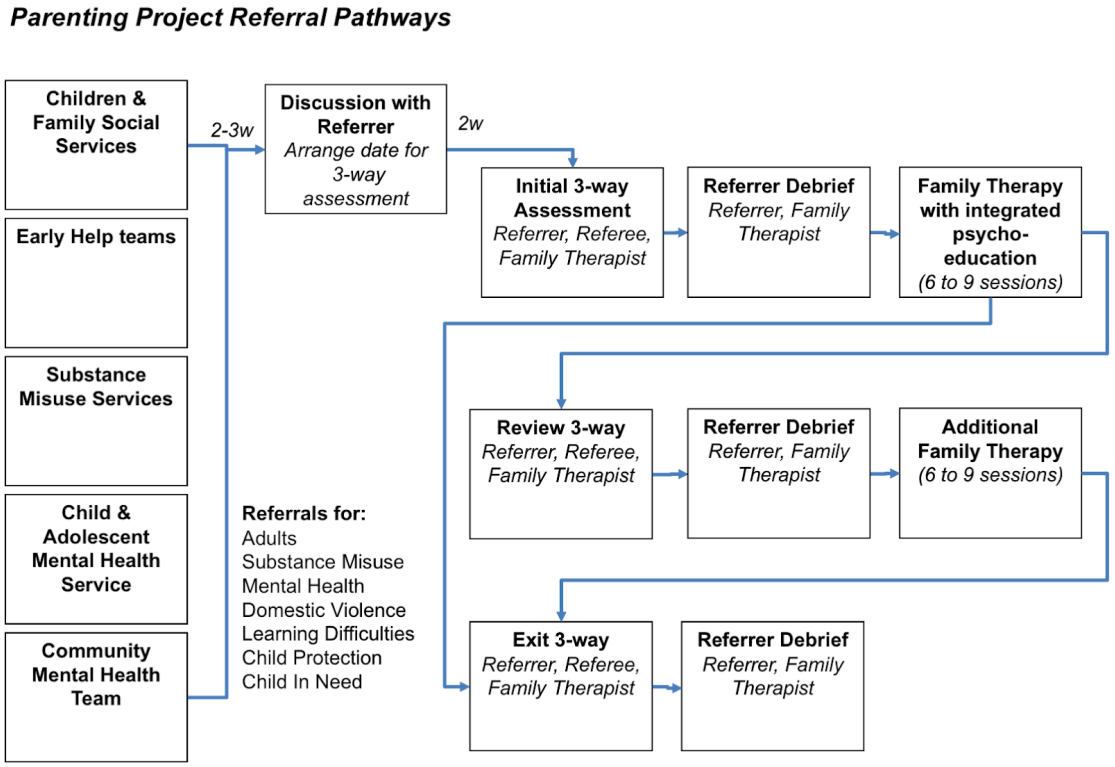

Figure 11: Service Pathway with Debrief

The referrers used both the focus group and individual interviews as a reflective space and at times as consultation with me. They talked about their experience in the 3-way meetings with the families, their relationship with the family, unexpectedly sensitive information from the family, feelings that arose, and the perceived associated threat to their safeguarding responsibility. Rober (2011) argues that having time and space to reflect with colleagues is not a 'luxury' but a 'necessity'. I have been struck by the referrers' appreciation of the opportunity to give feedback and reflect on the approach and their own positions. To give space for reflection I intend to add a 15 minute debrief session with the referrer after each 3-way meeting, both Initial Meeting and Review Meeting (see Figure 11). The family therapist would ask the referrer about their overall experience and significant moments during the meeting. We would have space to discuss both positive and challenging experiences. The therapist would explain that the space is for them, and to

help the family therapist to learn from their experience, to be more sensitive to their role and context, and tailor their involvement accordingly. In this way the systemic family therapist is able to include themselves and their context in order to sustain their own self-reflexivity. As Bagge (2012) highlighted, being part of an ongoing process and dialogue, not striving for solution, makes space for new meanings, new perspectives, actions, and feelings that can develop in both external and internal dialogue. This was the intention of the debriefing session.

Finally, I am considering adding questions to the Review Meeting to encourage more transparency. I think it would be beneficial for the referrer and family to discuss their relationship more openly. I propose asking the family about their needs from the referrer at that point, with an acknowledgement of any changes the family has made. This would be an invitation for a dialogue between the family and referrers about their working relationship from that point onwards.

10.5. Limitations and further research

This study produced some evidence that families benefit from the introduction of the Referrer Engagement Method into their therapeutic work. However, a limitation of this study is that the participants were all professionals, either social workers or family practitioners, and I did not interview any of the families themselves. This means the reported benefits for the family are solely those perceived by the referrer. The families will have a different perspective to their referrers and including them directly in the research could have highlighted different experiences of the approach and any changes they had experienced. Further research could explore the family's perspective on the significant processes in the Referrer Engagement Method and the impact on the family. This would enrich the data about the method and help in

continuing to evolve the method to include both professional and family perceptions and needs.

I was an insider researcher and was the clinician working with some of the participants. This introduced an addition power dynamic between the referrer and the family therapist. The participants may have felt constrained in how they expressed their views and may have withheld information from me. The participants may have been more open if speaking to a neutral, outsider researcher and this may have resulted in a greater range of feedback including more criticism of the method.

As an insider researcher I was close to the design of the Referrer Engagement Method, the participants, and the families. Losing my co-researchers through service redesign meant I had to change the design of the research from Action Research to Process Research. The major loss in this design change was the reflective loop with my co-researchers, who could have helped in balancing my voice and who would have been involved in the feedback loops to develop the method further throughout the research process. Future research could revisit the action research element of the original design.

When analysing the interviews, it was challenging for me to be a naive researcher. There was a constant danger that I was looking for what I believed (Burck, 2005). With the help of my supervisors and using memos, I was able to see more clearly how my knowledge and biases influenced my questions in the semi-structured interviews and the process of examining the data.

The participants in this study were recruited from both statutory and voluntary branches of the Children's Social Care system within one London borough, where this research took place. The majority of referrers were social workers from the statutory service and only one participant was a family practitioner from the voluntary service. These two participant groups were similar in many

ways, however, the family practitioner appeared to have a more collaborative relationship with her families and the power dynamic was more 'power together' than 'power over' (Kettle, 2018). It would be interesting to conduct a study to further explore the significant processes for the voluntary referrers. This would help in tailoring the Referrer Engagement Method for different types of professional within the context of child protection, taking into consideration their professional values and ethics, and the constraints of the system within which they work.

The richness of the data from the focus group and the way the participants built on each other's accounts to reflect on their own practice as well as on the approach, made me wonder whether it would have been better to finish the research with a second focus group of the interview participants. Such a focus group, at the end of the individual interviews, may prompt a richer set of data than came from the individual interviews.

The study exposed the referrers to new ideas and practices and there was evidence that referrers were adopting these. However I did not explore how sustainable these changes were and whether these techniques were embedded in social worker practice. This would, for example, have been possibly by convening a focus group with the interviewed participants after a period of time. It would be particularly useful to explore in more depth the challenges for referrers in managing power inequalities in their relationships with families in contexts of risk.

Selvini-Palazzoli et al. (1980) first demonstrated the value of referrer involvement in the context of working with young people with a psychiatric diagnosis. I adopted this idea in the context of families affected by substance misuse (although never researched), and then adapted the approach for the context of the current study, families who are on the child protection register. What I found in common to all three contexts is that the families had a large system of professionals around them. This study indicates that adapting a

referrer involvement approach to different contexts can benefit the family therapists in their work with the systems around the family and help create a platform for collaborative work. Further research could help refine and tailor the Referrer Engagement Method to the different needs of the different contexts.

Two referrers could not complete the pathway because their families dropped out of therapy. Families that are mandated to attend often drop out of therapy, with the hypothesis that this might be due to a lack of motivation or lack of ownership in the process of change. It would be helpful to conduct research with referrers who had families drop out of therapy, learn from their experience, explore their ideas about the cases, and what we could have done differently to reduce drop out.

10.6. Self-Reflexivity

I embarked in conducting this research on the Referrer Engagement Method from a position of the creator, manager and a clinician. I have created a method that reflected my own strong view on the importance of the therapeutic relationship when working with families in the process of change.

Starting my clinical journey as a social worker who was trained in Israel, psychodynamic engagement theory was the main influencing theory, focussing on the therapeutic alliance and the impact the social worker has on the client in the therapeutic setting, and vice versa (transference/countertransference). Attention to the therapeutic relationship, became an important component in my practice.

Later, when studying Family Therapy in London, I was surprised how little attention systemic theory paid to the therapeutic relationship. The majority of writings on therapeutic relationship within family therapy were written by

therapists who were also trained psycho-dynamically, for example Flaskas and Dare.

The therapeutic relationship has remained a key principle when I worked with families to enable change. I try always to be aware of my presence and the power I might represent to families when I enter their system. I'm also aware of how their presence and life stories impacts the way I feel, and can move me. We are a co-created system who influences each other in the journey of a therapeutic change.

I gained more experience in working with the system around the family through my work as a family therapist with families affected by substance misuse. Each part of the system viewed the issues through different lenses and the communication between the different services, and at times between the services and the family, was difficult, contradictory, and confusing. We started to invite other professionals to a '3-way' meeting where families could voice their views, and wish for change, and usually left the meeting feeling clearer about what was expected of them.

In 2009, I was asked to lead on The Meanwhile Parenting Project, to provide family therapy to families presenting with parenting challenges and safeguarding concerns due to mental health, substance misuse and domestic violence difficulties. I felt it was important to involve the referrer as a way of sharing information and establishing a collaborative relationship with the family and their referrer.

The incident described in the beginning of this thesis when a social worker asked whether I thought they could have good relationships with their clients triggered my interest in the social worker's position with their families. I became more curious about the relationship between the social workers I was seeing in the clinic and the families they had referred to us. In a small way, in the context of my service, I started a kind of a 'campaign' to emphasise the importance of the therapeutic relationship to the social work profession. I was

passionate about it and wanted to influence the social worker practices by introducing them to systemic thinking when working with families and building relationships. This interest became the focus of my study in the doctorate programme.

The referrers in my study moved in their position in relation to the families during the approach and interviews, and I went through a similar process during the research. I started the research feeling passionate about family therapy and 'preaching' about the importance of the therapeutic alliance when working with families. I was always asking the referrers about their relationship with their clients and, to my surprise, they were uncomfortable and uninterested. Then I started the research and, as an insider researcher began to look for validation of my method and beliefs. Upon reflection and through reading my notes, I realised how at times I was critical of the referrers' position and relationship with the families. Indeed I realised that I was at times judgemental of their practices. I was also challenged in the process of interviewing the referrers and analysing the data. I struggled with referrers who did not find the method useful to their own practice. I thought they did not fully understand and wondered how they could not see the importance of their relationship with their clients, how could they expect changes in the family without seeing themselves as the one who can influence their motivation to change.

Being an insider researcher who is also a clinician and the creator of the approach I initially lost sight of the power imbalance between myself and my participants. I have taken them through a journey and introduced them to a different way of working and relating with their families. This new approach challenged their practice, and had not always taken into consideration their context of work and the challenges it entailed. Paradoxically, I wanted to introduce them to the concept of 'power together' (Kettle, 2018) and move away from 'power over' when working with their clients, yet I have come to realise that my initial position with them was itself more of 'power over', which

was extremely important learning. This is very similar to the see-saw of power between the referrers and the families (Figure 7) just this time with different players.

In addition, I now believe I was initially overwhelmed by my closeness to my own approach and hence to the data as an insider researcher and the sheer volume of it. I struggled to hear different views to my own. At the beginning of the study this compromised my position of curiosity. I suspect, to help me filter this great quantity of material, I subsciously sought that which I already believed. I ran the risk of letting my close position as an insider researcher lead the process of analysis, concentrating on the data that instantly resonated with me, I had less data with which to deal.

Through supervision sessions and my discussions with colleagues, I started to make more space for different voices and listened more carefully to the referrers' experience. Later I found this very significant for the development of the method.

During the process of writing my analysis, and identifying the significant processes for my participants, I was able to turn the volume down on my own preconceptions and pay greater attention to their experience. I gained a better understanding of the referrers' context of work, their duties, and how these influenced their position with the family. I could appreciate how these influenced their position with the families and and how this sometimes held them back from forming a strong therapeutic alliance and working collaboratively. I found myself empathising in their struggle to balance risk and care. I became conscious of their desire to attain a greater balance but also appreciated their fear that this would sideline their main task (risk), which was the primary concern of their organisation and managers.

Although "power is everywhere", I learnt from the referrers how different their position to power is to my own. I was always aware of my professional position and power with the families but my contract with them was voluntary

(this is not always true for clients in the Parenting Project, but was true for this study). The referrers, coming from a mandatory power position, found it new and challenging to consider a collaborative relationship with the families. It did not make sense to them. They could not see how they could combine both/and positions. The systemic thinking techniques helped create different ways of relating that did not compromise their task.

Although I trained as a social worker, I was never a social worker in the context of child protection. This research made me realise the importance of understanding the context in which the referrers work, when adapting referrer engagement to a different setting. it is only truly possible to understand the challenges of social workers when hearing about their context, professional duties and values. These are not always clear to an outsider.

This research journey was beneficial and challenging to all - the referrers and myself. We both shifted positions and opened our curiosity to different and new ways of working.

11. Conclusion

My motivation for carrying out the research was to further develop the method used in my service to work with families and their referrer in the context of child protection - the Referrer Engagement Method. At the heart of the method is a collaborative approach to work with both the family and referrer aiming to improve their therapeutic alliance and the family's motivation for change.

The referrers highlighted four significant processes in the Referrer Engagement Method: Naming power, Opening dialogues, Engaging the system in the room, and Working collaboratively. These processes are complex and overlapping, yet complement each other.

I found the Referrer Engagement Method to be valuable to all participants. The referrers saw the families start to take ownership of their changes. Introducing and modelling systemic thinking and techniques was seen as an invitation to the referrers' to expand their practice with families. However, the referrers also found some aspects of the approach challenging.

I look forward to integrating the ideas developed in this study back into the method and sharing with both new and experienced social workers referring to my service. I have already begun working differently. Working collaboratively created an important space for reflection and both the proposed research and development of the method focus on creating even more space for reflection.

The process of the research has made me more aware of my position with both the referrers and the families and the importance of keeping alive my curiosity about their contexts.

I look forward to sharing ideas with family therapist colleagues working in a similar context. I believe Referrer Engagement is a useful approach and can be adapted and further developed when working with families in different contexts.

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13. Appendices

13.1. Appendix 1: Ethical approval

APPLICANT DETAILS

Name of Principal Investigator (PI) (For research degree students, the Director of Studies)	Galit Haviv-Thomas
School	**Law and Social Science**
Status (please tick relevant box)	**UEL STAFF** ☐ **RESEARCH DEGREE STUDENT** ☒
Email address	**galit@balagan.org.uk**
Contact telephone number	07980 280 993
Name of co-researchers	Alison Smith, Jenny Cousins
Will parts of the proposed research or research administration be carried out by independent contractors or partner institutions, domestic or international?	**YES** ☐ **NO** ☒ If **YES**, please provide a brief explanation of who the contractor or partner is, what their role will be and how their contribution will be monitored. Please note, responsibility for proper conduct of all parties involved in the research resides with the Principal Investigator.

CONFLICTS OF INTEREST

Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above their normal salary package or the costs of undertaking the research? **YES** ☐ **NO** ☒ If **YES**, please detail below:
Is there any further possibility for conflict of interest? YES ☐ **NO** ☒ If **YES**, please detail below:

FOR ALL APPLICANTS

Has external ethics approval been sought for this research? **(i.e. submission via Integrated Research Application System (IRAS) to the Health Research Authority (HRA) or other external research ethics committee)**	**YES** ☐ **NO** ☒
If **YES**, please supply details below:	

DEAN OF SCHOOL OR ASSOCIATE DEAN

- Does the proposed research as detailed herein have your support and endorsement to proceed?
  YES ☑ **NO** ☐

Signed	
Date	13.05.14

13.2. Appendix 2: Participant information forms

13.2.1. Focus Group Information Form

PARTICIPANT INFORMATION SHEET (Referrer A)

An Action Research Project to explore and develop a systemic approach to working with the referrer in the context of child protection.

Introduction

I would like to invite you to take part in my professional doctorate research project exploring and developing a systemic approach to working with the referrer in the context of child protection.

I have been involved in building a family therapy service for parents who experience challenges in parenting their children, who are on the child protection register, and who are involved with a large system of professionals. As part of this service I have developed a service pathway that involves the referrer (care coordinator) throughout the family involvement with our service.

As a result of my training as a systemic psychotherapist and as social worker I am interested in the process of engagement as it applies to the entire system.

I am interested in the referrer's view on the systemic approach, as this will help me to define and refine the method of working with the referrer. It will also help me form a general explanation (model) on referrer involvement. In particular I now wonder how being engaged in systemic approach to psychotherapy has impacted the referrer's own practice with their clients and colleagues.

I am also curious as to whether this approach can be added to the family therapy 'tool box' when working in the context of child protection.

Why me?

You have been invited to take part in this research because you

- are a social worker from H&F Children and Families ,
- have referred a family to us in the past, and
- have been exposed to our approach.

If you decide to join the study you will be asked to sign a consent form. You are free to withdraw at any time, without giving reason.

Save Date: 11 May 2014

What will happen?

You will meet with the researcher once. You will be invited, together with 5-7 other social workers from H&F, to join a focus group discussion around the issue of referrer involvement.

All the participants in this focus group will have experience of the Referrer Involvement Method from prior interaction with the Parenting Project service. These participants will be familiar with the service pathway and the systemic approach of working closely with the systemic psychotherapist and the referred family.

The aim of the focus group is to explore diversity and a range of views rather than to find a consensus

Confidentiality

The focus group discussion will be audio and video recorded for the purpose of transcription and analysis. This material will be shared only in the context of the academic community at the Tavistock and University of East London for the purpose of supervision, peer review and final doctorate examination. Data will be retained in accordance with the University's Data Protection Policy. It will be destroyed at the very end of the professional doctorate process. In the transcription of the focus groups all identifying factors will be made anonymous including who you are, your team and workplace. However, in this study, the small sample size limits the level of confidentiality / anonymity possible. The discussion will not ask for any clinical anecdotes as it is important to protect client confidentiality.

Risks

There are no serious risks inherent in this project.

University of East London

This research is being undertaken as part of my studies at the Tavistock and Portman within the Law and Social Science School, University of East London. The research has received formal approval from University Research Ethics Committee (UREC).

If you have any concerns about the conduct of the researcher(s), or any other aspect of this research project, you can contact researchethics@uel.ac.uk.

Save Date: 11 May 2014

13.2.2. Interview Information Form

PARTICIPANT INFORMATION SHEET (Referrer B)

An Action Research Project to explore and develop a systemic approach to working with the referrer in the context of child protection.

Introduction

I would like to invite you to take part in my professional doctorate research project exploring and developing a systemic approach to working with the referrer in the context of child protection.

I have been involved in building a family therapy service for parents who experience challenges in parenting their children, who are on the child protection register, and who are involved with a large system of professionals. As part of this service I have developed a service pathway that involves the referrer (care coordinator) throughout the family involvement with our service.

As a result of my training as a systemic psychotherapist and as social worker I am interested in the process of engagement as it applies to the entire system.

I am interested in the referrer's view on the systemic approach, as this will help me to define and refine the method of working with the referrer. It will also help me form a general explanation (model) on referrer involvement. In particular I now wonder how being engaged in systemic approach to psychotherapy has impacted the referrer's own practice with their clients and colleagues.

I am also curious as to whether this approach can be added to the family therapy 'tool box' when working in the context of child protection.

Why me?

You have been invited to take part in this research because you

- are a social worker from H&F Children and Families, and
- have recently referred a family to us for the first time

If you decide to join the study you will be asked to sign a consent form. You are free to withdraw at any time, without giving reason.

What will happen?

You will meet with the primary researcher three times: two individual interviews and a mini-focus group. The interviews will be 30 minutes and immediately after the first and second 3-way meeting with the family. The interview will take place at the same location as the 3-

Save Date: 11 May 2014

way, the Masbro Family Centre. The mini-focus group will involve yourself and 2 other social workers from H&F and will happen after the exit 3-way with family. The purpose is to explore your experience of the service pathway and the systemic approach of working closely with the systemic psychotherapist and the referred family.

Note: The aim of the mini-focus group with your colleagues is to explore diversity and a range of views rather than to find a consensus

The Family Therapist you will be working with is a co-researcher in this project. Based upon the feedback from yourself and other participants we will modify the way the Family Therapist involves you in the therapeutic engagement in the future.

Confidentiality

The individual interviews and min-focus group discussion will be audio recorded for the purpose of transcription and analysis. The mini-focus group will also be video recorded. This material will be shared only in the context of the academic community at the Tavistock and University of East London for the purpose of supervision, peer review and final doctorate examination. Data will be retained in accordance with the University's Data Protection Policy. It will be destroyed at the very end of the professional doctorate process. In the transcription of the focus groups all identifying factors will be made anonymous including who you are, your team and workplace. However, in this study, the small sample size limits the level of confidentiality / anonymity possible. The discussion will not ask for any clinical anecdotes as it is important to protect client confidentiality.

Risks

There are no serious risks inherent in this project.

University of East London

This research is being undertaken as part of my studies at the Tavistock and Portman within the Law and Social Science School, University of East London. The research has received formal approval from University Research Ethics Committee (UREC).

If you have any concerns about the conduct of the researcher(s), or any other aspect of this research project, you can contact researchethics@uel.ac.uk.

Save Date: 11 May 2014

13.3. Appendix 3: Participant consent forms

CONSENT FORM

Researcher: Galit Haviv-Thomas

An Action Research Project to explore and develop a systemic approach to working with the referrer in the context of child protection.

Please initial box

1.	I confirm that I have read and understand the information sheet dated ..... for the above study.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	☐
3.	I understand that all identifiable material will be made anonymous and all audio and video recordings will be destroyed at the conclusion of the project.	☐
4.	I agree to being quoted in the data analysis and results and understand any quotation will be made anonymous (although the small sample size limits the level of anonymity possible)	☐
5.	I give permission for the research project, including quotations to be published	☐
6.	I agree to take part in the above study.	☐

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Name of participant	Date	Signature
----------	----------	----------
Name of researcher	Date	Signature

Copies: 1 for participant; 1 for researcher

13.4. Appendix 4: Semi-structured Interview Questions

13.4.1. Questions for Clinical Lead / Service Manager / Researcher

Interviewer of the Clinical Lead was given these questions use as a basis for the interview:

1. What were the reasons for developing the method?
2. What are the main elements of the method?
3. How has the method has evolved over time? Why did it evolve in that way?
4. What difference has the method made to your practice with:
    a. the clients?
    b. the system?
5. What other outcomes were you hoping for?
6. What challenges did you or your colleagues experience in using the method?
7. Describe any situations where the method didn't quite work and you had to do something different

13.4.2. Questions for Focus Group

The facilitators of the focus group had these questions to help structure the session:

1. Why did you refer the family to a Family Therapy service?
2. When you were invited to the initial 3-way assessment -
    a. What was your reaction?
    b. What was your expectation of the initial 3-way assessment?
3. The approach aims to be collaborative –
    a. Was it successful in this?
    b. What contributed to the collaborative nature of the work?
4. How did you find being interviewed in front of the client?
    a. What did you like about it?

    b. What did you find useful to your practice and to the family?
    c. Is there any thing you found difficult / unhelpful about it?
    d. How would you change it?
5. Have you noticed any changes in the way you work as a result of being involved in this process?
6. Was there any particular intervention / question by the Family Therapist that you have used, or are likely to use, in your work with clients?
7. Has the approach changed your relationship with the family?
    a. And the family's relationship with you?
8. Did the approach give you a different perspective on your work with the family?
    a. If so, what was it?
9. Has the approach made a difference for the client?
    a. In what way was the experience positive for the client?
    b. In what way negative?
    c. Has it had an impact on the family aims and motivation for change?

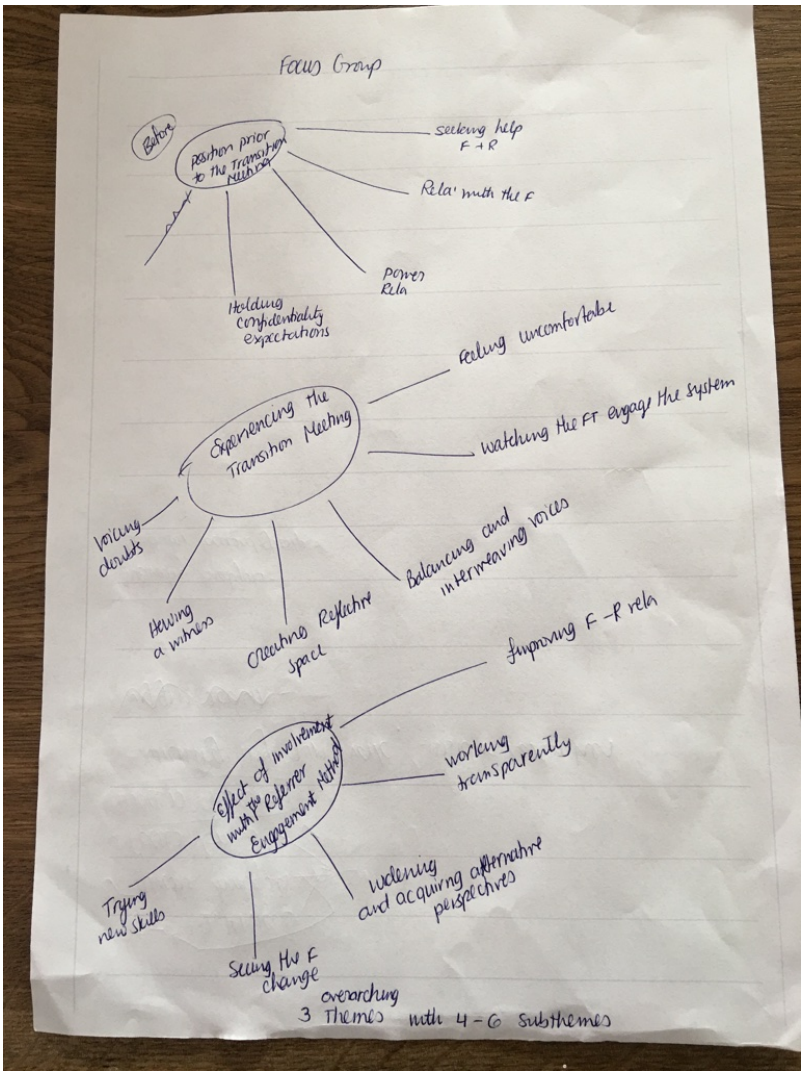
13.4.3. Questions for Referrer Interviews

I used these questions to structure the individual interviews:

1. Why did you refer the family to a Family Therapy service?
2. How did you find the process of referring the family to the Family Therapy service? (Including filling in the referral form)
3. When you were invited to the initial 3-way assessment -
    a. What was your reaction?
    b. What was your expectation of the initial 3-way assessment?
4. The approach aims to be collaborative –
    a. Was it successful in this?
    b. What contributed to the collaborative nature of the work?

    c. Was there anything the Family Therapist did to ensure all voices were heard – yours and the family's?
5. How did you find being interviewed in front of the client?
    a. What did you like about it?
    b. What did you find useful to your practice and to the family?
    c. Is there any thing you found difficult / unhelpful about it?
    d. How would you change it?
6. Have you noticed any changes in the way you work as a result of being involved in this process?
7. Was there any particular intervention / question by the Family Therapist that you have used, or are likely to use, in your work with clients?
8. Has the approach changed your relationship with the family?
    a. And the family's relationship with you?
9. Did the approach give you a different perspective on your work with the family?
    a. If so, what was it?
10. Has the approach made a difference for the client?
    a. In what way was the experience positive for the client?
    b. In what way negative?
    c. Has it had an impact on the family aims and motivation for change?

13.5. Appendix 5: Thematic Map



13.6. Appendix 6: Spencer and Ritchie Scheme for Assessing Quality

Spencer and Ritchie (2012) describe three guiding principles for assessing the quality of a qualitative research study: contribution, credibility and rigour. Contribution is about the value and relevance of the study. Credibility is about whether the claims of the study are defensible and plausible. Rigour demands appropriate decision making and thoroughness of research conduct. The authors suggest a number of questions, in each of these guiding principles, to assess the quality of a study.

13.6.1. Contribution

Contribution is "the extent to which the study has contributed to wider knowledge and understanding or had some utility within the original context" (Spencer and Ritchie, 2012, p. 233)

Central questions	**Response**
How has knowledge / understanding been extended?	The study attempts to show how engaging the referrer in the therapeutic process results in a collaborative action plan, better engagement in therapy from mandated client families, referrers changing their social work practice, and better a referrer-family relationship. The discussion section describes how the data supports these claims and links to the relevant literature.
How well is the basis of drawing wider inference explained?	The study extends to family therapy practice within the context of social services and social work practice in the context of child protection. The discussion section describes the wider inferences, outlines the evidence for drawing these conclusions, and discusses the limits of drawing inference beyond the study context. .

What value has the study evidence had for participants / service users?	The study shows how a change to social worker practice can positive impact the referrer-family relationship and the family's willingness to embrace change. The discussion section elaborates on the impact on the participants.

13.6.2. Credibility

Credibility is "the extent to which findings are believable and well-founded"

(Spencer and Ritchie, 2012, p. 234)

Central questions	**Response**
How does the evidence support the findings?	The results section makes full use of extracts from the transcripts to demonstrate how interpretation is based on the data. The results are organised by significant process and sub-process. And within those sections the common elements are described before outliers. Generally I have tried to keep the interpretations in the results section explicit, i.e. given by the participants. In contrast the discussion section has both explicit and implicit interpretations (inferred by myself as the research).
How plausible are the findings?	"Clear, transparent and reflexive documentation of the research process" (p. 235) enhance the plausibility of the study. The reflexivity section outlines how I approach reflexivity. The discussion section describes how the research findings fit with existing knowledge.

What forms of validation have been attempted? Why? Why not?	I used multiple research methods (focus group, interviews), with multiple participant groups (Service Manager, experienced referrers, new referrers), and analysis techniques (thematic analysis, grounded theory) to increase credibility of the results. In addition my co-researcher (Alicia) and supervisors provided some peer review of the analysis. I did not use multiple analysts. Nor did I seek confirmation from referrers. Logistical constraints made this impossible.

13.6.3. Rigour

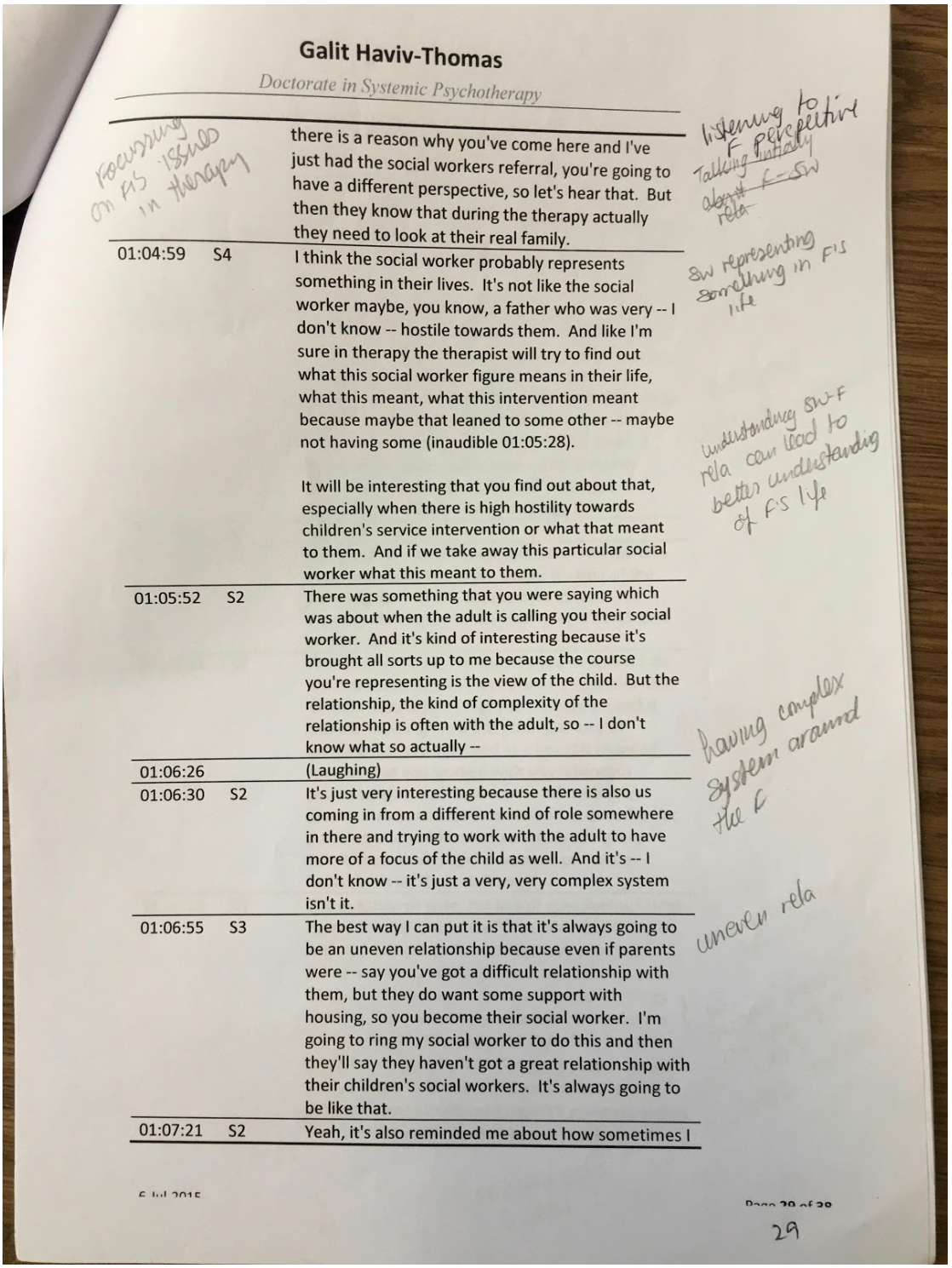
Rigour is "The transparency of the research process, the defensibility of design decisions and the thoroughness of conduct" (Spencer and Ritchie, 2012, p. 235).

Central questions	**Response**
How well-documented and reflexive is the research process?	I have explicitly stated my epistemological stance and my approach to reflexivity. The discussion section outlines some of the key decisions made during the research process, and the rationale for those decisions. The appendix includes a number of key documents including information sheets for participants, consent forms, analytic frameworks.
How well defended is the overall	The methodology section explains

research strategy and design?	the research strategy and design. As a reminder this study is exploratory and focussed on the experiences of referrers engaged in a therapeutic process. This makes inductive qualitative methods appropriate, including grounded theory and thematic analysis.
How appropriate are the methods used?	The methodology section explains how the original design included action research and grounded theory and the rationale for these choices. The section also describes the unforeseen events that lead to abandoning the action research element. Finally the section explains why thematic analysis was adopted for the analysis of the focus group.
How well have ethical issues been considered and addressed?	The ethics section outlines a number of ethical issues from the perspective of the participants. The section explains how the study was presented to the participants, the manner in which I gained their consent, and the commitment on the participant's anonymity. Support services were offered to the participants but none took up the offer.

13.7. Appendix 7: Sample of transcripts with codes

The first extract is from the focus group.



Galit Haviv-Thomas

Doctorate in Systemic Psychotherapy

		there is a reason why you've come here and I've just had the social workers referral, you're going to have a different perspective, so let's hear that. But then they know that during the therapy actually they need to look at their real family.
01:04:59	S4	I think the social worker probably represents something in their lives. It's not like the social worker maybe, you know, a father who was very -- I don't know -- hostile towards them. And like I'm sure in therapy the therapist will try to find out what this social worker figure means in their life, what this meant, what this intervention meant because maybe that leaned to some other -- maybe not having some (inaudible 01:05:28). It will be interesting that you find out about that, especially when there is high hostility towards children's service intervention or what that meant to them. And if we take away this particular social worker what this meant to them.
01:05:52	S2	There was something that you were saying which was about when the adult is calling you their social worker. And it's kind of interesting because it's brought all sorts up to me because the course you're representing is the view of the child. But the relationship, the kind of complexity of the relationship is often with the adult, so -- I don't know what so actually --
01:06:26		(Laughing)
01:06:30	S2	It's just very interesting because there is also us coming in from a different kind of role somewhere in there and trying to work with the adult to have more of a focus of the child as well. And it's -- I don't know -- it's just a very, very complex system isn't it.
01:06:55	S3	The best way I can put it is that it's always going to be an uneven relationship because even if parents were -- say you've got a difficult relationship with them, but they do want some support with housing, so you become their social worker. I'm going to ring my social worker to do this and then they'll say they haven't got a great relationship with their children's social workers. It's always going to be like that.
01:07:21	S2	Yeah, it's also reminded me about how sometimes I

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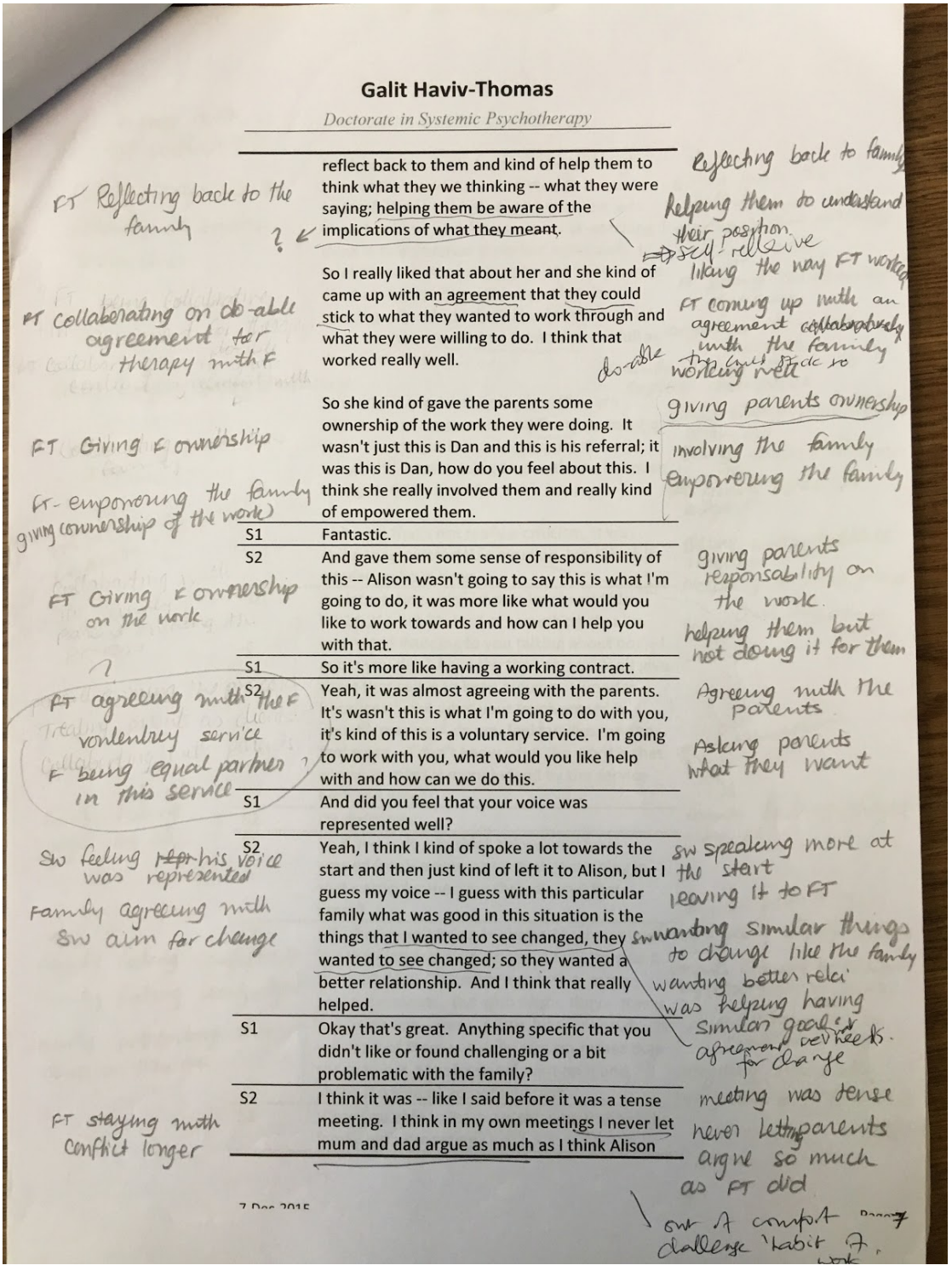
The second extract is from the the first interview with David.



Galit Haviv-Thomas

Doctorate in Systemic Psychotherapy

	reflect back to them and kind of help them to think what they we thinking -- what they were saying; helping them be aware of the implications of what they meant.
	So I really liked that about her and she kind of came up with an agreement that they could stick to what they wanted to work through and what they were willing to do. I think that worked really well.
	So she kind of gave the parents some ownership of the work they were doing. It wasn't just this is Dan and this is his referral; it was this is Dan, how do you feel about this. I think she really involved them and really kind of empowered them.
S1	Fantastic.
S2	And gave them some sense of responsibility of this -- Alison wasn't going to say this is what I'm going to do, it was more like what would you like to work towards and how can I help you with that.
S1	So it's more like having a working contract.
S2	Yeah, it was almost agreeing with the parents. It's wasn't this is what I'm going to do with you, it's kind of this is a voluntary service. I'm going to work with you, what would you like help with and how can we do this.
S1	And did you feel that your voice was represented well?
S2	Yeah, I think I kind of spoke a lot towards the start and then just kind of left it to Alison, but I guess my voice -- I guess with this particular family what was good in this situation is the things that I wanted to see changed, they wanted to see changed; so they wanted a better relationship. And I think that really helped.
S1	Okay that's great. Anything specific that you didn't like or found challenging or a bit problematic with the family?
S2	I think it was -- like I said before it was a tense meeting. I think in my own meetings I never let mum and dad argue as much as I think Alison

7 Dec 2015

13.8. Appendix 8: Research audit trail

Lincoln and Guba (1985) listed six categories of information to inform the audit process: raw data, data reduction and analysis notes, data reconstruction and synthesis products, process notes, materials related to intentions and dispositions, preliminary development information. Audit trails can be either intellectual or physical (Carcary, 2009) and my study has both.

13.8.1. The intellectual research audit trail

The intellectual audit trail helped me to reflect on how my thinking evolved through the study (Carcary, 2009). The following represents the intellectual audit trail for this study:

- **Desire for a theory**: My original research design assumed I would use grounded theory as the sole analysis method. I was interested in developing a theory and grounded theory seemed a sensible vehicle for exposing any underlying theory behind the Referrer Engagement Method.

- **Initial research bias**: Although I believe in balancing the positions of 'Expert' and 'Not knowing' as part of my therapeutic practice (Anderson and Goolishian, 1988), I started this study from a position of being the expert on the Referrer Engagement Method. I created the method and worked within the service so, subconsciously, I found myself seeking validation for the method and, ironically, I found myself critical of the referrers for being stuck in their position of experts on safeguarding and prioritising risk over engagement.

- **Moving to 'not knowing'**: Once my bias became clear to me, I actively moved to a more open position and tried to balance my position of expert on the Referrer Engagement Method with a position on not knowing about the referrer's experience of the method and their context of work. The focus group was pivotal in this change as the

referrers provided rich insight into their experience of the method, both positive and negative. My more open position to the study was more aligned with my social constructionist stance (Charmaz, 2006; Dallos & Draper, 2010). I was more able to co-create and evolve reality with the referrers.

- **Choosing story over theory**: The realisation of my bias and the need to increase my focus on the referrers' experience coincided with my decision to move away from using grounded theory as the sole analysis method and include thematic analysis. This combination of analysis methods helped me generate a more coherent story about significant processes from the referrers' perspective. With a greater focus on the story about the processes within the Referrer Engagement Method, I abandoned the desire to develop an underlying theory.

13.8.2. The physical research audit trail

The physical audit trail documents the stages of my research study, and reflects the key decisions about the research methodology (Carcary, 2009). The physical audit trail for this study is as follows:

- **Deadend topic**: I started my studies in the September 2010. I initially explored research options related to attachment theory and siblings. After a year my supervisor at the time (Bernadette Wren) advised me to look elsewhere for a topic as my first interest was over researched.
- **New topic**: At work my commissioner was keen to have evidence based services in her portfolio and encouraged me to research the Parenting Project. Initially she supported this study by funding 0.5 days per week for research. After some reflection I settled on researching referrer engagement within the context of child protection.
- **The research proposal**: I developed a proposal around this topic and submitted it to the research institution's research sub-committee for approval. The proposal was entitled "An Action Research Project to

explore and develop a systemic approach to working with the referrer in the context of child protection." The proposal included an outline of the study, aims, objectives and the research questions, relevant literature, and methodology. The study was registered in September 2012.

- **Suspension 1**: I gave birth to my second child on 16 July 2012 and as a result officially suspended my studies for an academic year (September 2012 to June 2013). I restarted my studies in September 2013.
- **Ethical approval**: I submitted my project to the institutions Ethical sub-committee for approach. Approval was granted on 13 May 2014.
- **Interview with myself as Service Manager and insider researcher**: I arranged to have myself interviewed in August 2014. This enabled me to reflect on my initial position at a later stage in the research.
- **Start evidence collection**: I conducted my first semi-structured interview in October 2014 (David) and the focus group in November 2014.
- **Threat to service**: From 2015 the funding for the Parenting project has been uncertain and it was not clear it would continue. The funding uncertainty continues to the present time.
- **Slowed evidence collection**: With the funding uncertainty my motivation for research dropped as without funding there would be no service to research. I elected to focus on data collection, with a brief analysis between interviews, and writing memos. With drop out of some cases I had to recruit additional referrers. I conducted a total of nine interviews with four referrers. Evidence collection stretched over the period February 2015 to March 2018.
- **Acknowledgement of changes to research design**: In October 2015 I sought official recognition of three changes to my research design. Firstly, I had expanded the sample to include participants that are Social Services care coordinators in a child protection system, i.e. not

social workers. As it happens I only interviewed one care coordinator (Pam). Secondly, I reduced the number of semi-structured interviews with each referrer from three to two to reflect that some cases terminate early without the opportunity for all interviews. Thirdly, I expanded the sample from just new referrers to include repeat referrers who can provide in depth data on referrer involvement. These repeat referrers were the participants in the focus group.

- **Restructured service**: In 2016 the Parenting Project underwent a restructure and I lost both of my colleagues including the co-researcher in this study (Alicia).
- **Suspension 2**: I suspended my studies for a second time from September 2016 until September 2017. My father passed away in August 2016. I was very close to my father, so was feeling very sad and found it hard to stay focussed. In addition, I wanted the opportunity to spend time with my 85 year old mother who does not live in the UK. I restarted my studies in November 2017.
- **Moving to process research**: Having lost my co-researcher meant I had to reconsider my intention to conduct action research. After discussion with my supervisor I changed to a process research and abandoned the action research aspects.
- **Thematic analysis for focus group**: Although I had done a brief analysis during evidence collection I had to revisit this step. I used thematic analysis for the focus group to highlight general themes in the data.
- **Grounded theory for semi-structured interviews**: I used grounded theory of the semi structured interviews to provide a more granular level of analysis.
- **Combining thematic analysis and grounded theory**: I found a close alignment between the themes/sub-themes arising from the thematic analysis of the focus group and the categories/axial codes from the grounded theory of the semi-structured interviews. I combined the two

sets of analysis. Given this is a process research study I adopted the terms significant process (for theme / category) and sub-process (for sub-theme / axial code). Combining into processes was relatively simple as I had used gerunds ("-ing") in my codes to emphasise the analysis of processes, i.e. highlighting what people are doing (a recommendation from grounded theory).

- **Iterate on analysis**: Analysis was not a linear process. I used both an incremental and iterative approach to analysis. Gradually expanding the scope of the analysis with new codes, but also revisiting existing codes to check their relevance. I also explored several different codes hierarchies i.e. which sub-processes were part of which significant processes. This iteration continued throughout the writing process.
- **Write the findings**: Having completed the analysis I immediately wrote the draft findings chapter. In some ways this was an intense period of memo writing and resulted in further development of the analysis.
- **Review of the literature**: In keeping with grounded theory I left the detailed review of the literature until after data collection and analysis. I explored the literature related to the context of the Referrer Engagement Method and the development of the method. My analysis had revealed that power and dialogue were key elements of referrer engagement and I spent some time reviewing the literature in these areas.
- **Write the literature review**: I found as part of writing the literature review that my thoughts on the implications of the study were already developing. I struggled to separate the literature that informed the study and the method under study, from the discussion of the implications.
- **Write the discussion**: Writing the discussion helped me tease apart my thinking and separate the literature review from the implications. Even at this late date I was revisiting the analysis and renamed two of

the significant processes to better reflect the processes described by the referrers.

13.9. Appendix 9: Sample memos

I have included two sample memos. Both relate to the point of referral. The first focuses on the relationship between the referrer and client. The second on the decision to refer.

13.9.1. Memo: Relating to the client at referral (11 April 2016)

Having a relationship with your client at the point of referral. This is at the point of referring outside SS. Their willingness and level of their engagement with FTS is dependent on their relationship with their SW prior to making the referral.

Conflictual vs trusted.

This also will have an impact on the type/aim of the referral.

I'm stuck (SW: help me, support me, prove I'm right) vs we've tried everything and now we need someone else to help us

The relationship also indicated the client understanding and willingness in attending.

Agreeing with my SW or Objecting any help coming from my SW

S4 (00:07:15) Because of the complexities in this particular family's communication I think communication was the key. Helping them communicate in that family, how people are understood in this family, I mean, those are the families you have in mind. So it's all about how people communicate and what they think communication involves and how they feel they're understood, but those are the partners and I think I also see how the professional parts of communication, historical patterns and (inaudible 00:07:46).

Looking at the pattern of communication between family members but also between SW-family.

Referring to FT for communication and relationship stuff but also looking at the relationship between the system and the family identify patterns.

S5 (00:100:27) I think it's interesting what you're saying because I was going to say this anyway. I think the families that I've referred and I've thought about this before -- I've been at quite a low point in my relationship. It's where I felt stuck. It's where I felt, if I'm honest, they're just not getting it. Now it might be I've fallen in love with my hypothesis, but you know --

Some SW referred at the lowest point in their relationship with their client. 'Felt stuck'. Maybe both the family and SW need someone else to get involved in their relationship. When feeling stuck and in lowest place in their relationship SW might look for validation of their own hypotheses about this family. "It was right", "it is not me, it is them", "they don't get it".

13.9.2. Memo: Deciding to refer (9 Jan 2018)

In my interviews, I was asking the referrer why they referred to us at the moment they did.

David was talking about going in circles with the family and so he needed a new perspective from an outsider professional. David felt he was not progressing in his work with the family.

> *David (p.2) It's the progress of the work wasn't really going anywhere, so I referred to your service because things had -- I tried to meet with them myself, I tried to see if things were better. I tried to do a few different things, but nothing seemed to work. The family, which is the mum and dad, argued a lot particularly when they came to pick up their children. So things weren't really progressing, they were just going around in circles a little bit.*

David was hoping by referring the family to us to get a conflict resolution for the parents.

> *David (p.3) Sure. My hopes were that mum and dad would be able to have -- my best goal would be that would be able to have a better relationship where they could spend time with each other and not argue that the children can be around them and they can do things as a family. I guess maybe more realistically I was hoping that when dad came to pick up the girls from their mum's house every other week to have contact with him that they wouldn't be arguing and wouldn't be fighting and the children wouldn't be exposed to that level of conflict.*

David mentioned on a few occasions during the interview that he found the conflict between the parents difficult to manage, which fed his concerns for the children witnessing this. He was seeing the conflict resolution as one of the

aims of social services involvement and as no progress had been made he referred out as a way of getting help with this case.

From the focus group I found that the reason to refer can be impacted by the nature of the relationship between the client and social worker. One of the social workers was talking about a very difficult relationship and conflictual. The social worker was saying that in this case. She referred out to receive a validation to her hypotheses “need to be / feel right”.

In his case David spoke about feeling exhausted by the conflict and by not managing to find a resolution for this family. He referred from this place.

13.10. Appendix 10: Combining thematic analysis and grounded theory

In this appendix I explain how I combined the focus group themes with the grounded theory categories.

Both thematic analysis and grounded theory use the constant comparative method, constantly comparing and sorting (Bryman, 2002). However, grounded theory is usually distinguished from thematic analysis in two ways: the unit of text coded; the end result of analysis. Grounded theory relies on coding smaller units such as line by line or word by word (Charmaz, 2006). Thematic analysis, in contrast, does not specify the length or size of the text to code. Conceptual coding can be the end result of thematic analysis, whereas with grounded theory the aim is to articulate relationships between the identified themes (Strass & Corbin, 1994). Thematic analysis allows us to see patterns in our data and grounded theory helps us see how the patterns relate and connect (Floersch, Longhofer, Kranke & Townshend, 2010). Charmaz took this further and said the general aim of grounded theory is to describe a process. This is done by the process of linking single events (codes) as part of a larger whole.

For this study I analysed the data from the focus group using thematic analysis. I conducted the focus group prior to my individual interviews. The participants of the focus group were experienced practitioners and familiar with the Referrer Engagement Method. The intention was that, through their shared experience with my method, I would be able to start distancing myself from the data, and avoid the dangers in being an insider researcher. I also wanted to use the focus group to refine my interview questions and come up with a set of themes to guide me in my grounded theory analysis of the interviews.

Thematic analysis fitted well with the focus group data. It allowed me to identify patterns in a more complex data set, with multiple participants and the

interaction between them. The analysis was also not limited to small units of data. I could come up with themes focussing on the discovery of patterns.

At the end of this process I had a large number of sub-themes which I then clustered under a small number of high level themes. In my initial clustering I focussed on the actors in the process:

Theme	**Sub-theme**
Referrer / Social Services	Seeking help Relating to family before referral Being Statutory Respecting confidentiality / transparency Them and us
Referrer Experience of the transition session (3 way) - what they saw the family therapist was doing.	Engaging the system Balancing voices Creating Reflective Space Having system in the room Family Therapy Interventions
Crossing Domains / Reflection on their overall experience - the space between the social worker and the family therapist.	Improving Family-Referrer relationship Widening perspectives Developing self-reflexivity Being transparent Evaluating Family Therapy

Table 4: Focus group themes organised by actor

Moving into the second part of my analysis, analysing the individual interviews using grounded theory, I was both discovering new codes from the line by line analysis and identifying some similarities with the themes I had from the focus group data.

At this stage I placed all the focussed codes on coloured coded post-it notes. On each post-it note I mentioned both the participant and the interview it came from, e.g. J1 for Jez interview 1. Having the codes visually on my wall

enabled me to move codes around and find some new connections and overlaps between codes. It also helped in managing a large quantity of data.

I came up with a large number of categories (8) and along list of axial codes under each.

Category	**Axial Code**
Referring to Family Therapy	Referring easily Responding quickly Seeking help for the family Seeking help for referrer Assessing needs (R-F) Resisting change Choosing Family Therapy over alternatives Being anxious about initial 3 way

	Being anxious about review Evaluating 3 way
Domains	Differentiating Domains Being Statutory (R-F) Constraining relationship (R-F) Naming power Respecting confidentiality Crossing domains
Voices	Feeling heard (Referrer) Bringing in parent's voice Balancing voices Opening dialogue
Engaging / Connecting	Relating to family before referral Connecting with family (R-F) Engaging the family (FT-F) Engaging Referrer Giving family a choice Dealing with couple dynamic (R-F)
Creating Space	Having a Reflective Space (Family) Inviting referrer to reflect Reflecting on work (Referrer) Keeping space away from Social Services
Collaboration	Sharing information Collaborating on therapeutic agreements Collaborating on the referral Holding hands Sharing responsibility Referrer-Family Therapist

	Challenges of working with Family Therapist Learning from families (R-F) Having system in the room (FT-F/R) Enabling transparency with 3 way Working with other agencies Being transparent with family (R) Pushing for transparency (FT) Requesting transparency (F) Expecting more from client
Interventions	What FT do Appreciating Family Therapy What referrer does Being Galit
Outcomes	Changing Position (R-F) Benefiting from Family Therapy (Family) Improving Family-Referrer relationship Noticing change in family (R) Valuing Family Therapy (R) Widening perspectives Benefitting from Family Therapy (Referrer) Generating hope (FT-R/F) Empowering Family (FT-F)

Table 5: Draft categories and axial codes

At this point I began to systematically compare the themes with my axial codes and looked for similarities and differences. I initially followed the high level themes of the focus group analysis, organised by the main actors.

Category	New Axial Code	Old Axial Code
Social Services / Referrer	Seeking help	Seeking help for the family Seeking help for referrer
	Relating to family before referral	Relating to family before referral Giving family a choice
	Being Statutory	Being Statutory (R-F) Naming power Constraining relationship (R-F)
	Respecting confidentiality	
	Them and us	Differentiating Domains Working with other agencies
Family Therapy / Family Therapist	What FT do	
	Engaging system	Engaging the family (FT-F)
	Balancing voices	Balancing voices Feeling heard (Referrer) Bringing in parent's voice Opening dialogue
	Creating a reflective space	Having a Reflective Space (Family)

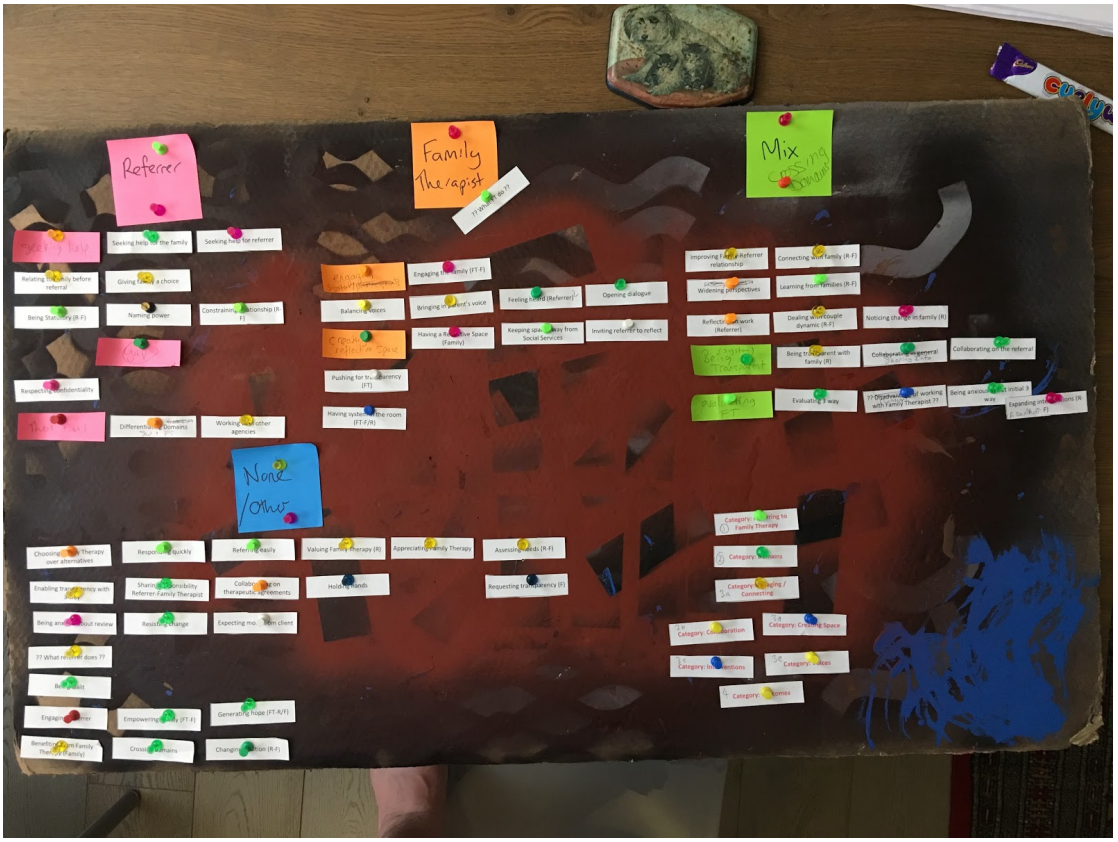
		Inviting referrer to reflect Keeping space away from Social Services
	Pushing for transparency	Pushing for transparency (FT) Crossing domains (part 1)
	Having system in the room	
Crossing Domains	Improving Family-Referrer relationship	Improving Family-Referrer relationship Connecting with family (R-F)
	Widening perspectives	Widening perspectives Learning from families (R-F) Holding hands Crossing domains (Part 2)
	Reflecting on work	Reflecting on work (Referrer) Dealing with couple dynamic (R-F) Noticing change in family (R)
	Being transparent	Being transparent with family (R) Sharing information Collaborating on the referral

		Sharing responsibility Referrer-Family Therapist Enabling transparency with 3 way
	Evaluating Family Therapy	Evaluating 3 way Challenges of working with Family Therapist Being anxious about initial 3 way Benefitting from Family Therapy (Referrer) Benefiting from Family Therapy (Family)
None / Other	Changing Position (R-F) Valuing Family Therapy (R) Empowering Family (FT-F) Referring easily Responding quickly Assessing needs (R-F) Resisting change Choosing Family Therapy over alternatives Being anxious about review Engaging Referrer Collaborating on therapeutic agreements Requesting transparency (F) Expecting more from client	

	Appreciating Family Therapy What referrer does Being Galit Generating hope (FT-R/F)	

Table 6: Draft categories from high level themes

At the end of this process I followed the table of my high level themes from the focus group and tried to place my draft axial codes under those themes.



I discovered I had quite a lot of axial codes that did not fit under the categories based on the high level themes of thematic analysis. These are listed under the category “None / Other” at the end of Table 6. I realised that viewing the actors as the categories was limiting my analysis.

I noticed the focussed codes and sub-themes were telling me about my participants experience over time. A timeline. I then went back to my focus group themes table and reorganised the sub-themes according to the stage of their involvement with the service.

Theme	**Sub-theme**
Positions prior to the transition meeting	Seeking help Relationship with the family – (a focus in the transition meeting) Relating to family before referral Being Statutory. Power relationships Respecting confidentiality
Experiencing the transition meeting	Feeling uncomfortable Throwing responsibility over the wall Handing over responsibility Observing the therapist engaging the system Balancing and interweaving? voices Creating Reflective Space Having a witness Observing and learning from the family therapist
Reflection on being engaged with family therapy	Voicing doubt Improving Family-Referrer relationship Bridging the gap through transparency Widening perspectives Understanding change in the family Seeing family gain skills (could be amalgamated with the above) Learning from family therapy. Learning from modelling

Table 7: Focus group themes organised on timeline

I then used the same high level themes as categories for the axial codes from the interviews to see how they would fit.

Category	**New Axial Code**	**Old Axial Code**
Position prior to the transition meeting	Seeking help	- Seeking help for the family - Seeking help for referrer
	Relating to family before referral	- Relating to family before referral - Giving family a choice
	Power Relationships	- Being Statutory (R-F) - Naming power - Constraining relationship (R-F)
	Respecting confidentiality	- Respecting confidentiality - Differentiating Domains - Working with other agencies
	[Green] Relating to family before referral Differentiating Domains	
	[Red] Them and us	- Differentiating Domains - Working with other agencies
Experiencing the transition meeting	Observing and learning from the family therapist	What FT do

	Watching the Family Therapist engage the system	Engaging the family (FT-F)
	Balancing voices	- Balancing voices - Feeling heard (Referrer) - Bringing in parent's voice - Opening dialogue
	Creating a reflective space	- Having a Reflective Space (Family) - Inviting referrer to reflect - Keeping space away from Social Services
	Having a witness Having system in the room (FT-F/R)	
	Reflection on being engaged with family therapy	
	Improving Family-Referrer relationship	- Improving Family-Referrer relationship - Connecting with family (R-F)
	Widening perspectives	- Widening perspectives - Learning from families (R-F) - Holding hands - Crossing domains (Part 2)

	[Red] Reflecting on work	- Reflecting on work (Referrer) - Dealing with couple dynamic (R-F) - Noticing change in family (R)
	Bridging the gap through transparency	- Being transparent with family (R) - Sharing information - Collaborating on the referral - Sharing responsibility Referrer-Family Therapist - Enabling transparency with 3 way - ?? - [Green] Pushing for transparency (FT) - [Green] Crossing domains (part 1)
	[Red] Evaluating Family Therapy	- Evaluating 3 way - Challenges of working with Family Therapist - Being anxious about initial 3 way - Benefitting from Family Therapy (Referrer) - Benefiting from Family Therapy (Family)
None / Other	[Red] Changing Position (R-F) [Red] Valuing Family Therapy (R)	

	[Red] Empowering Family (FT-F) [Red] Referring easily [Red] Responding quickly [Red] Assessing needs (R-F) [Red] Resisting change [Red] Choosing Family Therapy over alternatives [Red] Being anxious about review [Red] Engaging Referrer [Red] Collaborating on therapeutic agreements [Red] Requesting transparency (F) [Red] Expecting more from client [Red] Appreciating Family Therapy [Red] What referrer does [Red] Being Galit [Red] Generating hope (FT-R/F)	

Table 7: Categories and axial codes organised on timeline

This categorisation was a better fit to the interview data. I also found more overlaps and similarities started to emerge with the focus group data. However, there are still some axial codes that did not fit. I revisited the axial codes that did not fit throughout the process of analysis. By the end of the process only a few axial codes left not supported.

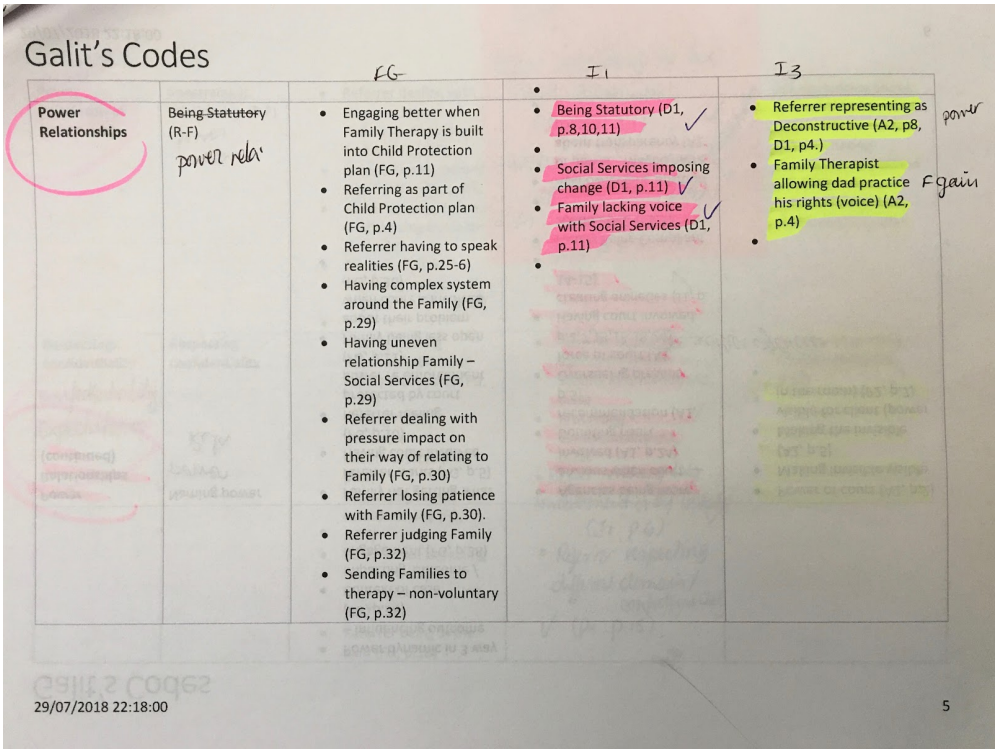
The timeline categories seemed to fit my research better. This is a process research and the timeline suggested an overall process within the Referrer Engagement Method.

At this point created my initial set of tables combining both focus group data and individual interview data. I adopted the terms from grounded theory for the combination because grounded theory fits better in highlighting process. So I used “category” and “axial code” even with data from the focus group and placed it side by side with data from both interviews.

The combination took several iterations. In each iteration I created a “code” document. These had several tables, one for each proposed category. Within each table I had a row for each proposed axial code. Within the rows I listed the sub-themes and focused codes from my initial analysis - I had a column for the focus group and separate columns for the two interviews. Having the sub-themes and focussed codes side by side illustrated the hypothesised alignment. I could see how the data supported each axial code and also which where less well supported. I also compared my sub-themes with my focussed codes to identify connections, similarities and differences.

The “code” document kept changing and evolving. I kept going back to the data, revisiting my analysis decisions, and refining my analysis and hence the tables.

The two photos show one example of how an axial code evolved over two months. In the first photo the axial code was called Power Relationships. By the second it was called Oppressing the Client. There are five columns in each photos: New Axial Code, Old Axial Code (from the previous iteration), Focus Group (all sub-themes that were relevant), Interview 1 (all focussed codes that were relevant) and Interview 2 (with more focussed codes).



Galit's Codes

		FG	I1	I3
Power Relationships	~~Being Statutory~~ (R-F) power rela	• Engaging better when Family Therapy is built into Child Protection plan (FG, p.11) • Referring as part of Child Protection plan (FG, p.4) • Referrer having to speak realities (FG, p.25-6) • Having complex system around the Family (FG, p.29) • Having uneven relationship Family – Social Services (FG, p.29) • Referrer dealing with pressure impact on their way of relating to Family (FG, p.30) • Referrer losing patience with Family (FG, p.30). • Referrer judging Family (FG, p.32) • Sending Families to therapy – non-voluntary (FG, p.32)	• Being Statutory (D1, p.8,10,11) • Social Services imposing change (D1, p.11) • Family lacking voice with Social Services (D1, p.11)	• Referrer representing as Deconstructive (A2, p8, D1, p4.) • Family Therapist allowing dad practice his rights (voice) (A2, p.4)

power

Fgain

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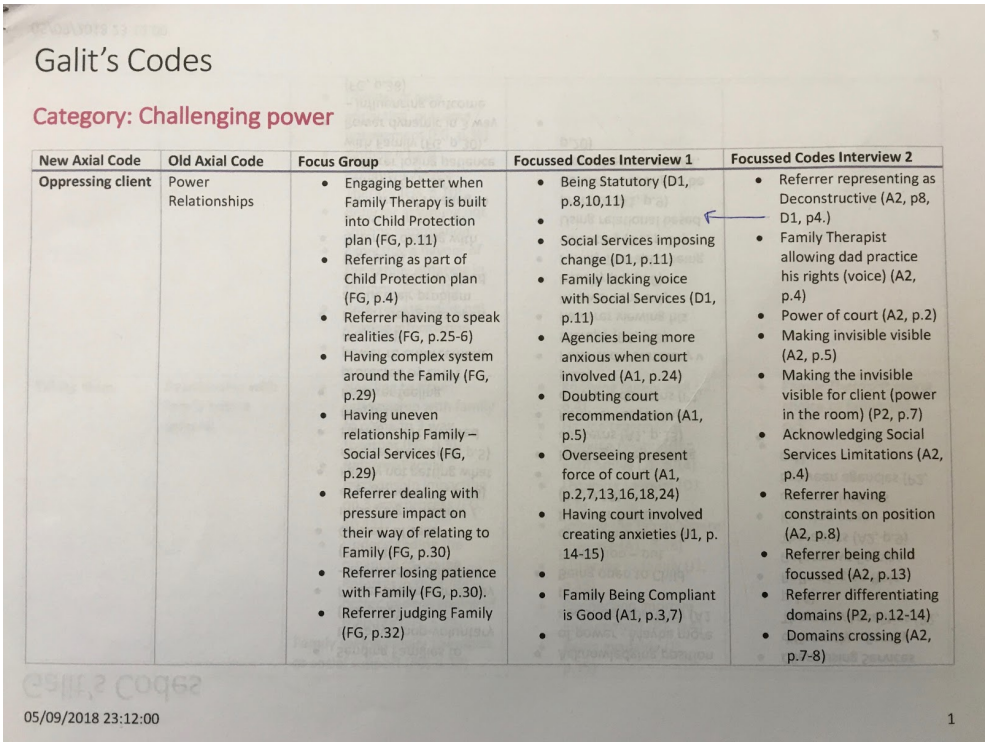

Galit's Codes

Category: Challenging power

New Axial Code	Old Axial Code	Focus Group	Focussed Codes Interview 1	Focussed Codes Interview 2
Oppressing client	Power Relationships	• Engaging better when Family Therapy is built into Child Protection plan (FG, p.11) • Referring as part of Child Protection plan (FG, p.4) • Referrer having to speak realities (FG, p.25-6) • Having complex system around the Family (FG, p.29) • Having uneven relationship Family – Social Services (FG, p.29) • Referrer dealing with pressure impact on their way of relating to Family (FG, p.30) • Referrer losing patience with Family (FG, p.30). • Referrer judging Family (FG, p.32)	• Being Statutory (D1, p.8,10,11) • Social Services imposing change (D1, p.11) • Family lacking voice with Social Services (D1, p.11) • Agencies being more anxious when court involved (A1, p.24) • Doubting court recommendation (A1, p.5) • Overseeing present force of court (A1, p.2,7,13,16,18,24) • Having court involved creating anxieties (J1, p. 14-15) • Family Being Compliant is Good (A1, p.3,7)	• Referrer representing as Deconstructive (A2, p8, D1, p4.) • Family Therapist allowing dad practice his rights (voice) (A2, p.4) • Power of court (A2, p.2) • Making invisible visible (A2, p.5) • Making the invisible visible for client (power in the room) (P2, p.7) • Acknowledging Social Services Limitations (A2, p.4) • Referrer having constraints on position (A2, p.8) • Referrer being child focussed (A2, p.13) • Referrer differentiating domains (P2, p.12-14) • Domains crossing (A2, p.7-8)

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However, using grounded theory terms for my thematic analysis themes didn't sit well. I was worried that it would appear as a grounded theory research and not a combination. In consultation with my supervisor, I decided to change the

language to process research. I changed “categories” to “significant processes” and both “sub-theme” and “axial code” to “sub-process”.

This renaming process sparked my thinking again. It made me think about the process or journey the referrer has gone through once he/she was invited to attend the service and be involved in the Referrer Engagement Method. Focussing on the process helped me to identify my final four significant processes - Naming power, Opening dialogues, Engaging the system in the room, and Working Collaboratively.

The timeline of the referrer’s experience was still present, but within the sub-processes within each significant process. For example, a process of moving from a constrained relationship to collaboration; from limited conversation to open dialogue.

Table 3 summarises my analysis and lists both significant processes and the associated sub-processes. Not all sub-processes were supported by all data sets (focus group, interview 1, interview 2). The table shows where a particular sub-process is supported by sub-themes of the focus group or axial codes of the two interviews.

13.11. Appendix 11: Collaborative Referral Form

REFERRAL DATA SHEET
Please complete both sides as fully as possible

CLIENT INFORMATION

Family Members Names:	M/F	Date of Birth
1.	[ ]	[.....]
2.	[ ]	[.....]
3.	[ ]	[.....]
4.	[ ]	[.....]
5.	[ ]	[.....]
6.	[ ]	[.....]

***If more family members please attach information on another piece of paper.**

Address: Ethnicity:

_____

_____

_____

Tel: Mobile: Can we call /text YES/NO

Wheelchair Access: Yes / No Other Special Needs

Any issues in family regarding?
Please tick all that apply .....

(1) Learning disability [ ]
(2) Adult mental health [ ]
(3) Child mental health [ ]
(4) Drug or alcohol misuse [ ]
(5) Domestic Violence [ ]
(6) Safeguarding Child/ren [ ]

FOR THE CLIENT TO COMPLETE:
In your own words please tell us how this referral will help you, particularly in relation to family and parenting?

FOR THE REFERRER TO COMPLETE:
What are your thoughts as to why making this referral may be helpful?

Referrer's contact information:

Referred by? (name) Team/role

Address:

Phone (office) **(mobile)** **email:**

General Practitioner
Surgery name & address

Telephone No. **Can we liaise with them?**

Other professional involvement?
Please provide contact names, job title, telephone number and email address if known.

Signature of Client:	**Signature of Referrer:**

Please attach supporting additional reports with this referral
(e.g. CAF, Child Protection, Child In Need plans)

13.12. Appendix 12: University Research Ethics Committee (UREC)

EXTERNAL AND STRATEGIC DEVELOPMENT SERVICES
uel.ac.uk/qa
Quality Assurance and Enhancement

6 June 2014

Dear Galit,

Project Title:	**An action research project to explore and develop a systematic approach to working with the referrer in the context of child protection.**
Researcher(s):	**Galit Haviv-Thomas**
Principal Investigator:	**Dr Rabia Malik**

I am writing to confirm the outcome of your application to the University Research Ethics Committee (UREC), which was considered at the meeting on **Wednesday 28th May 2014**.

The decision made by members of the Committee is **Approved**. The Committee's response is based on the protocol described in the application form and supporting documentation. Your study has received ethical approval from the date of this letter.

Should any significant adverse events or considerable changes occur in connection with this research project that may consequently alter relevant ethical considerations, this must be reported immediately to UREC. Subsequent to such changes an Ethical Amendment Form should be completed and submitted to UREC.

Approved Research Site

I am pleased to confirm that the approval of the proposed research applies to the following research site.

Research Site	Principal Investigator / Local Collaborator
University of East London	Dr Rabia Malik

Approved Documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
UREC Application Form	1.0	13 May 2014
Participant Information Sheet	1.0	13 May 2014
Consent Form	1.0	13 May 2014
Topic Guide	1.0	13 May 2014
Risk Assessment	1.0	13 May 2014

Docklands Campus, University Way, London E16 2RD
Tel: +44 (0)20 8223 3322 Fax: +44 (0)20 8223 3394 MINICOM 020 8223 2853
Email: r.carter@uel.ac.uk

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uel.ac.uk/qa

Quality Assurance and Enhancement

Approval is given on the understanding that the UEL Code of Good Practice in Research is adhered to.

With the Committee's best wishes for the success of this project.

Yours sincerely,

Catherine Fieulleteau
Ethics Integrity Manager
University Research Ethics Committee (UREC)
Email: **researchethics@uel.ac.uk**

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