**THE SHEEP DOG TECHNIQUE**

**Making appointments effective, efficient and maybe even ethical?**

**By Nick Child**

I discovered ‘the sheepdog technique’ in the 1970s as a trainee psychiatrist in Edinburgh.  In this context, you are the shepherd. The patient is the sheep. Your sheepdog is other agencies. Your dog whistle is the strategic use of letters and phone calls.

This idea is more acceptably contained in concepts like 'key worker' and in the coordinating function of a family doctor or case manager. But would you be reading this without the provocative title? The title is anyway more accurate for the method to be described.

Only now in retirement – and with the internet to hand – do I feel able to publish this appalling idea. As the title and the concept make instantly clear, this is an unethical way to think and work. It is unlikely then to be published by any authoritative academic journal.

Still, now you’ve started reading and can see that ethics will be considered, read on before you make your final judgement.

**The value of appointments ... even when they’re missed**

In all walks of life and work, we make appointments all the time. Generally when we make an appointment to see someone, the appointment is just a way to enable what the appointment is for, its inherent purpose. For example, the purpose or content of an appointment with a doctor is to talk about, assess and make plans for ill health. The sheepdog technique amplifies more of the formal structure and process of making appointments than the usual focus on the content of those appointments.

In business or in welfare state services – like the NHS in the UK – there is a lot of concern about wasting time and money on appointments that are not kept by those supposedly keen to get those services and help. See for example [this NHS page on missed appointments](https://www.england.nhs.uk/2014/03/missed-appts/). (NHS England website)

But sometimes continuing to make appointments can be useful, economic and helpful even when they may be missed.  The sheepdog technique intends the appointments to be kept. But it also demonstrates the value of appointments even when they are missed. The sheepdog technique pushes us to the sharpest edge of balancing cost, help and outcome. Ethics, in a word.

**Some basic ethics**

If cost were the only factor a government was bothered about, the cheapest health service would be none. If there was no health service at all, people would (once more) get used to illness, suffering and death. Other trades like religions and faith healing would prosper. Euthanasia and suicide would be the final cure for any and all ills once people could not bear them any more.

I would use this argument as a child psychiatrist when policy-makers and managers would push us to use minimalist approaches. Thus, for example, with suspected ADHD, the model being promoted would be a quick 20-minute assessment scale followed by the prescription of Ritalin. I gather that is now the model that has been rolled out across the UK since then. I would say: “Look, if you’re really wanting the cheapest and 100% effective final solution for ADHD, there is one treatment above all others that works: [Pause for interest to be engaged] ... Euthanasia.”

This brief look at ethics is to show the reader that I know at least a little bit about the subject – that I am an ethical person and professional. My abiding core driving reason for being in a helping profession is a genuine humanitarian dedication to helping troubled human beings. Please remember this ethical framework. Otherwise the sheepdog technique looks like – and could indeed be used in the wrong hands as – an entirely miserable miserly inhumane budget-driven and unethical approach.

**Sophisticated use of appointment patterns**

The sophisticated version of the structured use of appointment patterns is in the traditional kinds of psychotherapy or psychoanalysis. The pattern of regular reliable safe and boundaried appointments is with a skilled caring therapist who is at least (usually) awake and engaged in working with the patient to understand their problems better. The structure of appointments is in itself a secure base, an attachment that works whatever is also going on in the sessions too.

This general effect of safe appointments would be one of [the common factors of therapy](http://counsellingresource.com/lib/what-works/). (Hubble et al, 1999) These common factors are known to be more important to outcome than the specific model used. The specific model is usually what interests the practitioner and researcher because they have a vested interest in proving that theirs is the best one. Some time later, I described [family therapy as an integrated collection of 95 component parts of good practice](http://weebly-link/141591291165986), only a few of which were special to family therapy as a method (Child 1989).

However the sheepdog technique stands in marked contrast to the research on using routine [assessments in every session about what works](http://www.scottdmiller.com/wp-content/uploads/1%20Using%20Formal%20Client%20Feedback.pdf). That valuable approach does come from the drive to maximise change in as short a time as possible.  (Miller et al, 2006)

Actually, even in a bog-standard one-off appointment with your GP or similar professional, you will be placing yourself in their hands, and trusting that they are safe hands, in a relationship that is more like a vulnerable child needing a safe attachment relationship with their parent. There are many elements that make your experience of an appointment with your GP into a safe base. These elements have mostly been whittled away over the decades by bureaucratic and IT demands driven by tax-payers electing governments who promise and prioritise doing things quickly and cheaply instead of more holistically.

It is also true, as some GPs have said to me, that: “We’ve adopted a ten minute appointment system rather than the old five minute one. But I don’t really need more than seven minutes, and I don’t know what to do with the last three.”

**Unsophisticated use of appointment patterns**

A less sophisticated case example comes from my earliest years – the 1970s –  in psychiatry. The flower power effect in a medical school before meant that an unprecedented 17 of us in our year went into psychiatry. There was some attractive teaching too.

Interested in psychotherapy and mostly unsupervised – despite the supposed apprenticeship model of training in all branches of medicine (apprenticeship works best in surgery, of course) – I would offer regular appointments to anyone and everyone I saw who I thought might benefit from humane personally interested help not just pills.

Here's the story of Mrs B. Mrs B was admitted as an emergency on my shift. I continued to see after her discharge. She was a disturbed and troubled middle-aged woman. As well as various mental health problems, anyone could see when she would regularly and strangely inflict parallel scratches on her face.

Mrs B had been going to her GP for years. She would be what some have called a ‘heart-sink’ patient because of the GP’s feelings when they discover that the patient is yet again in their waiting room. Mrs B had had many psychosomatic troubles. That meant she was referred to and attended many other medical assessments and specialist services. Seldom was a physical cause found nor therefore any effective treatment possible.

Nevertheless Mrs B was on a list of medications anyway. The ritual of attending your GP finishes with the handing over of a prescription. Many people don’t take the tablets. But Mrs B was keen to be helped and she did take her pills. The side-effects of ineffective treatments created more symptoms and more referrals to more services.  Not surprisingly, Mrs B had some bulging fat case files as a result of all this. I think there’s even an unpleasant name for that syndrome: a fat-file case. The fat files of course show the professionals' limitations more than the patients'.

**The value of useless appointments**

I saw Mrs B reliably at the same time fortnightly for two years.

In retrospect I didn’t know what I was doing with her at these appointments. But I was then and still am a helpful person – I’m the sort of person who will help old ladies across the road even if they don’t want to go. The least I could do was make appointments. It seemed the sort of thing a psychiatrist was meant to do.  As I say, at the time I thought I was doing some kind of psychotherapy.

Essentially I used my newly acquired medical psychiatric authority and some basic humanity and interest and reliability to keep her coming to see me. She was as reliable in attending as I was. Perhaps, as we've noted, the basic human features were indeed the most important things Mrs B needed even if they didn’t specifically help her troubles that much.

Anyway, your troubles are your ticket to come. If the troubles stopped, Mrs B's justified fear might have been that I would discharge her. So there is a reason for patients to keep just enough troubles going.

With the wisdom of hindsight, I would criticise myself severely, along with the system I worked in. I reckon that her ‘hysterical’ presentation would have been better understood as a typical covert indirect attention-seeking that was driven by a secret awful history of sexual or similar abuse. Probably she would also have had some kind of serious relationship problems with her husband. More skilful relationship awareness and attention would have meant something much more useful could have been done in my appointments with Mrs B.

**An accidental long term outcome study**

After two years, I moved on to my next training placement. She did not get a keen novice like me to continue any appointments with.

Good outcome research tries to find the long-term outcomes of treatment. I met her GP completely by chance many years later. He greeted me as if I was a famous professor: “Oh YOU’re Nick Child!!” He remembered my name because I would write a letter to him after each and every appointment. No one had corrected my novice idea of what I thought the job entailed.

So to what did I owe my fame?  Well, he told me.

In marked contrast to the many huge hopeless heart-sink attendances before and after those two years – during those two years that she was coming to see me Mrs B hardly came to see him at all. During those two years Mrs B did not, therefore, need referring to multiple specialist services. Her file grew only slightly fatter than it needed to because of my careful fortnightly letters from the Royal Edinburgh Hospital.

**The sheepdog technique**

My next trainee psychiatrist placement was to work in the regional poisoning treatment centre at the Royal Infirmary. Here were admitted and assessed all those who self-harmed or took overdoses – up to 10 or more admissions per day. Often the patients were a bit surprised because they didn’t really expect their interpersonal strategies to be of that much interest to hospitals and psychiatrists.

But this client group offered the opportunity – and necessity – for a more proactive version of an economic but humanitarian use of psychiatric services to save other less appropriate medical and other agencies a lot or unproductive time and trouble with puzzling patients.

Typically the forms we had to fill in – it was a research centre – required us to designate the patient with disorders and personality disorders. What some ‘frequent attenders’ were doing was indeed disturbed and disturbing. But usually no one could do anything more to help. The commonest advice in the letter to the GP was to reconsider the prescription of the pills used for the overdose.

Professionals typically became angry and rejecting of these well-known patients, rather than offering kindness or constructive help. The few patients who continued or increased their rate of self-harm and attending kept being re-admitted. They continued being seen as unsuitable for any of the usual treatments.

Of course, many of them had a full set of personal and social problems that they took to other social services, the police, council departments, and front-line agencies. They may also have had non-specific things like Mrs B had. These they took to GPs or A&E departments.

**Attention-seeking: What works and what doesn’t**

A simplistic view of this massive amount of need and attention was that it was ‘attention-seeking’. Rather an obvious category really. Typically that idea implied that the best treatment was to deny the patient the attention they were seeking. This was a behariouist view: Don’t reward it. But that didn’t work. In fact, it would often re-double the patient’s efforts to get attention.

Anyway, to summarise the picture, many many hours of many many agencies’ time would sometimes be taken up frustratingly with these frequent multiple attention-hungry attenders and attendances.

So what did I do? Developing the humane but unproven (yet) approach with Mrs B, I saw it as my job to offer regular appointments. And here even more than with Mrs B, it seemed important to notify GPs and everyone else involved with copies of constructively worded letters. Secretaries complained that carbon copies on old typewriters became illegible when there were more than six of them. But it seemed important to me to let all those agencies know of my views and helpful involvement since they had or might be called on again by the patient. Letters might sometimes be backed up with phone calls as well.

The key ‘sheepdog’ feature lay in my encouragement in my letters to all other agencies to deal as briefly and kindly as possible with the patient should they appear. I implied that they should spend as much time as they felt was needed – but no more than that. They could end their brief encounter by something much more positive than they usually had. They could remind the patient and encourage them to attend their regular appointment with "that nice helpful" Dr Child next Whateversday at Whenever o'clock at the Wherever Clinic.

What might have been two hours of unproductive work in these other agencies was thereby reduced sometimes to a simple two minutes. What was usually a frustratingly negative ending was now a concrete, imminent and positive bit of help.

**And at Dr Child’s appointments?**

Of course, if and when the patients came, I would do my best to do something helpful if not actual psychiatric treatment or psychotherapy. Because appointments were likely to be missed, they would be perhaps fortnightly for 30 minutes rather than the hour of standard psychotherapy. For the more demanding patient, I might offer weekly or even twice weekly appointments.

For this purpose, it didn’t really matter what we were doing in the appointments. Indeed, as we’ve seen, it didn’t really matter in one sense if the patients didn’t come at all. If an appointment was missed, that was regretted. A letter was sent confirming that there was always the next one reliably available in a virtually unconditionally continuing way. Well, continuing as long as my placements lasted.

In effect, the structure of having the appointments in place allowed all the other agencies who might otherwise have had to spend large amounts of unproductive, negative time with the patient to ‘sheepdog’ the patient constructively back to me and my regular specified appointments.

The invitation to do this was conveyed by the initial letter with subsequent phone calls and further letters copied to everyone.

Since this was standard NHS doctors’ practice then, and plainly done with the motive to offer more effective help than was usually on offer (ie none), it didn’t occur to me that these rather desperate but difficult patients who anyway took themselves to multiple agencies, were needing me to have a discussion about confidentiality and permission and whether it was ok by them for me to be working like this and sending people psychiatrist's letters about them.

The provision of services for the people and troubles described in this paper has moved hugely in the decades since the 1970s. And so it should. For example: [BMJ Best Practice](http://bestpractice.bmj.com/best-practice/monograph/1016/treatment/step-by-step.html).

**The outcome?**

Well, who really knows what the outcome of this kind of approach was. I remember one angrily challenging young man who aggressively repeated overdoses. He came via the overdoses to see me, but seldom in the arranged way. He 'won' with a successful suicide attempt. But most patients seemed to respond constructively to the sheepdog technique.

This approach seemed to me to be better than what was being done or offered otherwise. It was at least a constructive way of managing a troubled patient. It plainly reduced to a major extent the collective amount of time and work that multiple agencies were unproductively ‘wasting’. I had many other things to do and research than to follow up more systematically to find out what I found out accidentally when I met Mrs B’s GP those many years later.

And the ethics? Well, actually I think I’ll just leave that for you, the reader, to think about.  I’ve said enough at the start to alert everyone to the serious dangers of doing the sheepdog technique, or anything else for that matter, without remembering that the purpose is to try to help troubled human beings.

The sheepdog technique does cut overall costs. But if costs are all you’re interested in ... well, it’s cheaper with suicide or euthanasia.

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