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Applying attachment theory to effective practice with hard-to-reach youth: the AMBIT approach

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Adolescent Mentalization-Based Integrative Treatment (AMBIT) is a developing approach to working with "hard-to-reach" youth burdened with multiple co-occurring morbidities. This article reviews the core features of AMBIT, exploring applications of attachment theory to understand what makes young people "hard to reach," and provide routes toward increased security in their attachment to a worker. Using the theory of the pedagogical stance and epistemic ("pertaining to knowledge") trust, we show how it is the therapeutic worker's accurate mentalizing of the adolescent that creates conditions for new learning, including the establishment of alternative (more secure) internal working models of helping relationships. This justifies an individual keyworker model focused on maintaining a mentalizing stance toward the adolescent, but simultaneously emphasizing the critical need for such keyworkers to remain well connected to their wider team, avoiding activation of their own attachment behaviors. We consider the role of AMBIT in developing a shared team culture (shared experiences, shared language, shared meanings), toward creating systemic contexts supportive of such relationships. We describe how team training may enhance the team's ability to serve as a secure base for keyworkers, and describe an innovative approach to treatment manualization, using a wiki format as one way of supporting this process.

Keywords: attachment; therapy; hard-to-reach; outreach; mentalization; adolescent

Adolescent Mentalization-Based Integrative Treatment (AMBIT) is an emerging team-based approach to working with highly troubled, "hard-to-reach" adolescents and young adults (Bevington & Fuggle, 2012; Bevington, Fuggle, Fonagy, Asen, & Target, 2012) that draws on and applies attachment theory at a number of levels. It is being developed in collaboration with over 80 local teams from UK state-funded social care and the National Health Service, as well as non-statutory services funded by philanthropy. This paper describes AMBIT, an evolving "open source" development of effective practice, emphasizing how attachment underpins its core principles and practice.

AMBIT as a mentalizing approach

At the heart of the AMBIT approach are efforts to develop an attachment relationship with a single keyworker. While many readers may question the commitment to establish such a

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bond with the young person, there is a strong line of theoretical reasoning underpinning this decision.

Mentalizing

AMBIT is a *mentalizing* approach. Mentalizing – the function of coming to understand and communicate about behavior (one's own or that of others) in mental state terms – is born in the context of an attachment relationship, and is the key to social communication and the gathering of social information (Fonagy, Luyten, & Strathearn, 2011). A strong body of evidence (Fonagy, Gergely, Jurist, & Target, 2002) supports the notion that mentalizing is not a biologically heritable function, but rather that it develops in the context of attachment relationships, through a process whereby the infant iteratively experiences his/her own mental states being accurately understood and communicated by a trusted other, via imitative facial and verbal gestures. Through experiencing this other mind being changed through contact with (and understanding of) one's own mind, self-agency, and mind-mindedness (of both one's own and of others' minds) develops. Mentalization is simply imaginative mental activity (primarily in the prefrontal cortex; Frith, 2007) to explain the behaviors of self and others by reference to the present mental state and intentions of the agent (beliefs, fears, hopes, wishes, etc.).

When activated, mentalization reveals itself in open acceptance of the limits of one's current understanding about the minds of self and other (the non-expert stance), inquisitiveness to develop and enrich such understanding, and humor that may be gently self-deprecating or focused upon common errors in the human experience of misunderstanding. Attachment and mentalizing are loosely coupled systems (Slade, Grienenberger, Bernbach, Levy, & Locker, 2005). Measures of maternal self-reflective function (mentalizing) in the Adult Attachment Interview are more predictive of infant secure attachment than the maternal attachment style per se (Fonagy, Steele, Moran, Steele, & Higgitt, 1991). Mentalizing is thus critical for affect regulation, trust, and the capacity to withstand triggering attachment behaviors (preoccupied, dismissing, disorganized) that may be seen as attempts to modulate affect in the context of interpersonal stress (Sharp et al., 2011).

When working with patients with severe personality disorder, therapists frequently find that mentalizing (in both the self and the patient) is challenged by emotional arousal, even by quite small fluctuations in affect (Fonagy & Luyten, 2009). Following the collapse of a patient's (or worker's) capacity to mentalize, a breakdown of the helping relationship is likely to follow. However, just as the distressed infant's terror may be regulated through the attuned ("marked") mirroring of a trusted (secure) attachment figure, so the capacity to mentalize may be recovered in the context of another mentalizing focus (Fonagy & Target, 2002). The challenge is that therapeutic contact inevitably provokes anxiety. This is likely to reduce both the client's and the "helper's" mentalizing capacity, unleashing defensive dismissing, preoccupied, or disorganized attachment strategies that further reduce mentalizing capacity (Fonagy & Bateman, 2006; Sharp et al., 2011).

Bateman and Fonagy (2012) have described a "therapist's mentalizing stance" that comprises curiosity and a tolerance of not-knowing, with an explicit focus on identifying and exploring (through "What?" questions rather than "Why?" questions) any patterned breaks in mentalizing that are noticed, as well as explicitly limiting the intensity of affect in sessions (often with self-deprecating humor) and stressing ordinariness in communication. This stance avoids assumptions of knowledge about the patient's mind, in favor of offering a mind demonstrating a willingness (an enthusiasm, even) to be changed itself through coming to a more accurate understanding of the patient's mind. The stance

promotes also the acknowledgement and positive connotation of those instances where mentalizing in the patient becomes apparent.

Attachment, mentalizing, and the pedagogic stance

We conceive of psychopathology in hard-to-reach adolescents not simply as the product of harsh personal histories (e.g., Stronach et al., 2011). Instead, we see such youth as struggling to manage without access to a key facilitating capacity for social adaptation: the *pedagogic stance*. Gergely and Csibra (2005; Csibra & Gergely, 2011) postulate the existence of a human-specific, cue-driven social cognitive adaptation, dedicated to ensuring efficient transfer of relevant cultural knowledge – especially knowledge that is "cognitively opaque" (for instance, it is not self-evident that at Western tables the knife is "properly" held in the right hand and the fork in the left). Humans are predisposed to "teach" and "learn" this kind of culturally specific information from each other, including one's own ideas, beliefs, expectations, and fantasies. Adaptation of this kind is not limited to infancy but is part of a developmental progression throughout life, with particular developmental phases (such as adolescence) when the capacity to learn from "teachers" is called upon intensively.

The pedagogic stance is triggered by special cues from teachers indicating that the "about-to-be-transmitted information" is trustworthy and generalizable beyond the current situation (Gergely, 2007). These cues in infancy include eye contact, turn-taking contingent reactivity, and a special tone of voice, and have in common the *marking* of this relationship as special by establishing that the adult/caregiver has imagined the child's subjective experience (i.e., mentalizes the child).

We believe that this template continues to hold beyond infancy. The communicator must first demonstrate interest in understanding the mind of the intended recipient of the information, before the recipient is ready to learn. Mentalizing the child or adolescent is a necessary precondition, an evolved key to establishing security and opening up his/her wish to learn about the world (both social and internal) from this other mind.

Thus, attachment as a system, in our view, serves an important additional evolutionary function: generating that specific form of *epistemic* trust in the social world that opens the mind for the transmission of social knowledge. It does this by generating the expectation of sensitive responsivity from others – preliminary indications to the recipients of communication that *they are recognized*. There is a well-established body of evidence supporting the greater cognitive openness and flexibility (including superior academic performance) of individuals with secure attachment (Thompson, 2008), which may have its roots in the greater openness to social communication of those who have more stable expectations of being comforted when distressed (Grossmann, Grossmann, Kindler, & Zimmerman, 2008).

AMBIT's target population: hard-to-reach youth

A case example

John (age 15 years) has a single parent with significant substance use problems, and he himself regularly uses cannabis and alcohol. He is currently excluded from school for verbal aggression and serial truanting, and he mixes with an older, delinquent peer group. There are concerns that his bravado and dismissing attitude toward social

workers, youth offending officers, and educational welfare officers may disguise anxiety and depression. Recently, he has cut himself, although he angrily denies any problems other than wanting to be rehoused away from his mother. Offered multiple appointments by professionals involved in his care, his most common response is to agree to attend, but then to miss the appointments. His mother's reaction to approaches from helping services is characterized by suspicion and at times outright hostility.

A general predicament for adolescents is that mentalizing is especially challenged in this developmental phase. The detection systems for social "non-contingency" that trigger fight–flight arousal (exposure to one's father dancing at a party, for instance) reach maturity by the beginning of adolescence, but this is well ahead of the prefrontal cognitive-regulatory systems (Nelson, Leibenluft, McClure, & Pine, 2005) that support explicit, controlled mentalizing (which is more forgiving of the perceived faux pas or threat).

The descriptive label of "hard to reach" could be seen as pejorative or blaming. Common sense dictates that these young people *should* seek help, since they appear to be troubled. The core assumption of AMBIT is that those considered "hard to reach" are hard to reach for reasons: their avoidance of help is frequently active and intentional, rooted as it may be in profound disorganizations within their attachment systems (Asen & Bevington, 2007). Such help-seeking as these young people show may manifest in unconventional ways (Veale, 2011), as offers of help (caregiving) are liable to activate dismissing, ambivalent, or disorganized attachment behaviors that disrupt delivery of care, however well-intentioned.

So why are the "hard to reach" so hard to reach and help? A pernicious aspect of social trauma may mean the destruction of trust in social knowledge of all kinds. Social adversity has the potential to close the trust-activated channel for new learning referred to above, leaving individuals inaccessible to change by routes other than pre-communicative learning processes shared with nonhuman species (operant and Pavlovian conditioning).

As "treaters" or "teachers," our natural response to the experience of being confronted with a closed (blocked) communicative epistemic channel to learning is to fall back on pre-mentalistic methods of teaching – that is, punishment and, to a lesser extent, reward (the latter requiring a better understanding of the psychological position of the other). Our typical, largely nonsocial, strategies for handling antisocial behavior (e.g., imprisonment, boot-camps) are powerful testament to the helplessness we can feel toward influencing individuals whom we experience (temporarily) as inaccessible to human communication. However, echoing Bowlby's (1988) assertion that internal working models are subject to adaptation through therapy, this mentalizing model suggests not only that evolution has prepared our brains for psychological therapy, to learn about ourselves and the social world from figures we are attached to and trust, but also that therapist behaviors might foster such trust.

"Hard to reach" describes a heterogeneous group of individuals, but commonalities are observed in young people served by the wide variety of AMBIT-influenced teams. Their social ecology is commonly marked by the absence of family or even informal systems of care that support them to seek or access help. Family members may actively dissuade such a young person from seeking help, often on account of their own preconceptions, rooted in their own harsh experiences (Dozier et al., 2009), which create expectations that punitive outcomes will result from engagement with services.

Another common feature in the "hard to reach" is the co-occurrence of multiple, reciprocally synergistic difficulties. These are rarely if ever limited to a single functional domain (for instance, the biological, intrapsychic, familial, social, educational, or legal/forensic domain). "Separate" problems within such domains may be judged to fall just beneath the diagnostic threshold qualifying for specialist services, even though the cumulative burden of these multiple problems seriously impact on youth developmental trajectories.

Implicit in this picture of poorly supported youth, who are either non-help-seeking or calling attention to their needs in aberrant and often risky ways, are life histories marked by chaos and crises, which further complicate efforts to engage and work therapeutically with them. A willingness to work in nonstandard outreach settings defined by the young person as safe; to balance structured, planned work with flexible, contingent care; to deploy the "non-expert" inquisitive stance; and to respond positively to crisis calls and demands from the young person (as indicators of budding attachment) are all critical to success. Working with such youth can (and, we argue, should) make workers anxious, and it is to this issue we now turn.

AMBIT working in teams: balancing keyworker-led exploration with team support

Therapists often work in isolation. AMBIT counters this tendency by offering training only to whole teams, and fosters a whole-team approach, dedicated to delivering treatment through individual relationships. It does this on the assumption that working with hard-to-reach youth requires effective intra-team communication to counteract the entropic influence of this challenging client group, supporting the therapist's capacity to maintain a mentalizing stance by creating security in contexts that ordinarily provoke anxiety by appearing to present few opportunities for therapeutic change.

We hypothesize that maintaining a mentalizing stance creates conditions for the activation of secure expectancies for care in key relationships (between worker and client, between worker and colleagues), and the "AMBIT stance" (the outer ring in Figure 1) addresses wider systemic factors to support this. The AMBIT stance encourages the development of an explicit team culture, providing workers with a memorable set of "grab-rails" for use in unsettling situations, supporting and prompting the maintenance of a safe and therapeutic balance between what are often competing priorities in the chaotic worlds of their clients. The training emphasizes the fact that the nature of this work means the worker is never in a fixed "right" balance, but will always be making dynamic corrections.

The AMBIT stance is defined by eight paired, and in field working conditions often mutually incompatible, markers. These are linked to four basic (predominantly mentalization-based) practice elements applied to clients, the team, and the wider service networks. All these elements are integrated around efforts to protect and promote mentalizing, which is seen as the "axle" carrying forward therapeutic change. Finally, AMBIT eschews monolithic certainties in practice, instead presenting itself as a learning framework that constantly adapts to evidence and experience. Beyond previous publications (Bevington & Fuggle, 2012; Bevington et al., 2012) the fullest description of AMBIT and its locally adapted variants is accessible online ("open source") via the signposting website www.tiddlymanuals.com.

Clearly, teams are composed of multiple separate minds, but we think there is value in a metaphorical understanding of teams as existing in "strange situations" created by their clinical milieu and in training events, both of which call forth either anxiety and its

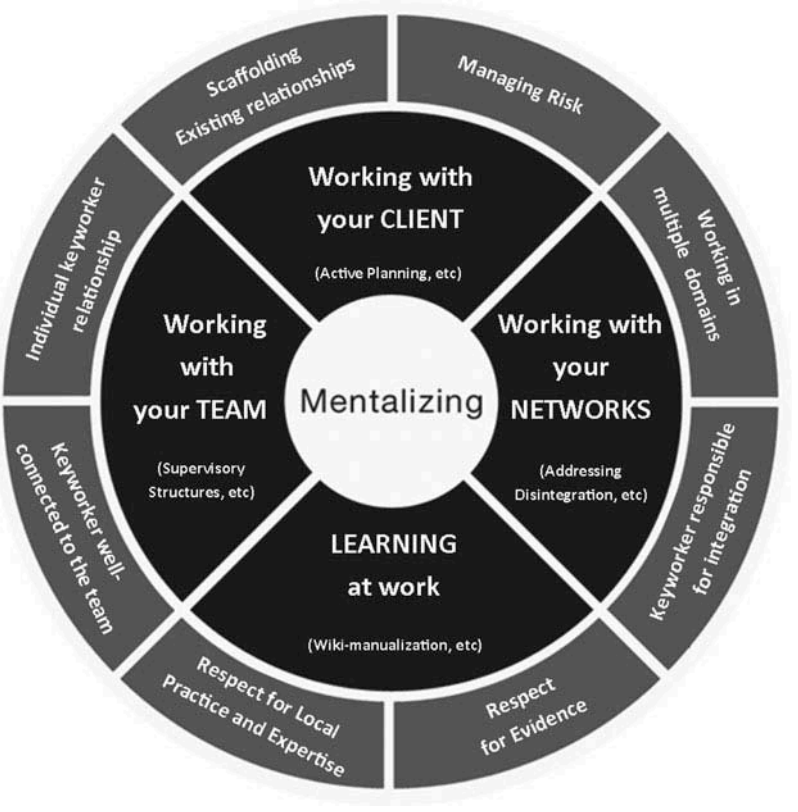

Figure 1. The AMBIT stance and basic practice.

concomitants – or, given sufficient security, may invite exploration and mentalizing of the youth's needs, as well as those of the team in sustaining and increasing the effectiveness of their work.

To mitigate the potential for training to be experienced as a threat to the professional self, AMBIT explicitly adopts a respectful and curious stance towards the existing practice of teams engaging in training. Training that seeks to impose alien protocols risks delivering non-contingent experiences (which are seen as hostile to existing expertise) and triggering anxiety in the team, with predictable consequences. Although AMBIT comprises a robustly manualized approach, it seeks to support teams in exploring, developing, and defining their own "treatment as usual" in systematic ways (see below).

AMBIT has as its primary therapeutic goal the establishment and maintenance of individual therapeutic contact. Why is this so? In attachment terms, the goal for the AMBIT keyworker is to provide the adolescent with a temporary attachment relationship that provides a secure base for emergent social curiosity and learning. This perspective on exploration is an important aspect of mentalization, reframing notions of the "secure base" derived from attachment studies in terms of the curious, tentative, and not-knowing stance.

Developing the kind of relationship to facilitate this process is fraught with professional risk, however. This is especially the case if in the early stages much of the work is conducted not in the controlled environment of a clinic, but in outreach settings that the

young person designates as safe (e.g., schools, the family home, hostels, or even cafés). Workers may subtly be invited to collude, down-regulating the sensitivity of their own internalized measures of risk; equally, young people may act in ways that are alarming, intimidating, or seductive. In such situations, anxiety is often the appropriate response on the part of the worker, so the mentalizing capacity of workers is inevitably challenged. Thus, although efforts are frequently made to reduce the number of workers at the direct therapeutic interface, the emphasis on upholding the quality of connection between the worker and his/her team-mates is given equal weight to that between worker and client.

To offer increased security of attachment to workers, the team creates a range of explicitly adopted social rituals and disciplines intended to create robust but fluidly responsive supervisory structures (for instance, shaping critical worker-to-worker conversations in disciplined ways, insisting upon mentalized explanations, focusing attention on the mentalizing capacity of the worker; see below). Whilst basic "barefoot" interventions are delivered in the field, AMBIT-influenced workers make heavy use of mobile phones and other technology to support this "well-connected" quality. The regular and explicit use of "back-up" from colleagues models appropriate help-seeking. The worker who does not use frequent peer consultation would be a cause for concern.

In the following sections, two practical applications derived from attachment studies are described.

The team around the worker

A practical example of what we refer to as the "well-connected team," privileging the keyworker–client relationship, promotes the "team around the worker" as a complement to the more conventional emphasis on the requirement for a "team around the child" (Figure 2). Emphasizing the inevitability of professional anxiety in this work, we strongly resist anything that promotes shame in response to such a reaction. Instead, AMBIT

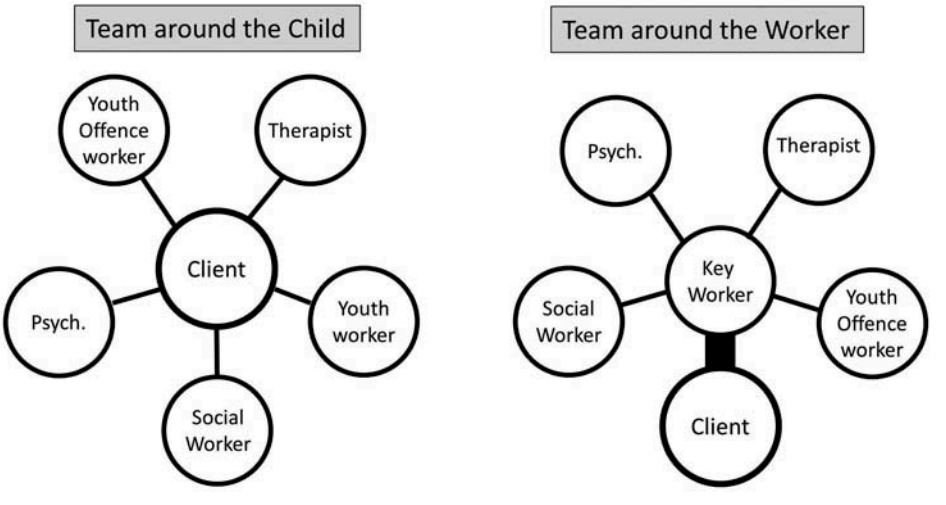

Figure 2. In AMBIT emphases on the "Team around the Child" and "Team around the Worker" complement each other.

promotes reflective understanding of the impact of such a loss of mentalizing capacity in the worker, and practical measures to reduce its likelihood or impact.

The "keyworker" is not a fixed administrative role; instead, the identity of the "keyworker" may be determined by the quality of any existing professional relationship judged to have elements of secure attachment (if such a relationship exists at all) through which more focused therapeutic work may begin (the worker who is key in the mind of the young person, as it were). Thus, rather than immediately asserting their "right" to face-to-face access to a young person, an AMBIT-influenced team may (initially, at least) arrange themselves around or behind an existing worker from another agency or team who is judged to have formed such an attachment. The team may actively scaffold the young person's relationship with that worker, supporting that worker to open conversations intended to help the young person make sense of involving a new team/worker, and in most cases explicitly offering that worker the authority to collaborate with the young person in helping to direct the AMBIT worker to make better sense of what is wanted and needed. (In some cases, young people may be invited with the support of this keyworker first to interview the aspirant AMBIT-influenced worker and test out their concerns about them, rather than being subjected themselves to scrutiny before such precautionary checks.) In most cases, such initial arrangements are then supplanted as an AMBIT-influenced worker comes to assume a more central keyworking role, themselves supported by colleagues. The essential point is that the team takes seriously the young person's perspective on "who 'gets' me best," while broadcasting the professional constraints within which they must work.

"Thinking Together"

Peer worker conversations involving casework are conducted in explicit, disciplined ways; this is not to supplant the role of formal supervisory structures, but to create a culture of co-supervision to augment these structures. First, such conversations are "marked out" by introducing them as "Thinking Together" conversations; this arbitrary label *ostensively* (Gergely & Csibra, 2005) alerts team members about the value and format of what is to follow. This shared language marks "Thinking Together" as a social discipline or ritual, part of an AMBIT-influenced team's culture. Creating shared understandings of meaning and intentions around critical interactions is designed to increase security, much as mountaineers adopt formalized rituals when communicating about the handling of their ropes.

"Thinking Together" promotes four key steps, which constitute a framework to support and encourage the delivery of help by a "peer consultant" that is sensitively contingent with the needs of the field worker. These steps (Bevington & Fuggle, 2012) are summarized as *Marking the task, Stating the case, Mentalizing the moment*, and *Return to purpose*. In our experience, many clinical case discussions begin with stating the case and end with the return to purpose, but marking of the task and attempts to mentalize (especially to mentalize one's professional colleague) are missed out.

Crucially, in "mentalizing the moment," explicit attempts to mentalize are applied first to the worker (what is their predicament, and how might this affect their capacity to mentalize) and only then to the current clinical predicament (the service user and other protagonists). An analogy can be drawn between this process and the instructions given in preflight safety talks: airline passengers are warned that in the event of sudden decompression, supplementary oxygen (analogous to mentalization) will be supplied from overhead masks (analogous to the peer consultant). Parents in charge of young children are advised *first to attend to their own mask, before* attempting to fit their child's oxygen supply.

Thinking Together

Hearing of a minor episode of self-cutting in response to news that John's mother has restarted a relationship with a heavy drug user, who has been violent toward her in the past, John's keyworker establishes basic safety in the here and now, and then says, "*John, you're telling me important things. Quite properly, it seems you worry for your Mum's safety. We've thought about how to keep things safe. You remember I talked about my team? We use each other as back-up, especially to help us think clearly when the temperature rises, because it is easy to miss stuff in these situations. I'd like to think with one of my colleagues, Liz, right now, if you don't mind, to check our plan makes sense. If you're OK with this I'll call her and put the speakerphone on, so you can listen to our conversation for about 5 minutes*."

John's keyworker calls Liz; they agree to "think together" with John listening to the conversation on speakerphone [this is not always appropriate, but models powerfully to the young person the worker's own use of relationships].

The task is marked as getting an outside opinion about the current safety plan – is it safe and inclusive enough?

John listens as his keyworker describes their collective take on his dilemma ("stating the case"); he hears Liz validate the worker's emotional context: "*Firstly, I can see there's lots at stake; it seems you want to get this right – not over-react, but not under-react either – is that something like how it feels?*" Mentalizing aloud, John's keyworker and Liz draw out the formal safeguarding policy constraints within which they work, but also the risks of precipitating action that John's mother may find intrusive or unnecessary. In returning to the purpose (their original task), they agree that existing plans are robust, but Liz also highlights the fact that in thinking about the mother's and John's safety in relation to her new partner, they may have underestimated John's risk of exacerbated self-injury. Further safety planning for this contingency is agreed.

AMBIT working with clients: balancing scaffolding existing relationships with risk management

A marker for the young person's achievement of sufficient security in the therapeutic relationship is his/her capacity to move beyond simply responding to the immediate social context to begin to explore his/her predicament in this context. Rather than being directed at elements of the external world, *exploration* here relates to the young person's (and the family's) attempts to track, contextualize, and "play" with the narrative of how they came to face their current predicament, and where they might opt to go next. As therapy progresses, the intention would be to move towards more coherent integration of these new perspectives (Grossmann et al., 2008; Slade, 2008). Supporting secure exploration has a great deal in common with what Ryan and colleagues have termed "supporting autonomy in relatedness" (see Ryan, 2005). Bretherton and Munholland (2008) suggest that the freedom to explore the internal, as well as the external, world is a key marker of attachment security throughout life.

It is a feature of the complexity and the heterogeneous presentations that teams using AMBIT are faced with that a high degree of flexibility and "light-footedness" is required in ordering and delivering interventions (of course, mentalization itself emphasizes the need for *particular* and *specific* understandings of a person's present subjective dilemma). This is necessary if the worker is to maintain contingent attunement to the young person's reality that aims to minimize the triggering of attachment behaviors that undermine mentalizing and the therapeutic relationship.

This means that, alongside the development of a therapeutic working alliance, AMBIT practice might include enhancing client motivation, teaching skills for coping with symptoms (or care systems), facilitating therapeutic processing of distressing emotions, or more eco-systemic interventions with (for instance) family, education, social care, or offender management systems. The AMBIT discipline of "Active Planning" in this work is not described in detail here, but, briefly, it emphasizes the need to balance attention to *scaffolding existing (attachment) relationships* with a counterbalancing attention to maintaining good *risk management*. Many of the relationships available to "hard-to-reach" young people are far from ideal, and justice, as well as service sustainability, insists that there can be no compromise on the mandate for proper risk management and safeguarding.

Without a high degree of structure in planning and sequencing the work, there is a risk that the worker will be drawn into a reactive relationship that loses any proactive therapeutic leverage. The emphasis in AMBIT on very robust supervisory structures counters this threat, and holds workers to the task of continuously planning, explicitly broadcasting the intention behind these plans, and, where necessary, adapting those plans in line with contingencies that arise.

Examples of AMBIT-influenced practice

After preliminary risk assessment agreed by the team, John's keyworker met him for an initial assessment at a place of John's choosing: a local café. This was the only place John was prepared to meet "yet another worker." Assessment proceeded across a number of meetings and via telephone contacts.

Despite several missed follow-up appointments, regular text messaging with John was established, following initial boundary-setting in the café. Further meetings took place at the café, as well as a meeting in the local youth club, where the worker was able to report to John about his own efforts to reduce the number of face-to-face contacts required for other parts of the multi-agency network, responding to John's sense of being overwhelmed.

The keyworker contacted these other agencies, offering to act temporarily as a "remote operating arm" addressing some of their priorities, as the keyworker recognized that the alternative was John's retreat, refusing all contact from these agencies, and triggering statutory escalations that all parties were keen to avoid.

John's overarching concern in these early meetings was the sense that everyone was treating him as a child and attributing to him frailties that he robustly denied. As he talked about his sense of responsibility for his mother, family work began as "virtual family therapy," with the worker occasionally inviting John to wonder aloud about what his mother would make of their conversation if she was able to listen quietly,

and praising evidence of any small efforts on John's part to mentalize. Eventually, a meeting at John's home was arranged, at which he agreed his mother could be present.

Negotiations with John's school were primarily conducted through the keyworker now, rather than the welfare officer; the minimum required changes that the school could accept were agreed, and a stepped program of reintegration into the school was planned.

Over time, exploration of John's self-injury and anxiety became possible; basic anxiety (cognitive-behavioral) management strategies were instigated, and his mother's substance use was addressed. As part of this, his use of cannabis and alcohol was discussed, recognizing that he had found in this use a partly effective "quick fix" for his worries, albeit with associated costs. A meeting with a psychiatrist was arranged, to which John's keyworker accompanied him.

AMBIT working with networks: balancing multi-domain work with integration

Because the problems faced by our target youth are multiple and complex, interventions that address only single domains (the intrapsychic domain, as with one-to-one therapy; the biological domain, in the form of harm reduction or medication; the family domain, as in systemic therapy; or the social-ecological domain, via educational or youth-work interventions) may be experienced by the youth as failing to recognize or address their overwhelming circumstances. This misattuned or *non-contingent* (Gergely & Watson, 1996) response, arising out of the therapist's preconceptions of the client's need (rather than the actual need), may itself trigger disruptive memories of neglect and abandonment (Dozier, Stovall-McClough, & Albus, 2008). Examples include offering therapy when the client's immediate experience is hunger, or educational reintegration when the immediate concern is about threatened legal culpability for a recent offence.

Equally, in developed settings, a large multidisciplinary "team around the child" often gathers, offering the promise of specialist multi-domain interventions (see Twemlow et al., 2001). However, paradoxically, this may challenge a young person whose capacity simultaneously to develop not just one, but numerous trusting relationships with different professionals is severely limited. While biologically we are all prepared to create bonds with multiple caregivers, this generic process inevitably becomes constrained in individuals whose previous attempts at forming attachments were not greatly successful (Feeney, 2008).

Case example

John describes how he must see four different workers every week:

Social worker (prime concern: safety, and adequacy of parental supervision);

Youth offending officer (prime concern: preventing escalation of petty offending and avoiding custodial sentencing);

Educational welfare officer (prime concern: achieve compliance with statutory obligations to attend education, and minimize disruption at school);

Family worker (prime concern: John's mother's underestimation of the impact her own substance use has on her son's anxiety for her safety).

John reflects in anger that none of these people seem to agree on what the problem is or what to do, and concludes that none of them really want to help him, as keeping appointments with all of them prevents him achieving "anything else."

Such professionals inevitably approach their work from within the constraints of different theoretical and organizational positions, too. Misunderstandings (non-mentalizing) between separate parts of such multi-agency networks are common, just as disrespectful "mythologies" about other agencies often build up in teams over time; these may be transmitted to young people and families either implicitly or explicitly, diminishing secure expectancies.

We propose that risk in a complex system is closely associated with the failures of different parts of that system to mentalize each other accurately. Such contexts (often perceived as contradictory or exasperating) may overwhelm workers as well as the young person, resulting in behavior and risks that can be very hard for the professional network to make sense of or predict. In the AMBIT model we have described these as "dis-integrated" interventions; in spite of the best intentions from all members of such a network of care, the experience of such care is aversive for the young person. We see dis-integration as inevitable in multi-agency working, and as requiring explicit attention rather than blaming and shaming.

AMBIT counters the opportunity for dis-integrative processes implicit in multi-domain working by the "balancing" prompt for the keyworker to take proactive responsibility (within their ambit – literally, their "sphere of influence") for integrating different parts of the young person's care network. It has developed specific tools and practices (especially the "dis-integration grid" described in Bevington et al., 2012) to support a systematic approach to mentalizing different parts of multi-professional networks, identifying the most critical dis-integrations (commonly at the levels of (1) explanation, "What is the problem?"; (2) intervention, "What to do?"; and (3) systemic responsibility, "Who should do what?"), and fostering connecting conversations to minimize the impact of these dis-integrations on the young person's experience of care.

AMBIT and learning at work: balancing exploration of evidence and local expertise

AMBIT rejects the notion that a single fixed standard model of practice, applicable across multiple settings, is ever a practical goal, given heterogeneous client groups, cultures, and the wide variety of organizational contexts in which such work is delivered. AMBIT, therefore, is about not just the *what*, but the *how* of learning. Mentalizing occurs in relation to specific minds and specific settings, rather than addressing general truths.

Examples of AMBIT-influenced teams in the United Kingdom

A statutory (National Health Service [NHS] and Social Care) service working with young people on the edge of the care system in north London (AMASS, Islington)

A statutory (NHS) intensive outreach service with the aim of reducing in-patient admissions for acutely unwell adolescents in south-east London (Bexley Intensive Support Service)

A statutory (NHS) substance use service for complex, multiply disadvantaged youth across a mixed metropolitan and rural area in East Anglia (CASUS, Cambridgeshire).

A voluntary sector project working with highly socially excluded and gang-related youth, using music-making as the context within which mental health interventions are delivered to previously non-help-seeking youth (MAC-UK, London).

A statutory (NHS) child and adolescent mental health service delivering integrated day hospital, assertive outreach, and early intervention in psychosis services for severely unwell youth in Scotland (Lothian CAMHS).

Just as the precursors of attachment security are to be found in the formal qualities of the communication with a parent/caregiver, rather than the content of the communication (Belsky & Fearon, 2008), so the "sensitivity" of the therapist is paramount – not because of the specific contents of minds that he/she may thus be able to depict with clarity, but rather, because this attitude of sensitivity generates trust (a partially secure attachment), which opens the hard-to-reach person up to be influenced by the therapist. Thus, AMBIT-influenced work may strive to change a young person's expectancies with regard to social communication, but it does not assume that it is what is "taught" in therapy that brings change in behavior, emotions, and cognitions. What truly helps ("teaches") is the *social environment*, in which the evolutionary capacity for learning from others is rekindled through the creation of a new attachment bond. AMBIT-influenced working achieves its goal as much through *how* it offers help as through the content of that help. In order to create such conditions, the "how" of engagement strategies, implementations of principles, and of evidence-based practices (EBPs), must be flexible – and itself adaptive to new learning.

AMBIT's principled stance includes requirements for respect, both for "local practice and expertise" and for scientific evidence – acknowledging that there may be tension between these sources of information in the exigencies of fieldwork. The AMBIT manual includes a range of EBP protocols such as cognitive-behavioral therapy, family work, and so on, integrated around the overarching aim of creating attachments and thereby improving mentalizing capacity in the young person. We conceptualize EBP with less emphasis on specific intervention protocols, instead focusing on empirically supported general content-domain practice elements (Chorpita, Daleiden, & Weisz, 2005; Rosen & Davison, 2003).

Wiki-manualization

Using novel open-source wiki technology,[1] AMBIT offers an explicit, web-based platform of core manualized content, which is shared to multiple local versions where teams are supported to record and share their own local learning, developments of effective and specifically attuned local practices, and implementation strategies (the core and local AMBIT manuals can be viewed by following the links to AMBIT from the website www.tiddlymanuals.com).

This response to the rejection of a "one size fits all" approach is also an invitation to local teams to adopt the stance of a "learning organization" (Senge, 2006) toward the gathering of local outcomes evidence; that is, learning about what works in their particular cultural and service ecology. The question "What works *here*, for *these* young people?"

should be asked of all therapies that demonstrate effectiveness in randomized controlled trials (Cartwright & Munro, 2010). We hypothesize that this process of co-production of a local manual, blending externally sourced EBP with locally sourced "practice-based evidence," enhances the coordination, collaboration, and enculturation of a team, increasing its capacity to act as a secure base – for its workers as much as its clients. AMBIT's core content is enhanced by the experience accrued from working with multiple field deployments (at the time of writing, there are over 80 AMBIT teams in the United Kingdom) – learning that is "digested for redeployment" in the ever-developing wiki-manual.

This element of AMBIT is inspired by "open-source" methods of Web-based software development (e.g., the "Firefox" Web browser), in which virtual communities creatively, and largely voluntarily, respond to challenges by offering innovative solutions to specific technical and conceptual difficulties around a specific project, with systems in place to organize and field-test the incrementally advancing whole. Our model is thus close to the definition of the "deployment-focused model" for the development of new effective treatments, as defined by Weisz (2004) and Weisz and Simpson Gray (2008) – refining practice through iterative field implementations.

As increasing numbers of teams engage with this aspect of AMBIT practice, the project is now developing more formal structures for adjudicating on inclusions or edits to the core content.

Examples of local manualizing

The AMASS team in Islington recognized distinct changes in referral patterns, with increasingly frequent concerns about childhood sexual exploitation. They added local pages on this subject.

The CASUS team has added extensively to material on substance use disorder, recording its own care pathways and care plans.

The MAC-UK team works with young people who may have access to firearms. Young people helped them to draw up guidance on responding in the event of the team learning that a firearm is on site.

Lothian CAMHS has added material about working with young people with early-onset psychosis.

Community of practice

Anthropological examination of apprenticeships (Lave & Wenger, 1991; Wenger, 1998) shows that substantial proportions of the "syllabus" are held and taught not by remote experts but by other apprentices (who, we maintain, are best placed to create trust in the learner through better grasping their dilemmas). "Communities of practice" are defined as groups sharing a *domain of interest* (in this instance, "What works for complex, troubled, excluded youth?"), a *community* (a mutually supportive membership with shared competencies and commitment to the domain), and a *practice* (with the implication of a set of resources, tools, skills, and techniques that might usefully be pooled, shared, and developed).

The Web in general (and, we believe, the AMBIT manual in particular) offers unique opportunities for the practical development of these emerging ideas about knowledge management (Cox, 2005). Just as local teams work to develop and utilize attachment security between team members, so the relationship of teams to their Web-based treatment manuals emphasizes attachments, affiliations, and support from further afield. Thus, AMBIT includes a "social networking" element, enabling geographically distant teams to "look over each other's shoulders" via each other's manuals, sharing methods, techniques and protocols that have proven value in specific local settings. In the longer term, incremental and iterative improvements in the content of the manual, added via explicit processes from a widening pool of expertise and experience may, we hope, lead to it becoming increasingly trusted.

As teams do explore (and mentalize) their practice, AMBIT embraces the necessity for clear outcomes frameworks, which encourage the development and exercise of genuine curiosity in a team about what happens with clients: who they work best with; what fails to work well; how that situation may be improved. Measuring performance activates themes of "threat by ranking" ("Our outcomes may be worse than they should be") as easily as themes of "security through proof" ("This will prove that what we do works"). We agree with Kaplan and Porter (2011) and Porter and Teisberg (2006) that outcomes frameworks should avoid becoming fixed at either end of this dichotomy.

Alongside a range of common validated clinical outcomes measures, the manual includes the interactive AMBIT Adolescent Integrative Measure (AIM), a clinician-rated 40-item adaptation of the validated Hampstead Child Adaptation Measure scoring symptoms across multiple functional domains. When the AIM is completed in the manual, the responses interact with manualized content, generating lists of links to suggested interventions based on specific scorings. However, this measure is used by only a proportion of AMBIT-trained teams. Finding the balance between encouraging local adaptation and creating a robust and inclusive outcomes framework is challenging. A concerted effort is now underway to: (1) Develop and validate measures of AMBIT fidelity, using the active AMBIT Community of Practice to support this; (2) Using this to insist upon routine clinical outcomes measurement, in line with the UK's Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) program – a task acknowledged as challenging (see website: www.cypiapt.org). As teams using AMBIT are especially heterogeneous, identifying core measures that are appropriate across such a wide range of contexts remains difficult. Nonetheless, a description of clinical outcomes and learning in AMBIT-influenced teams is available (Fuggle et al., 2014); (3) The AMBIT project is also developing outcomes measures for use at a team and organizational level – *post-training outcomes*, as it were. A pre- and post-training questionnaire that probes workers" attitudes, experience of the work, and their use of AMBIT concepts and tools, is now routinely issued, and publications on this subject are in preparation.

Progress and conclusions

AMBIT is an innovative emerging model of practice that is powerfully influenced by attachment theory in its approach to client and interprofessional relationships, and which avoids over-rigid unmodulated command structures in favor of local learning. The wiki-manualizing aspect of AMBIT has engaged some teams more than others, due partly to technological constraints, partly to anxieties about such explicitly transparent practice, and partly to the struggle between such "meta-level" practice and the demands of day-to-day clinical work. AMBIT needs more formal evaluation in the coming years, and its

emphasis on necessary flexibility presents additional challenges in this respect. We are painfully aware that the very positive staff evaluations of AMBIT do not equate to evidence of effectiveness, and that, amid resource-led administrative reorganizations, training is only one (relatively weak) factor in the implementation of positive change.

Note

1. A wiki is a user-editable website. See www.tiddlywiki.com and http://tiddlyspace.com.

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