The SFRR is produced and distributed by the UK Association for Solution Focused Practice (UKASFP).

SFRR has aimed to provide a platform for the sharing and dissemination of research on Solution Focused Brief Therapy (SFBT). Our hope was also to support practitioners in carrying out research and encourage researchers interested in the practice of SFBT and in Solution Focused approaches more widely.

In the time since our last publication, with the support of the Advisory Board and the hard work of Reviewers and Authors, I have been gathering together a collection of studies which we are keen to share with a wider audience. We are pleased to add these contributions to the growing evidence of the usefulness of SFBT. Clark and Hampson’s quantitative study reports benefits from a SF approach for children and young people attending CAMHS. Proctor and Diamond describe the evolution of a peer support group for students who were at risk of isolation and academic failure and the contribution of SF facilitation. Fisher describes the part played by a SF approach in a family intervention service for families with complex issues. Hampson describes the part played by a SF approach and an SF Reflecting Team in consultation for Health Visitors. The Journal concludes with Firth and Farrington’s qualitative study of satisfaction with a SF approach and subsequent attendance rates in CAMHS.

We are grateful to our International Advisory Board. Their names and brief CVs are included in this edition.

John Wheeler, Editor
February 2014
An Evaluation of the Effectiveness of a Brief Solution Focused Family Intervention, based within Early and Preventative Tier 2 CAMHS

Lindsey Hampson and Lauren Clark

Abstract
This retrospective study provides a quantitative analysis of the effectiveness on outcomes of a Solution Focused Clinic (SFC) within a tier 2 Child and Adolescent Mental Health Service (CAMHS). The SFC had been started as an initiative to reduce waiting lists which had risen to seven months. The retrospective study was carried out using descriptive and outcome data routinely collected by the service. In total, the data from 18 carers and 11 children was analysed. Although the sample is limited, the study shows statistically significant improvements in conduct, hyperactivity, emotional and peer problems as measured by the SDQ as well as a reduction in emotional difficulties as rated by the parent as measured by the GHQ-12. Subjective self-reported ratings of the difficulties also decreased significantly.

Background
CAMHS waiting list initiatives
Access to “timely” assessment and intervention is emphasised in the Children’s National Service Framework (Department of Health, 2004). Referral rates to Child & Adolescent Mental Health Services (CAMHS) continue to rise with the knock-on effect of increased delay between referral and first appointment (Foreman & Hanna, 2000). To some extent, waiting lists have become part and parcel of CAMHS (British Psychological Society, 1993) and are considered unavoidable due to limited resources. However, they can have a detrimental impact on team morale (Jones, Lucey & Wadland, 2000), family attendance (Foreman & Hanna, 2000), and referrer’s opinion on the service (Bryce, 2000). Additionally, evidence highlights a relationship between increased waiting lists and failure to attend first appointment (Foreman & Hanna, 2000), and delays in treatment leave service users feeling despondent and disgruntled when they finally do receive treatment (Stallard, 1994). Several initiatives to reduce waiting times to first appointment have been developed and implemented by CAMHS across the country. These initiatives include triage systems (Jones et al., 2000); specialist teams (Lynch & Hedderman, 2006); information surgeries (e.g. Hobday & Dickson, 2003); opt in appointment systems (Stallard & Sayers, 1998); and brief interventions (e.g. Heywood, Stancombe, Street, Mittler, Dunn & Kroll, 2003; Goldberg & Campbell, 1997).

1A summary of this paper was previously published as, Hampson & Clark (2011) ‘An evaluation of the effectiveness of a brief solution-focused intervention, based within early and preventative tier 2 CAMHS’. The Magazine for Family Therapy and Systemic Practice in the UK. 118, p 12-16.

2Lead Author. Chartered Clinical Psychologist, Sefton specialist child and adolescent mental health service, Alder Hey Children’s NHS Foundation Trust. 3tc House, Crosby Road North, Waterloo, UK. Can be contacted on lindsey.hampson@alderhey.nhs.uk

3Clinical Psychologist, University of Liverpool.
Brief interventions as waiting list initiatives

Of relevance here is the use of brief interventions as a waiting list initiative. Research shows that clinical outcome is in fact unrelated to number of sessions offered (Andrade, Lambert & Bickman, 2000) and one of the most replicated findings in mental health research is the similar effectiveness of planned short-term therapy and time-unlimited therapy (Bloom, 2001).

‘Brief therapy’ is an umbrella term for a variety of approaches to psychotherapy which differs from traditional schools of therapy in that they are concerned, not with the root of the problem, but current factors maintaining and preventing change. A number of therapeutic models have been adapted to fit the criteria of ‘brief intervention’ and used to treat a variety of clinical problems (see Hawker, 2007, for review).

Solution Focused Brief Therapy (SFBT)

Solution Focused Brief Therapy (SFBT) is a therapeutic approach emerging out of clinical practice, strongly influenced by social constructionist approaches (de Shazer, 1991, 1994) and is based on solution building as opposed to problem solving (Lloyd & Dallos, 2006). Briefly, In SFBT the therapist encourages the person to voice their hopes for therapy, identify their strengths and identify times when the problem is absent or less intrusive. SFBT focuses on clients’ strengths and goals in an attempt to produce therapeutic change.

There is a growing body of evidence which highlights SFBT as an effective intervention across a wide range of clinical presentations and problems seen in CAMHS (e.g. oppositional disorder (Conoley et al., 2003); suicidal ideation (Triantafillou, 1997); parenting skills (Zimmerman et al.,1996); and Schizophrenia (Eakes et al., 1997) (for review of evidence base see Wheeler, 2001 and Stams, Dekovic, Buist and de Vries, 2006). Rothwell (2005) found SFBT had comparable results to Cognitive Behavioural Therapy CBT with adults, but needed far fewer sessions (mode= 4). Additionally, NICE (2004) recommends SFBT for improving support and palliative care with adults with cancer.

The Solution Focused Clinic

A Solution Focused Clinic (SFC) was started in 2006 in a tier 2 Early and Preventative CAMHS. Tier 2 is regarded as “the interface between tier 1 ‘front line’ professionals and multi-disciplinary specialist services, and may be defined as a level of service provided by specialist CAMHS professionals working on their own who relate to others through a network rather than through a team. Tier 2 represents the first line of specialist services, and is clearly distinguished from the work of multi-disciplinary specialist teams who provide secondary level (Tier3) and tertiary level (Tier 4) care for children with severe, complex and persistent disorders” (Appleton, 2000).

The SFC was developed and implemented as an initiative to decrease Tier 2 waiting times which had escalated to 7 months which was at odds with the aims of an early and preventative CAMHS team.

The approach consisted of two therapists trained in SFBT, working together to see families. One clinician would take a ‘lead’ role, interviewing the family, the other in a
reflective role, offering feedback to the family as well as taking notes. Initially the clinic was based on 2+1 therapeutic approaches (Barkham, 1989) whereby, after one appointment, another appointment is offered in four weeks’ time, then a follow up two months later if required. During the initial appointment, the lead clinician would start by engaging the family in problem-free talk, talk about the concerns that have brought them, identify best hopes and a preferred future and then introduce scaling questions related to this. There would then be a short break where clinicians would leave the room and reflect on resources, exceptions, competencies and “what’s working” (George, Iveson & Ratner, 2010). The non-lead clinician would feed this back to the family when they returned to the room. Subsequent sessions would focus on signs of movement towards the goals using scaling questions and deconstructing exceptions.

Keeping within the SF philosophy, each session was carried out as if it were the last, (George, Iveson & Ratner, 2010); not presuming that the family would attend all offered sessions and a detailed letter was sent to the family following each meeting, highlighting their preferences and resources as presented in the feedback. Cases were chosen carefully based on perceived level of complexity (e.g. quite recent onset and/or difficulties with relatively low impact on family functioning) and a care pathway into Tier 3 CAMHS was identified, for families where 3 sessions were found to be insufficient. This was due to clinicians ‘finding their feet’ with the approach of the clinic as well as being mindful of the brevity of the sessions offered.

**Rationale for the Study**

Subjectively, the feedback the clinicians had received from families has been positive, however, the clinicians had yet to determine the clinic’s effectiveness in making an objective difference to presenting problems. Routine pre and post measures had been administered to families attending the clinic over a 20-month period (measures will be explained further below) and these completed service-evaluation data-sets were used for the present study to evaluate clinical effectiveness.

**Aims and Hypotheses**

**Aims**

To obtain descriptive information, including average wait time and the duration of the SF intervention for all children discharged from the SFC whose family completed pre and post intervention measures between the dates July 2006 and March 2008. To evaluate the effectiveness of the SF intervention by analysis of routinely administered evaluation questionnaires completed by the young person and main-carer.

**Hypotheses**

This service evaluation set out to test the following hypotheses:

1. There would be a significant difference between pre and post SF intervention scores for all measures completed by the main-carer.
2. There would be a significant difference between pre and post SF intervention scores for all measures completed by the young person.
3. The difference seen for the main-carer Strengths and Difficulties Questionnaire scores would be greater than would have been predicted for a community population of young people with psychological difficulties, not receiving intervention.
Methodology

Participants

In the 20 months the SFC had been running, 32 cases had been discharged. Of these, 18 main-carers completed full service-evaluation data (pre and post measures). Out of the thirty two families, three attended only the initial appointment, but did not return their questionnaires. Eight families did not attend the initial appointment and three notified the service that they no longer required intervention without being seen. These families are not included in the study, given they did not complete pre and post questionnaires.

Of the 18 families with complete main-carer service evaluation there were also service evaluation data for 11 young people.

Measures

Strengths and Difficulties Questionnaire (SDQ)

The SDQ (Goodman, Meltzer & Bailey, 1998) is a short behavioural assessment for children and young people aged 4 – 16 years. It has several versions and those used in the service were a self-report version for ages 11 – 16 and a version completed by the main-carer for the child aged 4 – 16.

The 25 self-report SDQ-items are divided between five scales of five items each. The five scales are conduct, hyperactivity, emotional symptoms, peer problems and pro-social. Each item is marked on a 3-point scale (0 = ‘not true’, 1 = ‘somewhat true’, 2 = ‘certainly true’). The score for each sub-scale is generated by summing the total number of items on each scale; thus the maximum score for each sub-scale is 10. A total difficulties score is made up of the scores for the conduct, hyperactivity, emotional and peer problems sub-scales. Total difficulties scores range between 0 – 40. In addition, the SDQ has an impact score reflecting what the respondent thinks about the problem in terms of chronicity, distress, social impairment and burden to others (Goodman, 1999).

The SDQ is a widely used treatment outcome measure (Mathai, Anderson & Bourne, 2003), with good reliability and validity (Goodman, 2001).

General Health Questionnaire – 12 (GHQ-12)

The GHQ-12 (Goldberg & Williams, 1998) is a 12-item self-administered questionnaire. It has been extensively used worldwide as a valid and reliable measure of non-specific psychological distress (Schmitz et al., 1999). Respondents are asked to rate on a 4-point Likert scale how much they have experienced a particular symptom or behaviour recently, ranging from ‘much less than usual’ (weighted as 0) to ‘much more than usual’ (weighted as 3). Total scores range from 0 – 36, with raised scorers indicating higher levels of distress.

Problem Rating Scales

Main-carers and (age appropriate) young people were asked to identify their main problems and rate the severity of problem on a subjective visual analogue scale, whereby 0 is “best possible” and 10 is “worst ever”. Families could rate the severity of up to five problems.
Data Collection and Analysis

Data Collection

The service routinely collected outcome measures for all their work. Service evaluation data was acquired by asking all main-carers of young people referred to the service to complete the SDQ, GHQ-12 and problem rating scales. Young people aged 11 and over were also asked to complete the SDQ and problem scales. SDQ and GHQ-12 measures were completed prior to the family’s first appointment. Problem rating scales were completed in the first and last session with the therapist present. Post SF intervention data were obtained during the break in the last session.

Data Analysis

Descriptive Analysis

Descriptive statistics were used to describe the gender, age, referral information, wait time, length of intervention and discharge details of young people seen and discharged over the 20 months the SFC had been running whose families completed service evaluation data.

Inferential Analysis

In order to determine if there was a significant difference on the SDQ, GHQ-12 and problem rating scales, inferential statistics were carried out on main-carer scores and, where possible, the young person’s scores. Given that scores were all rank data, a non-parametric within-subjects test was chosen using Wilcoxon signed rank tests (Wilcoxon, 1945).

It is generally agreed that scores on the SDQ can improve over time even without specialist intervention. Improvements may be a result of measurement error or spontaneous recovery. Youth in Mind (2005) have devised a formula to calculate the SDQ added value, allowing clinicians to estimate the impact of specialist services on child mental health. The formula is based on a longitudinal survey of young people diagnosed with psychiatric disorders not receiving intervention. Outcome studies have benefited from the SDQ added-value score, which relates to predicted improvement (Vostanis, 2006).

In order to determine if SF intervention provided gain beyond that expected without intervention, this study calculated an added-value score for the main-carer version of the SDQ.

Results

Descriptive Analysis

The following demographic and referral information are based on the 18 families who had complete service evaluation data sets.

The mean age of the young people referred was 9.1 years (range 3 – 15). Age groups of the young people are 1% were in the 0 – 5 year old age range. 72% were in the 6 – 11 year old range and 17% were in the 12 – 16 year old age range. Of the young people discharged from the SFC 5 (28%) were female and 13 (72%) were male.
Referral

Table 1 and Table 2 show the different referral problems for the 18 families included in the analysis, and the frequency with which they occurred. The referrers often listed more than one problem and the data is therefore broken down into referred problem 1 (Table 1) and referred problem 2 (Table 2). As can be seen the most common referral problem 1 is behavioural difficulties (77.8%). By contrast, the most common referral problem 2 is ‘difficulties adjusting to a change in domestic situation’ (27.8%).

Table 1. Referral Problem 1

<table>
<thead>
<tr>
<th>Referral Problem 1</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioural</td>
<td>14</td>
<td>77.8</td>
</tr>
<tr>
<td>Change in domestic situation</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>Sleep difficulties</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Emotional</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 2. Referral Problem 2

<table>
<thead>
<tr>
<th>Referral Problem 2</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in domestic situation</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>Emotional</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>Sleep difficulties</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>Bullying/altered friendship</td>
<td>2</td>
<td>11.1</td>
</tr>
<tr>
<td>No secondary problem identified</td>
<td>7</td>
<td>38.9</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100</td>
</tr>
</tbody>
</table>

Onset of main problem

Onset of main problem is illustrated in Figure 1. Referral information highlighted that the majority of young people seen in the SFC onset of problem fell in the range of 0 – 6 months (61%). 27% problem had occurred in the range of 6 – 12 months and 11% was greater than 12 months.
Waiting times for first appointment

The average time to wait following opt-in for the 18 families included in the analysis was 12 weeks (range 1 – 22 weeks). Table 3 shows the frequency of different ranges of wait times. The majority fell in the range of 11 – 15 weeks range (55.6%). This reflects the decrease in wait times as the clinic progressed. When the clinic commenced the longest wait time was 7 months.

Table 3. Waiting Time for First Appointment

<table>
<thead>
<tr>
<th>Wait time</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 4 weeks</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>5 – 10 weeks</td>
<td>5</td>
<td>27.8</td>
</tr>
<tr>
<td>11 – 15 weeks</td>
<td>10</td>
<td>55.6</td>
</tr>
<tr>
<td>16 – 20 weeks</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>21 – 25 weeks</td>
<td>1</td>
<td>5.6</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>100</td>
</tr>
</tbody>
</table>

Number of therapeutic sessions

Figure 2 illustrates the number of sessions each family attended. The average number of sessions for the 18 families included in analysis was 3.38 (range 2 – 6). For some families, more than the initial 2+1 model was required. These cases were still felt to fit within the tier 2 remit and therefore kept within the clinic and offered additional sessions and not transferred to tier 3 services. Additionally, as only families who completed pre and post data were included, families who only attended for one appointment or discontinued are not included in the study.
Referred on after intervention

Of the 18 families included in the analysis, 2 (11%) were referred on to Tier 3 services following SF intervention.

**Inferential Analysis Main-Carer**

**Strengths and Difficulties Questionnaire**

Table 4 shows the means and standard deviations for main-carer SDQ scores pre and post SF intervention. Higher scores signify more difficulties. As can be seen mean scores on all scales reduced following intervention.

**Table 4. Means (standard deviations) and Clinical Range for Main-Carer Pre and Post Intervention SDQ Scores**

<table>
<thead>
<tr>
<th>Main-Carer</th>
<th>N</th>
<th>Pre Intervention Mean (SD)</th>
<th>Range</th>
<th>Post Intervention Mean (SD)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total SDQ Score</td>
<td>18</td>
<td>18.1 (6.2)</td>
<td>‘Abnormal’</td>
<td>10.4 (8.1)</td>
<td>‘Normal’</td>
</tr>
<tr>
<td>Conduct</td>
<td>18</td>
<td>3.6 (2.2)</td>
<td>‘Normal/Borderline’</td>
<td>1.8 (1.8)</td>
<td>‘Normal’</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>18</td>
<td>5.6 (2.8)</td>
<td>‘Normal/Borderline’</td>
<td>3.8 (2.4)</td>
<td>‘Normal’</td>
</tr>
<tr>
<td>Emotional</td>
<td>18</td>
<td>5.5 (2.8)</td>
<td>‘Abnormal’</td>
<td>2.3 (2.5)</td>
<td>‘Normal’</td>
</tr>
<tr>
<td>Peer Problems</td>
<td>18</td>
<td>3.3 (3)</td>
<td>‘Borderline’</td>
<td>2.5 (2.6)</td>
<td>‘Normal/Borderline’</td>
</tr>
<tr>
<td>Impact Score</td>
<td>17</td>
<td>3.7 (2.8)</td>
<td>‘Abnormal’</td>
<td>1.1 (1.6)</td>
<td>‘Borderline’</td>
</tr>
</tbody>
</table>
Table 5 shows the results from the Wilcoxon signed ranks test for main-carer SDQ scores. Analysis highlighted a significant difference between pre and post SF intervention SDQ scores for all scales.

**Table 5. Wilcoxon Test on Main-Carer SDQ scores**

<table>
<thead>
<tr>
<th>Main-Carer</th>
<th>Z</th>
<th>Asymp.Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total SDQ Score</td>
<td>-3.248</td>
<td>.001</td>
</tr>
<tr>
<td>Conduct</td>
<td>-2.831</td>
<td>.005</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>-2.268</td>
<td>.02</td>
</tr>
<tr>
<td>Emotional</td>
<td>-3.535</td>
<td>.000</td>
</tr>
<tr>
<td>Peer Problems</td>
<td>-2.228</td>
<td>.026</td>
</tr>
<tr>
<td>Impact Score</td>
<td>-3.045</td>
<td>.002</td>
</tr>
</tbody>
</table>

**Added value of Solution Focused intervention**

Table 6 displays the added-value of SF intervention. A mean score of 4.8 implies that the actual total difficulties score following intervention was 4.8 points lower than would have been expected without intervention. This may be taken as evidence that the SF intervention was successful in reducing the total difficulties score.

**Table 6. Added Value of Intervention**

<table>
<thead>
<tr>
<th>Added Value of Solution Focused Intervention</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Mean</th>
<th>Standard deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17</td>
<td>-8.70</td>
<td>12.90</td>
<td>4.8</td>
<td>5.45</td>
</tr>
</tbody>
</table>

**General Health Questionnaire-12**

Main-carer pre and post-intervention GHQ-12 mean scores are shown in Table 7. Higher scores indicate greater difficulties. As can be seen, the mean GHQ-12 score reduced following SF intervention and Wilcoxon signed ranks test confirmed this to be statistically significant at the two tailed level (z = -3.472, p < 0.01).

**Table 7. Means (standard deviations) for Main-Carer Pre and Post Intervention GHQ Scores**

<table>
<thead>
<tr>
<th>GHQ Score</th>
<th>Pre intervention Mean (SD) (N = 18)</th>
<th>Post intervention Mean (SD) (N = 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14.67 (4)</td>
<td>8.78 (3.6)</td>
</tr>
</tbody>
</table>
Subjective Problem Rating Scales

Pre and post intervention problem rating scores are shown in Table 8. Higher scores indicate greater difficulties. There was some missing data and analysis was based on 14 and 9 main-carers, for problem 1 and problem 2, respectively. As can be seen, mean problem rating scores for both problem 1 and problem 2 were reduced following intervention and Wilcoxon signed ranks test confirmed this to be statistically significant (z = -3.192, p < 0.01 and z = -2.207, p < 0.05, respectively).

Table 8. Means (standard deviations) for Main-Carer Pre and Post Intervention Problem Rating Scales

<table>
<thead>
<tr>
<th>Problem</th>
<th>N</th>
<th>Pre intervention Mean (SD)</th>
<th>Post intervention Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem 1</td>
<td>14</td>
<td>6.07 (2.75)</td>
<td>1.93 (1.5)</td>
</tr>
<tr>
<td>Problem 2</td>
<td>9</td>
<td>5.56 (2.83)</td>
<td>1.67 (1.5)</td>
</tr>
</tbody>
</table>

Inferential Analysis Young Person

Strengths and Difficulties Questionnaire

The following analysis was based on 8 young people. The young person pre and post SDQ mean scores for all scales are shown in Table 9.

Inspection of Table 9 shows that, with the exception of the impact score and conduct scale which fell in the abnormal and borderline range respectively, all scores fell in the normal range pre intervention. Nevertheless, all mean SDQ scores reduced following intervention.

Table 9. Means (standard deviations) and Range for Young Person Pre and Post Intervention SDQ Scores

<table>
<thead>
<tr>
<th>Young Person</th>
<th>N</th>
<th>Pre Intervention Mean (SD)</th>
<th>Range</th>
<th>Post Intervention Mean (SD)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total SDQ Score</td>
<td>8</td>
<td>13.7 (7.8)</td>
<td>‘Normal’</td>
<td>9.1 (6.0)</td>
<td>‘Normal’</td>
</tr>
<tr>
<td>Conduct</td>
<td>8</td>
<td>4 (2.4)</td>
<td>‘Borderline’</td>
<td>2.6 (1.6)</td>
<td>‘Normal’</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>8</td>
<td>4.1 (3.1)</td>
<td>‘Normal’</td>
<td>3.6 (2.2)</td>
<td>‘Normal’</td>
</tr>
<tr>
<td>Emotional</td>
<td>8</td>
<td>3.5 (3.4)</td>
<td>‘Normal’</td>
<td>1.3 (1.9)</td>
<td>‘Normal’</td>
</tr>
<tr>
<td>Peer Problems</td>
<td>8</td>
<td>2.5 (2)</td>
<td>‘Normal’</td>
<td>1.5 (1.8)</td>
<td>‘Normal’</td>
</tr>
<tr>
<td>Impact Score</td>
<td>8</td>
<td>2 (1.5)</td>
<td>‘Abnormal’</td>
<td>0.14 (0.3)</td>
<td>‘Normal’</td>
</tr>
</tbody>
</table>
Table 10 shows the results from the Wilcoxon signed ranks test for young person SDQ scores. With the exception of the hyperactivity scale, analysis highlighted a significant difference between pre and post intervention SDQ scores for all other scales.

Table 10. Wilcoxon Test on Young Person SDQ scores

<table>
<thead>
<tr>
<th>Young person</th>
<th>Z</th>
<th>Asymp.Sig. (2-tailed)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total SDQ Score</td>
<td>-2.389</td>
<td>.017</td>
</tr>
<tr>
<td>Conduct</td>
<td>-1.994</td>
<td>.046</td>
</tr>
<tr>
<td>Hyperactivity</td>
<td>-.744</td>
<td>.457</td>
</tr>
<tr>
<td>Emotional</td>
<td>-2.060</td>
<td>.039</td>
</tr>
<tr>
<td>Peer Problems</td>
<td>-2.060</td>
<td>.039</td>
</tr>
<tr>
<td>Impact Score</td>
<td>-2.121</td>
<td>.034</td>
</tr>
</tbody>
</table>

Problem rating scales

Table 11 displays means and standard deviations for the young person problem rating scores. Higher scores indicate more difficulties. As can be seen mean scores for problem 1 and 2 reduced following intervention and Wilcoxon signed ranks test confirmed this to be statistically significant (z = -2.680, p < 0.01 and z = -2.070, p < 0.05, respectively).

Table 11. Means (standard deviations) for Young Person Pre and Post Intervention Problem Rating Scales

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Pre intervention Mean (SD)</th>
<th>Post intervention Mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem 1</td>
<td>11</td>
<td>4.8 (1.7)</td>
<td>2.2 (2.8)</td>
</tr>
<tr>
<td>Problem 2</td>
<td>7</td>
<td>4.7 (2.8)</td>
<td>1.7 (1.9)</td>
</tr>
</tbody>
</table>

Reflections

Descriptive data and service criteria

Waiting times for SFC was on average 12 weeks. The service felt that this was a more acceptable wait time to first appointment and fell within the service’s 12-week goal. Prior to this, the longest wait was 22 weeks. The study demonstrated that this brief intervention reduced the waiting list from 7 months to: 33% waiting between 0-10 weeks and 55% being seen between 11-15 weeks. The average number of sessions of 3 was in line with SF ways of working and fitted with the perception of the service.
Recent research demonstrates providing families with control over the number of sessions leads to less sessions being used and extended time between sessions (Carey & Mullan, 2007), thus freeing up clinicians and allowing for more families to be seen.

McGarry, McNicholas, Buckley, Atkin & Ross (2007) argue that when using brief interventions, poorly screened cases can generate more work as families end up being referred back to generic services. It was felt that a good safety-net of care (choosing less complex cases and being able to refer to Tier 3 services if needs be) had been established. Only two of the 18 families discharged were referred on to Tier 3 services. As mentioned previously, when the clinic was first started the clinicians felt it was important for them to choose (albeit from limited referral information) less complex cases that may respond to a very brief approach. Therefore, these results may not generalise to difficulties which may be typically seen in Tier 3 services. However, many clinicians acknowledge from their clinical experience that complexity does not necessarily indicate how successful SFBT might be.

**Outcome analysis and clinical effectiveness**

It was hypothesised that there would be a significant difference between pre and post SF intervention for all measures completed by the main-carer. Outcome analysis was entirely in line with this, with main-carer scores on all measures showing significant improvement following intervention. Similarly, analysis highlighted a significant improvement following intervention for most measures completed by the young person measures, thus confirming the second hypotheses. Finally, the suggestion that improvements on the main-carer SDQ may have been due to measurement error or spontaneous recovery do not hold given that the added-value calculation for the SDQ indicated an added-value of the SF intervention, thus confirming the third hypothesis.

Overall the data demonstrate that both the main-carer and the young person benefited from SF intervention. It is tempting to argue that these results lend weight to the growing body of evidence demonstrating the clinical effectiveness of SFBT (Wheeler, 2001). However the small sample size, especially for the young person data, makes it difficult to draw any meaningful conclusions from this group. In addition, given that the evaluation relied purely on analysis of complete evaluation sets, the sample is biased towards those completing treatment. Thus any conclusions drawn from this evaluation apply only to a sub-sample who completed treatment (Meier & Letsch, 2000). The study should be replicated in the future when more families have been discharged from the service to see if the significant effects found here hold with a larger sample.

According to Lee, Jones, Goodman & Heyman (2005) the child version SDQ may be too broad a measure to capture specific difficulties and the authors advise the use of ‘narrowly’ focused measures when evaluating the clinical effectiveness of a service. Despite significant improvements on the child SDQ scales (with the exception of hyperactivity), it is important to consider that prior to intervention most scores fell in the ‘normal’ range. This suggests that the measure may have lacked clinical sensitivity in detecting specific difficulties, or alternatively, that the young people did not view themselves as having difficulties. Therefore, results from the ‘narrowly’ focused subjective problem scales may be more informative. Moreover, given that the child version SDQ is suitable for 11 – 16 years and considering that the majority of young
people in the sample were under 11, greater attention should be paid towards the use of narrowly focused measures in the future in order to better evaluate clinical effectiveness in line with clinical governance. On reflection, some members of the team felt that collection of child data had been at times overlooked by giving greater onus to gathering parental ratings. To ensure that the collection of child data is not overlooked in the future, a ‘child friendly’ subjective rating problem scale has been developed that is a large, simple, colourful scale with visual anchors of a sad face at the bottom of the scale and a happy face at the top.

Overall, despite limitations, the clinicians were cautiously positive in their evaluation of the results and felt that the SFC as a waiting list initiative had reduced waiting times and crucially, this had not compromised quality of service (Hawker, 2007). These results added weight to the favourable qualitative data already collected by the service.

**Conclusion**

This study has evaluated the effectiveness of a Tier 2 waiting list initiative - the SFC operating within a CAMHS. The study found significant improvements between pre and post SF intervention measures for both main-carer and young person – highlighting the clinical effectiveness of this intervention. The SFC reduced waiting times without compromising on quality. Small sample size and sampling biases were considered as methodological limitations, and study replication would be of benefit in the future. The study raised short-falls with regards to the way in which child data is collected and as a result a child-friendly rating scale was developed.

**References**


Exploring the role of the Solution Focused Approach in a University Social Support Group

Dr Anne Proctor¹ and Liz Diamond²

Abstract
The paper describes the setting up of a Social Support Group in a United Kingdom university, considers the potential for such an initiative in enhancing the engagement of students with their courses and with their personal development, and the part played by the use of a Solution Focused (SF) approach in the facilitation of the group. Comments from group members shed light on how the SF approach worked for them and encouraged the facilitator to continue to facilitate social support groups in this way.

Introduction
Staff involved in Higher Education (HE), are concerned to place students at the very heart of their work. It is a glaring waste of scarce resources when students enter a course and then “drop-out” without completing it and, even more importantly, it is very disappointing and distressing for students to embark upon a teaching programme with hopes and expectations only to have those dashed by an “inability” to meet the requirements of that same programme. The Higher Education Academy (HEA) has embarked upon an intensive programme to explore and address these issues. Out of their detailed research a number of critical pointers have been identified, three of which are that:

- Friends are crucial to many students’ retention and success
- Students are more likely to turn to friends for support than academic staff or institutional support systems
- Friendship groups formed early in the student experience are enduring (HEA, 2011, Briefing 6, p.5)

The experience in this university confirms that students who gain confidence from friendship groups not only have a greater sense of belonging, but are also more likely to access the services which are available to them.

Research methodology
In order to explore how group members experienced the group, and the use of a Solution Focused (SF) approach in particular, a Grounded Theory (Charmaz, 2006) methodology was adopted, which involved comprehensive gathering of data as

¹Counsellor (now retired) Edge Hill University, UK. Lead author, can be contacted on anne.proctor1@btinternet.com

²Head of Counselling and Supervisory Services, Edge Hill University, UK.
the group developed over time, the dual role of researcher and facilitator was challenging, so to support her and add a degree of independence to the discussion of the data, she worked in partnership with a “critical friend” (Edwards 1999). This was known and agreed to by group members. Records of each group session, including feedback from the group members were compiled by the facilitator and discussed at intervals with the “critical friend”. At the end of each academic year, interviews were conducted with group members. These were recorded, transcribed and then subject to detailed analysis, to highlight aspects of group development through three stages.

**Stage One**

The Social Support Group was initiated with the hope that the presence of a support and social network would encourage in students a feeling of belonging, and a sense of self-efficacy which would enable them to articulate their needs and act to meet them. At this stage the group was advertised via the Student Services Division and on posters at selected places in the university. Initially three students expressed an interest, two having heard about it from their Learning Facilitators based in the Student Services Division and a further one in direct response to a poster.

To outline the SF approach in Stage One, each of the three initial group members were given a small laminated card outlining the approach, adapted from a description by George et al (2006), as shown in Appendix I. At the outset, each person was invited to talk briefly about something with which they had been pleased and then to articulate any areas within which they wished change to take place. The willingness of the participants to share experiences including personal issues of mental health was almost breath-taking. Anybody who has worked with students will know that loyalty to a weekly group is not widespread.

At the start of the spring term, one member was on an extended work placement away from the university, maintaining contact only through email. However, three new members joined the group as a result of recommendations to them from the Student Services Division. The group maintained itself on a weekly basis for the rest of the academic year, even asking to meet during the summer vacation.

Evaluation comments from group members indicated that the group was a supportive and tightly knit group, and that sharing was easy and comfortable.

“…from an early outset there was a sense of camaraderie…and I guess that it’s through that sense of camaraderie that there has been continuity”

This also seemed to enhance self-efficacy:

“…a bit more confident about going to tutors and asking for help…a while ago I would have just sat back and panicked until it passed which it never did”

And a focus on solutions:

“…I have started looking on the bright side of things in general as …if something bad happens I start to look at ways I can solve it rather than concentrating on how awful it is.”

**Stage Two**

Positive feedback from group members encouraged the facilitator and “critical friend” to continue the group for a second year and to carry out a more detailed evaluation.
Use was made of the university internal plasma screen system to promote the group, as well as posters and leaflets, and staff in the Student Services Division who might inform students with whom they worked. The numbers expressing an interest grew, including members from the previous year who maintained contact and other individuals who were looking for social engagement and/or a supportive environment. New members usually contacted the facilitator via an email address and she made every effort to meet them and, if necessary, accompany them to a first session.

During stage two numbers ranged between 7 and 25 with a core of 8 members who showed the same commitment as those in the previous year. During this year the activities of the group broadened, for example going out for meals. Group members met outside the group and supported each other in different settings. Regular group meetings took place in one of the eating outlets of the university. However, it was recognised that this was not ideal and, on one occasion, the group chose to use the “Group Room” in the Health and Well-being Centre. In the event this was not a success as the room created an uneasy silence on the part of the members who later described the room as “cold, like a committee room”. The facilitator invited group members to do something about this and the group decided to have a competition to develop plans to transform the room in order to make it more fit for purpose.

The increase in numbers in the group during this second stage appeared to affect the motivation of some members, depending on the extent to which individual needs were met. The facilitator was concerned that this lack of stability was a difficulty for members who missed the closeness and trust which had been built up in the previous year.

Although this raised questions, at the time, about the extent to which use of an SF approach was helping, persistence was eventually rewarded. Comments from group members confirmed that, despite the fluidity of the group, the SF approach was more effective than the facilitator had thought, as the following comments suggest.

**Processing the SF approach in the group**

“She always asks us for one good thing and goes onto the next person and then onto the bad things that may have happened during that week…we’re always able to ask A (the facilitator) how her week has been…she is as much part of the group as anybody else.”

Drawing on a SF approach the facilitator invited group members to look at challenges which might be changed into “best hopes”. Participants included personal challenges and aspects of university life which created difficulties including managing academic group work when other members did not play a full role, interacting with tutors, managing issues in Halls of Residence, loneliness and friendship and bullying. Each member of the group played a role in identifying solutions and, although the participants were direct in offering advice at times, they appeared to recognise the efforts of the facilitator not to take too much initiative.

The members were not necessarily used to taking part in a group and they appeared to welcome the role of the facilitator in encouraging this:

“…but I think it is good that she can go around different people and speak to them and obviously give a chance for somebody else to talk and so everybody has a fair go about who wants to speak when…and I don’t recall anybody really interrupting each other or getting upset or anything because we each have our own turn…”
The effects of the SF approach

Some comments pointed towards ways in which an SF approach was influential for group participants, including the development of a positive outlook and the role of the group in promoting this:

“I like that whole ‘say at least one positive thing that happened’. It goes a surprisingly long way to generally making me think more positively about things in general.”

“It’s weird because I don’t really get to share what is good in my life…not really used to it… it takes a long time to get used to the fact that people want to listen to me…I got used to it and now I am happy to share what has gone well for me.”

Potentially indirect effects of the SF approach

“It’s…er…a very good group if you are a little bit, you know, behind a wall if you like…you have built yourself a wall and you can’t get out, and you want to get out of this wall but you can’t get out so you need that extra help…this group can do this.”

Comments such as this suggested the development of social skills and self-expression in participants who might otherwise struggle and there was evidence of realisations that the reactions could affect future behaviour:

“I emphasise positive things rather than negative things and it’s had a noticeable effect on my general demeanour”

“Especially with the way the …………..industry works…its kind of all shared basically…a lot of socialising involved…you need a team for that”

The group survived the year and ended with a strong core of six committed members and some who attended as they felt they needed or wanted to

Stage Three

At the entry into the next academic year, a number of significant factors influenced the next stage of the group,

- The group had a significant role in the lives of some student members
- For some the small group atmosphere was significant whereas others welcomed a more flexible social environment, with diversification of activities
- New members needed quite a lot of support in the initial stages
- The use of an SF approach was significant in the short and long term and group members themselves could promote the approach
- Comments from group members confirmed that a SF approach could help to develop group cohesion, encourage self-efficacy and solution building.

This presented the facilitator with the challenge of developing a social environment while, at the same time, maintaining the intimacy of a small supportive group which encouraged and supported new members.

At the start of the next academic year the group was promoted as previously and, additionally, there was a table at the “Fresher’s Fair” staffed by the facilitator and group members. Students were given information about the group and were invited to leave contact details. In order to make a place for a more intimate setting, a drop-in session
was planned on a weekly basis to be held in the Health and Well-being Centre. Group members took on the challenge to initiate plans for a refurbished room for their meetings and to implement them. During the course of the year the group continued to meet regularly, growing in numbers, and group cohesion. The numbers were flexible and varying between 10 and up to 20. The extra drop-in sessions were offered and were used most often by potential new members, enquirers and regular group members who wanted to talk privately or to up-date the facilitator on a group matter. The climax of the year came when the refurbishment of the “Group Room” was complete and the room was opened.

A SF approach continued to be used as a basis for the regular meetings except when there was some specific activity, such as going out for a meal or a games evening. One member who had been with the group from the beginning became particularly familiar with the SF approach, undertook some training in Solution Focused group work and became skilful in co-facilitating the group with the support of other longer term members. From the beginning of stage three the weekly group, although having increased in size, appeared to sustain the intimacy which had sometimes been missing during stage two. It was not possible to confirm a causal relation between this and the use of a SF approach, but group members frequently shared their good times and their best hopes and this was noted by new members.

The drop-in group did not appear to generate the same intimacy, although it did provide further discussion time with individuals or very small groups and acted as a potential bridge for new members who wanted and needed more information before deciding to join the usual weekly sessions.

The project to make the group room fit for purpose represented the implementation of significant best hopes for the group with members deciding what was wanted and creating the next steps. The presentation to the winner of the competition was organised especially so that a small number of special guests could be invited, and was followed by an outing to “treat” the two winners to a meal locally. The students presenting their best hopes for the group made a very strong impression on the invited audience from Student Services Division and the Student Union. This was repeated at the formal opening of the room which was attended by the Vice-Chancellor of the university along with other representatives from Student Services Division, the Student Union and staff members from the Faculties of the university. The numbers were limited by the size of the room and a drop-in session was held during the afternoon to give other interested staff and students an opportunity to share the hard work of the people concerned. The event took place out of term time with some members making long journeys to be there. The group, with the support of the university Media Services, made a film called “It’s All Change at Milton House” (See Changing Rooms in the references for a U-Tube link).

As the group grew in size there was no evidence that members felt excluded in contrast with Stage Two. Some members of the group, in particular, seemed to know all the others and even very new members commented upon how they had seen and been acknowledged by other group members. Further illustrations of self-efficacy emerged in the way group members had taken on responsibilities at the Fresher’s Week, in organising “games nights” and external events whilst pro-actively managing their own personal challenges.
Discussion

Evaluation of the three stages showed a move from a small tightly-knit, intimate group, through a much larger loosely formed group seeking an identity, to a larger group which seemed to have developed an established but flexible way of working.

The group was set up to enable students to become engaged in the university and to benefit from their teaching programmes. Underpinning this was the development of a positive approach and the promotion of self-efficacy which many writers, such as Macdonald (2011) and O'Connell (2005) believe can be generated by the use of an SF approach. Comments from group members suggested that when Solution Focused principles were applied in a supportive group situation, they were influential in enabling participants to build on their strengths in order to manage personal challenges and those relating to university life and even having effects which carried on into life after university.

Comments from group members indicated that an SF approach created a framework for the sessions, offered a degree of familiarity which led to expectations for the sessions, became influential in the way some participants began to see themselves in a more positive light, led to group members beginning to put it into practice themselves within the group and offered a ready-made format for when the facilitator was held up or not able to be there.

Group members developed in different ways, and this was partly related to group development. In the first year with its tightly knit intimate group, all the members made an equal contribution to the dialogue. During the second year with a much more fluid group, and the introduction of social activities, some members participated fully in dialogue whereas others came more spasmodically in order to join in the predominantly social aspect. This changed again in the third year during which a larger group enjoyed the intimacy of the first year. These changes may be related to the growing maturity of the group or to the fluid nature of the student population as students leave the university and new ones arrive. The social element and friendship were thought to be important, in line with the findings of HEA (Briefing 6, p. 5), because of their role in providing a supportive environment within which members may have confidence to share achievements and challenges. However, our best hopes were that these two, social and support, would run in parallel with each other and this may depend upon the nature of the facilitation. Future work may focus on ways of exploring in more depth how social interaction is developed and its wider influences outside the group.

Based on our experience of how this group created an environment for students where they can make friends, share strengths, express best hopes and work towards creating solutions, we identified a number of ideas to guide the group in the next academic year:

- The location should be a relaxed and comfortable place to be. For this group the student eating places met these criteria as did the newly refurbished room. The underlying principle is that the members of the group will know what meets their needs and will be given the opportunity to make the decisions which meet those needs.
- Joining a new group can be challenging, especially for students who struggle in social situations. Location of meetings and following up initial enquiries in a non-threatening way are crucial.
• The SF approach has a significant role in promoting both group cohesion and personal self-efficacy. Every opportunity should be made to share the approach with group members and encourage its application, which may include providing opportunities for training among group members. Underlying this is respect for group members and their best hopes and an open-ness to possibilities both of which are hallmarks of a SF approach.

• Group work literature suggests that beyond a certain size group interaction may become unwieldy (Beaudoin & Walden, 1998, Benson, 2010, Sharry, 2007). Decisions about that need to be trusted to the group members. In connection with this, the drop-in sessions, despite not meeting the needs for which they were set up, appeared to serve a function in providing a slightly different type of forum.

• Maintaining such a group in a university is difficult because of the fluid student population and, if the group is to survive, strategies to enable this will need serious consideration.

• Maintaining our own sense of self efficacy and determination was difficult during some of the lows of group development when nothing seemed to be working very well. On-going evaluation was not just helpful in finding out how useful the group was for the participants it also provided beneficial feedback to those who were facilitating.

It is also important to consider how closely the facilitation of the group corresponds to the SF approach (Bliss and Bray, 2009). From the outset the facilitator had deliberately drawn on the following practices from George et al (2006, pp 5-18), summarised below:

• Creating a climate of appreciation
• Defining/creating best hopes/ preferred futures
• Recalling times when best hopes/preferred futures have happened in the past or are beginning to happen now, or in the future.
• Marking up progress as a basis for further development

Comments from group members indicated that the first two of these were recognised by the group as being regular aspects of their experience of the group. The second two were aspects introduced at points by the facilitator as opportunities presented. In outlining the parameters of SF group work, Ratner et al (2012, p.192)) look for each member to outline their best hopes for the meeting, articulate their preferred futures and scale their progress. Scaling had not been used in the group and the facilitator plans to incorporate this into future facilitation.

Sharry (2007) emphasises that in order for groups to be effective it is important to establish parameters in advance and to ensure the agreement of the group members. In practice this was implicit rather than explicit in this group due to a concern that such rules might exclude from the group the very participants it was intending to encourage, in particular those who had felt, or had been excluded. A number of the group members had disclosed to the university a range of emotional, cognitive and physical challenges and it was important for them to feel that they were participating in a social situation within which those challenges did not need to be the defining factor. Any approach which did not reinforce such links was more acceptable. This is not the same as saying that procedures linked to confidentiality and safeguarding were neglected only that an attempt was made to handle them sensitively and in a non-obtrusive way.
Mutual support and the sharing of issues which Sharry (2007) advocates were certainly apparent. Similarly, Ratner et al (2012, p 192) highlight as an important element,

“The attention paid to what happens between people in the group”, and,

“The solution focused mantra would be that a success shared is a success tripled and without diminishing freedom of expression and without ignoring difficulties, it is the solution focused worker’s task to direct conversation towards hopes and achievements.”

For us this expresses so well what the facilitator for this group was trying to do. We found that an on-going input about the SF approach in such groups was likely to help participants gain a greater awareness have debated whether training should be carried out with the whole group or whether it might be an activity which certain participants chose to take part in, say in the drop-in sessions. Using such sessions would bring in an element of choice and might allow us to share more detail with those who are already skilled within the group, using, for example, the SF group work training programme outlined by Froerer and Smock (2010), which could be a model for such an input.

**Conclusion**

The aim of this project was to consider ways in which enhancing students’ interaction using a SF approach could help them to develop important social skills and create in themselves that sense of self-efficacy needed to enable them to face and manage challenges and participate meaningfully in their course programmes. Because of the sensitive nature of group development, objective measures, such as course attendance, were not used, although it may be significant that, despite facing some serious challenges, no members of the group “dropped out” of their courses. The qualitative information in the form of detailed, rigorous notes and interview analysis, offers evidence of the ways in which these group members, a number of whom experienced considerable and acknowledged challenges with social interaction, fully participated in an intense social experience. In doing this they also found ways of managing and overcoming challenges and seeking and offering mutual support.

Also significant to us is the evidence which indicates that these were skills, which were underpinned by a new sense (for some) of being able to act and to change their behaviour and environment for the better, outside of the group situation. As well assimilating these personal changes, the group showed the potential to become self-sufficient, with group members taking on a facilitative role. Although the research focused on the group itself, the members also reported on their greater willingness to meet outside the group, both with group colleagues and others, although the latter was not explored as part of this project.

A final point relates to the SF approach itself. The SF approach is underpinned by basic principles which, in our view, offer a strong foundation for work of this type. Perhaps, most importantly, it puts the emphasis on the expertise of the group members themselves and requires respect for their understanding of what they want and need. Facilitation can only work if this is fully acknowledged and is always the driver for what happens next. Balancing the best hopes of facilitator and participants was and promised to be an exciting challenge for our further involvement with students through group work.
References


Appendix I: Outline of the Solution Focused Approach

Making a difference is something we usually have to do for ourselves.

Some SF suggestions may help:

- Try to recall the things you are good at and enjoy – lots of them.
- Now think about what are your best hopes for tomorrow, or next week, or next month, or next year.
- Remember times when you have done anything like this things in the past, or are just beginning to do them now.
- Don’t forget to keep noticing and marking up your progress.
Solution Focused Therapy within an Intensive Family Intervention Service

Lynda Fisher

Abstract
An intervention service in Wales in the UK, working with families where parental substance misuse has raised child protection concerns, has incorporated Solution Focused Therapy (SFT) into the work alongside Motivational Interviewing (MI). The account reflects on the challenges of using SFT in a structured intervention alongside MI. A case example describes how SFT contributed to the work at various stages. The account concludes that when working with high risk and often hard to engage families, an intervention which draws on approaches with sufficient commonality, that is flexible, builds on family strengths and has a shared purpose, is a promising way forward. The account also notes that being present as the family experiences difficulties and are in crisis, can result in SFT and the ‘intensity’ of the crisis combining together to produce solutions.

Introduction
Delivering services that reduce risk and increase better outcomes for vulnerable children and their families can be a challenge. In Wales, in the UK, interventions have been developed to address these issues by adopting comprehensive approaches with an emphasis on collaboration and partnership working that goes across organisational and professional boundaries (Families First, Welsh Government, 2011). The Families First agenda developed an integrated approach to family support focusing in particular on prevention and early intervention for families. A key initiative from the Families First agenda is the Integrated Family Support Service (IFSS)\(^2\), whose goal is to maximize outcomes for children with substance misusing parents, promoting change both with the family and the systems around them. This involves addressing complex problems with families, bridging the gap which exists between adult and children’s services, training the wider workforce and integrating services (Emlyn-Jones and Bremble, 2010).

The IFSS intervention uses Solution Focused Therapy (SFT) and Motivational Interviewing (MI) to provide an evidence-based approach with families to support key outcomes by promoting engagement, empowerment and increasing the families’ self-sustainability and access to social networks. This article discusses the overall structure of the intervention, the challenges of using SFT within the IFSS and describes how this has worked in practice with reference to work with one particular family.

\(^1\)Community Psychiatric Nurse, Integrated Family Support Service / Y Gwasanaeth Cymorth Integredig i Deuluoedd, Lambpit Street / Stryt Lampint, Queen’s Square / Sgwâr y Frenhines, Wrexham / Wrecsam, LL11 1AR. UK. Author can be contacted on Lynda.Fisher@wrexham.gov.uk

\(^2\)For more information about the IFSS: [http://wales.gov.uk/topics/childrenyoungpeople/parenting/help/ifst](http://wales.gov.uk/topics/childrenyoungpeople/parenting/help/ifst)
The Integrated Family Support Service

The IFSS is a service for families considered to be vulnerable and to have complex problems, where parental substance misuse coexists with concerns about the welfare of the child. The service aims to safeguard children who are at risk of harm and to improve family functioning, reducing the need for public care (Forrester et al, 2008b). The intervention is flexible and works collaboratively with the whole family towards sustained change, with results from an earlier service pointing to benefits that address multiple aspects of families’ lives (Forrester et al, 2012). The service has been developed from an pre-existing project in Cardiff, UK known as 'Option 2' and works in line with the substance misuse strategy for Wales which seeks to reduce the risks of harm from drug and alcohol misuse, particularly to children (WAG, 2008). The Welsh Government has commissioned a study in 2010 which will consider the implementation and delivery of the IFSS.

SFT and MI components are applied strategically when families are contemplating change to help them think about and support change, and to locate resources that might improve how the family is managing (de Shazer et al, 2007; Miller and Rollnick, 2013; Ratner et al, 2012). For example, some families realise that change is important but feel hopeless about their situation, and tools such as the Preferred Future, as described below, help them to explore what change might look like.

In the UK, there has been some controversy over the use of SFT in the child protection arena with a recent literature review concluding that SFT may, as part of a comprehensive package of on-going assessment and intervention, facilitate positive change in parenting where children are considered at risk (Woods et al, 2011). However, Turnell has argued that when the approach is used with reference to both current and past child protection issues within a family, SFT can be a helpful tool in child protection work (BBC, 2009). Benefits have been identified, elsewhere, for using SFT in child protection suggesting, for example, that the strength based perspective of SFT builds on partnerships and offers a systemic view of change (Berg & Kelly, 2000; Crocoran, J. 1999. Turnell & Edwards, 1999).

The IFSS is designed to provide an intensive therapeutic intervention in response to the family at a time of crisis and where it is possible that the children will be subject to further Child Protection proceedings if no changes are made. The intervention uses this natural turning point to help the family move in a positive direction, working with the family to deal with the short term crisis whilst offering long term support (Emlyn-Jones and Bremble, 2010). Families that access the intervention usually recognise the importance of making changes to stabilise the situation in order for them to stay together and prevent further child protection procedures. Families’ needs and circumstances are varied so a tailored approach is offered that works towards strengthening parental capacities, with the assumption (Berg and Steiner, 2003, p 17) that parents “want to have a good relationship with their child(ren)” and are “hopeful” about them even when the situation appears otherwise. To promote more effective child protection and ensure the intervention remains child centred, the children within the family are actively involved (Munro, 2011; Munro, 2012). Additionally, working in the family home allows for the multiple needs of all the family to be addressed by working alongside the parent, child and the whole family.
The IFSS constructs working partnerships with families and key services throughout the intervention by building on collaboration and communication (Emlyn-Jones and Bremble, 2010). A respectful approach is fostered with families so that the information shared includes their views, ensuring greater involvement from them and promoting a transparent decision making process. Research has shown that families are more likely to have confidence in the practitioner when the practitioner is transparent, honest and open (Cleaver et al, 2008). As Berg and Kelly (2000) suggest, we have found that engagement with families is crucial for effective working and cooperation, with the consequent greater sharing of responsibility, and more accurate information then improving the quality of the child protection assessment.

Team members are from a variety of backgrounds, including Social Work, Substance Misuse, Mental Health and Parenting. Practitioners are provided with training and regular clinical supervision to ensure reflective practice, with recent research confirming the importance of on-going training and skill development for IFSS practitioners to help further inform practice (Roscoe and Marlow, 2013). The intervention has a structured format to help keep the family engaged and motivated, with attention to all concerns to ensure the family are safe during the intervention. Families are seen within 24 hours of the consultation with the referring Child Care Social Worker, with an immediate intervention providing a 72 hour assessment. The subsequent intervention then consists of two phases.

Phase one involves working flexibly with the family for around two hours each day, five days per week, for four to six weeks with out of hours telephone support. The intervention follows a prescribed format which includes a safety plan, setting goals, a range of exercises, education and the development of a Family Plan to respond to the on-going needs of the family. Throughout, the practitioner identifies the progress already achieved, draws out strengths, beliefs and resources, and works with the family to build their confidence that change is possible. Various approaches are used, responding to the pace of the family to keep them engaged and motivated.

Phase 2 involves follow ups over 12 months at set intervals to support change, review progress, risks and needs, with the option of further support and lapse prevention in the form of booster sessions. The IFSS practitioner works with one family at a time in order to have the capacity to deliver the intervention flexibly to meet all the family’s needs. During the intervention the referring Social Worker maintains case management responsibility, addresses legal requirements and continues to assess, monitoring the child’s developmental needs, parenting capacity, and wider family and environmental factors.

The challenges of Incorporating Solution-focused Therapy into the Intensive Family Support Service

Delivering a prescriptive intervention that incorporates SFT creates both challenges and opportunities. This is first experienced when the referring Social Worker typically shares a problem saturated history of the family and service-determined outcomes. This often contrasts with the preference in SFT to explore ‘current resources and future hopes rather than present problems and past causes’ as highlighted by Iveson, (2002, p 149), with the position of ‘not knowing’ of SFT being replaced with the position of ‘knowing’ by the professional system (Iveson, 2002,p 149). The IFSS practitioner then faces the
challenge of both acknowledging the Social Worker’s perspective whilst respecting the family’s knowledge and their unique view of the situation.

To address this challenge we endeavour to see the family and the Social Worker as customers, drawing on the work of de Shazer, (1988) to co-construct a solution between all the customers through exploring outcomes and progress that make sense to all parties. When developing goals we commonly find that those of the family differ from those of the referring Social Worker and the IFSS. There is often a delicate balance when establishing goals due to the conflicting requirements of the problem focused goal of the Social Worker and the SFT position (de Shazer et al, 2007) of viewing the family as experts in their own lives. In practice, we are usually able to establish an overall joint aim along the lines of reducing the concerns so that Social Services do not need to be involved with the family anymore. This echoes the experience of Turnell and Edwards (1999) who reflected that it is rare in child protection for a family and agency to see things in the same way in terms of either the problem or of the solutions, but argue that focusing on goals that address child protection can encourage cooperation and develop a mutual understanding between key stakeholders.

Although families who access the service are meant to do so voluntarily, some are reluctant or feel that the IFSS has been forced upon them, with the result that the relationship between practitioner and family can be challenged by resistance on the part of the family, as noted by Berg, (1994. p 58). The service also faces the challenge of the difference in power between the practitioner and the family which cannot be removed due to the work being carried out in the child protection arena, as noted by Turnell and Edwards (1999. p 35). With this in mind we have found it to be particularly important to draw on SFT to ensure that our conversations with families are non-confrontational, gaining cooperation by amplifying the family’s goals, strengths and resources, as recommended by DeJong and Berg, (2001), so that when we need to address child protection concerns there is already a relationship of trust in place.

SFT is often defined as brief, and going at the pace of the client who chooses what has been sufficient and when the sessions should end, for example Ratner et al, (2012). In contrast the IFSS intervention cannot be considered brief as it has a fixed time scale and a service agenda, which leads to it being structured, directive and potentially disempowering for the family. Also, the pace is dictated by the intervention which may pressure the family to develop solutions before they are ready, and the intervention then being experienced as ‘solution-forced’ (Nylund and Corsiglia, 1994). The intensity and structure of the IFSS intervention has challenged the extent to which the engagement can be entirely SFT and practitioners have tended to work more to the tenets of the SF approach, as advocated by Bliss and Bray, (2009).

Working in the family home has also meant that unexpected disruptions have sometimes led to sessions being more informal and appointments being less fixed in order to deal with the issues the family are encountering. At times sessions have needed to be organised around what is happening practically for the family, requiring the practitioner to manoeuvre these hurdles whilst maintaining a SFT conversation and trying to retain the emotional climate, as commented on by Lipchik, (2002).

We have also found that intensive daily appointments risks SFT conversations being repetitive, overuse of scales may reduce their impact and the frequent meetings might
mean that the family have less opportunity between sessions to build on their competences and for change to occur.

However, we have also found that the intensity, and seeing the family within their own home, can promote swift engagement and collaboration, with the family language being more quickly embedded into the sessions. More knowledge is gained about the family’s life, frame of reference, each person’s viewpoint and what’s important for the family to work on in the present. Being time limited from the beginning can create energy and a focus towards the ending of the intervention and the desired outcome.

On balance, during Phase one, the mixed pace does appear to have often generated opportunities between sessions for the family to reflect and consider different perspectives. Being present as the family experiences difficulties and when crisis happen intermittently, has allowed SFT and the ‘intensity’ to combine productively. As the family strives to make changes the practitioner witnesses the hard work this entails, allowing for compliments to be genuine and successes to be highlighted. We have found the use of SFT within the IFSS has helped us to conduct strengths-based conversations through not studying the problem, focusing on the desired future, and helping families to access their strengths and discover areas of competence at times of crisis. Not dwelling on the history of complaints or hypothesising about the problem appears to have fostered hope and given families an opportunity to work towards alternatives through constructing their own solutions, as reported elsewhere in the Solution-focused literature (de Shazer et al, 2007; DeJong & Berg, 2013).

**Illustrative case presentation**

**Referral**

The Harris family\(^3\) consented to the referral by the Child Care Social Worker who provided a short summary that related to the intake criteria based on the presence of substance misuse (alcohol), child protection concerns (exposure to domestic violence) and a crisis (threat of further Child Protection procedures). The Social Worker felt the family were recognising the importance of making changes in response to some recent incidents that had impacted on the children. The concerns were that the parents, Lucy and Sean, were exposing their two children to domestic abuse, with a recent escalation in the conflict within the relationship, consumption of alcohol and violence within the home. Lucy admitted to the Social Worker that she drank large amounts of alcohol daily, had been diagnosed with depression and had experienced past trauma, and was not accessing treatment or support for this. At the time Lucy was due to attend court for assaulting a neighbour and had previously been in prison for a similar charge. The children were presently classed as “Child at Risk” with the possibility of proceedings on the grounds of significant harm (Children Act, DfES, 2004), if the parents could not achieve good enough changes to safeguard their children.

**Consultation**

The IFSS practitioner and the Social Worker met to clarify the child protection concerns and to gain an understanding of the perceived risk within the context of the family. The

\(^3\) The surname and first names of family members have been changed to protect confidentiality.
main purpose of the consultation was to explore the Social Worker’s expectations, identify what specific changes he needed to see, and identify family strengths and resources. We then explored the Social Worker’s view on whether this was the right time for the Harris family to access the intervention through considering their readiness for change (Prochaska et al., 1983; Miller and Rollnick, 2013). This ensured timeliness in the assessment of risk which is considered to be important when families are experiencing crisis (Kinney et al., 1991).

SFT questions were used throughout the consultation to help the Social Worker remain goal orientated and specific. The Social Worker was asked in particular what his best hopes were from the intervention for the Harris family, the family resources he knew about, what changes the family had already made to safeguard the children and the reasons for requesting the intervention at that time. To clarify the Social Worker’s present concerns he was then asked on a scale of nought to ten, nought being the family situation at its most concerning and ten being concerns are reduced enough for the case to be closed, if things remained the same where would he consider the concerns to be, which he scored as four. This helped the Social Worker to be clear about his goals for the family so that they were realistic and achievable so that everyone knew what was to be expected. Key goals identified were for the children to be safe, the parents’ relationship to improve, and Lucy to be able to stabilise her drinking and manage her emotions. The Social Worker reported that the family’s goals were for there to be no conflict and therefore no need for Social Services involvement with their family. These goals were later defined in more detail during the Phase 1 involvement with the family. It was agreed with the Social Worker that it appeared appropriate to offer a 72 hour assessment to the family as they met the criteria of being in crisis and wanted to make changes to prevent the risk of further child protection procedures.

The 72 hour assessment

The first meeting with the IFSS practitioner and the Harris family gave an opportunity to involve the family in the process and to decide together whether the time was right for the intervention. Prochaska et al., (1992) and Rollnick and Miller (2013, p373) have argued that change is more likely to occur when the timing corresponds with family’s ‘current level for readiness for change’ which in turn increases the chances of success. When I met the family I endeavoured to develop a collaborative working relationship so they would be able to discuss the difficult issues, take responsibility, and acknowledge the concerns and the impact they are having, as recommended by Emlyn-Jones and Bremble (2010). Munro (2008) identified that a key contributor to effective risk management is the quality of the relationship between the family and the worker which then promotes successful engagement with the family and allows for challenging questions to be asked. In my work with the Harris family this helped to build trust and openness in the sessions, with the parents demonstrating more confidence in being able to safely explore different aspects of their lives.

Although engagement with services was regarded by professionals as a positive indicator of the parents’ attempt to overcome their difficulties, care was taken to keep focused on the children to prevent the work becoming too ‘parent-centred’ as cautioned by Emlyn-Jones and Bremble, (2010) and Forrester et al (2008a). Time was given to engage all the Harris family to reduce defensiveness and build a cooperative
partnership by talking to them openly about the referral and their best hopes for the work together as recommended by Turnell and Edwards (1999). During discussions with the family SFT conversations were introduced, with careful questioning and listening with a 'constructive ear' (Lipchik, 2002), exploration of pre-session change, strengths and resources. This helped to emphasise the importance of change, to focus on what the family wanted to change and to understand where they wanted to get to.

During the 72 hour assessment a Safety Plan was developed with the family to ensure the immediate risks were addressed and safety explored, as recommended by Emlyn-Jones and Bremble (2010). We specifically looked at when risk was more likely to occur and devised a plan to cover each family member’s responsibility when this happens, ensuring the safety of each member of the family. The plan incorporated Turnell and Edward’s (1999) thinking that, within risk assessment and planning for safety, there should always be recognition that safety can be influenced by a range of contributing factors and these factors include both what helps to keep a family safe and what contributes to risk.

Lucy, for example, felt people judged her about her past, and reflected on what she would like instead and what changes she was already making towards this. Identification of a reduction of Lucy’s use of alcohol and her enrolment in college prompted discussions on how she had managed to make these decisions and what difference these changes had made. Lucy described how she wanted to provide a safe home for the children with a better family life and how this was motivating her to make changes, scoring her confidence in making the changes on a nought to ten scale at six. In our experience a conversation like this can sometimes be the first time that a parent has experienced curiosity about other aspects of her/his life, and recognition that some things have gone well, even when there have been difficulties. At the end of the assessment the Harris family had responded positively to the approach by being cooperative, open and honest, and consented to the intervention. A report was then provided to the family and the referring Social Worker outlining the agreed focus of the subsequent intervention.

**Phase one Intervention**

In an IFSS intervention attending to the needs of parents often become part of the solution so Lucy and Sean were offered both individual work and work as a couple. The children also participated in the work, in keeping with the views of Emlyn-Jones and Bremble, (2010, p.3) that ‘at the heart of the intervention the health and wellbeing of children is paramount’.

The first two weeks of the intervention addressed the crisis that had brought the family to the service and set an agenda to develop a ‘common project’ that incorporated both the Social Worker’s and the family’s goals (Korman, 2004; Ratner et al 2012). The IFSS uses Goal Attainment Scaling (GAS) (Kiresuk and Sherman, 1968), as a process that can have some therapeutic value through collaboratively negotiating goals with the family to monitor progress and create achievable plans for change, as proposed by Forrester et al (2012). The scale used on the goal to determine progress is from minus two to plus two - the nought point being the description of good enough, the best outcome being plus two and the worst outcome being minus two, as can be seen in Appendix I. In our work with the Harris family the goals prioritised the areas that would
most improve safety, defined preferred behaviour and clarified the expectations of change of both the Social Worker and the family. Goals provided a focus for the whole intervention, areas of agreement and shared purpose, and provided us with outcomes that could be scored at the end of Phase one and all of the subsequent follows ups in Phase two. Discussion with the parents with the goal that focused on protecting the children from conflict and them being kept safe created a 'light bulb' moment with them appearing to recognise the Social Worker's concerns. Reflective letters were written to the family to capture these discussions using Solution-focused language, the family’s terminology and any scales used in the sessions. The letters invited further reflection on different perspectives, and new meanings that might help to build towards solutions. The family was given a file as a resource to keep all the reports, exercises and letters. To ensure that we were all working together communication was kept open and all information shared between the family, the Social Worker and the IFSS.

Through subsequent meetings we used a range of exercises to further encourage recognition of the need for change, hope that change was possible, and confidence that the family was able to make those changes, as recommended by Emlyn-Jones and Bremble (2010). The first exercise, the Preferred Future question, elicited from each individual in the family, in as much detail as possible, what their desired future would be. For Sean, at the end of the exercise he scaled his preferred future at a six which showed him that there were already signs of change and he was being more honest with the Social Worker, leading him to identify that there were some core changes that both he and the Social Worker wanted to see. Next, to encourage self-knowledge and recognition of the importance of change, the value and beliefs exercise helped Lucy to explore a discrepancy between her beliefs and what is important right now (Emlyn-Jones and Bremble, 2010). Finally, the Strengths exercise used a set of strengths cards (St Luke’s Innovative Resources, 2005) which can be an enjoyable method of acknowledging existing strengths and resources that could be drawn upon, especially during times of crisis to support and maintain change. To further help with engagement and involvement these exercises were typed on individualised decorated paper for the family to add to their file. The children, for example, requested cats to be on their documents and chose the colours.

The last two weeks of Phase one aimed to build on the family's progress, gave them time to practice new skills, and provided the referring Social Worker with an opportunity to see that satisfactory changes were being made. The intervention became less prescriptive; allowing space for more client-initiated Solution-focused conversations. This required us to be flexible, ready to move in any direction family members wish to go and sometimes ‘pointing out a different direction for them to consider’ (de Shazer et al, 2007. p.4). Relationship questions about the parent and child relationship ensured the children’s views were included and coping questions allowed us to focus on risk and resilience, helping to expand on possibilities for change and encourage helpfulness as recommended by Berg and Steiner (2003). During this part of the work Lucy expressed anxiety about an impending court appearance as there was a serious threat of her being sentenced. She described how she had been unable to remain calm when previously in court and that her desired outcome was to be able to do this so that she could tell her side of the story. Scales on ‘importance’ and ‘confidence that she could remain calm and in control’ helped Lucy to explore how behaviours can affect situations. Lucy identified past successes that she could draw on to achieve this and asked for further ideas on how to remain calm, allowing for suggestions from the IFSS.
practitioner that provided both practical and cognitive strategies. Child Protection meetings gave an opportunity for the family and all agencies involved in decision making to share information related to the safety and protection of the children, observations and key information relating to the children. Experience has shown us that these meetings could be problem saturated. To encourage a more balanced and shared view of the family any progress made was reported alongside the concerns being discussed. The parents were fully involved in the discussion and decision making in these meetings in the hope that this would build a more trusting partnership, helping to tighten the safety around the children as recommended by Turnell and Edwards (1999). The ending of the intensive phase of the intervention provided a time to reflect with the family on their experience of Phase one, and to look together through their file. We asked about what it took for them to agree to the intervention, how they got through and the changes that had already been made. The family’s strengths, resilience and determination were validated, which contributed to their feelings of hope and motivation for a better future. When the goals were re-scored they indicated the family’s progress and highlighted any areas that might need further exploration or support. For example, the goal that focused on conflict (appendix I) was scored minus one at the beginning of phase one and had moved up to nought at the end of phase one. A Family Plan agreed by the family and the Social Worker was then drawn up to capture this discussion and specialist resources in the community were identified to increase the family’s support network and self-sustainability.

**Phase two intervention**

Follow up appointments at set intervals over a 12-month period provided an opportunity to re-score the goals and evaluate progress. After four months Lucy requested a ‘booster’ as she was struggling to manage her emotions now that she was drinking less which was increasing the conflict between herself and Sean. In these sessions the conversations were initiated by the parents and focused on what they hoped to achieve. During the intervention the family made progress on all the goals identified, which were for the children to be safe, the parents’ relationship to improve, and Lucy to be able to stabilise her drinking and manage her emotions.

The goal that focused on conflict (Appendix I) was rescored at plus one during phase two. This is in keeping with the hopes of the intervention that most families will continue to make improvements by using supports and strategies (Emlyn-Jones and Bremble, 2010). The approaches used in the intervention appeared to have encouraged the parents to have an alternative view of themselves, have more confidence to move forward with their lives and to keep their children safe. Lucy managed to stabilise her drinking and access supports for her mental health enabling her to manage her emotions better. Lucy did not receive a sentence when in court, the parents’ recognised improvements in their relationship and there were no more reports of domestic abuse. At the end of the 12 months the children were re-categorised from Child at Risk to Child in Need (Children Act, DfES 2004), with the Social Worker looking to closing the case altogether.
Conclusion

We see the development of IFSS as being part of an international movement towards innovative ways of working with families. By taking this approach forward in the UK, Forrester (2010) believes that Wales has placed itself at the forefront of creative family focused practice. These developments are intended to produce more opportunities for strategic integrated working between services requiring commitment to a shared purpose and to provide targeted approaches that use evidence-based interventions to meet the needs of both parents and children as advocated by Davies and Ward (2012). Taking an adaptable tailored approach to families that addresses many of the complex issues is consistent with the view that a responsive service is needed to promote positive outcomes when working with families (Henry-Edwards et al, 2003). It seems clear to us that when working with high risk and often hard to engage families, having a model which is evidence based, that builds on strengths and works alongside them with a shared purpose is a promising way forward. The case presentation has provided some insight into the IFSS and describes how SFT was tailored to the uniqueness of the family described. In our view it was possible to use SFT alongside Motivational Interviewing (MI) and the prescriptive elements of the intervention. Although SFT and MI approaches vary they both, in our view, have an emphasis on change, engagement and the practitioner not being the expert. Much of this article has discussed the specific challenges encountered. However, we have also found opportunities, in keeping with the views of DeJong and Berg (2013) that a strength of the solution focused approach is its flexibility and adaptability, which is often an advantage when confronted with the complex issues presented by families referred to the IFSS. By recognising the challenges and taking advantage of the opportunities of incorporating SFT into the IFSS we are confident that SFT can make a significant contribution to the work with families, promoting good practice and ensuring better outcomes for children and their families.

References


St Lukes Innovative Resources (2005). *Strength Cards*. WWW.innovativeresources.org


Appendix I: Goal sheet for Harris family

**Goal:** For Lucy and Sean to use strategies when they are at risk of arguing, to prevent things from escalating into domestic abuse. To ensure they are keeping the children safe and meeting their needs

**Statement of Problem:** Arguments escalating especially when Lucy and Sean have been drinking alcohol, resulting in verbal aggression and at times physical violence, which both the children have been exposed to.

**Rating when scored at the beginning of Phase One:** -1
**Rating when scored at the end of Phase One:** 0
**Rating when scored during Phase Two:** +1

**Who’s Goal:** Lucy, Sean and Social Worker

<table>
<thead>
<tr>
<th>Best anticipated success: <strong>we keep going! ( +2)</strong></th>
<th>Recognising when there is an atmosphere and confidently using strategies if at risk of arguing. Talking things through and dealing with issues as they arise. Aware of the children’s needs at all times</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than expected level of success: <strong>we’ve passed our target ( +1)</strong></td>
<td>Some bickering, realising they need to put strategies from Safety Plan in place to prevent things from escalating. Starting to share feelings and talking about issues. Ensuring the children are removed from situation. Able to apologise to each other</td>
</tr>
<tr>
<td>Expected level of success: <strong>this would be good in 4 weeks (0)</strong></td>
<td><strong>Lucy and Sean recognising they are at risk of arguing. They are trying to use strategies from the Safety Plan and talk things through. They are aware of the children, removing them from the situation or trying to resolve issues when the children are not around.</strong></td>
</tr>
<tr>
<td>Less than expected level of success: <strong>What if things change a little? ( -1)</strong></td>
<td><strong>Having arguments, verbal aggression increasing including shouting swearing and some threats. Struggling to follow the strategies on the Safety Plan. Lucy feeling she is loosing control. Children present and being exposed to situation</strong></td>
</tr>
<tr>
<td>Most unfavourable outcome thought likely: <strong>what if things don’t change ( -2)</strong></td>
<td><strong>Full scale arguments, not caring who they argue in front of. No holding back with threats or aggression and lasting for long periods. Conflict escalating and becoming physically violent. Children exposed to this. Police needing to be involved</strong></td>
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Stories of Competence:
A Social Constructionist Approach to Tier 1 Consultation:

Lindsey Hampson¹

Abstract

A reflecting team approach informed by the work of Andersen, De Shazer, Norman and White was used for consultation with Health Visiting teams. This paper describes the process of the consultation, and describes an interviewing scaffold for post reflection discussion with the consultee. A questionnaire was given to consultees to evaluate their opinions on the change in the consultation process. Generally, consultees welcomed the new approach. Methodological limitations are discussed.

Introduction and Background

As a Clinical Psychologist in a Child and Adolescent Mental Health Service (CAMHS) Tier 2 ² Brief Intervention and Consultation Service (BICS), my role involves offering consultation to Tier 1 ³ health professionals. After reading several papers regarding models of consultation (Southall, 2005, Norman, 2003) I decided to discuss a social constructionist informed method of consultation as an alternative to the current case discussion format with the Health Visiting teams. I was drawn to the ideas of Norman (2003) about different ‘phases’ that the consultation could offer (i.e. a ‘presentation’ phase where the person describes the situation they find themselves in, a ‘clarification’ phase where the person is invited to define their ‘best hopes’ for the consultation with the reflecting team and ‘affirming’ and ‘reflecting’ phases where a positive feedback is given and creative solutions are offered). I was also drawn by Southall’s (2005) honouring of the contexts that other professionals operate in and a curiosity of their expertise in these contexts.

The format at the time involved a Health Visitor or Community Nursery Nurse, ‘consultees’, outlining a family’s difficulties where the ideas were explored as a group discussion and with the clinical psychologist’s response typically including advice, hypotheses and tentative parts of a formulation, being the main focus. From a solution focused(SF) perspective, I realised that this process of consultation did not bear witness to the resources and competencies these professionals had, as the focus was on the consultee asking advice, and consulting the psychologist as an expert for a right

¹Chartered Clinical Psychologist, Child and Adolescent Mental Health Service, Alder Hey Children’s Foundation Trust, 3tc House, Crosby Road North, Sefton, L220NY UK. Lindsey can be contacted on lindsey.hampson@alderhey.nhs.uk

²Tier 2 CAMHS is usually an early and preventative service, with one worker rather than tier 3 which is often an acute or enduring service, where other workers can be accessed in working with families.

³Tier 1 is defined as any front line professional who comes into contact with a child. In this case, health visiting staff
way of approaching the work. Indeed, often consultees would say “I don’t know whether I’m doing the right thing” which implied a correct and true way of dealing with the difficulties that might be outside their competency base. It seemed to me that these comments could be viewed as problem-focused accounts about their competencies to deal with children and families where there may be emotional or behavioural difficulties. The consultation process used at the time could be seen as reinforcing structuralist notions that when people experience difficulties it is because something is wrong with underlying psychological structures. This then requires an expert with specialist knowledge to understand and intervene (Fox, 2005).

In creating a model for local use, the work of Tom Andersen was very influential. The reflecting team model, (Andersen, 1987), allows multiple perspectives and encourages individuals to reflect and draw upon, their own expertise. Influential also were Lipchick and deShazer’s (1986) focus on best hopes, recent progress and exceptions to put consultees in touch with resources and competencies they could draw upon in moving forward. White’s (2005, p 15-18) work on outsider witness groups was also influential. These conversations would serve as a context for the rich descriptions of people’s lives where preferred stories and accounts of their identities are privileged. From my point of view non-structuralist therapies suggest that there is no right way to approach families’ difficulties and there are many possibilities. I wondered whether the model of consultation in use at the time might lead to feelings of deficit rather than resource as consultees privileged my knowledge above theirs and feared that they may be approaching a difficulty wrongly. I attempted to integrate these ideas by offering a reflecting team consultation session using some of Norman’s phases of the Solution Focused Reflecting Team (presentation, clarification, affirmation and reflection) and a SF and Narrative style scaffold of questions post reflection.

This ethical shift was made with the hope of allowing alternative, preferred accounts of consultees’ competencies and exceptions gaining strength and visibility in their lives. I also hoped the reflecting conversation would lead to preferred accounts, not only for the person seeking consultation, but also for the families that they wished to discuss. In practice the process also allowed me to develop greater understanding of the role and pressures on Health Visiting staff. Whilst I had some knowledge of psychological theory and practice, I came with little knowledge of what it is like to be a Health Visitor and the contexts within which they operate (Jones, 2005).

**Organisational Context**

The BIC Service encourages innovation and new ways of working and clinicians are given autonomy in deciding how to facilitate their consultations by the service lead. Alongside the group consultations, I also operated a consultation phone line for shared thinking and regular training sessions on topics selected by Tier 1 professionals. Different types of consultation were available if these suited a professional’s preferences.

Health Visiting staff were asked whether they would like to continue with the current style of consultation or try out the reflecting team approach. In the event they were unanimous in wishing to try the new style and we agreed to trial it for a year. Health Visiting managers were happy to support the consultation sessions and were committed to partnership working to promote good practice and quality serviced delivery.
The Consultation Process

1. **Setting a Safe Context**

‘Good group manners’ (Jones, 2005) were co-constructed to ensure group members felt safe enough to share personal feelings about their work. The reflecting team process was re-stated at the beginning of each session to orient consultees to the process and to remind consultees about the differences in this type of consultation, for example talking to other members of the reflecting team rather than the consultee. Participants were given documents on the process and use of reflecting teams to take away as well as a hard copy of the co-constructed ‘group manners’ which included ground rules that the group constructed to feel ‘safe’ during the process and to get the most out of the process itself, such as ‘respecting confidentiality’ and ‘all ideas are valued equally’. Many of the team had experienced CAMHS professionals using a reflecting team in one off training sessions. The team was also invited, after the first session, to consider if they would like to continue with the approach next time they met.

2. **‘The Question’ and setting the context**

The process began with the consultee stating her/his ‘best hopes’ which were then written on the whiteboard to ensure clarity over what she/he wanted. The facilitator then interviewed the consultee to clarify the background, such as the family circumstances, the work that had been done to date, the issues that the consultee was struggling with, and areas of success or exceptions (George, Iveson & Ratner, 2002, p 8-9). As I was concerned that my own ideas might shape the conversation, I endeavoured to be led by the consultee’s concerns and only gathered background information that was relevant to those concerns.

3. **The Reflection**

The team then reflected for approximately ten minutes and I joined in this reflection to contribute to multiple perspectives. Consultees typically offered thoughts, impressions, suggestions, metaphors, compliments, questions and reframes in a spirit of helpfulness as described by Norman (2013). The consultee then listened to the reflections and made notes if they wished. It was emphasised that during this process the members of the team would talk to one another, rather than the consultee, to allow space for the consultee to think about the conversation rather than how to respond interpersonally.

4. **Post Reflection Interview**

In this stage of the process, use was made of the narrative idea of ‘transport’. White (2005), has talked about reflecting teams as “moving’ all participants in that the process contributes to options for them to become other than who they were - being moved in the sense of being transported, in the sense of being elsewhere in life on account of this participation” (ib id p16). With this in mind, as part of the post-reflection scaffold with the consultee, I asked where the reflections may have ‘transported’ the consultee on account of listening to it and what possibilities it opened up for their professional life and the effects this would have on the people they consulted with. Unlike Norman’s (2003) solution focused reflecting team, reflections and affirmations were delivered in a more
free-form way, much more like Tom Andersen’s reflecting team ideas, rather than in two separate phases and in a turn-taking way.

Social constructionist therapies describe the therapists’ stance as decentred, discussing what the consultee judges as important, rather than the facilitator, and directive, using imposed categories of inquiry, (White & Morgan, 2006). This was the stance that was adopted post reflection with the intention of reducing hierarchical notions of what the facilitator thought to be the important aspects of the reflection whilst acknowledging that a scaffold of questions may allow the consultee to transport those ideas into practice.

Prior to the session, a scaffold of questions was generated that was drawn together from various questions from Narrative and SF practice. These questions were aimed at

- identifying the parts of the reflection that fitted with the consultee and their knowledge of the family,
- helping the consultee transport, visualise and reflect on a way forward with the family based on these preferences,
- inviting the consultee to reflect on how this might affect the outcome.

Following the reflection, the facilitator then interviewed the consultee using the following

- So you were listening very attentively to our talk about your question and your ‘best hopes’. Some of the things might have been helpful to you. What do you think was most helpful?
- What caught your attention about what you heard or captured your imagination?
- What was it about that that caught your attention/captured your imagination?
- What might you do as a result of listening in on this conversation that might not have struck you before?
- And if that turned out to be helpful, how would you know? How would you find yourself being with the family? What else? What else?
- What would you find yourself doing between now and next time you meet with the family? What else? What else? Would they like that?
- What difference will that make to you?
- What difference might this make to the family?
- What was it like to hear people talking about your question in this way?
- Would you recommend this way of thinking to someone else? What might you tell them about it?
- On a scale of 0-10, ten being the most helpful it could ever be and 0 being very unhelpful, what number would you give this experience? How do you know? What else?

**Debrief**

The group was then given the opportunity to ask any questions of the facilitator as to why they may have asked a certain question, introduced a certain idea or about any part of the process.
**Evaluation**

**Methodology**

Following each reflecting team consultation, an anonymous questionnaire was used asking consultees to rate the consultation process on domains of helpfulness, interest, relevance, safety, respectfulness and how much the process gave them ideas for families they are working with now or may work with in the future. The domains were rated on Likert scales 0-10, 10 being ‘most’ or high levels.

**Descriptive Results and Discussion**

**Table 1: A table to show attendance and mean scores following evaluation of reflecting team session.**

<table>
<thead>
<tr>
<th>Reflecting Team consultations date</th>
<th>Session 1</th>
<th>Session 2</th>
<th>Session 3</th>
<th>Session 4</th>
<th>Session 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendance</td>
<td>5.0</td>
<td>6.0</td>
<td>0</td>
<td>4.0</td>
<td>1</td>
</tr>
<tr>
<td>Helpful</td>
<td>9.4</td>
<td>8.3</td>
<td>-</td>
<td>8.3</td>
<td>-</td>
</tr>
<tr>
<td>Interesting</td>
<td>9.6</td>
<td>8.3</td>
<td>-</td>
<td>9.3</td>
<td>-</td>
</tr>
<tr>
<td>Relevant</td>
<td>9.6</td>
<td>8.8</td>
<td>-</td>
<td>8.3</td>
<td>-</td>
</tr>
<tr>
<td>Respectful</td>
<td>10</td>
<td>9.8</td>
<td>-</td>
<td>9.8</td>
<td>-</td>
</tr>
<tr>
<td>Safe</td>
<td>9.8</td>
<td>8.5</td>
<td>-</td>
<td>9.5</td>
<td>-</td>
</tr>
<tr>
<td>Gave me Ideas for families I am working with now</td>
<td>8.8</td>
<td>7.7</td>
<td>-</td>
<td>7.0</td>
<td>-</td>
</tr>
<tr>
<td>Gave me Ideas for future work with families</td>
<td>8.8</td>
<td>8.0</td>
<td>-</td>
<td>8.0</td>
<td>-</td>
</tr>
</tbody>
</table>

10=most helpful, relevant, respectful, safe, definitely gave me ideas for families I am working with now/I might work with in the future.

**Discussion**

Five reflecting team sessions were scheduled, but only three were facilitated because of low numbers. This had also been a feature of the consultation sessions before the reflecting team was introduced. Recent service evaluation had revealed that reasons for non-attendance included uncertainty around dates and times, clinic commitments and not enough time. To ameliorate this, a service leaflet was been drafted with the appropriate information and the service commitment itself to sending regular electronic and paper memos.
Analysis of descriptive evaluation scores shows that Tier 1 professionals rated this approach very highly on dimensions of helpfulness, interest, respectfulness and relevancy as well as giving them ideas for families they are currently working with and ones they may work with in the future. However, these terms were not defined or operationalised with the group. On reflection, it would have been helpful to co-construct the evaluation terms with the group as the facilitator was choosing the values the consultation was to be judged by, which may not have been how the group would evaluate the consultation by.

Additionally, a comparison cannot be made to the previous consultation approach as no evaluation data was collected during this period. From a facilitator’s perspective, this seemed like a more empowering and valuing way of working. It seemed to encourage Tier 1 staff to use their expertise together with a sense of transferring skills and increasing self-awareness and competence as well as learning from peers and being an active part of the consultation process (a story of competence) and that there are multiple possibilities and opportunities to work with families.

In the debriefing phase of consultation, consultees said that they found this an interesting and positive approach but “weird” due to not being able to talk directly to the consultee. They commented that the structure of the sessions kept conversation focused, and previously conversation could become unintentionally ‘side tracked’ by other group members. Future research would be helpful in terms of how this approach has affected Tier 1 professionals’ view of themselves as practitioners as well as how this has impacted on the families that they work with.

Conclusions

Tier 1 professionals valued the imposed structure of the sessions to keep the discussion focused. Basic descriptive data demonstrated that the staff group rated this approach highly on dimensions of helpfulness, respectfulness, interest, relevance and safety.

Results also suggest that the process gave all team members ideas for their practice, not just those seeking consultation. In hind sight, co-constructed evaluation terms would have been more in keeping with the approach and possibly a more accurate way to evaluate the consultation’s utility. Further research, such as a qualitative study comprising interviews with consultees, to assess the impact of this style of consultation on feelings of competence and practitioner identity and on their work with families, could shed more light on the benefits of providing consultation in this manner.
References


Outcome and Satisfaction Study of Solution Focused Therapy in a Child and Family Clinical Psychology Service

Dr Clare Firth¹ & Dr Joanna Farrington²

Abstract
This paper reports results from a study of outcome and satisfaction of clients treated using solution focused therapy (SFT). The study aimed to investigate the effectiveness of SFT and satisfaction with the model and was comprised of a case note audit and a short satisfaction questionnaire. The case notes of 48 clients discharged from a child and adolescent mental health service over a 12 month period were examined to find out the number of sessions attended and the effectiveness of therapy using a solution focused scale of zero to ten.

A short satisfaction questionnaire was also sent to 50 per cent of clients. The results showed an overall 69% good outcome rate with an average improvement from 3.5 to 6.9 on the scale score. Those who completed therapy with agreed ending reported higher scale scores compared to those who terminated early. The average number of sessions attended by the group was 3.2 sessions. The satisfaction data indicated high satisfaction. The average number of sessions attended for the sample as a whole is comparable to previous findings. The results are discussed with attention to directions for future research.

Introduction
Across the UK, solution focused therapy (SFT) is becoming extensively used across a range of services including social services, education, child and adolescent mental health services (CAMHS), residential care settings and substance misuse. The approach offers specific advantages when working with the range of difficulties which present in child and adolescent mental health. For example, it can help with keeping ‘problem-talk’ at bay and thereby interrupting cycles of blame between children and their families and helping with family relationships and self-esteem (Wheeler, 2001).

The brevity of the approach offers advantages in terms of resources. Furthermore the government is encouraging clinicians to listen to the views of service users as well as adopt clinically resourceful methods, both of which are inherent to the SFT approach.

¹Clinical Psychologist, Central North West London NHS Trust, Child and Family Adolescent Mental Health Service, Violet Melchett clinic, 30 Flood Walk, London, SW 3 5RR. UK. Clare can be contacted on Clare.firth@nhs.net

²Clinical Psychologist, Leeds Community Healthcare NHS Trust. UK.
Brief Overview of the Model

SFT evolved from clinical practice in Milwaukee in the late 1980’s (de Shazer et al, 1986). The theory behind SFT is philosophical – relating to the nature of language and reality as socially constructed. It aims to separate the client from the problem, rather than viewing the client as the problem. SFT therapists assume that: clients want to change, clients can imagine how they would like their future to look, and that they are already doing at least a part of their solutions. The solution does not have to be related to the problem in any way, it is simply what the client would like to be doing instead of their problem. The most economical approach to therapy involves having the client do more of ‘what already works’. Change comes about through the clients’ successful deployment of skills, strengths and resources with the focus of SFT remaining on the client’s goal(s) that they bring to therapy without straying into other areas of their life, and this means that therapy tends to be briefer.

Previous Research

Solution focused methods were constructed using a research methodology based on client feedback. Research on therapy outcome shows promising results. For example, Macdonald (2005) reported good outcomes of 70% in adult psychiatry, with 25% of clients having only one session. Knekt & Lindfors (2004) conducted a major randomised comparison trial examining the effect of four forms of psychotherapy on depressive and anxiety disorders. This showed that SFT had similar outcomes to other types of psychotherapy during a one year follow up. Gingerich and Eisengart (1999) reviewed the outcome research with 15 controlled studies, of which 13 reported improved client outcomes with a wide variety of client populations. More recently, Gingerich and Peterson (2012) reviewed 43 studies and found that 75% reported significant positive benefit from SFT and 23% reported positive trends. DeJong & Berg (1998) reported success rates of 70% for many clinical problems as measured by those reaching goals or partly meeting goals.

In child and family settings, Beyebach et al (2000) reported an 82% improvement with 83 cases in a family therapy centre, as measured using the solution-focused 1-10 scaling question with improvement from 4.2 in the first session to 7.2 in the last session, with a trend towards better improvement for those who continued compared to those who dropped out. Simm et al (2010) found that 64% of parents reported improvements since attending SFT sessions at a Child and Family clinical psychology service. Gingerich and Peterson (2012) found that 12 out of 13 outcome studies involving children showed significant positive outcomes or positive trends with regard to psychological outcomes, e.g. self-esteem.

Studies investigating the average number of sessions of SFBT report figures of 2.0 in primary care (Rothwell, 2005), 2.9 (DeJong & Berg, 1998), 4.03 (Macdonald, 2005), and 4.67 (DeJong & Hopwood, 1996) and 4.7 (Beyebach et al, 2000). Macdonald (1994) in an earlier study found that those who reported a good outcome had an average of 5.47 sessions compared to those who reported their situation was the same, or worse, than before therapy attending on average 2.67 sessions. Macdonald (2011) also points out solution focused therapy has been shown to have outcomes which are comparable to other treatments in spite of requiring less therapist time and less training. This is shown in the review by Gingerich and Peterson (2012) with 3 studies found to
show SFT using fewer sessions than alternative therapies. This has important implications for resource planning in services. It can also have a useful impact on waiting lists, e.g., Simm et al (2010) reported that increasing SFT provision decreased waiting lists from 14 months to four weeks over 2 years.

There are few studies which have examined specifically client satisfaction with the model although some researchers have commented on clients appreciating the questions asked and the positive atmosphere of the therapy (e.g. Metcalf et al, 1996). Simm et al (2010) found that over 75% of parents and 100% of children felt that solution focused sessions had made a difference to their lives.

The present study aimed to provide some more empirical data on a CAMHS population in an outpatient setting with specific aims to provisionally investigate

1. The effectiveness of SFT
2. The number of sessions required to produce change
3. Satisfaction with the model

Methodology

Participants

The sample consisted of 48 clients who received solution focused therapy and were discharged during a 12 month period in a semi-urban outpatient child psychology department within the National Health Service (NHS). The referred clients were aged between three years and 18 years old and were referred by GPs, health visitors, social workers, paediatricians and psychiatry. Table 1 gives some examples of the types of problems reported in the referral letter together with the child or young person’s preferred future which emerged during the solution focused conversation.

Table 1: The types of problems described on the referral letter together with the description of the preferred future which emerged during the therapeutic discussion

<table>
<thead>
<tr>
<th>Referred Issue</th>
<th>Preferred future (What the client would like to see being different)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School refusal (13 year old)</td>
<td>Mother’s relationship with her partner to change</td>
</tr>
<tr>
<td>Post-traumatic stress disorder (15 year old)</td>
<td>To be able to go on public transport again</td>
</tr>
<tr>
<td>Conduct disorder (adolescent)</td>
<td>To act more responsible, e.g., to do homework (parents)</td>
</tr>
<tr>
<td>Parental separation</td>
<td>To have more confidence, e.g., to be able to speak out more in the classroom</td>
</tr>
<tr>
<td>Bereavement issues</td>
<td>To be able to move on, to talk more to mother about feelings</td>
</tr>
<tr>
<td>Self-Harm</td>
<td>To have a better relationship with mother</td>
</tr>
<tr>
<td>Panic attacks</td>
<td>To be calmer, more in control</td>
</tr>
<tr>
<td>Sexual abuse</td>
<td>To get on better with friends, ‘get a life’, to learn that they were not to blame</td>
</tr>
</tbody>
</table>
Solution Focused Intervention

The two therapists were a qualified clinical psychologist and a clinical psychologist in training. Referrals were taken from the top of the department waiting list according to clinician availability. Therapy closely followed the form of SFT as described by De Shazer (1994) with interviews containing the specific elements, problem-free talk, preferred future, exceptions to the problem, scaling the problem, compliments and advice to the extent of, ‘do more of what is already working’. Return visits followed the pattern of asking ‘What’s been better?’ Meetings were convened according to who the client and/or their parents wanted to attend along the principle that the client is, ‘the client is the person most knowledgeable about the circumstances’ (Ratner, George, & Iveson, 2012, p.45). This meant that meetings consisted of family groups, child plus parent, parents on their own or children/young people on their own at their request.

Measures

Evaluation of outcome comprised of an examination of clients’ case notes to extract their answers to the solution focused scale of zero to 10 which was routinely asked during every therapy session, with 10 indicating that clients had reached their preferred future and zero indicating the furthest away from 10 that they had been, or could imagine being. When there were multiple people attending the session the average scale score from the session was used. Satisfaction was measured with a short satisfaction questionnaire (SSQ) adapted from Miller’s Outcome Rating Scale (Miller & Duncan 2000). This involved asking the people involved in therapy to rate their responses on a 10 point Likert scale (with 10 being fully agree and 0 being fully disagree ) to the following statements:

- I feel satisfied with the service provided
- I feel I was listened to and understood
- In the session we talked about the things I wanted to talk about and worked on the things I wanted to work on

Clients were also asked to make additional comments about their experience. The SSQ was sent in the post at random to 50 per cent of the clients in the sample (N=24). When there were multiple people attending the session the questionnaire was sent to all parties, and the average satisfaction score was used

Results

Of the total sample of 48 families involved in the study the average number of sessions attended by the group was 3.2 sessions. Of these, 33 (69%) reported improvements in their scale score either when they completed therapy with an agreed discharge from the service (n=26) or at the last appointment they attended prior to disengaging from the service by not attending their next scheduled appointment (n=7). The average improvement for these 33 participants was from 3.3 to 6.86 on the ten point self-report scale. The improvement for those who completed therapy with an agreed discharge
(n=26) was from 3.3 to 7.1 and they attended on average 3.8 sessions. The improvement for those who disengaged from the service was from 3.4 to 6.3 (n=7) and they attended on average 3.7 sessions.

Eight participants (17%) attended for just one session. These participants either did not feel that they needed to be seen again, or arranged another appointment but then cancelled it at a later date. The average scale score for these participants was 5.9.

Four participants (8%) reported no change in their difficulties. This was indicated either in their scale score (n=2) during therapy or on two occasions where scale score was not noted it was indicated during client’s description of their difficulties and recorded in their clinical records (n=2). These participants attended on average 2.7 sessions before agreeing discharge or dropping out. Three participants (6%) reported their problem becoming worse on their scale score (n=2) or as expressed in the session (n=1). These participants attended on average 3.7 sessions.

**Satisfaction Data**

Fourteen out of 24 families returned satisfaction questionnaires. The mean scores on the three satisfaction questions were 8.9, 9.0 and 8.9 (1-10). These are shown in table 2 (below).

**Table 2: The average score for the three items on the satisfaction questionnaire**

<table>
<thead>
<tr>
<th>Item number</th>
<th>Mean scale score (0-10)</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Item 1: I feel satisfied with the service provided</td>
<td>8.9</td>
<td>5-10</td>
</tr>
<tr>
<td>Item 2: I feel I was listened to and understood</td>
<td>9.0</td>
<td>5-10</td>
</tr>
<tr>
<td>Item 3: In the session we talked about the things I wanted to talk about and work on and the things I wanted to work on</td>
<td>8.9</td>
<td>6-10</td>
</tr>
</tbody>
</table>

Four clients wrote in the space provided for additional comments.

1. “As a parent, concerned about her daughter I felt the therapist helped me to understand how my daughter would be feeling and question my own approach to her thoughts and feelings.”

2. “I have been able to discuss many different issues both personal and about my daughter, I have been listened to, fully, and have been able to come up with some solutions myself, by just being able to talk out loud and seeing it from a different perspective”
3. “The problem is no longer a major influence. I think we have become more accepting of the fact that it is still okay to grieve.”

4. “X [client] still lacks confidence, but is getting better each week, he attends scouts every week and has friends for tea. He is much better, thank you”.

Discussion

This study showed an overall 69% good outcome rate. This is similar to findings in previous reports showing the benefits of SFT (e.g. Beyebach et al., 2000., Macdonald, 2005). The 24 families who completed therapy with agreed discharge had on average an increase in scale score from 3.3 to 7.1 which again is similar to previous results by Beyebach et al (2000) who reported improvements of 4.2 to 7.2.

Those families who improved and had an agreed ending had slightly higher scale scores at their final sessions compared to those who dropped out of therapy early. While not statistically proven, it suggests lower ‘success’ in those who dropped out of therapy early, although according to Beyebach et al (2000) families who dropped out of therapy early continued to improve after therapy discontinued suggesting that SFT may continue to carry on working after therapy sessions have ended. Alternatively, research from Beyebach & Carranza (1997) suggests that clients who remain in SFT have a better relationship with their therapist. They found that when therapists were seen as supportive and respectful, clients were more likely to complete treatment. As therapeutic relationship is linked to treatment outcome (e.g. Henfrey 2010) it is possible that in this study those who stayed in treatment did better overall in treatment. More research is needed in this area to untangle which components of the model are necessary for therapeutic success and/or adherence to therapy. Clients who attended only one session were on average at a 5.9 on the scale, suggesting that dropout is not necessarily a bad outcome and might be caused by clients’ perception that they do not need further help. 12 per cent of the cases did not improve or even deteriorated. This indicates that the approach or the therapist style was not suitable for some clients.

The satisfaction data indicates high satisfaction with the therapy received showing good acceptability of the model and the responses to the open-ended question point to the therapy being useful as it helped clients to identify their own resources to help with their situation. This links with findings by Henfrey (2010) who showed that therapy is effective when clients are encouraged to find their own resources.

The average number of sessions attended for the sample as a whole is also comparable to previous findings (e.g., DeJong & Berg, 1998; Macdonald 2005). Families that reported no change or things getting worse attend around three sessions, suggesting that clients are willing to ‘try out’ therapy for a number of sessions before dropping out. Research indicates that therapists need to pay closer attention to client progress in early stages of therapy as it is a significant predictor of outcome (Duncan, Miller and Sparks, 2004). Also, clients who get worse by the third visit have been found to be more likely to drop out (Brown, J., Dreis, S., & Nace, D.K. (1999) and feedback has been found to be important for assessing actual client change, enhancing therapeutic alliance and fostering richer discussions of potential change in treatment plans (Hatfield & Ogles, 2006). It would be good for future research on solution focused therapy to investigate the impact of session by session feedback on outcome.
Limitations

Firstly, the study numbers are small thereby making conclusions tentative. Secondly, there is a lack of control group making it difficult to conclude that the outcomes are specifically due to SFT, or other clinician based factors, although Wheeler (2001) points out that it is difficult to know whether the approach is useful because of its techniques or because the techniques enhance the extent to which clinicians relate to clients in ways that are useful. It is also difficult to know if the outcomes in this sample are superior to spontaneous remission rates.

Thirdly, the satisfaction questionnaires were anonymous; therefore it was not possible to determine how improvement linked to satisfaction rating. It was also not possible to know the levels of satisfaction in those that did not return their questionnaire, or did not receive the questionnaire. It might be interesting to examine whether differences in the time between discharge from the service and receiving the SQ impacted on return rate and satisfaction levels as a ‘halo effect’ can occur.

Fourthly, the study did not use standardised measures. However, problem-oriented daily measures which require families to focus on the problematic behaviour are opposed to the techniques and philosophy of the solution-oriented approach (DeJong & Berg, 1998). Furthermore there is some evidence that scaling by clients is as reliable as testing using objective measures (e.g. Gostautas et al, 2005). Finally, it would be useful for future research to include follow up measures to find out whether improvements were maintained.

Despite the study’s limitations, this preliminary research adds to the growing evidence that solution focused approaches can make important contributions to the field of child and adolescent mental health in a resource limited NHS.

References


DeShazer, S. (1994). Words were Originally Magic. New York: W.W. Norton


**Acknowledgements**

Thanks to Dominic Bray and Alasdair Macdonald for reading the initial drafts.

---

**E. Veronica (Vicky) Bliss**

E. Veronica (Vicky) Bliss has a Master of Arts Degree in Counselling Psychology from the University of Nebraska (USA) and a Master of Arts Degree in Solution Focused Brief Therapy from Birmingham University (UK). Presently, Vicky has her own business, Brief Therapy Support Services, Ltd and works part time for Lancashire Care NHS Foundation Trust as a Solution Focused Practitioner for Children, Young People and their Families. She is also Editor for the UKASFP Quarterly Newsletter, Solution News.

**Dr Dominic Bray**

Dominic was the inaugural Chair of the UKASFP and served as Chair once again in the year 2010-2011. Dominic is currently Chair of the Psychology Clinical Network Group for the Merseyside and Cheshire Cancer Network, where he has been responsible for the introduction of a large number of doctors, nurses and other health professionals in the region to SF approaches.

**Kidge Burns**

After a postgraduate diploma in Clinical Communication Studies (1991 – 1993) Kidge Burns began work as a speech and language therapist at the Royal Free Hospital. Since 1998 she has been at the Chelsea and Westminster Hospital using a solution focused approach to help adults dealing with acute or chronic health conditions to develop their best hopes for the future. Kidge was awarded a Diploma in Solution Focused Practice in 2006.
Dr Peter DeJong

Peter DeJong, Ph.D., LMSW, is an emeritus professor of sociology and social work at Calvin College in Grand Rapids, Michigan and former adjunct at the Brief Family Therapy Center in Milwaukee where solution-focused brief therapy (SFBT) originally was developed. Dr. DeJong is a board member of the Solution Focused Brief Therapy Association (www.sfbta.org) and chairs their training committee.

Yvonne Dolan

Yvonne Dolan, M.A., is the Director of the Institute for Solution-Focused Therapy. She is a co-founder (with de Shazer and Berg) and Past President of the Solution Focused Brief Therapy Association (SFBTA) and conducts trainings in Solution-focused Brief Therapy all over the world. Her work is an integration of solution-focused therapy and Ericksonian hypnotherapy and reflects a lifelong interest in the linguistics of hope and its practical applications to clinical and everyday life situations.

Michael Durrant

Michael Durrant is a psychologist in Sydney, Australia. He is Director of the Brief Therapy Institute of Sydney and also holds an honorary academic appointment in the Faculty of Education and Social Work at the University of Sydney (where he teaches Solution-Focused approaches to educational psychologists). He previously taught clinical psychology students at the University of Western Sydney and also held a clinical appointment in the Faculty of Medicine, University of Sydney.

Chris Iveson

Chris Iveson trained as a social worker and worked for twenty-five years in most areas of child, family and adult social work practice and management. He is a UKCP registered family therapist. He is a member of the Institute of Family Therapy, where he helped set up and was a faculty member of its Masters course, a member and former national secretary of the Association for Family Therapy, a member of the United Kingdom Association for Solution Focused Practice and a founder member of BRIEF, largely responsible for the introduction of solution focused brief therapy to the UK.

Paul Z. Jackson

Paul Z. Jackson designs and presents training and development courses for a wide range of corporate and public organisations. With expertise in Solutions Focus, accelerated learning and applied improvisation, his company offers consultancy, facilitation, coaching and training. Clients range from blue-chips such as P+G to government agencies and business schools including Cranfield, Ashridge and LSE. With a background as a journalist and BBC comedy producer, his presentations are always well-researched, lively and amusing.

Harry Korman

Harry has been doing brief therapy since the early 80's and is one of the co-authors on Steve de Shazer's last book “More than Miracles”. Harry is a physician. He is a
specialist in Child and adolescent psychiatry and a certified family therapist and supervisor in family therapy. Harry works in private practice at SIKT in Malmö, Sweden. He worked in child and adult psychiatry for 15 years before entering into private practice in 1996.

Dr Alasdair J. Macdonald

Alasdair works in the NHS helping to care for children with learning disabilities and challenging behaviour. His freelance work includes training, supervision and management consultancy as well as unpaid work for local charities. He was a former Medical Director and a former President of the European Brief Therapy Association, and the Research Coordinator.

Dr Mark McKergow

Dr Mark McKergow PhD MBA is co-director of sfwork – The Centre for Solutions Focus at Work. He is an international consultant, speaker and author. His ground-breaking work in taking Solutions Focus (SF) to a worldwide business audience is creating new paradigms and communities in over 25 countries around the world. Mark is a global pioneer applying SF ideas to organisational and personal change. Mark was instrumental in the founding of the SolWorld (Solutions in Organisations Linkup) organization, and is a member of the SolWorld international steering group. He was one of the founder members of SFCT, the worldwide association for SF consultants, coaches and leaders, and edits the SFCT academic journal InterAction. He is also a member of the Association for Management Education and Development (AMED) and the Association for MBAs (AMBA).

Thorana Nelson

Thorana Nelson Emerita Professor, is retired from Utah State University, but continues professional pursuits in private practice, consulting, writing and editing, and training in Solution-Focused Brief Therapy and Marriage and Family Therapy. She is a Clinical Member and Approved Supervisor in the American Association for Marriage and Family Therapy and has presented in the US and Sweden on various topics in those fields. She has received awards from her professional associations for significant contributions, board service, and education and training.

Bill O’Connell

Bill is currently the Director of Training for Focus on Solutions, an independent training agency. Bill designed and led the first Master’s degree in Solution-Focused Therapy offered in a British university – the University of Birmingham. Bill is a Fellow of the British Association of Counselling and Psychotherapy and a Senior Accredited Counsellor with BACP.

Peter Sundman

Peter Sundman, Social Worker, is a Solution Focused Trainer, Clinical Supervisor, Developer; member of the TaitoBa Group in Helsinki; and board member of the European Brief Therapy Association (EBTA). Peter was trained by MRI and BFTC in the
1980s and collaborated with Elam Nunnally, Insoo Kim Berg and Steve DeShazer. He is one of the pioneers who brought Solution Focused ideas and models to Finland. He works currently as Work Supervisor, Coach, Trainer and Developer mostly in Social- and Health Care. He is an expert in family work and therapy, child welfare, SF-supervision and training issues through several certificated training programmes.

**Dr Frank Thomas**

Frank Thomas, PhD LMFT is Professor of Counselling at Texas Christian University, Fort Worth (USA), where he teaches solution-focused and strength-based approaches to both masters and doctoral students. He is a licensed marital and family therapist and supervisor, maintaining a counselling and consulting practice in the Fort Worth area. Dr. Thomas is a Clinical Member and Approved Supervisor of the American Association for Marriage and Family Therapy (AAMFT) and currently serves on editorial advisory boards for four international psychotherapy journals. He was awarded the Distinguished Lifetime Achievement Award by the Louisiana Division of AAMFT in 2010.

**Dr Wallace Gingerich**

Wallace J. Gingerich is Professor Emeritus of Social Work at Case Western Reserve University, Cleveland, Ohio. Prior to moving to Cleveland, Wally was on the faculty of the University of Wisconsin-Milwaukee and during his time became a member of the team at the Brief Family Therapy Center where he was Director of Research during the 1980’s. Wally collaborated with team members on wide range of research projects and scholarly papers, including the 1986 article “Brief therapy: Focused solution development” which described for the first time a new approach which became known as solution-focused brief therapy. Wally received his MSW and Ph.D. degrees from Washington University in St. Louis, and was a post-doctoral fellow in mental health intervention design at the University of Michigan. Early in his career he was a psychiatric social worker in community mental health settings in California.

**Guy Shennan**

Guy Shennan is an independent practitioner, consultant and trainer specialising in solution focused practice based in London, UK. As a social worker he pioneered uses of the solution focused approach in the statutory children’s services sector, and has been credited by its founder as being the first practitioner in the UK to use the Signs of Safety approach to child protection work. Guy developed the Diploma course at BRIEF, and was its co-director from 2005 to 2010.

* * * * *

**John Wheeler – Editor**

John Wheeler is a Social Worker and UKCP Registered Systemic Psychotherapist who has worked in child mental health for over 25 years. John currently works as a freelance Solution Focused trainer, supervisor and consultant. John has delivered training in Solution Focused Practice to a wide range of practitioners since 1993 and is an external lecturer to several professional courses in the North East of the UK.
This will be the last issue of SFRR, as a result of two key changes since we first started. Many authors writing about the Solution Focused approach now successfully pass through the review processes of a wide range of professional journals and in the intervening years three SF publications have come into being – ‘Interaction’ published by SFCT; the ‘International Journal of Solution-Focused Practices’ (IJSFP) and the ‘Journal of Solution-Focused Brief Therapy’ (JSFBT).

Contact details are as follows for those who wish to publish further research on the SF approach:

- **SFCT**
  www.asfct.org/our-members-voice/journal/for-authors/

- **IJSFP**

- **JSFBT** Email Michael Durrant on michael@briefsolutions.com.au

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If any reader would like to contact any author, the editor will forward your request.

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