AN EVALUATION OF THE
SOLUTION-FOCUSED BRIEF THERAPY PROJECT
ON SIX ACUTE ADULT IN-PATIENT WARDS
IN
LEEDS MENTAL HEALTH TRUST

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LIST OF ABBREVIATIONS

CPA    Care Programme Approach
CTM    Clinical Team Manager
MDT    Multi Disciplinary Team
NIMHE  National Institute for Mental Health England
PDL    Practice Development Lead
PMG    Project Management Group
SFBT   Solution Focused Brief Therapy
TARS   Training Acceptability Rating Scale
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FOREWORD
EXECUTIVE SUMMARY

The overall aim of this project was to improve the brief psychological intervention skills of in-patient mental health nurses on acute in-patient wards in Leeds. To achieve this staff were to be assisted by a consultant trainer to acquire skills that recognised the rapidly changing clinical environment in which they worked, whilst ensuring that service users received meaningful psychological interventions. Solution Focused Brief Therapy was identified as the therapeutic approach to be taught and applied by the staff. The project also sought to equip staff with SFBT skills through a work based learning approach and to explore the benefits of work based learning over more traditional forms of teaching and learning.

A consultant trainer with knowledge and experience of SFBT was identified to work with six in-patient clinical teams to educate and assist selected members of staff to acquire SFBT skills. Sixteen members of staff and the PDL attended an initial two days of introductory level teaching. Following this, the consultant trainer visited each of the wards over the next six months for up to nine half-days to facilitate the development of core skills in SFBT by staff members. During these half-days a combination of teaching, coaching, supervision and live casework was provided.

In the ending questionnaires, staff members noted the applicability of an SFBT approach to their work on the wards and all members of staff reported utilising the core skills learned within their contact with service users. Staff demonstration to the consultant trainer of core skills in SFBT during the on-ward sessions was achieved to varying degrees. A third of those who attended the two days teaching achieved these skills and was able to demonstrate this in their practice with service users in “live” supervision. Another third achieved these skills and demonstrated this through discussion with the consultant trainer. The final third of staff members acquired a reasonable level of knowledge in SFBT but were unable to demonstrate application of their skills in live supervision or discussion sessions. A key factor in the variable levels of skills and knowledge demonstrated was individual staff availability to meet with consultant trainer. However, irrespective of the varying levels of core skills that staff were able to demonstrate, all staff members reported an enthusiasm to continue to use these skills with service users beyond the lifetime of the project.

There was also an expectation that SFBT skills were to be “cascaded” by the trained staff members to other staff members on their respective wards. Cascading took place on all wards with varying degrees of success. Wards that were most successful at this were those where the CTM had decided to attend the two days training and where staff had also integrated SFBT into other aspects of their daily routines. All staff members from these wards were more likely to utilise the
consultant trainer when he was present and staff on these wards, unexpectedly, also independently developed applications of an SFBT approach to other aspects of ward life including supervision, team meetings and reviews.

The project also sought to improve the experience of in-patient wards for service users and carers by developing a more meaningful day and contributing to a reduction in the level of absconding by service users. Whether service users received meaningful psychological interventions and their on-ward experiences improved was not measured as part of project, but further evaluation or research should be key feature of any continuing project work. It was not within the remit of the project to measure levels of absconding from wards as this will be reported upon elsewhere within the Trust. However, service users were reporting both locally and nationally that one of the causes for their absconding is the lack of a meaningful day activity, particularly the absence of meaningful psychological interventions. It is thought known from the questionnaires completed by staff that, throughout the project period an increase occurred in staff levels of confidence, competence, willingness and frequency in engaging with service users to provide meaningful psychological interventions. Hence, improvements in patient’s experiences were achieved from the perspective of ward staff who increasingly applied an SFBT approach, though in the future the perspectives of service users would require further evaluation.

In conclusion, the project identified the value of having a consultant trainer present on the ward to provide “live” demonstrations of practice, suggestions and immediate supervision to staff, as opposed to, staff leaving the ward to attend teaching sessions or to read books. The initial teaching days and on-ward teaching sessions proved beneficial in assisting staff to provide increasing amounts of meaningful psychological interventions with service users. Also, core skills in SFBT were more likely to be developed by those staff who were able to regularly met with the consultant trainer. These benefits are likely to be enhanced by increasing the consultant trainer’s contact time with each ward and the use of a “shadowing” where the consultant trainer is present and can provide guidance for staff throughout many more instances of their interactions with service users. Staff learning and competence in the approach would also be likely to be enhanced by the encouragement of a wider application on wards of the SFBT approach within a variety of day-to-day practices including: ward rounds, reflective practice groups, recording in daily contact sheets and the CPA. To evaluate whether such an approach would be beneficial for service users, a comparison study between wards trained in SFBT and another ward not so trained could cater for this.

The recommendations from the project are:

1) Essential to any continuation of the project should be an evaluation of the perspectives of service users and their carers of the usefulness of the SFBT practice of staff on wards.

2) The training of all ward staff in SFBT to continue - from consultants to cleaners and “bank staff”– and to include an increase of practice opportunities within the teaching days by either slight alteration to the programme or the addition of a third day to embed practice skills.
3) On-ward sessions to be provided by a consultant trainer until staff become confident in their own ability to apply the approach and to teach it to others. The “shadowing” of staff by the consultant trainer would be an important element of this.

4) Consideration to be given to different ways of providing more frequent levels of contact between staff and the consultant trainer during on-ward sessions. This could be achieved by either extending the consultant trainer’s time allocated to the Project, or by focusing any future project on one or two wards at a time.

5) The promotion of CTM involvement with the SFBT training to be encouraged to enhance their own and their staff understanding and use of the approach.

6) A ward culture of SFBT to be established. This would include CTMs on wards where SFBT has been utilised in different ways - beyond one to one work - to share their findings with staff from other wards and the continuation of this process via regular meetings between both staff on the same ward and staff on different wards.

7) Manual of SFBT practice on-wards to be developed containing SFBT resources details of possible exercises to be utilised with staff members to develop their skills.

8) Finally, in terms of continuing professional development, a programme of accreditation should be pursued with local universities to provide participating staff with a suitable and transferable qualification and acknowledgement of their knowledge and skills in SFBT.
1. INTRODUCTION AND BACKGROUND TO THE PROJECT

This project, which ran from September 2005 to February 2006 sought to equip in-patient mental health nurses with Solution-Focused Brief Therapy (SFBT) skills through a work based learning approach. See Appendix One for full project proposal.

The National Institute for Mental Health England (NIMHE) guidance for adult acute in-patient wards (2004) indicates psychological intervention skills for staff as being important towards improving the experience of these wards for service users and carers.

Studies into the effectiveness of SFBT have been undertaken over the past 25 years with adults and children from a variety of settings and published outcome studies have featured in several journals (www.ebta.nu), including those aimed at mental health practitioners (PRIME 2003 and 2005). SFBT is recognised as a clinical speciality (Collier, J., Longmore J and Scully P 2003) and studies involving adults with mental health difficulties note 70-80% of patients reporting improvements in their circumstances with goals achieved in an average of five sessions (Beyebach M, Morejon A, Palenzuela D and Rodriguez-Arias J 1996 and Macdonald, A. 2005). The latter study reflected the findings of several other studies in noting that, no significant difference of outcome related to social class was identified when a solution focused approach had been applied. The approach has also been applied in adult psychiatric in-patient settings. In the USA the average length of hospital stay was reduced from 20 to 6 days (Vaughn, K., Cox Young, B., Webster, D. and Thomas, M 1996) and within the UK there are currently nine hospitals acting as pilots for the use of SFBT in in-patient units (www.nihme.org.uk). An SFBT approach has also been seen as effective within organisations and several mental health Trusts, including North Staffordshire, currently employ a solution focused approach throughout their whole service.

An SFBT approach was identified as suitable for this project as it is known to both, be successful in improving the communication and intervention skills of nurses and is an inexpensive approach that encourages nurses to interact with service users where perhaps this would not have been previously the case (Bowles, N., Mackintosh, C. and Torn, A. 2001). The approach has also proved useful to patients and popular with SFBT trained nursing staff working within acute psychiatric settings 83% of whom indicated they would continue to use the model (Stevenson, C., Jackson, S. and Barker, P. 2003).
2. AIMS, EXPECTED OUTCOMES and ANTICIPATED BENEFITS OF THE PROJECT

Aims

For a Consultant Trainer to:

- Teach three staff from each ward core in depth knowledge* regarding SFBT.
- Work intensively with three staff members from each of the six acute in-patient wards on live supervision and feedback regarding their work with six service users. These three staff will then act as supervisors to the remainder of the ward team in teaching them the core knowledge regarding solution focused therapy.
- Offer intensive mentoring and supervision to the three members of staff from the six wards over the life of the project with the intention of generating a greater degree of expertise, so as to ensure continuity beyond the project ending.
- Run weekly supervision groups for the six in-patient wards.
- Administer before and after measures regarding the staffs’ knowledge and aptitude towards using psychological intervention skills. This data will serve as an important component of the review of the project with a view to learning lessons for future work based learning approaches with ward teams.
- Produce an evaluation report, with the assistance of the Project Management Group (PMG), that will assist the Leeds Mental Health Trust in managing further similar approaches and the West Yorkshire Confederation (WDC) in commissioning work based learning activities.

*Core in-depth knowledge – for the purpose of this project this is defined as ‘demonstrating a clear understanding of both useful assumptions in solution focused practice and the common techniques applied when practicing SFBT.

Anticipated benefits

a) To improve the brief psychological intervention skills of in-patient mental health nurses on acute in-patient wards in Leeds.

b) To improve the experience of in-patient wards for service users and carers by developing a more meaningful day.

c) To contribute to reducing the level of absconding by service users from in-patient wards.

d) To explore the benefits of work based learning over more traditional forms of teaching and learning.
3. TRAINING METHODS

The Consultant Trainer was employed to provide all the training as follows:

- 2 full days teaching away from the ward environment
- Regular half-day sessions when the Consultant Trainer worked on the wards with staff who have attended the initial two days of teaching. This included:
  - Live Supervision – time when the Consultant Trainer was present during interactions between staff and service users
  - Mentoring - 1:1 discussions for the purpose of supporting and guiding Solution Focused interventions
  - Group supervision – time for staff to come together in groups to recollect and learn from their use of SFBT techniques

Note: As there were six wards, the Consultant Trainer was available for four half-day sessions per week and each ward anticipated receiving a dedicated on-ward session approximately 10 to 14 days apart.

Following the initial training of staff from the Wards over the first three months a period of “cascading” was expected to take place where these staff members would pass their learning onto other members of staff on their Ward.

See Appendix Two for Timetable of Project Events and Evaluation
4. FINDINGS / RESULTS

Results are presented as follows

4.1 Initial Two Days Teaching

   A. Grading of Staff who attended initial two days teaching
   B. Staff’s Previous Knowledge, Training and Use of SFBT
   C. Test results following two days of teaching in SFBT

4.2 Questionnaires – Staff Evaluation of Teaching and On-ward Sessions

   A. Impact of SFBT Training
   B. Training Acceptability Rating Scale (TARS)

4.3 On-ward sessions conducted by Consultant Trainer

4.4 Other Questionnaires

   A. Use of techniques by staff who attended initial two days of teaching and
      on-ward sessions
   B. Impact of SFBT project on staff not directly involved in training

4.5 Comments by the Consultant Trainer on the Cascading Process
4.1 INITIAL TWO DAYS TEACHING

Preparation

Prior to the two days teaching the consultant trainer visited each of the wards to meet with staff and patients and introduce the project. Subsequently, a file was left on each ward containing written information about SFBT to be accessed by all ward staff whether they attended the teaching or not. Lastly, during the project period additional SFBT Resources to be utilised by all ward staff were bought and stored in the Training Unit at Becklin Hospital. All relevant staff were notified of these available resources.

Staff involved in initial two days teaching

22 members of ward staff and the Practice Development Lead (PDL) were identified in July 2005 to attend the initial two days of training provided by the Consultant Trainer. However, prior to the training, due to various reasons, some of these staff members became unavailable. Though attempts were made to replace these members of staff, the attendance on Teaching Day One was 18 and the PDL. On Teaching Day Two the attendance was 16 and the PDL. Consequently, 16 members of ward staff attended for the full two days of training and were available to participate in this and the sessions on the ward.

Note: Throughout the report the term “staff” will refer to the sixteen members of staff who attended the teaching days. Reference to other members of staff will be indicated in the text.’

Aim of Initial Two Days Teaching

The aim of these two days was to provide staff with an introduction to the assumptions and techniques of SFBT and to have the opportunity to discuss and practice this approach. This was to prepare them to return to their respective wards to implement the approach with patients and demonstrate the approach to other staff members. Three staff from each ward were expected to attend the teaching days, though in practice, the number of staff attending ranged from two to four per ward. The teaching was open to staff of all grades and a variety of grades attended. See Table One for grades of staff attending.

<table>
<thead>
<tr>
<th>Grade</th>
<th>Number of staff attending two days training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Nurse</td>
<td>7</td>
</tr>
<tr>
<td>“F” and “G” Grades</td>
<td>4</td>
</tr>
<tr>
<td>Clinical Team Manager</td>
<td>3</td>
</tr>
<tr>
<td>Service User Development Worker</td>
<td>1</td>
</tr>
<tr>
<td>Health Support Worker</td>
<td>1</td>
</tr>
<tr>
<td>Practice Development Lead</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
</tr>
</tbody>
</table>

Table One - Grading of Staff who attended initial two days teaching
The grade of staff attending the training was revealed to be predominantly Staff Nurses and “F” and “G” grades. Also notable was the attendance on the teaching days by Clinical Team Managers from half of the wards who were participating in the project.

**B. Staff’s Previous Knowledge, Training and Use of SFBT**

On the first of the two days of teaching, the 19 staff in attendance were asked to complete a questionnaire (see Appendix Three). The questionnaire contained three parts. Part one identified those who had previous knowledge of SFBT (see Figure 1 below). Part two identified those staff that had previous training in SFBT. Part three identified those who had used the SFBT techniques whether or not they had identified these techniques as being part of the model (see Figure 2 below). For a full description of the “techniques” and “tools” associated with SFBT refer to the handout (see Appendix Four) that was provided to all those attending the two days teaching. Copies of this handout were also left on each of the wards.

The purpose of this questionnaire was to establish the levels of knowledge, training and utilisation of SFBT techniques already held by staff. This would enable consideration to be given to any possible influence this may have had upon the project.

**Figure 1 - Reported previous knowledge of SFBT techniques prior to training**

Less than one in three staff attending the teaching days had knowledge of the Best Hopes / Miracle Question / Preferred Future and Strengths based questions. In later discussion, only a few of these staff members associated this type of question with
SFBT. Similarly, less than one in three of staff members were aware of the technique of Scaling and none of these associated this with SFBT. Fewer members of staff were aware of the other SFBT techniques and there was no recognition of the key techniques of identifying possible Pre-Session Changes and Exceptions.

**Previous Training in SFBT Techniques - summary**

Of the 19 staff attending on the first day of teaching one person had previously undertaken training in SFBT. This person recalled one of the 10 techniques – Miracle Question – which they had used and was to be taught and practiced on the teaching days.

**Figure 2 - Reported previous use of SFBT techniques prior to training n= 19**

Less than one in six members of staff reported regularly identifying patient’s strengths or incorporating compliments of patients into their work. Less than one in nine members of staff would regularly utilise scaling, provide feedback or identity tasks with patients. Slightly higher numbers of staff reported utilising some of the techniques “a little” though overall prior to the teaching days the SFBT techniques to be taught were either rarely used by staff or not at all.

Overall, the levels of previous training, knowledge and utilisation of SFBT techniques - whether recognised as such or not - amongst the nineteen staff members in attendance on the first day of teaching were either low or non-existent. Indeed, for all but one of the staff this was the first time they received training in SFBT and had been introduced to the approach. Hence, their levels of knowledge and aptitude in SFBT at this time could be said to be minimal. Thus the project was not particularly influenced by from prior knowledge and abilities in SFBT already held by staff.
C. Test results following two days of teaching in SFBT

At the end of the two days teaching a 20 minute written test (see Appendix Five) was set by the consultant trainer. All of the questions in the test related to the content of the previous two days teaching. This test was undertaken by all 16 ward staff and the PDL present on the second day. Test scores are presented in the table below. The Test was to assess the uptake of knowledge of SFBT gained from the two days of teaching and the pre-course reading reading material provided.

<table>
<thead>
<tr>
<th>Scores</th>
<th>No. of Staff</th>
</tr>
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<tbody>
<tr>
<td>0%-50%</td>
<td>0</td>
</tr>
<tr>
<td>50-59%</td>
<td>1</td>
</tr>
<tr>
<td>60-69%</td>
<td>2</td>
</tr>
<tr>
<td>70%-79%</td>
<td>9</td>
</tr>
<tr>
<td>80%-90%</td>
<td>5</td>
</tr>
<tr>
<td>90%-100%</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>17</strong></td>
</tr>
</tbody>
</table>

The findings and indicate everyone scored at least 50% for the test and 14/17 staff members scored over 70%. Hence, following the two days of teaching all staff demonstrated a reasonable level of understanding of the basic assumptions and techniques of SFBT and most staff demonstrated a good level of understanding of SFBT.

The test also provided and indication of particular areas of the approach the staff members would need to revise if they wished to incorporate these into their practice. Each member of staff was provided with a notebook to do this and these “sparkly moments” books were to be utilised as a way of recording their “successes” and to assist their recollection of events when sharing these with the consultant trainer during his arranged visits.

4.2 QUESTIONNAIRES – STAFF EVALUATION OF TEACHING and ON-WARD SESSIONS

A. Impact of SFBT Training

Confidence and Capability Questionnaire (Bowles et al 2001)

Increasing staff levels of knowledge and aptitude in using the psychological intervention skill of SFBT was a key component of the project. An indication of whether such staff development occurred and led to increasing levels of staff confidence and capability in their engagement with patients was to be measured by this questionnaire. Although not validated, the questionnaire had been utilised in the evaluation of previous SFBT training with nursing staff. Within the questionnaire individual staff self-assessed several areas of their practice and perceptions of their ward including their levels of confidence and capability in engaging with patients. Staff responses were gathered at both the beginning and end of the project.
Part One of this questionnaire (see Appendix Six A) was utilised at the beginning of teaching days. Part Two of this questionnaire (see Appendix Six B) was utilised following the completion of both the teaching days and on-ward sessions. Part Two contains the same set of questions as in Part One plus questions about the extent to which the SFBT training had, or had not, increased the respondent’s level of confidence / capability etc. Hence, this questionnaire enabled both, specific changes perceived as occurring by the staff members over the length of the project time to be rated, as well as, providing a separate rating of the extent to which staff perceived the SFBT training to have made a difference to any changes that occurred.

For purposes of the evaluation the responses of the PDL have been removed given that there is no on-going ward practice with this job role. Also, two of the initial 19 respondents were removed due to their absence on second day and limited on-ward participation in project. Hence the total number respondents are 16.

In the first four questions staff reported upon their individual practice and in the last two questions staff commented upon their colleagues and their ward.

**Figure 3 – Impact of SFBT training in the workplace n=16**

<table>
<thead>
<tr>
<th>Scale dimension</th>
<th>Confidence</th>
<th>Capability</th>
<th>Willingness</th>
<th>Frequency</th>
<th>Accepting</th>
<th>Scope</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginning of project</td>
<td>6.6</td>
<td>6.4</td>
<td>4.9</td>
<td>3.3</td>
<td>8.2</td>
<td>7.2</td>
</tr>
<tr>
<td>End of project</td>
<td>8.2</td>
<td>7.8</td>
<td>8.1</td>
<td>8.5</td>
<td>8.1</td>
<td>7.4</td>
</tr>
<tr>
<td>Contribution of SFBT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

**Note:** The contribution of SFBT teaching and the on-ward sessions towards any change in the last two fields are not measured.
1. CONFIDENCE

Increase in confidence between the beginning and end of the project

Twelve members showed an increase in confidence in talking to people who were troubled. Of the remaining four staff members, three maintained their high (8 or 9 out of 10) levels of confidence and one dropped slightly from a score of 9 to 8. Even though almost half of the staff (7/16) already reported having high (8 / 9 out of 10) levels of confidence, four of these increased their levels of confidence and one remained at 9. Overall, throughout the six month period of the project, approximately four out of five staff member showed either an increase in, or maintained their high level of confidence in “talking with people who are troubled”. Within this time the mean for this staff group score rose from by 16% from 6.6. to 8.2 out of a possible 10.

Extent to which the SFBT training had increased their confidence

Thirteen members rated their increase in confidence to talk with troubled people as 5 or more out of 10. Three staff members rated the contribution of SFBT training to their increase in confidence as low (3 or below). This second group of staff also indicated in their questionnaires that the teaching had little scope for developing them in this area as they already had high levels of confidence in talking with people who are troubled. With a mean score of 6.4 out of a possible 10 the SFBT training was viewed by the trained staff as having made a notable contribution to their increase in confidence.

2. CAPABILITY

Note: Question 2a and b. (see Appendix 6a. and 6b.) focused on staff capability and the similar terms “competence” and “capability” were used interchangeably by mistake. This may have influenced the results, though none of the respondents commented upon this on the two occasions the questionnaire was utilised.

Increase in capability between the beginning and end of the project

Fourteen members showed an increase in their level of capability in talking with people who are troubled. Of the remaining two staff members, both noted sustaining their high level (8 out of 10) of capability. Overall throughout the six month period of the project, all of the staff member showed an increase in, or maintained their high levels of capability to “talk to people who are troubled”. Within the six month project period the mean score for the staff group rose by 17% from 6.1. to 7.8 out of a possible 10.

Extent to which the SFBT training had increased their capability

Thirteen staff members rated their increase in capability in talking with people who are troubled as 5 or more out of 10. Three staff members rated the contribution of the SFBT training to increase their capability to talk with people who are troubled as low (4 or below). This second group of staff also indicated in their questionnaires that
the teaching had little scope for developing them in this area as they already had high levels of capability in talking with people who are troubled. With a mean score 6.8 out of a possible 10 the SFBT training was viewed by staff as having made a notable contribution to their increase in capability.

3. WILLINGNESS

Increase in willingness between the beginning and end of the project
Eleven staff members showed an increase in their levels of willingness in talking with people who were troubled. Of the remaining five staff members, three maintained the highest rating of 10 out of 10 for willingness, one staff member showed a slight decrease of one point and one staff member’s score dropped by three points. Overall, throughout the six month period of the project fourteen of the sixteen staff members showed either an increase in, or maintained their high level of willingness to “talk to people who were troubled”. Within the six months of the project the mean for this staff group score rose by 9% from 8.1 to 9 out of a possible 10.

Extent to which the SFBT training had increased their willingness
Eight staff members rated their increase in willingness to talk to troubled people as high (7 or more out of 10). Two staff members rated the extent to which the SFBT training had increased their willingness as low (2 out of 10) and another two as not influential at all. Three of the respondents in this second group of staff also indicated in their questionnaires that the teaching had little scope for developing them in this area as they already had high levels of willingness in talking with people who are troubled. With a mean score of 4.9 out of a possible 10 the SFBT training was viewed by the trained staff as having made a contribution to the increase in their willingness to engage with patients.

4. FREQUENCY (of ENGAGEMENT)

Increase in frequency of engagement between the beginning and end of the project
Eleven staff members showed an increase in their levels of frequency during an average week to engage patients in conversation. One of these staff members doubled their initial score to a maximum 10 out of 10. Of the remaining five staff members, three staff members remained at the same high level (8 out of 10) and another two reported a slight decrease in their level of engagement. Overall, throughout the six month period of the project, fourteen of the sixteen staff members showed an increase in, or maintained their already high levels of frequently “talking with people who are troubled”. Within this time the mean for this staff group score rose by 11% from 8.5 to 9.6 out of a possible 10.
Extent to which the SFBT training had increased their frequency of engagement
Six staff members rated the extent to which the SFBT training had increased the frequency with which they engaged patients in conversation whether they are troubled or not as 5 or more out of 10. Eight the staff members rated the extent to which the SFBT training had increased the frequency with which they engaged people in conversation as low (3 or below). This second group of staff also indicated in their questionnaires that the teaching had little scope for developing them in this area as they already had high levels of frequency in talking with people who are troubled. With a mean score of 3.3 out of a possible 10 the SFBT training was viewed by the group of staff as having made some contribution to their increase in their frequency of engagement with patients.

5. ACCEPTING (of ENGAGEMENT)

At the end of the project period, five staff reported an increase in their day to day colleague’s levels of acceptance of them engaging patients in conversation. Another five staff indicated that amongst their colleagues a high level of acceptance of them engaging patients in conversation was already present and that this had continued. Three of these respondents scored their colleagues level of acceptance at the highest rating of 10 at both the beginning and end of the project. Six staff members reported a decrease in their day to day colleague’s levels of acceptance of them engaging patients in conversation. Overall, there was a slight drop in the mean level of acceptance from 8.2 to 8.1 throughout the period of the project.

6. SCOPE (for ENGAGEMENT)

Seven staff reported an increase in their perception of the scope within their day to day work to engage patients in conversation (whether they are troubled or not). Five staff members reported a decrease in scope. Four staff members reported the same levels in scope within their day to day work to engage patients in conversation (whether they are troubled or not) at both the beginning and end of the project. There was a slight increase in the mean level of scope from 7.2 to 7.4 throughout the period of the project.

B. Training Acceptability Rating Scale (TARS) Questionnaire

This questionnaire TARS (see Appendix Seven) is a validated questionnaire has been applied in various parts of the Trust as a standard tool for compiling feedback on training events. It was utilised twice, firstly at the end of the two teaching days and secondly at the end of the project following the on-ward sessions. On this second occasion within the questionnaire the word “workshop” was replaced with the word “sessions”. For purposes of this evaluation the PDL’s responses were included in the first application of this questionnaire only. Hence, total possible respondents to the first application of the questionnaire was 17 and for the second application 16.

The adapted TARS is a 19-item self-report measure in three parts. Part one (questions 1 to 6) is from the original TARS (Davis et al., 1989) and comprises 6 items concerned with the acceptability of the training (see Table Three below). Each item is rated on a six-point bipolar scale ranging from ‘1 = strongly disagree’ to ‘6 =
strongly agree`. The six items are the general acceptability, effectiveness, negative side-effects, appropriateness, consistency, and social validity of the training. Part two (questions 7 to 15) is taken from Milne & Noone, (1996) and consists of 9 items concerned with the effectiveness of the training. Each item is rated on a four-point scale ranging from `not at all = 0` to `a great deal = 3 with higher scores indicating a greater endorsement of the training provided (see Table Four below).

The results are contained in Table Three below.

**Table Three - TARS (Part one) mean scores (maximum score = 6)**

**Note**: Questions 3 and 4 have had their scores reversed for easier interpretation. Higher scores indicate a greater endorsement of the training provided.

<table>
<thead>
<tr>
<th>TARS Questions 1 - 6</th>
<th>Initial Two Days Teaching</th>
<th>“Sessions” on-wards</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q. 1 General acceptability:</strong> This approach would be appropriate for a variety of staff.</td>
<td>5.2</td>
<td>5.6</td>
</tr>
<tr>
<td><strong>Q.2 Effectiveness:</strong> The training will be beneficial for the staff</td>
<td>5.3</td>
<td>5.2</td>
</tr>
<tr>
<td><strong>Q.3 Negative side-effects:</strong> The training will result in disruption or harm to clients</td>
<td>5.1</td>
<td>5.6</td>
</tr>
<tr>
<td>(Reversed)</td>
<td>(Reversed)</td>
<td></td>
</tr>
<tr>
<td><strong>Q.4 Appropriateness:</strong> Most staff would not accept that the training provided an appropriate approach to client care</td>
<td>4.8</td>
<td>5.5</td>
</tr>
<tr>
<td>(Reversed)</td>
<td>(Reversed)</td>
<td></td>
</tr>
<tr>
<td><strong>Q.5 Consistency:</strong> The training was consistent with common sense and good practice in helping staff to work effectively</td>
<td>5.5</td>
<td>5.4</td>
</tr>
<tr>
<td><strong>Q.6 Social validity:</strong> In an overall general sense, most staff would approve of training in this method (e.g. would recommend it to others)</td>
<td>5.2</td>
<td>5.1</td>
</tr>
</tbody>
</table>

In the area of the general acceptability of the training, a high score was given by staff to the two days teaching and the on-ward sessions scored excellently. Similar high scores for the teaching were reported for the areas of effectiveness and social validity and these scores dropped only slightly for the on-ward sessions. The scores for negative side effects and appropriateness of the two days teaching scored lowest in this section though both rose markedly by the end of the project following the on-ward sessions. Possible reasons for this are included in the Discussed section below. Finally the highest overall score was given to the consistency of the approach. Staff comments, contained within the qualitative section of this questionnaire, indicate that the lack of jargon and the relative ease with which people can gain an understanding of SFBT approach in comparison with other approaches is likely to have been influential in the high score achieved for consistency.
Table Four - TARS (Part two) mean scores (maximum score =3)

<table>
<thead>
<tr>
<th>TARS Questions 7-15</th>
<th>Initial Two Days Teaching</th>
<th>“Sessions” on-wards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q.7 Did the workshop / sessions improve your understanding?</td>
<td>2.7</td>
<td>2.8</td>
</tr>
<tr>
<td>Q.8 Did the workshop / sessions help you to develop work-related skills?</td>
<td>2.2</td>
<td>2.1</td>
</tr>
<tr>
<td>Q.9 Has the workshop / sessions made you more confident?</td>
<td>1.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Q.10 Do you expect to make use of what you learnt in the workshop / sessions in your workplace?</td>
<td>2.4</td>
<td>2.5</td>
</tr>
<tr>
<td>Q.11 How competent was the workshop / session leader?</td>
<td>2.8</td>
<td>2.8</td>
</tr>
<tr>
<td>Q.12 In an overall, general sense, how satisfied are you with the workshop/ sessions?</td>
<td>2.4</td>
<td>2.4</td>
</tr>
<tr>
<td>Q.13 Did the workshop / sessions cover the topics it set out to cover?</td>
<td>2.8</td>
<td>2.6</td>
</tr>
<tr>
<td>Q.14 Did the workshop / sessions leaders relate to the group effectively (e.g. made you feel comfortable and understood)?</td>
<td>2.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Q.15 Were the leaders motivating (e.g. energetic, attentive and creative)?</td>
<td>2.8</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Both the teaching days (workshop) and on-ward sessions were reported by staff to have greatly helped with their understanding of the SFBT approach, which was as previously noted, an approach that the vast majority of the staff was unfamiliar with. Also, whilst the scores for the development of workplace skills are good there is room for improvement in this. In particular, the qualitative section of this questionnaire indicated that, for some staff, further opportunities for practicing the techniques on the teaching days would have been useful. Also, some staff noted that their work related skills would have improved if they had been available to meet more often with the consultant trainer. Possible reasons for the relatively low score for confidence indicated by staff following the two days teaching are discussed below and though this did rise in the project period, further increases are clearly possible in this area. However, these indicated levels of confidence do not appear to have affected the staff levels of anticipation in using the approach on their wards and their intentions to continue to use what they had learned over the six months beyond the lifetime of the project. Overall, staff indicated their general satisfaction of both the teaching days and on-ward sessions.

The remaining questions specifically relate to the performance of the consultant trainer (workshop leader). The consultant was seen as highly competent and able to motivate staff on both the teaching days and in the on-ward sessions. The topics covered in both settings were reported by staff to be highly consistent with what they had expected and overall the respondents reported being: highly satisfied with his performance of the trainer during the two days teaching and very satisfied with his performance in the on-ward sessions. As one member of staff commented,
The commitment was clear from the trainer and that was appreciated. The opportunity to talk about the whole philosophy of SFBT was a great help in getting my own head clear about what process is about. The contact on the ward was very very useful.
Staff member – end of project

**TARS (Part three)**

Part three of the TARS questionnaire consists of three questions which ask respondents to qualitatively comment upon which parts of the training they have found the most useful, what parts of the training they would change and to make any other comments. A representative selection of quotes chosen by members of the PMG are provided below.

**Q.16 What was the most helpful part of the workshop for you personally?**

*Helpful that there was little “jargon”. Clear examples given a lot, which I could relate to. The video also supported this process a lot.*

*Watching it in practice and discussing people’s experiences/questions as a group.*

*Practising SFBT in role-play. Discussing underpinning theory and seeing SFBT in action. Video.*

*Completing exercises and having a chance to try it out in practice.*

**Q.17 What change if any would you recommend (e.g. to the content or teaching)?**

*Don’t know - think that the idea of on-ward training is a good one and will work really well. But will have to see*

*Practising SFBT more in groups of three- in role-play and discussing scenarios in groups.*

*Maybe using case studies from the clinical environment.*

*More chance to reflect with others. Opportunities to discuss over-coming barriers which may arise in workplace with peers.*

**Q.18 Please make any other comments that you would like to offer**

*I felt the course was very useful and that there will be more opportunity to practise SFBT skills on the ward and continued input from Greg. Thanks.*

*I thought the individual elements of the approach i.e. scaling/miracle question etc. were easy to understand. The only bit I struggled with was how to bring it all together. This was why the video was good and why I suggested lecturer to demonstrate.*
It will be interesting to see how the project goes and how it fits in to the environment of an acute admissions ward.

Think it would be good to meet up with everyone who has done the training in a couple of months for group discussion/feedback/supervision.

TARS Q's 16-18 (end of project)

Q.16 What was the most helpful part of the “sessions” for you personally?

Role plays/ practical exploration of techniques.

1:1 supervision- receiving feedback on my use of techniques with a service user/member of staff in supervision.

Seeing service users I knew well talking with someone skilled/ who knew what they were doing. Seeing an alternative way of looking at a situation. Easy access to consultant trainer to discuss specific ways of furthering the project as well as individual points of “stuckness” with service users.

Reflecting on my own practice- new ideas of how to work with particularly challenging service users. Enjoyed learning new skills.

Q.17 What change, if any, would you recommend (e.g. to the content or teaching) ?

Teach a ward at a time. This way the whole ward would support each other and their learning needs. Would also be easier to implement SFBT techniques into care plans.

A further refresher session- most staff fed back that they felt it was a useful sharing of experiences and a means to maintain their motivation.

Although the initial two-day sessions were really useful, I think that there was a lot to cover. I think that I would have benefited from possibly a third day were we could spend time practising the new techniques with each other before trying it with service users.

I know that on our ward our time could have been planned better for when Greg was due to attend, but it was sometimes difficult to arrange 1:1 time with service users at the time/day when Greg attended. I think that more visits from Greg would have proved useful.

Q.18 Please make any other comments that you would like to offer

Overall excellent.
I remain very motivated to the use of SFBT in practice- is easily applied in the inpatient setting which is not the case with various approaches on offer.

The commitment was clear from the trainer and that was appreciated. The opportunity to talk about the whole philosophy of SFBT was a great help in getting my own head clear about what the process is about. The contact on the ward was very useful.

I think it is really useful and would be great if used more by ALL staff. Unfortunately because a lot of staff do not understand it they get the wrong impression and believe it is colluding with service users delusions or going directly against other team approaches, so it can cause a lot of conflict and lead to mixed messages being given to service users. If for example I’m working in a SFBT way and the rest of the team are not service users get mixed messages.

4.3 ON-WARD SESSIONS CONDUCTED BY CONSULTANT TRAINER

Over the six month period following the teaching days, the consultant trainer made a total of 51 visits to the six wards to conduct the on-ward sessions. This was to assist staff in developing their skills as solution focused practitioners and to gather information about the possibilities of developing a work based learning approach.

During the on-ward sessions the consultant trainer engaged with staff as a coach, supervisor or “live” supervisor. In practice, these roles regularly overlapped within the on-ward sessions with individual staff, but for the purposes of this report they are described separately below.

Coaching
As a coach, the consultant trainer promoted general discussion of the solution focused approach and encouraged its use by all ward staff. This included, prompting staff to read and discuss information contained in the SFBT file placed on each of the wards and addressing any uncertainties held by staff regarding their understanding of the approach and how to utilise it.

Supervision
As a supervisor, the consultant trainer would encourage discussion of particular sessions with clients as recalled by the staff. The “sparkly moments” books had been provided to assist with their recollection of events and to identify what SFBT techniques they had learned and utilised with patients and what techniques they could utilise in the future. These did not form a part of the evaluation and ultimately were rarely used by staff. Also as a supervisor, some guidance would be offered by the consultant trainer in the form of prompting particular SFBT questions or re-reading the handout, though largely staff were encouraged to note and repeat with other patients what they found that was useful and to try different solution focused questions when discussions appeared “stuck”. On occasions demonstration of practice with patients was provided by consultant trainer for staff who had attended the teaching days and no-trained staff, but mostly the taught staff were encouraged to practice and develop their own skills through their interactions with patients.
Live supervision
As a live supervisor, the consultant trainer was present in sessions where an individual trained member of staff was utilising solution focused techniques with patients. During the session, the consultant trainer would make notes on the staff member’s knowledge and aptitude for a solution focused approach (see s 4 and 5). Following such sessions, the consultant trainer and staff member would reflect upon the session to identify what gone well could have been done differently.

Live supervision took place on a total of 18 occasions and a record sheet (see Appendix Eight) was utilised by the consultant trainer to note which SFBT techniques were utilised and what statements and questions were constructed by the worker. Table Five below indicates the totals for the techniques used in these sessions. Note: all of these techniques are included in the handout (Appendix Four) provided for the trained staff members.

Table Five – Techniques utilised in observed live supervision sessions.

<table>
<thead>
<tr>
<th>Technique</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scaling</td>
<td>17</td>
</tr>
<tr>
<td>“Best Hopes” / Miracle Question/ Preferred Future</td>
<td>16</td>
</tr>
<tr>
<td>Compliments – client’s Strengths, Resources Coping Skills</td>
<td>14</td>
</tr>
<tr>
<td>Pre-suppositions - that change will occur and that the client is an active participant in that change</td>
<td>12</td>
</tr>
<tr>
<td>Other person questions</td>
<td>7</td>
</tr>
<tr>
<td>Pre-Session change</td>
<td>6</td>
</tr>
<tr>
<td>Exceptions</td>
<td>6</td>
</tr>
<tr>
<td>Problem Free Talk</td>
<td>5</td>
</tr>
<tr>
<td>Worker Feedback – tasks noticing and difference</td>
<td>3</td>
</tr>
<tr>
<td>EARS: Elicit, Amplify, Reinforce, Start (Again)</td>
<td>0</td>
</tr>
<tr>
<td>Break</td>
<td>0</td>
</tr>
<tr>
<td>Other(s) – please state</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Total Live supervision sessions</strong></td>
<td>n=18</td>
</tr>
</tbody>
</table>

The SFBT techniques Scaling, Best Hopes and Compliments were the ones most regularly applied by staff. Pre-suppositional statements were also made by the staff member in an average of two out of three sessions. None of the workers used the possibility of a break in the session to gather their thoughts before providing feedback to the patients. However, on a few occasions some staff members were able to summarise the sessions and provide feedback that was accurate and appeared to be helpful for the patient.

Interestingly, problem free talk and pre-session change were not utilised as often in the live supervision sessions as was anticipated. However, most of the staff had already spoken to patients regarding this prior to the meeting with the consultant trainer and this knowledge was sometimes paraphrased at the beginning of sessions. Similarly, exceptions were often asked for in the initial contact between the staff member and the patient. The Consultant Trainer would thus be observing a session where the client had already met with the staff member on several occasions.
The Consultant Trainer also noted the particular phrasing of questions asked and statements made by the staff members that are common in solution focused practice (see Appendix Eight). These are included in the Table Six5 below.

**Table Six – Solution Focused Aspects**

<table>
<thead>
<tr>
<th>To be encouraged</th>
<th>Utilised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curiosity</td>
<td>16</td>
</tr>
<tr>
<td>Client led goals – ability to identify solutions</td>
<td>16</td>
</tr>
<tr>
<td>Compliments – based on patient’s narrative</td>
<td>14</td>
</tr>
<tr>
<td>Future focus</td>
<td>13</td>
</tr>
<tr>
<td>Small changes</td>
<td>11</td>
</tr>
<tr>
<td>Affirmation / validation of client experience</td>
<td>10</td>
</tr>
<tr>
<td>Identification of choices / options</td>
<td>10</td>
</tr>
<tr>
<td>Use of client’s words / phrases</td>
<td>9</td>
</tr>
<tr>
<td>Normalisation</td>
<td>9</td>
</tr>
<tr>
<td>Identification of Strengths and Resources – based on patient’s narrative</td>
<td>8</td>
</tr>
<tr>
<td>Recognising competence</td>
<td>5</td>
</tr>
<tr>
<td>Past successes</td>
<td>3</td>
</tr>
<tr>
<td>“What else” questions</td>
<td>3</td>
</tr>
<tr>
<td>Client’s future responsibility</td>
<td>0</td>
</tr>
<tr>
<td>Other(s) – please state</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Total Live supervision sessions</strong></td>
<td>n=18</td>
</tr>
</tbody>
</table>

In the majority of these sessions staff members were observed by the Consultant Trainer to adopt an attitude of curiosity (rather than “expert” or “knowing”) towards the patient’s circumstances and were also able to compliment clients for their achievements and assist them to identify possible solutions for the future. Affirmations of client’s experiences were also regularly stated by staff and encouragement provided for patient’s to attempt to make small changes to aspects of their lives. Staff members were generally able to maintain the future focus and solution building aspects of the approach. There were less examples of staff identifying the patient’s past successes. The “what else” question was only occasionally utilised, despite it being an effective tool for eliciting additional details.

The consultant trainer met with all staff who attended teaching days on at least one occasion. In terms of their knowledge and aptitude for SFBT these 16 people can be divided into approximately three groups. One third of the staff members were observed undertaking “live” sessions with patients and participated in supervision following this. Live supervision was deemed to be useful by staff members, two of whom reported this in the TARS questionnaires when asked about the usefulness of the on-ward sessions.

- Receiving feedback
- Helped with developing skills practically
- Staff members - end of project
Consequently this first group of staff were able to demonstrate their knowledge of SFBT and develop their aptitude to understand and utilise their core skills in SFBT.

For another third of the staff members arranging sessions with patients at times when the consultant trainer was be present and participating in live supervision proved difficult. Thus for this group, supervision was provided in the form of retrospective discussions of sessions that had occurred between the staff member and patients in the consultant trainer's absence. Despite the lack of their participation in live supervision staff in this group noted some benefits in the supervision, coaching and demonstrations provided for by the consultant trainer and commented upon this as helpful.

*Although I was unable to facilitate a 1:1 session in the consultant trainer's presence I found that discussing particular cases really useful… Seeing service users I knew well talking with someone skilled / who knew what they were doing.*
Staff member – end of project

Those in this second group were able to verbally demonstrate their knowledge and aptitude for applying SFBT and may have achieved this in practice, but they were unable to demonstrate this in a live session attended by the consultant trainer. Lastly, for one third of staff only a general discussion of the approach with the consultant trainer occurred. The staff in this final group were could be described as partly developing their knowledge and aptitude for an SFBT approach.

### Group Supervision

Due to workload demands upon staff and the staff shift system the PMG recognised that it would be extremely difficult to make staff available for the originally proposed weekly group supervision sessions with staff that had been trained. However, in November 2005 a “refresher afternoon” was held for staff to come together as a group to recollect their experiences of applying the approach and to learn from each others use of SFBT techniques. All but one member of staff from the original 16 were able to attend. Generally this meeting was perceived as very useful with several staff noting this in the TARS Questionnaires and requesting further similar sessions to be held as noted below.

*Being able to discuss your experiences of SFBT with other members of the group It was helpful to hear other people’s experiences of using techniques on their wards.*
Staff members - end of project

### 4.4 OTHER QUESTIONNAIRES

#### A. Use of techniques by staff who attended initial two days of teaching and on-ward sessions

This seven item self-completion questionnaire (see Appendix Nine) was compiled by the consultant trainer and implemented to provide some evaluation of the staff perceptions of the SFBT techniques they had used on the wards. It was completed
by all 16 staff members who attended the initial teaching and were available for the on-ward sessions.

When the responses to the questionnaire were amalgamated it emerged that every staff member had attempted to use to the SFBT techniques they had been taught on the teaching days and all reported that they intended to continue to use these techniques beyond the end of the project.

The specific techniques used and their perceived usefulness by staff were combined and are contained in the table below.

Table 6 – Specific SFBT techniques used by staff who received training and their perceived usefulness (n=16)

<table>
<thead>
<tr>
<th>TECHNIQUES USED</th>
<th>Yes</th>
<th>No</th>
<th>Overall Usefulness (mean score out of a possible 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Scaling</td>
<td>16</td>
<td>0</td>
<td>8.8</td>
</tr>
<tr>
<td>b) Miracle Question / Perfect Day / Best Hopes</td>
<td>16</td>
<td>0</td>
<td>7.7</td>
</tr>
<tr>
<td>c) Problem Free Talk</td>
<td>11</td>
<td>5</td>
<td>8.8</td>
</tr>
<tr>
<td>d) Exceptions</td>
<td>11</td>
<td>5</td>
<td>7.6</td>
</tr>
<tr>
<td>e) Pre-session change</td>
<td>6</td>
<td>9</td>
<td>8</td>
</tr>
</tbody>
</table>

The usefulness and regular application of the scaling technique matches the findings of the consultant trainer drawn from his observations in the live supervision sessions (see Table Five above). Problem free talk was reported by staff to have been an equally useful technique, though as noted earlier is likely to have been utilised more outside the live supervision sessions in initial contacts with patients. Indeed, some members of staff reported its usefulness shortly following a patient’s arrival on the ward in gathering background information about a patient’s - and their families - wishes and strengths that could prove useful in later conversations with the patient. Exceptions, Best Hopes and Pre-session change were also regularly utilised and reported as being useful by staff.

Also, included in this questionnaire was a section for further comments about the project to be made by staff. One of these comments is included below and reflect the some of the perceived benefits the project brought to the wards for patients, individual staff and other ward staff.

It induces hope and optimism in client care i.e. exceptions, miracle question, best hopes.
Staff Member - end of project

B. Impact of SFBT project on staff not directly involved in training

This six item self-completion questionnaire (see Appendix Ten) was compiled by the consultant trainer and implemented to provide some evaluation of the impact of the
SFBT project on staff who did not attend two days teaching or consultant trainer sessions on-wards. Questionnaires were distributed to all six wards and a total of 22 were returned. This total included at least one response from each of the six wards.

Within the 22 responses, 18 staff who had not attended the teaching days said they were aware of the SFBT project and 12 said they were aware of some of the techniques used. Of the 12 staff that were aware of the SFBT techniques 11 had attempted to use them. Table Seven below provides details of the perceived usefulness of the techniques used.

**Table Seven – Usefulness of SFBT Techniques**

<table>
<thead>
<tr>
<th>TECHNIQUES USED</th>
<th>Utilised - Yes</th>
<th>Utilised - No</th>
<th>Overall Usefulness (mean score out of a possible 10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Scaling</td>
<td>9</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>2) Miracle Question / Perfect Day / Best Hopes</td>
<td>3</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>3) Problem Free Talk</td>
<td>6</td>
<td>5</td>
<td>7.7</td>
</tr>
<tr>
<td>4) Exceptions</td>
<td>2</td>
<td>9</td>
<td>6.5</td>
</tr>
<tr>
<td>5) Pre-session change</td>
<td>4</td>
<td>7</td>
<td>8</td>
</tr>
</tbody>
</table>

Similar to those who had been provided with two days teaching; Scaling and Pre-session change were seen as the most useful with Problem Free Talk being the next in usefulness. Exceptions and Miracle Question / Perfect Day / Best Hopes did not score as highly, though it is possible that with further training and explanation these scores would rise.

Also, included in this questionnaire was a section for further comments about the project to be made by staff members. Similar to the findings for the staff members who attended the two days of teaching; some of the staff expressed some scepticism or perceived limitations in this approach, though still wished to know more, whilst others saw some potential in the approach.

*Nice therapy to me. Not useful for helping people with meds compliance or insight, to my knowledge. Better for social problems. Would like to know more about this therapy and others.*

Staff member (who had not attended teaching days) – end of project

*Solutions focused practice is valuable, as it allows the individuals to evaluate practical issues that can improve their circumstances.*

Staff member (who had not attended teaching days) – end of project

**4.5 Comments by the Consultant Trainer on the “cascading” process**

The Project also attempted to implement a “cascading” process of learning. Staff members who had attended the teaching sessions and on-ward sessions were to act as supervisors to the remainder of the ward team in teaching them core knowledge regarding SFBT. The PMG determined that as the wards had different ways of
working, the wards would decide how they would implement learning for staff members on a ward by ward basis.

Although this part of the project was not formally evaluated, during his ward visits, the consultant trainer became aware of the various approaches that were being utilised. Some wards decided to integrate aspects of the SFBT approach into several features of their day to day functioning, including Supervision, Team Meetings, Reflective Practice Groups, CPA and Daily Report Sheets. On other wards staff ensured that their colleagues and students read the handout provided. They were then given opportunity to discuss this and sometimes watch the SFBT approach in practice; as demonstrated by other members of staff or the consultant trainer. Another ward implemented a more structured training programme where parts of the handout were presented and discussed on a weekly basis. Whilst the cascading process was not separately evaluated it was commented upon in some of the qualitative responses of the ward staff.

*My supervisor (clinical) has commented that I have become more useful and supportive to my colleagues. This probably because I am more confident in talking to other staff about their dilemmas in delivering care.*
Staff member - end of project

Feedback gathered from those members of staff who were involved in the cascading process was mixed. One staff member commented upon the relative inexperience of staff cascading their learning and the limitations of this.

*I also think that the members of staff who were receiving the information from the people who did attend the training would have benefited far more from actually attending the training themselves and the accompanying support from Greg (or another person who has had many years practising such techniques) as opposed to individuals who are still new to the approach.*
Staff member (who had not attended teaching days) – end of project

Also some of the trained staff found difficulties also presented themselves in terms of the practicalities of making time available and the existing attitude of some staff members.

*Although I can see the logic in staff who attended the project cascading the information to the rest of the team in their workplace, this proved difficult, for a number of reasons, i.e. time and general reluctance of some members to “try something new”.*
Staff member – end of project

The author's own observations on the cascading process were that some wards were able to cascade the training more effectively than others. These wards had several common factors including: their respective CTMs attended the teaching days; an ability to utilise the SFBT approach in situations other than one to one work; and trained staff members being available to meet the author for the on-ward sessions. On these wards the author was more likely to see examples of the SFBT approach being practiced and non-trained staff members being available for both coaching sessions with the author and observation of his practice with patients.
5. DISCUSSION

Staff members participating in the project were drawn from a variety of nursing grades. Most of these staff members brought with them considerable experience in working with adults in an acute in-patient setting and many contributed towards the management of their respective wards. However, their overall level of previous knowledge, training and utilisation of SFBT techniques was either low or non-existent. Hence, for almost everyone in attendance at the initial two days of teaching, this was the first time they had been introduced to the techniques of SFBT. However, by the end of the two days the test scores achieved indicated that all the staff members had learned the basic SFBT techniques and consequently the teaching methods applied were seen to have been effective.

The teaching days were then followed by on-ward sessions provided by the consultant trainer, which formed the work based learning element of the project. When these sessions occurred, this part of the project was effective in assisting members of staff to develop their knowledge and practice skills. However, the consultant trainer noted that staff found it difficult to join him in discussing their practice and were often distracted or interrupted by other events happening on their busy ward. Difficulties in staff attending live supervision sessions and demonstrating their utilisation the approach stemmed largely from the unpredictable demands of ward life, the necessity for staff to be available to deal with a variety of situations and the unavailability of patients. All staff, regardless of their grade, found it difficult at times to organise and attend sessions with the consultant trainer, or to avoid being interrupted within sessions, due to the need to manage situations involving distressed patients. Also, on some occasions that sessions were arranged, patients were not available due to undertaking other commitments such as meetings with professionals and / or family members, as well as, being “off ward” in preparation for a return to the community. Staff were also unavailable to attend set sessions due to changes in shifts and supporting their colleagues on other wards. This had the effect of reducing the number of live supervision sessions that staff and patients were able to participate in and led to supervision and coaching taking place on an ad hoc rather than planned basis. Finally, the project impacted upon time available for the staff member to undertake other necessary tasks and had a consequent effect upon their colleagues. As one staff member commented

“The only problem was finding time to see Consultant Trainer. It’s always busy on the Ward and it took a big chunk out of the shift – which other staff did not tolerate.”

Staff member - end of project

Within the PMG possibilities to address difficulties in the availability of staff were discussed. This included the use of audio and video recordings of staff in one to one sessions with patients to share later with the consultant trainer, which was not deemed feasible due to concerns about the safeguarding of patients’ confidentiality. Also, towards the end of the project it was arranged for the consultant trainer to move between wards within the Becklin Unit if staff were unavailable on the designated ward. However, this was only partially successful as his unexpected arrival on another ward only occasionally led to the provision of coaching and supervision and no additional live supervision sessions.
In retrospect, rather than the patients and staff coming to the consultant trainer, perhaps the consultant could have shadowed staff members throughout much of his time on the ward. This would have greatly increased the number of observations made by the consultant trainer of interactions between patients and staff members and allowed him to provide some immediate suggestions and brief supervision sessions with staff shortly afterwards. Such an approach could also have been used to develop skills by promoting the use of SFBT questions in various situations where they were not asked when they could have been. Also, if such an approach was developed and applied in the future, direct observation of practice would be particularly useful as a demonstration of competency towards certification as part of a qualification on university nursing courses.

In conclusion as a consequence of limited staff availability to meet with the consultant trainer only approximately one third of staff members were able to demonstrate to the consultant trainer their developing knowledge and practice skills. Another third of staff were able to demonstrate their developing knowledge and the final third were unable to demonstrate further development of their knowledge or practice skills.

Whilst putting time aside to meet with the consultant trainer was at times difficult for all staff involved in the project, for the two thirds who did manage to meet with him to discuss their utilisation of the techniques they had learned, or demonstrate their practice of the approach, their overall perception at the end of the project was that this had been beneficial. This is likely to have been influential in the overall rise in confidence and capability reported by staff in both the TARS (Milne and Noone 1996) and the Bowles et al (2001) questionnaires, an example of which is noted below.

*The sessions have helped me to become more confident in talking to patients especially when they are distressed plus the fact that I now have more options in terms of therapeutic approaches to use during 1:1 sessions.*

Staff member – end of project

This regular access to someone with experience of applying the approach was acknowledged as being useful by the staff involved and the reasons for the relative shortage of live sessions are most likely to be related to actual ward life rather than the SFBT approach which greeted with some initial wariness and scepticism by several of the staff members involved. All ward staff are likely to have been familiar with the both the traditional medical model and the resulting PAP (Problem Action Plan) approach. Within such an approach the importance of the problem is emphasised. In stark contrast, the SFBT approach emphasises patient strengths and exceptions (times when the problem is not there, or is happening less). The SFBT approach of building solutions rather than identifying and solving problems was understandably greeted with some uncertainty by staff members. During the teaching days, staff were discouraged by the consultant trainer from challenging the perceptions of patients and to generally validate their feelings and thoughts about their experiences before moving on to identifying what the patient wanted. Some members mentioned their doubts to the consultant trainer during the teaching days, whilst others later noted their colleagues on the wards were sceptical to such an approach.
“Unfortunately because a lot of staff do not understand it (SFBT) they get the wrong impression and believe it is colluding with service users delusions or going directly against other team approaches…”
Staff member - end of project

However, once staff tried applying the SFBT techniques that they had learned during the teaching days on the wards, their scepticism lessened and the approach was seen as more appropriate. This enthusiasm for the SFBT approach was noted by the consultant trainer on the first day of visiting certain wards when some staff had either come in early or stayed or following the end of their shift to meet and discuss some of their initial applications of the approach with him. Although some difficulties emerged in staff availability to attend live supervisions with the consultant trainer this enthusiasm continued throughout the length of the project.

Two other unexpected learning points emerged from the project. Firstly, the presence of the presence of the CTM on the two days teaching is likely to have been influential in their wards being able to utilise SFBT in a variety of ways and the promotion of the project amongst all ward staff. Generally the wards that sent their CTM were able to utilise the SFBT approach in more innovative ways than the other wards that largely stayed with the one to one approach. For example, on these wards in addition to one to one sessions with patients, the approach was used in supervision, team meetings, induction and the reflective practice group. Also, on one occasion one CTM utilised it when supporting staff following an incident of patient self harm. Lastly, wards that sent CTMs appeared to have less difficulty in gaining approval of other team members for using the approach with patients as their team members were more accepting of their colleague’s use of the approach and consequently they were also more receptive to the cascading of SFBT practice.

Secondly, the adaptability of an SFBT approach by staff to various aspects of ward life became apparent throughout the project period. This use of the SFBT approach beyond the anticipated one to one sessions between staff and patients. For example, as noted above some CTMs reported using the techniques within team meetings and line management supervision. Additionally, two members of staff began to utilise SFBT within the CPA daily record sheets and upon the initial arrival of patients on their ward. Another member of staff was developing its possible use within groupwork. This flexibility of an SFBT approach even spread to the consultant trainer when he met with the relatives of patients and engaged them in useful conversations around the care of their relative. Thus, although it was not expected several indicators of the establishment of a “ward culture” of SFBT practice began to appear on some wards stimulated by both the CTMs attendance on the teaching days and various staff member’s imaginative use of the approach.
6. CONCLUSIONS

In May 2005 a proposal was made by the Assistant Director of Nursing & Clinical Governance for a project to be undertaken with staff working in acute adult in-patient settings. The anticipated benefits of the project were to:

a) To improve the brief psychological intervention skills of in-patient mental health nurses on acute in-patient wards in Leeds.

b) To improve the experience of in-patient wards for service users and carers by developing a more meaningful day.

c) To contribute to reducing the level of absconding by service users from in-patient wards.

d) To explore the benefits of work based learning over more traditional forms of teaching and learning.

A consultant trainer was appointed to provide two days of introductory teaching in SFBT for 16 selected members of staff who were then working on six wards. The consultant trainer also regularly attended the wards to provide sessions with staff to assist their knowledge and practice skills in applying SFBT.

Improving the brief psychological intervention skills of in-patient mental health nurses on acute in-patient wards in Leeds.

Of all the SFBT techniques, Scaling was reported to be the one most regularly utilised by staff. The ease with which staff and patients were able to make use of this tool was unsurprising for the consultant trainer as it is known to be the technique staff most often begin to utilise after being provided with training in SFBT. Scaling is used in a particular way in SFBT and the relatively low score given to it in feedback from untrained staff in comparison with the other techniques perhaps indicates the need for further training.

* I find the new techniques that I have learnt extremely useful, and I now work in a way that is more structured- mostly underpinned by the scaling techniques which service users and I incorporated into treatment plans.

Staff Member – end of project

On the other hand, staff found it more challenging to identify a patient’s past successes and their present strengths. This apparent difficulty for staff may be related to the prevalence of problem solving approaches utilised on the wards and the lack of staff practice in recognising the presence of such attributes. It is the consultant trainer’s experience that such awareness can be encouraged through regular practice of the techniques and reflection upon sessions conducted with patients. Consequently, staff who were able to participate in more of the on-ward sessions provided by the consultant trainer were those most likely to have developed their abilities to recognise patient’s resources than those who attended less sessions.
Improving the experience of in-patient wards for service users and carers by developing a more meaningful day.

The service user and carer experiences were not formally evaluated as part of the project. Also, due to the specific requirements of collecting information from patients, the PMG decided to focus the project upon the staff involved and their perspectives, rather than those of the patients and carers. It is however, strongly recommended that such an evaluation of patient and carers perspectives would form an integral part of any possible continuation of the project. Staff members reported the use of SFBT techniques as useful with patients. It can be surmised that patients benefited from the project as no concerns were voiced. Consequently, the evaluation of the project focuses upon staff knowledge and acquisition of skills and the experience of attempting to provide work-based learning opportunities. The perspectives of patients and carers will be needed as the project continues.

Contributing to reducing the level of absconding by service users from in-patient wards.

As levels of absconding were addressed by a separate project no formal evaluation of this element was attempted. The absconding project will be reported on elsewhere.

Explore the benefits of work based learning over more traditional forms of teaching and learning.

Both the second questionnaire completed by staff, and the notes kept by the consultant trainer, indicated that live supervision sessions were an effective way for staff to demonstrate their developing knowledge of SFBT and their practice skills. However, the anticipated number of sessions did not take place for a variety of reasons related to the demands of ward life. This limited the opportunities for staff to demonstrate their developing knowledge and skills to the consultant trainer, though approximately one third managed this and another third indicated they were utilising the techniques regularly in their contact with patients. These demands upon staff are likely to remain and hence other possibilities to enhance the usefulness of the on-ward sessions need to be examined. Two such possibilities which could be scrutinised further are the accompaniment of staff during shifts by the consultant trainer and the use of video / audio recording of sessions. Both would enable further opportunities for reflection by staff on their practice and feedback by the consultant trainer to be provided. Limited staff availability also affected the possibility of their attendance at weekly meetings to discuss their practice of SFBT and consequently was not pursued. However, staff noted the benefits of the one “refresher” session that took place. Hence other ways of encouraging peer discussion of the approach between staff from the same wards, and staff from different wards, could be beneficial in improving staff levels of knowledge and skills. Despite these limitations to the on-ward sessions staff overwhelmingly found the SFBT approach useful for themselves in engaging with patients and continued to use it throughout the project period. Also, all staff indicated their intention to continue practicing this way beyond the length of the project and in some cases within new workplace settings.
The CTMs attendance at the teaching days and the recognition of the different uses of SFBT within day to day ward life beyond one to one sessions with patients was found to be important in the "cascading" of the project to other staff members. Ensuring that CTMs have good levels of knowledge and understanding of the SFBT approach, whether via training or other methods, would appear important in any future promotion of the approach among all staff on individual wards. Also, the sharing with all staff from other wards of how some wards integrated the SFBT techniques into their ward practices would provide good opportunities to cascade useful information about SFBT practice across all six wards. Also, the SFBT approach on these wards was seen as flexible enough to incorporate into the daily working practices of the whole ward team which increased the opportunities for all staff to gain knowledge and practice the techniques. As consequence of these unexpected uses of SFBT, staff on these wards who had not attended the teaching were given more opportunities to observe staff modelling an SFBT approach and the cascading was more effective. Also, as staff had more opportunities to practice SFBT they were less reliant upon one to one sessions with patients to increase their proficiency in this approach.

Finally, there was no formal accreditation provided to staff for the training they had undertaken and the practice they had demonstrated. The introduction of University recognition of the teaching days and on-ward sessions would be likely to enhance the status of any future continuation of the project amongst staff and encourage the use of SFBT on the wards and staff participation in continuing to learn and practice the approach. Also, certification of staff practice would boost their likelihood of career progression within the Trust and provide them with a set of knowledge and skills which could be transferred to any future work setting.
7. LIMITATIONS

The main driving force behind this project was a need to improve the psychological interventions of mental health staff on acute wards. The evaluation focuses on the perceptions of staff. The views of service users and carers were not sought at this time. Only 16 staff members were involved throughout the whole project period and this is a minority of the total staff employed on the six acute in-patient wards. No attempt was made to ensure a representative range of staff from the wards attended and hence this is not necessarily reflective of the staff group as a whole.

How the project was to be cascaded to other ward staff was not formalised at the beginning of the project and subsequently different approaches were applied on all six wards. Unsurprisingly, this produced different outcomes with the wards who sent their CTM and more members of staff generally finding it easier to attend sessions with the consultant trainer and implement the cascading of the project with other staff. However, there was no evaluation or comparison of the different approaches and subsequent learning from this of how cascading could be more effectively applied in the future.

The conducting of the evaluation including the utilisation of questionnaires and the compiling of this report has been undertaken by the consultant trainer. There is an obvious potential for bias within this process, though some of this has been lessened by the involvement of the PMG in both the project and the report.

Finally, the project has been conducted on a “stand-alone” basis with no commitment being given to the future direction and funding at the outset. If staff are to maintain and increase their skills a commitment to establishing future support and guidance for the staff who have been trained is required to reduce the likelihood of the skills that have been developed by staff slowly diminishing and patients receiving less interventions and benefit from an approach that has shown considerable potential.
8. RECOMMENDATIONS

If the project is to continue, funding would need to be identified to address the following recommendations:

1) Essential to any continuation of the project should be an evaluation of the perspectives of service users and their carers of the usefulness of the SFBT practice of staff on wards.

2) The training of all ward staff in SFBT to continue - from consultants to cleaners and “bank staff” - and to include an increase of practice opportunities within the teaching days by either slight alteration to the programme or the addition of a third day to embed practice skills.

3) On-ward sessions to be provided by a consultant trainer until staff become confident in their own ability to apply the approach and to teach it to others. The “shadowing” of staff by the consultant trainer would be an important element of this

4) Consideration to be given to different ways of providing more frequent levels of contact between staff and the consultant trainer during on-ward sessions. This could be achieved by either extending the consultant trainer’s time allocated to the Project, or by focusing any future project on one or two wards at a time.

5) The promotion of CTM involvement with the SFBT training to be encouraged to enhance their own and their staff understanding and use of the approach.

6) A ward culture of SFBT to be established. This would include CTMs on wards where SFBT has been utilised in different ways - beyond one to one work - to share their findings with staff from other wards and the continuation of this process via regular meetings between both staff on the same ward and staff on different wards.

7) Manual of SFBT practice on-wards to be developed containing SFBT resources details of possible exercises to be utilised with staff members to develop their skills.

8) Finally, in terms of continuing professional development, a programme of accreditation should be pursued with local universities to provide participating staff with a suitable and transferable qualification and acknowledgement of their knowledge and skills in SFBT.
REFERENCES


PRIME (2003) Primary Care Mental Health and Education - Vol. 7 no.3 Whole Issue

PRIME (2005) Primary Care Mental Health and Education –Vol. 8 no.3, 81-87


www.ebta.nu – European Brief Therapy Association

www.nihme.org.uk National Institute for Mental Health for England website


Leeds Mental Health Teaching NHS Trust

PROJECT PROPOSAL TO INTRODUCE SOLUTION FOCUSED THERAPY IN ADULT MENTAL HEALTH IN-PATIENT UNITS

Author: Ian Clift, Assistant Director of Nursing & Clinical Governance – May 2005
1. INTRODUCTION AND BENEFITS

This project seeks to equip in-patient mental health nurses with solution focused therapy skills through a work based learning approach. The NIMHE guidance for adult acute in-patient units (2004) indicates the importance of psychological intervention skills for staff as being important towards improving the experience of these units for service users and carers.

Solution focused therapy is known to be successful in improving the communication and intervention skills of nurses. It is known to be an inexpensive approach that encourages nurses to interact with service users where perhaps this would not have been previously the case (Bowles et al 2001).

This approach will engage a consultant trainer to work with six in-patient clinical teams to educate and assist them to acquire such skills. This will be achieved through a combination of teaching, coaching, supervision and live casework.

It is envisaged that the project will benefit staff by assisting them to acquire skills that recognise the rapidly changing clinical environment in which they work, and ensuring that service users will receive meaningful psychological intervention.

This project will compliment an existing project which is seeking to reduce the rate of absconding by in-patients. Service users are reporting both locally and nationally that one of the causes for their absconding is the lack of a meaningful day activity, particularly the absence of meaningful psychological interventions.

This project will also seek to explore a dynamic process regarding the manner in which staff acquires new skills. It seeks to find a new model from that which is traditionally known, i.e. university based academic teaching and theoretical assessments to one which is work based learning where the acquisition of new skills is undertaken during live clinical situations.
2. PROJECT AIMS

The project within a period of six months will seek to achieve the following aims:

- For the external consultant trainer to teach three staff from each unit core in depth knowledge regarding solution focused brief therapy.
- For the external consultant trainer to work intensively with three staff members from each of the six acute in-patient units on live supervision and feedback regarding their work with six service users. These three staff will then act as supervisors to the remainder of the unit team in teaching them the core knowledge regarding solution focused therapy.
- For the project consultant to offer intensive mentoring and supervision to the three members of staff from the six units over the life of the project with the intention of generating a greater degree of expertise, so as to ensure continuity beyond the project ending.
- For the project consultant to run weekly supervision groups for the six in-patient units.
- For the project consultant to administer before and after measures regarding the staffs’ knowledge and aptitude towards using psychological intervention skills. This data will serve as an important component of the review of the project with a view to learning lessons for future work based learning approaches with unit teams.
- For the project consultant and management team to produce an evaluation report that will assist the trust in managing further similar approaches in the West Yorkshire WDC in commissioning work based learning activities.
3. PROJECT TIMELINE

**July 2005**
- Establishing and completing a core teaching programme.
- For the project consultant to establish arrangements for live supervision and supervision groups.
- For the project consultant to establish arrangements for intensive work with three members of staff from each of the six units.
- To establish and commence reporting arrangements to the Clinical Team Manager Project Management Group.
- To undertake pre-project measures of the staff’s psychological intervention skills.

**August to December 2005**
- Continuity of arrangements for supervision, mentoring, project management arrangements.

**January 2006**
- Completion of project evaluation report. Report findings to the Trust, Workforce Development Confederation and seek to publish project outcomes.

4. PROJECT MANAGEMENT ARRANGEMENTS

The Clinical Team Manager Group will act as the Project Management Team for this project. The group meets weekly and the membership also includes the Clinical Services Manager for the adult in-patient units as well as service user development workers. The external consultant trainer will report fortnightly to this group. It is anticipated and recognised that the group will seek to solve all issues at the earliest opportunity. With the Clinical Team Managers acting as the Project Management Team, this will serve to enhance continuity as well as a successful completion of the project. The Clinical Team Managers will have the added benefit of being line managers of the staff involved in the training, thereby enhancing communication and resolution of issues.

The consultant trainer and the Clinical Team Managers will work jointly to both monitor ongoing project management issues as well as the production of a final evaluation project report. The report will be further enhanced using measures (to be agreed), which the Clinical Team Managers will ensure are effectively used and implemented.
5. PROJECT COSTS

The project will be completed within a six month period of the current financial year. The major, and only, cost will be the time of the consultant trainer. Therefore, the costs are as follows:

26 weeks x two days per week (£360 per day), Inclusive of employer costs £18,720

Project administration costs – secretarial support (copying, use of assessment measures etc). £1,200

TOTAL £19,920

6. ANTICIPATED BENEFITS

The anticipated benefits of this project are as follows:

a) To improve the brief psychological intervention skills of in-patient mental health nurses on acute in-patient units in Leeds.

b) To improve the experience of in-patient units for service users and carers by developing a more meaningful day.

c) To contribute to reducing the level of absconding by service users from in-patient units.

d) To explore the benefits of work based learning over more traditional forms of teaching and learning.
### Appendix Two - TIMETABLE OF PROJECT EVENTS AND EVALUATION

<table>
<thead>
<tr>
<th>DATES</th>
<th>PROJECT EVENTS</th>
<th>EVALUATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Late August / early Sept 05</td>
<td>Consultant Trainer makes “introductory” visits to all 6 wards</td>
<td>Notes made by Consultant Trainer</td>
</tr>
<tr>
<td>Early Sept 2005</td>
<td>Identification for SFBT training of selected Staff and Managers from Wards 1-5 Becklin and Ward 4 Newsam, plus Practice Development Lead</td>
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<tr>
<td>12th and 15th Sept 2005</td>
<td>Two Days Training with Consultant Trainer in SFBT Assumptions and Techniques) (n - 19)</td>
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</table>
| 19th Sept to 30th Jan 06   | Consultant Trainer visits all 6 Wards for SFBT “sessions” (9.30AM to 12.30PM or 1PM to 4PM) | • Notes made by consultant Trainer  
• “sparkly moments book” |
| 24th Nov 2005              | Refresher Training Session                                                      | Record of Attendance                             |
| Late Nov 2005 to end Jan 06| “Cascading” of Training to other staff and students                             | Questionnaire “B”                                |
| 30th Jan 2006              | End of “sessions” on-wards                                                      |                                                 |
| 28th Feb 2006              | Evaluation Report and end of Project                                            | Questionnaire “A” including  
• TARS (2)  
• Confidence and Capability (2)  
• Additional Questions |

Project Management Group Meetings held regularly between September 2005 and February 2006
### Appendix Three - Previous Knowledge and Training in SFBT

<table>
<thead>
<tr>
<th>SFBT “Technique” / “Tool”</th>
<th>Previous Training (in SFBT)</th>
<th>Previous Knowledge of SFBT</th>
<th>Utilised in Workplace</th>
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<td><strong>Other SFBT “Techniques”</strong></td>
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  • A little  
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  Please circle your answer |

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<tr>
<th><strong>Any Other Comments</strong></th>
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Appendix Four

History of SFBT

The development of SFBT has been influenced by the findings and discussions of several researchers and practitioners over the past 60 years. Key to this process has been Gregory Bateson, Milton Erickson, John Weakland, Steve de Shazer and Insoo Kim Berg. Also, influential institutions include: The Mental Research Institute of Palo Alto and the Brief Family Therapy Centre in Milwaukee. In recent years, similar approaches have appeared e.g. Solution Orientated Therapy (Ahola and Furman) that share with SFBT the concept of paying less attention to the problem and more attention to the possible solutions.

Further details of the SFBT history are contained in the last chapter of Jackson and McKergow (2002) Also, Alistair Macdonald (European Brief Therapy Association) is compiling a history of the development of SFBT which may be available later in 2004.

1. What is Solution Focused Brief Therapy?

Solution – Solutions not “problems”
The worker attempts to assist the client in identify what would be happening in the future when the “problem” is happening less or not at all. I.e. solutions are built rather than “problems” are solved.

Focused – Focused not forced.
The worker and the client are focused upon a future where the “problem” does not exist or is less of a problem and on the times in the past, and present, when the “problematic” events have not occurred.

Note: There will be times when the client wishes to speak about the “problem” and at these times the worker should acknowledge the difficulties, as well as, looking for and commenting upon the client’s abilities and strengths in coping with the “problem”.

Brief – Not one more session than is necessary.
The length and number of the sessions is agreed in partnership with the client. Both the client and the worker should be clear about what will be happening when the client no longer needs to meet with the worker. This can often be established in the first meeting. Thus, finishing is incorporated from the beginning and sessions are only as long as they need to be.

Therapy – Two people talking, with one trying to help the other.
Essentially, the purpose of the session(s) is for the worker and client to engage in conversations that are deemed useful by the client.

2. Solution Focused Brief Therapy “in a nutshell”

Four Steps
1. What do you want?
2. How will you know when you have it?
3. What are you doing already to get there?
4. What would be happening if you were a little closer to what you want?

Three Principles 1
a. If it ain’t broke, don’t’ fix it
b. Once you know what works do more of it
c. If it doesn’t work, don’t do it again: do something different
2. Concept of “Problem”

People seek help because they have a problem and want something to be “better”. Traditional approaches emphasise the problem and the need to understand it. Generally “problems” are just something that the client wants to do without, or something they want to do more of. Given that the client has constructed the “problem”, they are in the best position to say when a problem has been resolved. In solution focused work, it is not essential to understand the problem in great detail before identifying possible solutions.

3. Useful / Helpful Beliefs in SFBT

Useful and helpful are key terms in the application of SFBT. Both of these terms are applied to the client’s perspective of what is happening during and between sessions with the worker. Other assumptions include:-

- The client is not the problem. The problem is the problem. The problem occurs in the interaction between people rather than residing within people.
- All clients have the ability to find their own solutions to the difficulties that they have. An effective SFBT worker can assist in this process.
- A client’s solution is more likely to fit their particular situation and more likely to be implemented and maintained.
- Diagnosis is not destiny – the future is not fixed
- Change is inevitable and constantly occurring. Simply because an event has happened in the past does not mean it will always occur again the future
- Small changes can make a big difference
- Problems that appear complex, may not necessarily require a complex solution
- Problems are not always present, or at their worst. Exceptions occur.
- Try to identify what’s going well (rather than what’s going wrong)
- Everybody has had different life experiences and hence have different perspectives of what constitutes “reality”.
- It would be impossible to find a model that fits everyone – try to identify what works for each individual client.
- Aim for client’s to take responsibility for the future rather than to accept blame for the past.
- Interventions should increase choice. Don’t work towards “changing behaviour”; work towards “increasing choices”.


4. SFBT “Techniques” To Promote Competence

People’s lives contain much more than the sum of their problems. In Problem Free Talk the worker attempts to help client to locate their resources and build upon their strengths. It also establishes areas of competence – rather than underlining “incompetence” - in the client’s life. Additionally, the client’s abilities from the past and present can be utilised to build solutions in the future and encourage a view of themselves and others that is helpful in promoting change.

- What is happening in your life that you enjoy?
- What do you do well?
- What do you like about your family / son / partner etc
- What school classes do you enjoy?
- What interests do you have?

Change is happening all the time and hence change often takes place between the initial request for support and the first meeting with the worker. As this change has happened before the worker became involved; the client can take full credit for any change that has occurred. Additionally, inquiring about Pre-Session Changes can identify unsuccessful attempts to resolve the problem, which do not need to be considered again.

- “What differences have you noticed between the time that you decided to ask for help and today?”
- “What have you already attempted to do to reduce or eradicate the problem?”

Exceptions also identify solutions that have been utilised in the past, or are presently being used i.e. the behaviours that the client has previously, or presently, displayed to cope with or lessen the effects of the problem can be acknowledged and utilised again. Thus, the details of the Exception times can be used to encourage clients to do more of what they are already doing, or have done, that works.

- “Tell me the last time you did not lose your temper / offend with your friends when normally you would have done?”
- “What’s been your best lesson in the school this week?”
- ‘If tomorrow turned out to be a good day for you, how will you know your day was going well?’

Note: It is also possible at the initial referral stage (or in a letter confirming their place on a waiting list) to prompt clients to identify times when the problem is happening less or not at all. This information can then be acknowledged and utilised in the first session with the worker.
6. SFBT “Tools” To Establish Goals

Thinking in a future framework frees people from the limitations about what is not going right, their doubts, their difficulties and the reasons not even to try. Also, if the client’s contact with the worker is to be no longer than necessary, then it is important that clear goals are established, preferably in the first session. Alongside clarity, the goals of therapy need to have detail to ensure the client and the worker can identify both, the progress made towards the goals and when goals are attained. Finally, the clearer and more ‘do-able’ the future is, the easier it is to work out ways of getting there.

Note: the goals may change from session to session as often a point is reached where things are “good enough” rather than “perfect” and other life events can lead to a change in the client’s priorities for change.

• “What are your best hopes for today’s session?”
• “What needs to happen in this session to enable you to leave thinking that it was worthwhile coming here?”
• “How will you know things are good enough for you to stop requiring to see me / finish therapy?”
• “What needs to happen in these sessions so that Mr / Ms (Year Head) says, “I’m really glad you came to see me?”
• “What needs to happen in these sessions so that Mr / Ms (Social Worker) says, “We can now give serious consideration to removing your child’s name from the Child Protection Register / returning your children from care?”

Note: With these latter two questions it would be important for the client and worker to know what are the expectations of the other professionals. The details of these expectations can be identified either before, or following, the session.

“Suppose that tonight while you were asleep, there was a miracle and this problem that brought you here today disappeared. The miracle occurs while you are sleeping so you do not immediately know that it has happened”
“When you wake up, what is the first thing you will notice that will let you know that there has been a miracle?
Then, “What else?”
“What will others notice?”

Adapted from (http://www.brief-therapy.org/steve_miracle.htm)

Key Points

1) Locate the future description firmly in the context of their lives at home, or in school etc.
At school, “In your first lesson in school, what will be different when you enter the classroom that will tell you that things are different?”

2) Build rich description by asking about the fine details of what people will do. e.g., “When you wake up tomorrow.
• What time will that be?
• What is the first thing that will tell you that the miracle has happened and that things are different?

3) Gather other people’s perceptions
• “What’s the first thing that your mum will notice, that will let her know that things are different”?
• “Who will be the first person in school to notice? What will they notice?”
• When you do… what will your partner / children be doing?

4) Ask the client to identify which parts of the miracle are happening already. Typically, a significant part of the miracle is already happening.

Scales are one of the most accessible and flexible tools for establishing goals and identifying progress. Scales are also easily understood from the young to the old. Similar to the Miracle Question; scales are essentially conversational frameworks that encourage the client to create their preferred future and indicators of progress towards this goal. Scaling also identifies progress already made and can establish what would be happening if things were (even just slightly) better. Finally, scales can be constructed to encourage useful conversations about almost any situation and also elicit helpful details about the present and past, as well as, the future.

Scaling can be used for a particular heading or where in general the person is on the scale e.g.

- How stressed are you at this time in your life? 10 (ten) you are very stressed, 0 (zero) you are not stressed at all. What number represents what you are thinking?
- “Let’s say that 10 are the best things could be and 0 is the complete opposite of this. Where between 0 and 10 would you say you are today?”
- “If you are at X on the scale, what would be happening at X+1?”

0 1 2 3 4 5 6 7 8 9 10
{ Y – progress already made}(X) (X+1) {Z -Good enough}

Scales can also be constructed 0 - 100 and include minus figures if things are getting worse, or have been worse. Generally progress is movement towards 10, though some scales can have progress in terms of something happening less and progress is then towards 0.

Important Tips
- Do not “skip” progress the client has already made and go straight for the progress (X+1). Ensure details of progress already made are discussed fully.
- Let the client identify what needs to happen for them to get to (X+1). Often simply helping the client to identify what is happening at (X+1) is enough for the client to begin to plan what they would need to do differently.

In SFBT tasks are not necessarily given and often change relates to the way the client perceives their situation rather than the objective elements of the situation changing.

In terms of acknowledging strengths, exceptions, progress etc - remember EARS: Elicit, Amplify, Repeat, Start (Again)
7. Common “What if” Questions

1) What if the client wishes to speak in detail about their problems?
   – Listen to the problem story.
   – Try to identify strengths and exceptions.
   – Validate the client’s thoughts and feelings and praise the client for their attempts to cope with
     and resolve the problem.
     “How did you cope with this…?” or “How are you managing to cope despite…?” can be useful
     responses identifying strengths and resources whilst dealing with problems.

2) What if the client struggles in talking about themselves?
   – Ask for the perspectives of other people in the client’s life.
   – “If they were here, what would your friends / parents say they like about you?”
   Use other means of expression and communication; drawing, sculpting the miracle etc even making
   a scale on a computer with a picture of a bridge / tower, or printing off large numbers and walking up
   and down the scale.

3) What if the miracle stated seems impossible?
   Generally, it is useful to run with the miracle given even if it seems highly unlikely. E.g. “So you win the
   lottery. What would you do with the money? What difference would that make? Steve de Shazer has
   even spoken of asking people who talked of suicide “What do you imagine it would be like if you were
   dead? Often such a response can elicit the client’s goals that may be achievable without the client
   winning the lottery or killing themselves.
   Additionally, most clients recognise that the worker is not able to bring someone back from the dead or
   reverse an amputation etc. However, it may be useful for the client to identify what is the best that
   things could be given their circumstances. Thus, if 10/10 is not possible what would 8/10 (good
   enough) look like.
   - “It is understandable that you would want the return of that person / leg back in place. However, what
     would be happening if things were 8/10 and what would be happening if things were just a little bit
     better?”

4) What if the miracle stated is unethical / immoral / illegal?
   The worker is not obliged to assist the client in achieving their goals, particularly if the goals are
   harmful to another person. E.g. A client who wishes to continue abusing children, but does not want to
   be caught and sent to prison. However, identifying a shared goal of the client not being sent to prison
   can be a starting point for a conversation about what would have to change for this not to happen and
   what would increase the risk / decrease the risk etc. Obviously, such a conversation would include
   addressing alternatives to the abusive behaviour.

3) What if the client cannot identify a preferred future?
   This can often be an issue for teenagers and some adults and generally if the client cannot identify
   what would be better (even slightly better) in the future then encourage them to identify a time in the
   past when things were better.
   - “When, in the past, were things better for you than they are now? What was happening then? Is
     there anything that you, or others, did then that could be repeated now?”
   Sometimes reminding clients through the use of numbers on a scale (without details of what the
   numbers represent) is enough to remind them that in life change happens and at different times things
   can seem worse or better than in the past.
Finally, many clients usually respond well to writing letters to themselves from the adult they hope they will be in 10 or so year’s time. The letter contains details what they are doing and how they achieved this.

4) **What if in subsequent sessions the client says things are worse?**
   - Ask “How did you stop things from getting even worse?”
   - Ask “How did you get things “back on track?”
   - Ask “How are you coping with that?” or “How did cope with that?”

5) **What if the client does not want to be there?** (Involuntary clients)
   - If they have “been sent “ by another professional / parent; establish with the client (and possibly the other person) what this person would need to see happening before they agreed to the client not coming to any further sessions.
   - “What needs to happen to get XXX ‘off your back’?”
   - Also establish joint goals e.g.
   - “We do not want to meet more than is necessary. What needs to happen within these sessions and between our meetings to reduce the number of times we meet and to also make our time together useful for you?”

6) **What if the client wants someone else to change their behaviour?**
   - “What will you do when they start to behave that way that demonstrates you have noticed their change and encourages them to behave that way more?”
   - “Can you pretend they are already doing what you wish and begin to behave in that way?”
   - “What are the chances of that happening?” (Scale) “What can you do to increase the chances?”
   - “What if the person does not change?” “How will you cope?”

7) **Similarly, what if the problem is viewed by the client / their partner / family as located in one person?**
   Try and externalise the problem / “habit” and mobilise the resources of all of those present to beat it. E.g. Make a game of the couple / family vs the “habit” where everyone has to notice when the behaviour is taking place less or not at all (or more if that is the goal) and then everyone to compare notes and give praise, rather than criticism, on a daily or weekly basis. Aim towards building new skills rather than stopping unwanted behaviour.

References
5. Ibid p.147

Bibliography
"All of the facts belong only to the problem, not to its solution" Wittgenstein

"Each person is a unique individual. Hence, psychotherapy should be formulated to meet the uniqueness of the individual's needs, rather than tailoring the person to fit the Procrustean bed of a hypothetical theory of human behavior"

**Milton Erickson**

Appendix Five – SFBT TEST

NAME:

Total Score: / 100

SFBT TEST

Assumptions

1) A Solution Focused Practitioner attempts to have (what type?) ……….. of conversations? (5 points)

2) A Solution Focused Practitioner would emphasise a) the problem, or b) the solution?……………… (5 points)

3) Complete this phrase “Diagnosis is not ……………” (5 points)

4) How "big” do changes have to be to make a difference? Small / Medium / Large (circle one)? (5 points)

5) Give two examples of differences between the Solution Focused “Model” of practice and other models of understanding and working with problems.
   a) (5 points)
   b) (5 points)

   “Techniques”

6) In SFBT “Problem Free Talk” helps the worker and client to identify
   a) (5 points)
   b) (5 points)

7) In SFBT “Pre-Session Change” helps to identify
   a) (5 points)
   b) (5 points)
8) Times when the problem is happening less or not at all are called……………….? (5 points)

TURN TO PAGE TWO

“Tools”

9) Write down the words used by the worker to present the “Miracle Question” (20 points)

10) Construct a 0-10 Scale and on this diagram indicate three aspects utilised in SFBT? (15 points)

11) In feedback CNN is ………. (5 points)

12) In feedback CND is ………. (5 points)

THANKS

PLEASE RETURN TO GREG

Impact of SFBT Training Questionnaire

KEY

1.a. Please rate how CONFIDENT are you in talking with people who are troubled? (In this context the term “confident” means how self assured you feel).

Not at all confident 0 1 2 3 4 5 6 7 8 9 10 Extremely confident

2.a. On a scale of nought to ten rate how CAPABLE you are in talking with people who are troubled?

Not at all competent 0 1 2 3 4 5 6 7 8 9 10 Extremely competent

3.a. On a scale of nought to ten rate how WILLING you are in talking with people who are troubled? (In this context “willing” means how inclined you feel).

Not at all willing 0 1 2 3 4 5 6 7 8 9 10 Extremely willing

4.a On a scale of nought to ten rate how FREQUENTLY in an average week do you engage patients in conversation (whether they are troubled or not)?

Not at all 0 1 2 3 4 5 6 7 8 9 10 Very frequently

5.a. On a scale of nought to ten rate how ACCEPTING are your day to day colleagues of you engaging patients in conversation (whether they are troubled or not)? (“accepting” means how tolerant you feel your colleagues are).

Not at all accepting 0 1 2 3 4 5 6 7 8 9 10 Extremely accepting

6.a. On a scale of nought to ten how much SCOPE is there in you day to day work to engage patients in conversation (whether they are troubled or not)? (scope means how much opportunity you think there is).

None 0 1 2 3 4 5 6 7 8 9 10 Plenty
Appendix Six B – Nick Bowles Questionnaire (Part Two)

For the purpose of this questionnaire, the phrase “*people who are troubled*“ means someone who, because of what they say or because of their behaviour, you see as feeling upset, sad, worried, angry or in any way emotionally upset. All of the scales run from 0 to 10.

**Question 1a and 1b**

1a. Please rate how **confident** are you in talking with people who are troubled? (In this context the term "confident" means how **self-assured** you feel).

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<tr>
<th>not at all</th>
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1b. Please rate the extent to which the SFT training has increased your **confidence** in talking with people who are troubled?

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*Question 2a and 2b*

2a. On a scale of nought to ten rate how **capable** you are in talking with people who are troubled?

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<th>Extremely competent</th>
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<td>competent</td>
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2b. On a scale of nought to ten rate the extent to which the SFT training has increased your **capability** in talking with people who are troubled?

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**Question 3a and 3b**

3a. On a scale of nought to ten rate how **willing** you are to talk with people who are troubled? (In this context “willing” means how **inclined** you feel).

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<th>not at all</th>
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<th>Extremely willing</th>
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<td>willing</td>
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</table>
3b. On a scale of nought to ten rate the extent to which the SFT training has increased your **willingness** in talking with people who are troubled?

| Not at all | 0 1 2 3 4 5 6 7 8 9 10 | Significantly |

**Question 4a and 4b**

4a. On a scale of nought to ten how **frequently** in an average week do you engage patients in conversation (whether they are troubled or not)?

| Not at all | 0 1 2 3 4 5 6 7 8 9 10 | Very frequently |

4b. On a scale of nought to ten rate the extent to which the SFT training has increased the frequency with which you engage people in conversation (whether they are troubled or not)?

| Not at all | 0 1 2 3 4 5 6 7 8 9 10 | Significantly |

**Question 5**

5. On a scale of nought to ten how **accepting** are your day to day colleagues of you engaging patients in conversation (whether they are troubled or not)? (“accepting” means how tolerant you feel your colleagues are).

| Not at all accepting | 0 1 2 3 4 5 6 7 8 9 10 | Extremely accepting |

**Question 6**

6. On a scale of nought to ten how much **scope** is there in your day-to-day work to engage patients in conversation (whether they are troubled or not)? (“Scope” means how much **opportunity** you think there is).

| None | 0 1 2 3 4 5 6 7 8 9 10 | Plenty |
Appendix Seven - Training Acceptability Rating Scale (TARS)


Training Course: ..........................................................................................................

Date: ..................................................................................

Instructions: Please rate your agreement with the following statements on this scale:

1. strongly disagree
2. moderately disagree
3. slightly disagree
4. slightly agree
5. moderately agree
6. strongly agree

The first set of six statements concern the content of the training course that you have just completed. Please carefully note the wording for statements 3 and 4.

<table>
<thead>
<tr>
<th></th>
<th>General acceptability:</th>
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<tbody>
<tr>
<td></td>
<td>This approach would be appropriate for a variety of staff</td>
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<td>2</td>
<td>Effectiveness:</td>
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<td></td>
<td>The training will be beneficial for the staff</td>
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<td>3</td>
<td>Negative side-effects:</td>
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<td>The training will result in disruption or harm to clients</td>
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<td>4</td>
<td>Appropriateness:</td>
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<td>Most staff would not accept that the training provided an appropriate approach to client care</td>
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<td>5</td>
<td>Consistency:</td>
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<td>The training was consistent with common sense and good practice in helping staff to work effectively</td>
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<td>6</td>
<td>Social validity:</td>
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<td></td>
<td>In an overall general sense, most staff would approve of training in this method (eg would recommend it to others)</td>
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</table>
The next 12 questions focus on your impressions of the teaching process and outcomes i.e. how competently you think the training was conducted, and whether it was helpful or not. For each question please circle the statement that best expresses your opinion.

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<tr>
<th></th>
<th>Question</th>
<th>Not at all</th>
<th>A little</th>
<th>Quite a lot</th>
<th>A great deal</th>
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<td>7</td>
<td>Did the workshop improve your understanding?</td>
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<td>Did the workshop help you to develop work-related skills?</td>
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<td>Has the workshop made you more confident?</td>
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<td>Do you expect to make use of what you learnt in the workshop in your workplace?</td>
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<td>How competent were the workshop leaders?</td>
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<td>In an overall, general sense, how satisfied are you with the workshop?</td>
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<td>Did the workshop cover the topics it set out to cover?</td>
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<td>14</td>
<td>Did the workshop leaders relate to the group effectively (e.g. made you feel comfortable and understood)?</td>
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<td>15</td>
<td>Were the leaders motivating (e.g. energetic, attentive and creative)?</td>
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<td>16</td>
<td>What was the most helpful part of the workshop for you personally?</td>
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<td>17</td>
<td>What change, if any, would you recommend (e.g. to the content or teaching)?</td>
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<td>18</td>
<td>Please make any other comments that you would like to offer.</td>
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Appendix Eight
RECORD SHEET FOR SFBT PROJECT (28.9.05)

<table>
<thead>
<tr>
<th>DATE:</th>
<th>WORKER:</th>
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<td>OBSERVER:</td>
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**To Be Encouraged** *(tick if present)*

- Curiosity
- Affirmation / validation of client experience
- Normalisation
- Compliments – based on patient’s narrative
- Identification of Strengths and Resources – based on patient’s narrative
- Identification of choices / options
- Use of client’s words / phrases
- Future focus
- Past successes
- Client led goals – ability to identify solutions
- Small changes
- Client’s future responsibility
- “What else” questions
- Recognising competence

- Other(s) – please state

**Techniques**

- Problem Free Talk
- Pre-Session change
- Exceptions
- “Best Hopes” / Miracle Question/ Preferred Future
- Scaling
- Other person questions
- Compliments – client’s Strengths, Resources, Coping Skills
- EARS: Elicit, Amplify, Reinforce, Start (Again)
- Pre-suppositions - that change will occur and that the client is an active participant in that change
- Break
- Worker Feedback – tasks noticing and difference

- Other(s) – please state
Appendix Nine

Ending Questionnaire – Additional Questions for staff attending initial two days of teaching and on-ward sessions

A. QUESTIONS FOR THOSE WHO ATTENDED THE INITIAL TWO-DAY TRAINING IN SOLUTION FOCUSED BRIEF THERAPY HELD ON SEPTEMBER 2005

1) Since the initial training held in September 2005 have you used any SFBT Techniques?

2) Do you intend to continue to use the techniques following the end of the Project in February 2006?

3) If you did not utilise any of the SFBT techniques, please explain why not?

4) Did you attend the SFBT “refresher” afternoon at Seacroft Hospital?

5) If you answered “Yes” to Q.1 please list below the techniques you have used. If you answered “No” please move onto Q.7

6) Please rate the techniques in terms of their overall usefulness
   Circle the number closest to rating score.

7) Are there any other comments you would wish to make? Please include any comments upon the possible future direction of the project?
Appendix Ten

B. QUESTIONS FOR THOSE WHO DID NOT ATTEND THE INITIAL TWO-DAY TRAINING IN SOLUTION FOCUSED BRIEF THERAPY

If you did attend the two day training event in September 2005 do not answer these questions.

Name:      Ward:

1) Are you aware of the Solution Focused Brief Therapy Project that is presently taking place on the Wards 1-5 Becklin and Ward 4 Newsam?
   Yes / No - please circle answer

2) Are you aware of any of the techniques utilised in Solution Focused Brief Therapy?
   Yes / No - please circle answer

3) If you answered Yes to Q.2 Please name any of the techniques you are aware of that are utilised in Solution Focused Brief Therapy?
   If you answered No please move to Q. 6.
   a) 
   b) 
   c) 
   d) 
   e) 
   Others - 

4) Have you tried applying any of these techniques?
   Yes / No - please circle answer

5) Please rate the techniques in terms of their overall usefulness
   Circle the number closest to rating score

   Technique a)  1  2  3  4  5  6  7  8  9  10
   Not useful at all  Extremely useful

   Technique b)  1  2  3  4  5  6  7  8  9  10
   Not useful at all  Extremely useful
68

Technique c)  
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Technique e)  
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6) Are there any other comments you would wish to make. Please include any comments upon the possible future direction of the project?
### Appendix Eleven

<table>
<thead>
<tr>
<th>SFBT “Technique” / “Tool”</th>
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<tbody>
<tr>
<td>Problem Free Talk</td>
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<tr>
<td>Pre-Session Change</td>
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<tr>
<td>Exceptions</td>
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<tr>
<td>“Best Hopes”/</td>
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<tr>
<td>Miracle Question /</td>
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<tr>
<td>Preferred Future</td>
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<tr>
<td>Scaling</td>
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<td>Other Person Questions</td>
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<tr>
<td>Compliments</td>
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<td>Strengths</td>
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<td>Feedback – tasks, noticing and difference</td>
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<tr>
<td>Other SFBT “Techniques”</td>
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<tr>
<td>Any Other Comments</td>
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### Appendix Twelve

#### To be encouraged

- Curiosity
- Client led goals – ability to identify solutions
- Compliments – based on patient’s narrative
- Future focus
- Small changes
- Affirmation / validation of client experience
- Identification of choices / options
- Use of client’s words / phrases
- Normalisation
- Identification of Strengths and Resources – based on patient’s narrative
- Recognising competence
- Past successes
- “What else” questions
- Client’s future responsibility
- Other(s) – please state

#### Techniques

- Scaling
- “Best Hopes” / Miracle Question/ Preferred Future
- Compliments – client’s Strengths, Resources Coping Skills
- Pre-suppositions - that change will occur and that the client is an active participant in that change
- Other person questions
- Pre-Session change
- Exceptions
<table>
<thead>
<tr>
<th>Problem Free Talk</th>
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<tr>
<td>Worker Feedback – tasks noticing and difference</td>
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<tr>
<td>EARS: Elicit, Amplify, Reinforce, Start (Again)</td>
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<tr>
<td>Break</td>
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<td>Other(s) – please state</td>
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