Solution focused practice and assessment

Guy Shennan argues that solution focused practice can simplify the helping process by effectively allowing clients to assess their own progress.

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IN THIS article I hope to demonstrate how the use of solution focused practice can simplify the response of the professional helping services to a person seeking help. Solution focused practitioners have taken a radical step in largely removing assessment from the helping process. This affects both the referral stage, and the way in which the work can begin post-referral. I will use a transcript of the early stages of a first session to illustrate how solution focused work proceeds without an assessment in the traditional sense of the word.

By focusing on the specific problems that people experience and present with, the professional helping enterprise tends towards the categorisation and labelling of problems and mental health services are correspondingly split and compartmentalised. There are services for adults and for children, and within each of these major divisions a myriad of subspecialities, according to type of problem, perceived complexity, age group and so on. One consequence of this is that referrers often have great difficulty in negotiating their way through the thicket of services to refer on to. In turn, these services have developed highly refined ways of determining whether referrals are appropriate for them. As a result, individuals and families wanting help often find themselves waiting while negotiations between primary care referrers and specialist service providers are played out.

Central to this process is the professional practice of assessment. Mental health services are still heavily reliant on an expert model, which has at its centre the assessment of clients by professionals. Primary care professionals listen to the complaints that their clients bring and assess them, partly to categorise the client and their problems according to predetermined sets of categories, comprising mental disorders, types of behavioural problems and so on. This assessment leads to judgements about what type of specialist help might be available and best suited to resolve the complaints. In turn, the specialist services make their own initial assessments about the suitability of the referrals made. Once a referral is accepted, the professional will further assess what the problem is, what is causing it, and what needs to be done to resolve it.

One defining feature of the solution focused approach is that it is not based on any theory about problems and their aetiology. It does not involve assessing clients and their problems in order to arrive at a prescription of help. Rather, it is a set of practices aimed at enabling clients to consider how they would like their lives to be and locating the strengths and resources which will help them to live their lives in these preferred ways. Clients' descriptions of their 'preferred futures' are frequently unconnected to, and independent of, the specific problems that have led them to seek help. One consequence of this is that a service governed by solution focused principles need not be overly concerned with whether referrals have been 'appropriately' made to it or not.

This was a guiding principle of the Early Response Project, a therapeutic service for families set up by a voluntary agency, the Leicester Family Service Unit. The project operated within primary care settings, taking referrals mainly from general practitioners (GPs) and health visitors (HVs), which were triggered by a parent seeking help. Assessment played little part in the project's work. The assumption made was that if a parent was asking for help, then they must need help. In effect, the parent had carried out their own assessment, the conclusion of which led to their request for a service.

When the project began work with the parent or family, there was no assessment component included. The starting point of solution focused work is to find out what it is that the client hopes to achieve as a result of the work being done. This is followed by a detailed exploration of the differences the client would notice as a result of these hopes being realised. These discussions about preferred futures are not dependent on the type or severity of the problem that has led a client to seek help. This can simplify the process of finding the 'right' service for any particular person. A service operating according to a solution focused approach tends towards offering help irrespective of problem categorisation. The only essential criterion to be satisfied is that there is a person willing to be seen.

Connie's case helps to illustrate this process. Connie was referred to the project by her community psychiatric nurse (CPN). The CPN was involved with Connie due to her agoraphobia and postnatal depression following the birth of her second child, Ben. The CPN referred Connie to the project because of the difficulties she was having in relation to the behaviour of her four year old son, Tom. Connie sought help and when the service offered by the project was described to her, was willing to give it a go. The CPN contacted the project with this information and the project was immediately willing and able to offer a service. All that had to be done was to telephone Connie and arrange an appointment. Connie came alone to the first session and the business of helping her to achieve what she hoped for by coming to the project began immediately. Solution focused practitioners are not dependent on a process of assessment due to the way they frame the reasons that someone seeks help. This is traditionally thought about in the following way – the client has come because they have certain problems, which they do not want to have. The solution focused practitioner sees the flipside of this coin: the client has come because they want their lives to be different. There is no need to assess the problems – what is not wanted – we can move straight to enquiring about what is wanted.

The worker first checked the referral information, specifically who was who in the family. Connie talked at some length about Tom's health problems, associated developmental delay and behaviour difficulties. The worker's response was to listen to this information and to judge when the time was right to shift the conversation towards what Connie wanted as a result of coming. Experience suggests that a useful way of doing this is to ask about best hopes. A semi-joking response from Connie enabled the worker to elicit one of her strengths at an early stage.

W: OK, so what are your best hopes then, for coming here?
C: That I don't kill him! (laughs)
W: (smiling) How have you managed to not kill him so far?
C: Erm... I think Prozac and reserves of patience.
W: Reserves of patience? .. what, that you..
C: Yeah... I take a deep breath and take a step back.
W: Is that patience that you knew you had or have you found out that you've..?
C: No, I knew I had.
W: You knew you had.
C: Yeah, yeah,
W: That's the sort of person you are, is it?
C: Yeah, I've got a very difficult mother
W: Right, so you've had practice at being patient?
C: Yeah, I've had practice at being patient!
W: Right, OK.

C: So I can take a deep breath, and I can take a step back, but it's beginning to wear thin.

W: Um-hum, so it's something else that's needed, but I guess you do other things as well to cope, but you wanted something else.

C: I suppose really I just want someone to say, have you tried this? You know, just to make me think again, you know when you get stuck with repetitive thoughts and repetitive behaviour with them? And I wake up each day exhausted. I'm getting to that point now where...I don't know, I think my train of thought's gone and I don't know what to think, what to do next.

The session began with an exhausted and frustrated mother, stating her concerns about not being able to cope with her son's behaviour. By asking about how she has managed not to kill Tom already, the worker has discovered a mother in the room who also has reserves of patience. This is likely to be a more useful starting point for the exploration of her hopes and desires. This exploration is facilitated by the use of the 'miracle question'. By prefacing this with the statement that he is going to ask a strange question, the worker creates a sense of curiosity in Connie, who says "go on then", sits up straight and listens intently.

W: OK, well let me ask you a strange question then... just imagine that when you go to bed tonight, and go to sleep, that a miracle happens and the miracle is that these problems that you've come here about are all gone, OK? But you don't know this miracle's happened, because it happened while you're asleep, so when you wake up tomorrow morning, what's the first thing you'd notice that would tell you that the miracle had happened?

C: Errm... I could look at him and I'd know that he was calm and he was happy, and that he wasn't anxious; and he wasn't frightened; and he wasn't frustrated; and he wasn't in a rage and I'd think, 'ah, isn't that nice', and I'd be able to put him in the pram and take him out and I'd think oh, good, I'm going to have a normal family day today, not a day that's affected by Tom's rages.

W: When would you first spot this, when would you first spot that he was calm?

C: As soon as I get in the room and look at him.

W: Right, would you notice anything even before you went in to see Tom? What would you notice in yourself that would tell you the miracle had happened?

C: That probably a great weight had been lifted away from me...I felt lighter.

W: Ah-ha, so you'd notice that as soon as you woke up do you think, or after you got up?

C: Well, if it was a miracle I'd probably wake, open my eyes and...(sighs and uses her hands to suggest a weight lifting off her shoulders).

W: Yes, just feel lighter.

C: Yes.

W: Something's been taken off you.

C: Yes.

W: And what's the first thing you'd do then, when you woke up feeling like that?

C: Errmm...I'd probably smile.

W: Um-hum, yeah?

C: Yeah, yeah, it'd be nice.

W: Would you smile to yourself, or would John (Connie's partner) be there, or..?

C: Oh no, he'd still be asleep, come on, he's a man, it's Saturday morning!

W: It's Saturday tomorrow, isn't it? Yeah, yeah... (laughter) OK, so you'd wake up smiling..

C: Yes, I'd be up, I'd think, oh isn't this nice, and I'd go downstairs and make myself a cup of coffee, and drink it in peace and quiet.

W: OK, and what would you do next with this miracle having happened?

C: Errm..I'd go up, bring them downstairs, and..

W: Who would you go to first?

C: Well, I'd get Tom out of bed..

W: And as you walked in to get him out of bed, what's the first thing you'd notice that would tell you the miracle had happened?

C: 'Cause he'd be smiling and he'd go 'Hiya Mum, I'm awake'.

W: And what do you do?

C: I'd say 'Hi, morning Tom, give me a kiss', and he goes like this, and puts his head down...(puts her head down) he doesn't kiss, 'cause he's too manly, you get to kiss the top of his head.

W: Right, and what would Tom notice about you, when you went in to wake him up?

C: Probably the fact that I'm not shouting already.

W: Ah-ha?

C: I'm smiling at him, and I'm not threatening to kill him.

W: Yeah, yeah... so you're smiling, and if you weren't shouting, what else would you be doing?

C: I'd be talking to him, and then asking him what he wants for his breakfast...

This detailed description, of how Connie and her family would 'do' their lives in a problem free future, continued to unfold for most of this first session. Prompted by the worker's questions, Connie was able to describe this future in a way unqualified by any assessment of what had happened in the past.

In the next part of the session, the worker invited Connie to consider how much of her 'preferred future' was already happening. Connie said she was at 3, on a scale from 0 to 10, where 0 signified when the problems she had come about were at their worst, and 10 would be the miracle. The worker's role was now to be curious about the differences at 3 compared to 0, as perceived by Connie. She said that she was coping more, and had come off the antidepressants. She was able to leave the house: "I come here today without having to take Prozac and beta blockers". Tom was hitting Ben less often, and the worker was able to elicit from Connie what she was doing that was helping this, which ranged from physical restraint to praise for Tom's positive behaviour. While there is some assessment taking place here, it is the client who is doing the assessing, as Connie reflects on the progress she is already making. It is her choice of number on the scale – an independent view from the worker is not required.

A second and final session took place two months later. Connie described some further progress, together with some setbacks. She was no longer seeing her CPN and was still off the antidepressants. She was noticing having ordinary emotions again – anger, sadness, happiness. Tom appeared happier, and was no longer hitting Ben, just pushing him over now and then. Connie felt that the first session had helped her to think a little more clearly and she had been doing things differently with Tom. In particular, she was attempting to follow his lead more, helped by watching his preschool teacher play with him. On a scale from 0 to 10 where 10 signified that she was completely confident she could deal with anything, even Tom's behaviour going downhill, Connie felt at a 7 or 8. Given this level of confidence in her ability to maintain her progress, Connie decided that she did not need to come back for any further sessions. Here again, it is the client who 'assesses' when the work has been completed.

In describing this work with Connie, it can be seen how solution focused practice leads to a simplification of the helping process. The worker did not need to explore her difficulties or assess them. Given the referral information and Connie's initial references to Tom's health and behavioural difficulties, it is likely that any assessment would have led to a complex picture emerging. Using solution focused principles the referral stage is streamlined – if a parent wants help, then the referral is appropriate. When the actual work starts, it is not mediated by an assessment based largely on the professional's views about the client's situation. Instead, it is the client's views – about what is wanted rather than what is not wanted and about their progress – which are privileged. ●

REFERENCES
1. George E, Iveson, C, Ratner, H. Problem to solution: brief therapy with individuals and families (second edition). London: BT Press, 1999.