

# Solutions not problems: Improving outcomes in an integrated mental health rehabilitation service using a Solution-Focused Brief Therapy approach

Keith Isherwood<sup>1</sup> & Suzanne Regan<sup>2</sup>

**Abstract:** *The government's regime of target setting for public services has been subject to increasing criticism. The number of targets, who sets them and the interactions between the target setter and user have been challenged in reports from the Audit Commission. This article reports on the findings of an experiment in which a Solution-Focused Brief Therapy (SFBT) approach was used to define suitable targets for change and the improvement of service outcomes in one integrated mental health residential rehabilitation service. The paper describes in detail the type of information which was elicited from a Solution-Focused questionnaire containing 'the miracle question' which was distributed to both service users and staff. In particular, the discussion focuses on the advantages of using the approach as a management tool for translating the experientially based responses of both service users and staff into measurable practical action.*

**Key words:** *target setting, involving service users, solution-focused outcomes in mental health, team-based planning*

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1. Manager of Thornleigh Rehabilitation Unit Burnley Lancashire.

2. Senior Research Fellow in the Centre for Collaborative Intervention in the Public Sector Lancaster University Management School.

**Address for correspondence:** Suzanne Regan, Centre for Collaborative Intervention in the Public Sector Lancaster University Management School, Lancaster, LA1 4YX.  
s.regan@lancs.ac.uk

## **Introduction**

The service described in this study is a residential rehabilitation service for people with a severe and enduring mental illness. The unit is staffed by health and social services personnel working in an integrated team, operating within a single line of management and is responsible to a Joint Management Board. The unit accommodates nine adults aged between 16 to 65 years, who require assistance in becoming independent members of the community. The main aim of the service is to help people maintain their independence after leaving the unit by reducing the risk of readmission to hospital, promoting self-care and well-being and assisting residents in establishing social networks. As a rehabilitation service the unit is also designed to facilitate early discharge from hospital, to enable selected service users living in secure facilities to return to the community, and to provide short-stay accommodation for service users experiencing crises which cannot be managed in their own homes.

The object of the study was to assess the extent to which a Solution-Focused Brief Therapy (SFBT) approach could be used to involve both staff and service users in defining and improving service outcomes. The theoretical framework informing how the study is presented and what is highlighted follows on from Blackler et al. (2000) on activity, change and collective learning. They note that activity change can be stimulated (a) when a community recognises tensions in its activity systems, (b) searches for new approaches, (c) develops some early new models, then (d) seeks to elaborate these through engagement and experiment. Such a process can lead to the joint development of new or modified objects of activity and a reconfiguration of activity systems.

The discussion of the study and its findings begins with a brief comment on the shortcomings of existing models of service development in the public sector and then describes how data was collected and analyzed using a SFBT approach. The findings and the changes that occurred as a result of this intervention are detailed in the final section of the paper.

## **Recognising tensions in an activity system**

It is often the case that the development of a service is accomplished using a hierarchical top-down approach. While managers might consult staff and, more recently, service users, the overarching framework for change is often circumscribed by the availability of existing resources. The setting up of the rehabilitation service being discussed in this article was a case in point; it was expedient for both the local authority and the health trust to adapt a pre-existing building and staffing arrangements and to pool budgets rather than establish a service based on the assessed requirements of service users. Nonetheless, this solution enabled both

organizations to meet the requirement of the National Service Framework for Mental Health for the establishment of formal partnerships (Department of Health, 2000). In addition, the use of existing arrangements enabled the Health Trust to relocate hospital-based rehabilitation services to the community. This enabled the Trust to comply with national and local directives on reducing admissions to residential care and promote independence for mental health service users. While these objectives are worthwhile in principle, the quality of a service may be defined more by the way services are delivered and experienced than by the way they are designed. The same may also be true of service outcomes.

At the time the study was undertaken outcome measures for the rehabilitation service were being set by the Joint Management Board and were based on the numbers of service users who passed through the scheme. According to the Board, a good outcome for the service would be the movement of at least nine people through the scheme every twelve months. This outcome was specified as a target in performance management plans for the team, and contributed to the core objectives and performance indicators for the statutory authority's performance framework. However, what is defined as a good outcome by the management is not necessarily the same as a good outcome as defined by those who use the service and who work within it. The challenge for managers and others working in similar settings is to creatively settle this tension. As Forbes and Sashidharan (1997) observe:

The relationship between users and the services they receive is often constructed as an unmediated and purely functional transaction with uniform notions about users and their experience of services. (Forbes and Sashidharan, 1997, p.482)

In addressing a dilemma between what Blackler (2003, p.9) describes as 'contrasting conceptions of appropriate objects of activity,' the experiment with SFBT was adopted. It was used as a means of identifying targets for service improvement because of its emphasis on the establishment of personal goals for change. However, in the setting we are describing, the boundaries of therapeutic intervention moved beyond the individual therapeutic encounter where solutions are explored with a therapist to incorporate the individual goals of members of the care team and their managers as well. The SFBT approach proved to be successful in that both service users and staff were able to engage with an approach which incorporated their beliefs and aspirations for change.

## **Solution-Focused Brief Therapy as a model for change**

Solution-Focused Brief Therapy is a modification of brief therapy developed by de Shazer and Berg in the 1980s (George, et al, 1999). A central feature of the approach is that clients are treated as experts in all aspects of their lives and are encouraged to consider their hopes for the future. As part of the process they identify 'possible' and 'preferred' futures and begin 'listing the qualities of those well described preferred futures' (George, Iveson and Ratner 2000, pp.2-5). This technique for eliciting meaningful information was useful in considering the future development of the rehabilitation service because the exercise of listing the qualities of possible and preferred futures encouraged a shared approach to service planning. The approach offered those individuals actually experiencing the service the opportunity to shape its future. As George, Iveson and Ratner (2000, p.2) observe, SFBT 'charts a way forward and then seeks the resources needed to embark on the journey' (George, Iveson and Ratner 2000, p.2).

Importantly, SFBT encourages the participants of the process to see themselves as an essential resource. In many settings, it is not uncommon for people to think of resources in terms of buildings, finances or staffing levels, before they consider themselves, their management structure or the service users. In this respect, SFBT primarily concentrates on two types of resources; the internal resources of people, their skills, strengths, abilities, useful qualities, useful beliefs and capacities and their external resources such as supportive personal and professional relationships (George, Iveson and Ratner 2000, p.4). In different ways both types of resources draw attention to the prime importance of relationships in improving outcomes.

By extending the inclusivity of the service planning activity, members of the rehabilitation team were encouraged to explore and reflect upon their own resources. In doing so they rapidly discovered potential of which they were previously unaware. Seeing resources in this way encouraged them to engage in a more collaborative approach to service planning and this, as will be seen, substantially increased the possibilities for the introduction of meaningful change. As noted by George, Iveson and Ratner:

... until proved otherwise, Solution-Focused Brief Therapy chooses to assume that the client *and in this case the staff* already possesses the resources necessary to make the desired change even though ... they may not yet know this. (George, Iveson and Ratner 2000, p.4, authors' emphasis).

An approach which focused on solutions rather than on problems in this context also provided the staff team with a valuable tool for, not only resolving problems in the team itself, but also for embedding a fundamentally different attitude to problem solving and for planning changes. Questions such as *when is the problem not occurring?* or *when does the team function at its best?* focused their attention on the behaviours

and experiences which were 'wanted rather than on those which are not wanted' (George, Iveson and Ratner, 2000, p.17).

The SFBT approach also encouraged a fundamentally different view of the way service outcomes were measured in the first place. In place of models of change which begin with identifying a service's deficiencies, or pointing up areas where one service is not working as well as other services (as in the case of 'benchmarking') the Solution-Focused model sought to identify and value the rehabilitation service's existing strengths. Questions such as *What is the service doing well? What do service users think we do well? And at what point will the service be good enough?* and *What things should stay the same?* challenged the presumption of continuous improvement which is encouraged by the UK government's regime of 'Best Value' (for an overview of the Best Value debate see Calpin & Burton, 1999). This is not to suggest that improvements couldn't or shouldn't occur, but that change for the sake of change could be detrimental to services which are already functioning well. To paraphrase George *et al.*: 'Look at the service - the miracle might already be happening' (George, Iveson and Ratner 2000, p.8).

### **Articulating the 'germ cell' of a new solution.**

As noted earlier, the conventional use of SFBT is the facilitation of change for individual clients in therapeutic settings. In widening the boundaries to include a whole service in which both staff and service users were asked as a collective to consider service outcomes, it was possible to define a strategy for improving outcomes which was inclusive and which kept service users at the heart of any changes. This redefinition, or more accurately repositioning, of service users as equal partners to a process rather than as token service user 'representatives' finds common ground with Blackler's (2003, p.9) and Colombo *et al.*'s (2003) definitions of patients as collaborators. According to Colombo *et al.*:

Ultimately, effective care means that service users should be able to work with multi-agency teams by being recognised as part of that team. This will only be achieved however if the balance of power within the decision making process is fundamentally redefined (Colombo *et al.*, 2003, p.1569).

As we found in this study, the SFBT approach proved to be a highly effective vehicle for ensuring that all participants were of equal status in terms of the resources they brought to the change process (Macdonald, 2002). Basically, the 'model seeks to coax and author expertise from life, experience, education, and training...rather than to deliver or teach expertise from a hierarchically superior position' (Thomas, 1996, p.129).

## The Solution-Focused Brief Therapy Questionnaire

To begin the process of defining targets for improving outcomes, the residents and the staff group were asked to provide written responses to a questionnaire (See Figure 1 below) which was based on SFBT's 'miracle question' i.e.; *If a miracle happened and this service turned into the perfect rehabilitation service overnight, and nobody told you, how would you know?* In SFBT, the miracle question is the starting point which enables those involved to describe in specific terms their vision of a preferred future. As part of the process individuals were also asked to reflect on the views of significant others. For example, the question 'What changes would they [a significant other] see that would lead them to believe that a miracle had occurred?' acknowledged the centrality of (positive) social interaction to the construction of an individual's self-perception.

Figure 1

The Solution-Focused Brief Therapy Questionnaire:

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- 1) If a miracle happened and this service turned into the perfect rehabilitation service overnight, and nobody told you, how would you know?
  - 2) What would be different?
  - 3) What would you be doing that is different from what you do now?
  - 4) How would I be able to tell without you telling me?
  - 5) What might be the first thing you would notice?
  - 6) What would be a small sign for you that things were improving?
  - 7) How would this improve things for you?
  - 8) What might your first step be in achieving this?
  - 9) What would make problems less frequent?
  - 10) How would you know when outcomes are successful?
  - 11) What needs to happen for this to continue?
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To prevent pre-existing alliances between staff shaping their contributions, the staff group were not informed about the circulation of the questionnaire in advance and members were simply given the questionnaire at random times and asked not share their experiences with other colleagues. The service users were given the questionnaire and offered assistance in completing it. (For some of the service users this meant reiterating the questions with fuller explanations and writing out their responses.) The responses were then analysed and any patterns, commonalities in themes or differences were noted. In all, 17 full-time staff members and 9 residents responded to the questionnaire.

## **Discussion of the responses to the SFBT questionnaire**

The analysis of what emerged from the distribution and analyses of the SFBT questionnaire begins with a summary of the resident's responses followed by those of the staff team and the deputy managers.

In answer to the miracle question, many of the residents chose Sky Television, with one person opting for a swimming pool, one person a conservatory and one person a wife (things, it must be said, that people without a mental illness might consider life enhancing). Some residents thought that the facility's house rules should be amended to allow residents to smoke in their rooms, consume alcohol, 'chill out' more, play strip poker and that staff would cook their meals and do their laundry. To confound our expectations, not one resident chose good mental health as their desired miracle.

Analyzing responses to a SFBT questionnaire in a setting where one already knows the respondents will of course make a difference in how the responses are viewed. In this instance, we observed that those respondents who wanted to consume more alcohol were the same ones who needed the most support in reducing the amount of alcohol they regularly consumed, and who sometimes showed limited insight into how alcohol affected their mental health. Nonetheless, many of the residents showed clear insight into the things that needed to be in place in order to achieve better outcomes (as assumed by the proponents of Solution-Focused Brief Therapy).

In considering what would be different (after the miracle occurred) many residents said that they would be 'fully rehabilitated' (although for some this was construed as members of staff doing all the cooking, laundry and shopping for them). Some residents felt that care programme meetings would be easier and that they would receive full social security benefits, pictures of famous people would adorn the walls and they would eat 'real' potatoes and not oven chips. One resident thought that there should be clothes everywhere to make the unit more homely. While some residents conveyed the impression that rehabilitation was something that just happened to them without too much effort from themselves, the responses nonetheless enabled staff members to clarify what the concept of rehabilitation meant for each resident and to establish a new basis for more helpful engagement.

Overall there was a consensus amongst the residents that the general level of activity in the unit needed to increase. Many saw this as the difference between what they currently did and what the situation would be like following a miracle, in which case they would be taking part in more social activities and competitions (if the staff put up the prizes), enjoy a better mental state and be more optimistic.

In response to being asked how the manager or others would be able to tell that things were improving (without being told), two residents said that the staff would not be able to see any noticeable difference, while another thought that more cheerful decorations in the house would be noticeable. Interestingly, the majority of residents identified changes in the types of interactions between themselves and members of

staff; changes which suggested that they had insight into how clinical judgements were being made about their state of mental health. For example, residents identified the reduced need for pro re nata medication (medication taken by patients as and when they need it), displaying fewer side effects, increased eye contact, better concentration and the reduced need for reassurance as signs of improvement. While the presence or absence of these physical signs *could* be read as indicators of an improved state of mind, it is possible to question whether residents had become complicit with important aspects of the discursive practices of mental health: that is, the particular set of processes and practices which delineate 'mental illness' as a domain of knowledge and activity from other domains. The acquisition and use of knowledge about mental illness is based on the identification and appropriate categorisation (usually by professionals) of particular 'signs and symptoms' which indicate either 'well-being' or the onset of illness. Harre suggests that:

...people draw upon a set of cognitive resources – their shared social competence made up of regulative and interpretive rules – to produce effective and legitimate social activity, and to mesh their activity with other peoples actions. (cited in (Potter and Wetherell 1997, p.58-59)

According to Goffman (1959) 'when an individual appears before others he will have many motivations for trying to control the impressions they receive of the situation' (p.26). By drawing on a shared 'interpretive repertoire' and adopting the language and conventions an individual can display 'proficiency and rationality' to others as well as themselves (Potter and Wetherell, 1997, p.58). In some situations this display can mean the difference between whether or not somebody receives a service. For example, it is easier for social workers or service users themselves to access a hospital bed if they use words like 'risk' or 'suicidal ideation,' terms which are more likely to trigger a response from a from those working within accountable domains of the mental health service.

In asking residents to consider what might be the first thing they would notice if a miracle had occurred and what small signs would show them that things were improving, the beginning of a new shared interpretive repertoire emerged. Some residents thought that the unit would look untidy and therefore appear more 'lived-in'. Others mentioned that their days would seem brighter and that they would communicate more effectively with others and not 'bottle things up;' while others would need less prompting and have fewer personal problems. Small signs of improvement for others included drinking less tea and coffee, having better appetite, smoking less and consequently having more money, feeling more relaxed and being more active. Many residents thought that their symptoms would disappear ('my voices would stop') or be more manageable. Still others would have more confidence and feel stronger, they would watch more television, but also go out more as 'nobody would be watching them'.

Developing a positive attitude and the ability to worry less were seen by many as the



first steps to achieving this, as was being more committed to participating in activities and developing greater independence. The residents also considered that getting the right level of support for themselves was crucial in as much as problems would occur less frequently if they could talk more, have more contact with their families, look after themselves better, concentrate more and not 'see things'. Conversely one resident said that seeing things made problems less frequent; 'I see spiders and angels. The spiders keep an eye on me. I'm used to them now and I would miss them if they weren't there'. Positive thinking, medication and a wife (though none listed a husband!) were all identified as things that would help with problem solving.

In responding to the question over how each person would know when outcomes were successful, the residents thought that if they were busy every day and could do all the things they needed to do and have someone in their life to whom they could express their emotions, then this state of being would constitute success. As a result they would feel relaxed, stay motivated and have a sense of well-being. Many professionals might also consider these states to constitute successful outcomes: nonetheless, their articulation posed a challenge when considered in the light of the responses to the previous question. Overall the responses to question six suggested that the cessation of symptoms would only be considered by residents as a small sign of improvement, however keeping busy and having a good routine were seen by them as more important to improving their lives in spite of their illness. So is engagement in 'normal' routines and activity more important to good mental health than being treated for symptoms alone?

The responses to question eleven suggested that our analysis was only partially true; when asked what would need to happen for these improvements to continue, residents indicated that in addition to keeping busy and motivated they also thought that good communication with staff was needed so that requests for assistance were acted upon quickly. Getting the right support, getting help quickly when needed, and having supportive family networks were also seen as important to maintaining improvements; as was self-help, such as listening to music, deep breathing, lying down, smoking less, walking more often, developing coping skills, and having a regular job.

In summary, what the miracle question did was to supply a focus or object for the start of a process with the remaining questions helping to steer a way forward for each individual. As will be seen, by extending the boundaries to include the staff team, a SFBT approach also provided a method for amalgamating the 'internal' resources of service users and the 'external' resources of the care team in order to better meet individual needs. It provided the framework for staff to begin compiling pathways through the service, which entailed service users receiving support in the way that they themselves had described as their preferred future.

## **Staff team responses to the questionnaire**

The responses to the miracle question by staff were similarly surprising and generated new insights into how team-working could be improved in the unit. As a newly-integrated rehabilitation service there were historical contingencies to contend with; differences in pay and in approaches to practice being among them. We assumed that, because there had been some disquiet between health and social services staff in relation to unequal pay and 'conditions of service', that equity in pay and conditions would have been the miracle desired by some. Once again we were surprised when every member of the team listed improvements for service users as their primary response to the miracle question. In addition to more active rehabilitation plans and better community integration, the team listed the creation of a 'one to one' space for staff to talk to residents, or to each other, and having a 'quiet space' for residents as prerequisites for a perfect rehabilitation service. At the team level they also considered improved communication, a better 'team spirit' and less paperwork to be potentially miraculous.

The team considered that, following a miracle, the main difference would be residents needing less prompting to undertake tasks and activities. Residents would also want to access a wider variety of community services and be capable of self medicating. The service would employ more staff from different cultural backgrounds and a better atmosphere would exist within the unit. With regard to what they would be doing differently in the future, team members responded by saying that they would acquire more skills, knowledge and confidence in their practice. One member of staff felt that she would need less prompting and feel more in control of everything. In addition they would, undertake more work with residents in compiling residents' 'own plans,' participate more in psychosocial interventions and facilitate more group activities. As a result, the staff team thought that the 'to-do-lists' would disappear, as would the activities board and the residents during the day (because they would be engaged in outside activities). Some thought that they would notice residents being more independent and taking more responsibility; one member said that it would be noticeable if others asked her for guidance, rather than the other way around.

The staff thought that the first thing that *they* would notice would be an improvement in the residents' mental states and increased motivation, residents would appear more relaxed and get along better with each other, utilise more coping strategies, smoke less and do more. Things would improve for the team because they would have more one-to-one time and have a greater sense of achievement, a better working environment and greater job satisfaction. The team believed that working more closely with residents and being able to develop a good rapport with residents and other staff would be a good first step. In addition, assisting residents to take more responsibility for their lives and be able to keep themselves motivated were also listed. They considered that if there was better communication, increased staffing levels, more involvement and commitment from outside agencies and staff,

such as care co-ordinators, consultants and general practitioners, then problems would be less frequent.

For the staff team and their deputy managers, good feedback from residents and other agencies would be considered a sign of success. Residents would be seen to be actively making their own decisions and achieving greater levels of independence and would move into suitable accommodation in the community. They would also see residents who were happy to move on. Some felt that success could be demonstrated when residents have a clear idea of their future which included what to do and who to contact if they needed assistance. In order to continue having successful outcomes the team believed that more team training days were needed. This would enable staff to get together to resolve problems. Maintaining good staffing levels and only accepting suitable referrals was also seen as significant, as was learning from experience, good teamwork and good communication. In addition, the team thought that more psycho-educational work and better input from community mental health teams would contribute to delivering good outcomes, and that it was important for the team to continue to strive for good standards in care. (However the team made these responses prior to obtaining feedback from the questionnaires.)

By focusing on problems rather than on solutions, the staff team's responses appeared to follow a conventional model for service development. The team thought that more external resources were needed in the shape of more input from outside agencies and their staff. Although the team had considered gaining more internal resources in terms of skills and knowledge, they sought reassurance in external resources, for example in maintaining high staffing levels.

Overall, the responses to the questionnaire highlighted many common areas for improvement and helped the team to form a consensus about how the service could be developed. Both residents and staff wanted to do more. Residents wanted improved communication with staff while staff wanted to form better rapport with residents and have more one-to-one time with them: both staff and residents felt that promoting greater independence and developing coping skills were important. In addition to this, both groups believed that the level and continuity of approach for future support was essential in maintaining good mental health. New insights into residents as individuals were also afforded by the questionnaire. For example, the resident who had been referred for support with a problem over personal hygiene had stated that he would know things were improving because he would shower four times a day to wash away his voices. (As noted previously, 'signs and symptoms' can mean different things to different people in different contexts, showering frequently could have been seen as a sign of improvement in relation to improved personal hygiene, whereas showering four times a day to wash away voices could be a sign of deteriorating mental health.)

## **Deputy Managers' responses to the questionnaire**

If overnight a miracle had occurred for the two deputy managers, the support staff would be actively involved in sitting down with residents and formulating 'psychological rehabilitation' plans. This would happen in an environment where residents felt that the staff team were fully aware of their experiences and history. The team would be able to focus on developing coping strategies for residents which could be put to practical use following their move to independent living. There would also be good relationships with the Community Mental Health Teams (CMHT), whose staff would be interested in the developments and agreements reached with residents. The CMHT would also be active participants in continuing any agreed strategies for assisting residents if they experienced a relapse after leaving the service.

The main difference in what the deputy managers would see in the unit was their staff being busy in formulating and documenting intervention strategies and putting different theories into practice. Staff would also be interested in learning new skills and would be pro-active in implementing them. In their preferred future the deputy managers would be spending more time monitoring quality and professional standards, providing case supervision and personal supervision on a more regular basis; they would have more time to focus on clinical governance, Investors in People and risk assessments (because their staff would be working in a more efficient manner). The deputy managers would also be spending more time on implementing the sickness and absence policy, planning and arranging staff training and evaluating the effectiveness of the unit.

The deputy managers thought that the first thing others would notice was staff being pro-active in documenting information, formulating care plans, relapse plans, and undertaking more work with residents. There would be less confusion and more evidence-based practice. One deputy also thought that he would be spending more time documenting outcomes and working with the staff team in overcoming any difficulties. The first things that the deputy managers might notice would be staff interacting more with residents and undertaking more one-to-one sessions. They would notice staff putting therapeutic interventions into practice, client records would be written more clearly and staff would understand why they were using particular interventions, or why residents were undertaking particular activities. In this way the links between assessment, the type of intervention and outcomes would become more obvious.

A small sign of improvement would consist of a change in the content of staff discussions with more consideration being given to psychological well-being (instead of focusing on life skills) and psycho-educational interventions (to focus on education about mental illness and mental well-being including identifying 'triggers' for relapse and mapping relapse patterns). This would improve the situation for deputy managers and consequently provide greater job satisfaction. The first step to achieving this was for deputy managers to assist staff in developing skills and knowledge and agreeing interventions.

The deputy managers felt that problems would be reduced if there was consistency in the 'management message' coming from the Management Board and clear methods for interventions, including psychosocial interventions. The deputy managers would know when outcomes were successful because this would be judged against feedback from service users and outside agencies. However, in order to obtain this they thought that consistency in approach and message was essential. This required an agreed standard for practice, and an agreed team plan with timescales.

## **Making practical improvements to services**

In practical terms the findings of the study enabled the staff team to reflect on their practices and to clarify their thoughts about how the organisation of the service affected residents and themselves. It also enabled all participants to identify personal goals for change and define individual training needs for staff. Needless to say, moving from the identification of what needed to change to actually making the practical improvements to the service, required the willingness to change by all who participated. Having completed the questionnaires however, the staff team in particular were very interested in seeing what each team member and resident had identified as meaningful for them. Campbell *et al.* observed:

We find that people are very interested in how people are affected by the organisation and how the organisation is affected by the individual and so on, in a circular process in which the one cannot be separated by the other (Campbell, Draper and Huffington 1989, p.39).

In what follows we describe the type of changes which did occur in the service, broadly categorizing them as individual changes, organisational changes, changes to working practices and spatial arrangements, that is to say changes to the organisation of space within the unit. Blackler notes that:

People need to recognise how their actions relate to the overall activity of which they are a part. In part their actions take shape because of this activity, in part they influence the nature of the overall activity. At the same time people need to utilise the 'cultural infrastructure' i.e. the vocabulary, technology, procedures and roles of their community, whilst contributing to the development of these (Blackler 2003, p.11)

Despite the fact that a long list of items emerged from the study very few of the improvements required additional resources and most were within the remit of the service manager.

## **Individual changes for residents**

The availability of such a rich source of data meant that it was possible to incorporate many of the suggestions made by residents into their care plans. More support was provided in care programme meetings, more one-to-one time was created, specialist support for people who wished to stop smoking was arranged through cessation clinics and activities were balanced with 'chill out' time. More creative ways of responding to some suggestions were needed in regard to the provision of a wife, a swimming pool, sky television and a conservatory. The search for partners provided an opportunity for staff to discuss interpersonal skills, appearance, hygiene and socialising; some of which could be addressed through local men's groups. In overcoming the lack of funds to construct their own, the residents organised a group to attend the local swimming pool. In relation to the conservatory, an existing greenhouse was used by residents to participate in a gardening group, whilst some residents also undertook voluntary work with a local gardening charity. One resident co-opted a local youth charity into helping other residents to participate in outdoor activities such as caving and going to the races. Those interested in Sky Television were given the option of funding it themselves (as they would in their own homes).

## **Individual changes for staff**

In respect of staff responses, individual training needs were incorporated into personal development portfolios. Staff participated in psychosocial intervention training and additional training was arranged to supplement that provided by both employing organisations.

## **Changes to organisational arrangements**

Changes made at the organisational level included arranging regular meetings for the management team with an independent facilitator and the issues which were raised were subsequently resolved at team training days. This meeting was also used to develop ideas for future training. In addition, the times for convening team meetings were varied to enable night shift workers to attend. The importance of feedback on the rehabilitation service was discussed with the team and a 'How Was It For You' form was produced by the deputy managers for service users leaving the scheme. (The same forms are now given to students on leaving their placement at the unit.) A suggestion box was also purchased for residents to comment anonymously on any aspect of the service. Crisis cards, which were developed by service users elsewhere, were adopted as part of the

discharge process. (These cards tell service users who to contact in an emergency, including out of hours support.)

Due to the limited number of services providing twenty-four hour support, the rehabilitation service offers transitional support for residents who are relocating to other accommodation. Due to the lack of vacancies for new staff the unit was not able to increase the diversity of the team. However, two Asian workers, one male and one female had already been recruited under 'genuine occupational qualification rules'; one member of the team has compiled a resource base on different cultures and attends the County Council's black workers group.

The second member of staff participates in the local race equality action group as a representative for the team. Additional training on cultural awareness was arranged and representatives have supported the regional conference on diversity.

Although a number of responses were made recommending a reduction in the amount of paperwork it has not been possible to affect this change. If anything, integrated working appears to generate more paperwork as the team managers have to respond to the requirements of two employing organisations. Nonetheless, a part time administrator has been appointed to deal with routine paperwork and organise the office space.

## **Changes to working practices**

Changes in working practices were introduced at the team level. Prior to the SFBT, study members of staff acted as 'key-workers' for specific residents, but found that communicating changes to care plans and interventions was proving problematic. To improve communication, workers reorganised themselves into two support teams and devised their own communication books to relay information to each other. In addition, night shift workers have volunteered to spend one month on the day shift rota to enable them to get a better understanding of how other workers and the unit operate. The system for supervision has been changed to improve the quality of the communications cascading from senior management in the respective organisations. Formerly, Care Trust staff received supervision from the health service deputy manager, and social services staff received supervision from the deputy manager for social services. To provide some 'continuity of the management message', line management supervision for all staff is now being undertaken by the social services deputy manager including: the compiling of staff rotas; monitoring sickness and absences; and arranging training for individual team members. The health service deputy provides clinical supervision and support for the whole team and oversees the quality of assessments, care plans, record keeping and provides support and training in Psychosocial Interventions. These changes accorded with the particular strengths of each deputy manager.

Statutory and voluntary employment services have been invited into the unit to

provide information on employment regulations for people with disabilities and to help residents pursue vocational opportunities. In order to increase the income of residents, one member of staff now deals with welfare benefits and assists residents in claiming their maximum entitlement. The importance of continuity in the messages coming from senior managers has also been relayed to the Joint Management Board and was included as part of a presentation on joint working given to the strategic directors of the Care Trust. Consultant Psychiatrists were also given a presentation on the aims and objectives of the rehabilitation service and difficulties around joint working were discussed. Presentations on the scheme have been given to CMHTs and a presentation from the clinical governance lead person was incorporated into team training.

### **Changes to spatial arrangements**

In respect of changes to spatial arrangements, a ground floor room formerly used as a staff bedroom was converted into an office for staff. Another first floor office was converted for use as a quiet space for staff to work uninterrupted and for one-to-one work with residents.

### **Discussion**

In terms of organizational development, the study we described closely resembled Blackler's (2003) three dimensions for development in organizations; organisational development, personal development and the development of human practices. He notes:

... the object of peoples activities (i.e. the project they are working on) is intimately related to the communities they identify with and the systems of activity they have been trained to use ... [and that] ...any particular moment of practice can be viewed as part of a process of personal development for those involved, as part of organisational or systems development, or as part of a broader, historical trajectory of development involving long-term shifts in the nature of human practices (Blackler 2003, p.6).

Although Blackler maintains that 'tensions are often ignored as people determinedly improvise towards their priorities and make the best of an imperfect situation' (Blackler 2003, p.9) it could be said that it is through improvisation that the developments we described occurred. The interplay between personal knowledge and what Blackler describes as the 'collective infrastructure of knowledge' can promote



a system in which tensions are not ignored; collaboration rather than confrontation would seem to provide a solution.

Notwithstanding the successful outcomes emerging from this experimental study there have been a number of criticisms of short-term interventions like SFBT. These criticisms arise from the concerns of proponents of longer-term psychoanalytic therapies. For an overview of the debate see O'Connell (2000). Even so, O'Connell maintains that there is an increasing body of research demonstrating that brief therapy is equally effective and is preferred by 70% of service users (p.2). Although this criticism was levelled at therapeutic interventions with individuals, in this study a solution-focused rather than a problem-focused intervention was applied to a whole service rather than to individuals. Given that the average length of stay for each resident is relatively short term (twelve months maximum), the only drawback would be that the intervention would need to be repeated with every new group of residents and for any new staff member. (The individual focus of SBFT means that this exercise could be carried out with new individuals rather than with the whole group.) However, there may also be advantages in revisiting the work annually. As Campbell *et al.* observe:

If people are able to explore the relationship between the individual and the organisation and can recognise the reciprocity in this relationship, then they are raised to a higher level or a new context in which they can observe the patterns of behaviours or actions maintaining a problem. It goes beyond merely identifying anomalies, conflicts and contradictions in that relationship, and stimulates the development of different perspectives or views on people's dilemmas, giving them the tools to escape them (Campbell, Draper and Huffington 1989, p.39).

## **Conclusion**

The Audit Commission has called for 'a rebalancing from nationally set targets to targets set by local organisations' and for change which makes 'targets more intelligent, is grounded in what works and recognises the influence of contextual factors' (Audit Commission 2003, p.2). Although the tension between government and local authorities in relation to target setting calls for greater input from service users, there are no recommendations which reveal how this might happen. A Solution-Focused Brief Therapy approach, as applied in this study, highlighted one of the ways this could be achieved.

According to the Audit Commission, targets '...can align user expectations and service priorities and, in doing so, motivate frontline staff' (Audit Commission 2003, p.2). As we have demonstrated, this alignment can occur when those affected by the outcomes are central to the debate on target setting. This adaptation of Solution-

Focused Brief Therapy intervention enabled the rehabilitation service to reach a shared understanding of what kinds of targets might lead to good outcomes. The approach was particularly useful in this integrated service setting because it facilitated a consensus amongst staff members and residents and enabled priorities for change to be established. In this respect a Solution-Focused approach has proven to be a useful management tool for translating service users and staff desires for improvement into practical action.

In experimenting with a Solution-Focused Brief Therapy approach to service improvements a means of encouraging and managing change has emerged; one that enables stakeholders to comment on and to positively contribute to improving outcomes. It provides the means for the development of a new interpretive repertoire or framework which utilizes the resources of members in defining clear 'pathways' through the service. Through its use, residents may have a better chance of receiving the type of support that they themselves prefer.

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