Engaging with the Scottish Government's Agenda on Health and Social Care

Steve Smith[1] and Graham Buchanan[2]

Abstract:

Outside of SF circles, SF remains relatively unknown. The Scottish Solution Focused Network (SSFN) is an organisation of SF practitioners established to support and promote SF practice in Scotland. In this paper, the authors discuss their recent thinking, derived from a series of conversations within the SSFN, on how their organisation can engage with one aspect of the Scottish Government's (formerly known as the Scottish Executive) strategy for health and wellbeing. They argue that SF practitioners in this field have a moral obligation to engage in political discourse, and that in Scotland, the Government are actively promoting SF methodologies in practice.

Introduction

Solution focused (SF) interactions have been recognised and described for almost 30 years (de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, and Weiner-Davis, 1986). From its origins in strategic family therapy, SF has developed into an individual and group therapy applicable to a broad range of presentations, a personal coaching stance and a robust

[1] Enterprise Fellow / Lecturer in Mental Health, Robert Gordon University Aberdeen

[2] Manager Playfield Institute /Mental Health Quality Improvement Programme, Stratheden Hospital Fife

Address for correspondence: Robert Gordon University, Faculty of Health and Social Care, Garthdee Road, Aberdeen. AB10 7QG. Email: steve.smith@rgu.ac.uk

The authors are grateful to Dorothy Adam, (SF practitioner and Lecturer at Robert Gordon University) for proof-reading and editing this paper.

approach to consulting and training (Iveson, 2002, Trepper, Dolan, McCollum, and Nelson, 2006; Walsh, 2006; Jackson and McKergow, 2007; Szabó, 2009). At the 2012 United Kingdom Association for Solution Focused Practice annual conference, keynote speaker Peter Lehmann declared that SF practice has 'come of age' as a mature, fully fledged approach to interpersonal communication (Lehmann, 2012). Indeed, our ideas have spread into mainstream thinking and are informing much of contemporary culture. A drive on almost any motorway or autobahn will display a wealth of solution thinking (or the illusion thereof) displayed on the side of trucks and transporters: 'office solutions', 'IT solutions', 'distribution solutions' and even 'water solutions' advertise a range of services available to consumers.

Despite this, who we really are and what we really do remains little more than a 'rumour' in much of the wider world (Miller and de Shazer, 1998). In Scotland we have developed the Scottish Solution Focused Network (SSFN), an organisation of practitioners who wish to promote the model by sharing their thoughts and ideas based on SF and to provide peer contact between services and organisations engaging in SF practice. The aims of the Network are:

- to promote SF practice and thinking in Scotland,
- to support SF practice and thinking in Scotland, and
- to engage with the Scottish Government's agenda in Scotland.

This last aim is the most crucial and underpins the achievement of the other two (see figure 1.).

The illusion of (non)engagement

Our question in meeting this aspiration was, 'How do we engage with the Scottish Government?' However, the conversation we have is determined by the questions we ask and we came to realise that we were asking the 'wrong question'. As Bateson (1972) points out, the interpretation of events is

determined by the receiving context. Events not patterned for observation are not selected for survival, and it is as if they have not happened. In other words, we see what we expect to see. For example, when asked to count the number of passes of two basket-balls between a group of individuals in Simons and Chabris' (1999) Selective Attention Test, observers failed to notice a gorilla walking by. This truth formed the essence of the UK Electoral Commission's (2004) campaign 'If you don't do politics . . .', which aimed to demonstrate that 'politics' impacts on areas as diverse as road traffic management, sports training, the cost of living and everything from rubbish collection to the price of an egg. Thus politics affects everything, and 'If you don't do politics . . . there's not much you actually do.'

A more appropriate (and SF) question is, 'In what ways are we already engaging with the Scottish Government?' Since we work in the fields of health care, social care, education, commerce and the third sector, we are already heavily engaged with the Government; we are paid by them, work in services funded by them, and respond to an agenda set by them.

Benefits of engaging with the Scottish Government
Linking SF practice with current drivers for health and wellbeing.
Promoting SF thinking amongst policy makers.
Attracting funding for specific SF projects around the country.
Creating a context within which SF can grow.

Progress made so far
SSFN developed and meetings attended.
Online network of practitioners growing.
Presentation at UKASFP Conference 2012.

Possible next steps
Website to establish web presence.
Share success stories.
Regular meetings to maintain contact and links.
Newsletter / e-news letter.

Figure 1 The benefits of engaging with the Scottish Government in order to promote and support SF practice in Scotland.

In the specific field of health and wellbeing we are surrounded by a plethora of policy documents outlining and supporting the national strategy: 'Towards a Mentally Flourishing Scotland' (Scottish Government, 2007), 'Rights, Relationships and Recovery' (Scottish Executive, 2006), 'Children and Young People's Mental Health' (Scottish Executive, 2004), and most recently the 'Mental Health Strategy 2012–2015' (Scottish Government, 2012). Given that these policies and strategies are freely available and are actively promoted by the Government, perhaps our question should be 'How could we possibly avoid engaging with the Scottish Government's strategy on Health and Wellbeing?'

For example; 'Towards a Mentally Flourishing Scotland' (Scottish Government, 2007) sets out an action plan to support:

- mentally healthy infants, children and young people,
- mentally healthy later life,
- mentally healthy communities,
- mentally healthy employment and working life,
- reducing the prevalence of suicide, self-harm and common mental health problems, and
- improving the quality of life of those experiencing mental health problems and mental illness.

Since there can be little in the field of mental health not covered by such a broad-based agenda, we are clearly already involved with the Government at many levels and in multi-faceted ways. However, it is also evident that, in this context, our participation has been *reactive*. The question became for us, 'How shall we make this engagement *proactive*?'

The hard part is already done!

When we take a SF perspective on 'engaging with the Scottish Government's agenda on health and wellbeing', it becomes clear that the answers we have been looking for have been 'under our nose' all along! Imagine, if you will, a conversation

between the authors of this paper in which we explore our desire to engage with the Scottish Government.

Box 1

G: What are your best hopes for this conversation?
S: Well, I'd like to have a clearer understanding of how to engage with the Scottish Government's agenda on health and wellbeing.
G: Okay. How will you know when you've achieved that?
S: Well, I guess I'll have a clearer plan of how to actually do it.
G: Brilliant; okay, so … what will you be doing when you're successfully engaged with the health and wellbeing agenda?
S: I'll be delivering solution focused services that meet the Government's strategic plans.
G: How will you know that what you're doing meets the Government's strategic plans?
S: I'll be able to link what I'm doing to specific initiatives or policies.
G: Such as? …

The most recent mental health and wellbeing policy developed by the Scottish Government is the Mental Health Strategy for Scotland: 2012-2015 (Scottish Government, 2012, pp. 11 & 12). This document focuses on a range of improvements and interventions including:

> 'Early intervention for conduct disorder in children through evidence-based parenting programmes;
> Treating depression in those with long term conditions such as diabetes;
> Early diagnosis and treatment of depression; and
> Early detection and treatment of psychosis.'

In particular, the strategy supports the goal that health care should be person-centred, safe and effective, and identifies seven themes for the improvement of mental health services and mental health. These themes include:

1. Working more effectively with families and carers
2. Embedding more peer to peer work and support
3. Increasing the support for self management and self help approaches
4. Extending the anti-stigma agenda forward to include further work on discrimination
5. Focusing on the rights of those with mental illness
6. Developing the outcomes approach to include personal, social and clinical outcomes
7. Ensuring that we use new technology effectively as a mechanism for providing information and delivering evidence based services.

Clearly, there is ample scope for our engagement, and the Government's clues are sufficient for us to begin to visualise their positive future scenario. In fact, they provide us with even more detail on each of the individual themes. For example, they state that theme number six links specifically to the recovery model of mental health care (ibid. p. 17), noting that

> 'Recovery is the idea that individuals and services should look beyond purely clinical outcomes to see the whole person and their social and personal outcomes as equally valid.'

They list a number of initiatives, including the revised Scottish Recovery Indicator – the SRI2 (Scottish Recovery Network, 2011), and the Mental Health Improvement Outcomes Framework (NHS Health Scotland, 2011), which provide explicit, measurable benchmarks for practice. This, then, is where we engage with the Government's agenda on health and wellbeing.

By engaging with the organisations we work with and for, most of which are funded and / or directed by the Scottish Government, we are able to highlight the links between what we do and the benchmarks for practice supported by them. For example, as a group of mental health practitioners working

with children and young people in a rural setting, we have been able to identify clear connections between our service and these goals. Our foundation on inter-personal communication and our background in social constructivism and family therapy (de Shazer, 1994) allow us to argue that SF interactions are strongly positioned to help achieve outcomes such as 'increasing social connectedness, relationships, and trust in families and communities' and 'sustaining inner resources such as meaning, purpose and hope' (NHS Health Scotland, 2011). Continuing with this example, we can also demonstrate that our approach to working with young people and their families is congruent with the SRI2 framework (Scottish Recovery Network, 2011) in delivering services which are strengths based, goal oriented, and which promote and act on user involvement. More importantly perhaps, we can use these goals and outcomes to promote new services within our organisations. This is where our engagement with the Government's agenda becomes *proactive*.

As SF practitioners, most of us in the SSFN have been content to operate in our own arena of practice and leave politics to 'the politicians'. We know the outcomes of our work and are generally happy to continue to do what we do best; if it works, do more of it! For many, the norm consists of 12 to 20 sessions of Cognitive Behaviour Therapy and open-ended 'counselling' and 'talking therapy' (both terms are used extremely loosely), often lasting several years. Those of us in clinical practice are coming to recognise that in this environment we have a moral and ethical obligation to promote our approach to brief, effective interactions more widely than we have. It may be rewarding to know that we are treating people in four to six sessions and in our quiet way meeting the Government's targets. However, extended treatment times block access to services for other people awaiting any sort of service at all; SF Brief Therapy is as effective as any other model of therapy, but typically requires fewer sessions (Macdonald, 2011). In light of that realisation, it becomes incumbent on all of us to engage with the political agenda and to become *SF politicians*.

Conclusion

The context of health and wellbeing *is* politics. If we, as SF practitioners / politicians, are to have control over our development and practice, we have to engage in the political arena. However, it isn't necessary for us to do so from the top-down; we are already participants in political discourse from the bottom-up. If we adopt an SF ear when listening to political language games, we can hear some familiar refrains. Not only has the Scottish Government outlined a clear platform from which it has developed a well-articulated future-positive scenario, but it has provided clear counters, in the form of goals and outcome measures, for us to demonstrate the effectiveness of the services we provide. It would appear that, without us noticing, the SF agenda has been picked up by the Scottish Government and the gauntlet thrown.

Now that the Government has engaged with us, are we sufficiently prepared to engage with it?

References

Bateson, G. (1972). *Steps to an Ecology of Mind*. Ballantine Books: New York.

de Shazer, S. (1994). *Words Were Originally Magic*. W. W. Norton: New York.

de Shazer, S., Berg, I. K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W., and Weiner-Davis, M. (1986). Brief therapy: focused solution development. *Family Process*, *25* (2), 207–222.

Iveson, C. (2002). Solution-focused brief therapy. *Advances in Psychiatric Treatment, 8*, 149–157.

Jackson, P. Z., and McKergow, M. (2007). *The Solutions Focus (*2nd ed.*)*. Nicholas Brealey: London.

Lehmann, P. (2012). *Coming of Age: YODA, Criminal Justice, and Solution-Focused Brief Therapy*. [keynote presentation]. 9th UKASFP Annual Conference. United Kingdom Association for Solution Focused Practice. James Watt Centre, Edinburgh Conference Centre, Heriot-Watt University. June 15th 2012.

Macdonald, A. (2011). *Solution-Focused Therapy: Theory, Research & Practice*. Sage: London.

Miller, G., de Shazer, S. (1998). Have You Heard the Latest Rumor About . . .? Solution-Focused Therapy as a Rumor. *Family Process*, *37*, 363–377.

NHS Health Scotland. (2011). *Mental Health Improvement Outcomes Framework*. [online]. Edinburgh: NHS Scotland. Available from: http://www.healthscotland.com/OFHI/index.html. [Accessed 20 September 2012].

Scottish Executive. (2004). Children *and Young People's Mental Health: Framework for Promotion, Prevention and Care*. Scottish Executive, Edinburgh.

Scottish Executive. (2006). *Rights, Relationships and Recovery: The Report of the National Review of Mental Health Nursing in Scotland*. Scottish Executive, Edinburgh.

Scottish Government. (2007). *Towards a Mentally Flourishing Scotland*. Scottish Government, Edinburgh.

Scottish Government. (2012). *Mental Health Strategy for Scotland: 2012-2015*. Scottish Government, Edinburgh.

Scottish Recovery Network. (2011). *Scottish Recovery Indicator 2*. [online]. Glasgow: Scottish Recovery Network. Available from: http://www.sri2.net/. [Accessed 20 September 2010].

Simons, D. and Chabris, C. (1999). *Selective Attention Test*. [online video]. Available from: http://www.youtube.com/watch?v=vJG698U2Mvo. [Accessed 20 September 2012].

Szabó, P. (2009). Coaching Reloaded – assumptions of a Brief Coach. *Inter*Action, 1(2), 26–40.

The Electoral Commission. (2004). *If You Don't Do Politics . . .* [online video]. Available from: http://www.youtube.com/watch?v=zruGBWLk9s8. [Accessed 20 September 2012].

Trepper, T. S., Dolan, Y., McCollum, E. E., and Nelson, T. (2006). Steve de Shazer and the future of solution-focused therapy. *Journal of Marital and Family Therapy, 32(2)*, 133–139.

Walsh, T. (2006). Two sides of the same coin: ambiguity and complexity in child protection work. *Journal of Systemic Therapies*, *25(2)*, 38–49.