The South Australian Premier's Nursing and Midwifery Scholarships 2016/2017

Scholarship Study Tour Report

Name: David Hains

Title of Study Program: Investigating the use of Solution Focused Brief Therapy in acute mental health services in Canada: could it be used as a clinically effective and cost effective approach for nurses in South Australian mental health services?

Date of Tour 3/10/2016 to 26/10/2016

Government of South Australia

SA Health

Recipient's Name: David Hains

Recipient's Position/Title: Clinical Practice Consultant

Place of Employment: Flinders Medical Centre Emergency Department Mental Health Team

	Commenced	Finished
DATE SCHOLARSHIP TAKEN:	03/10/2016	26/10/2016

COUNTRIES VISITED: Canada

DATE & SITES/INDIVIDUALS VISITED:

5/10/16 Short Stay Unit, Peter Lougheed Centre, Calgary
6/10/16 Woods Homes Eastside Clinic, Calgary
7/10/16 Airdrie Addiction and Mental Health Clinic, Airdrie
10/10/16 Emergency Department, Peter Lougheed Centre, Calgary
11/10/16 Cochrane Addiction and Mental Health Clinic, Cochrane
12/10/16 South Calgary Health Centre, Calgary
13/10/16 Good Health Medical Centre, Westbrook, Calgary
14/10/16 Sheldon M Chumir Addiction and Mental Health Clinic, Calgary
16/10/16 Meeting with Professor Jeff Chang from Athabasca University
17/10/16 49th St. Addictions and Mental Health Clinic, Red Deer
18/10/16 Centennial Centre for Mental Health and Brain Injury, Ponoka
19/10/16 Centennial Centre for Mental Health and Brain Injury, Ponoka
20/10/16 Centennial Centre for Mental Health and Brain Injury, Ponoka
21/10/16 a.m. Emergency Department, Red Deer Hospital
p.m. 49th St. Addiction and Mental Health Team, Red Deer
24/10/16 a.m. Centennial Centre for Mental Health and Brain Injury, Ponoka
p.m. 49th St. Addiction and Mental Health Team, Red Deer
25/10/16 49th St. Addiction and Mental Health Team, Red Deer
26/10/16 Kentwood Place Supported Housing, Red Deer

Recipient's SIGNATURE: _____ **DATE:** _____

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Content

Executive Summary and Recommendations

The following document summarises the S.A. Premiers Nursing Scholarship tour to Canada in October 2016 undertaken by David Hains Clinical Practice Consultant (CPC) at the Flinders Medical Centre (FMC) Emergency Department (ED). These are the key findings and recommendations from the tour:

Key findings:

- Solution Focused Brief Therapy (SFBT) is successful as a therapeutic approach in a wide variety of clinical settings.
- SFBT and single session clinics have the potential to reduce waiting times for acute services, long term therapy, as well as reduce length of stay in inpatient units.
- SFBT is transferrable to a variety of clinical settings with few modifications. Process, practice, and language is all similar whether it be inpatient, outpatient, supervision, management, team leadership, or non-clinical areas.
- SFBT can be used anywhere from a long-term rehabilitation service to a 5 minute corridor conversation, and anywhere can be the place or the conversation that can bring about change.
- SFBT is easily taught, but perhaps is best taught by using and modelling the therapy within the health setting. You do not need specialist qualifications to do SFBT. Specialist education should use and model the therapy within the training.
- There are many benefits in having the same approach and language used across teams.
- When trying to implement the therapy within a traditional “medical model” environment it may be best to role model, allow your interventions to be observed by others, and incorporate positive and strength based language within meetings, ward rounds, and clinical discussions.

- SFBT is a positive, strength based, and client centred approach, therefore compatible with the National Mental Health Plan, the SA Health (2014) Nursing and Midwifery Professional Practice Framework, and the SA Health (2016b) Strategic Commitment 2016-2018.

Recommendations:

- That a nursing model of care be developed based on SFBT principles to create a truly client centred model within a positive, strength based paradigm
- That the use of SFBT be expanded across the both the South Australian Health Service, not restricted to the nursing workforce. Consideration should be given to the following areas in the first instance:
  - Inpatient mental health including short stay units
  - Community mental health – establishing an ultra-brief therapy team to work with both new referrals and current clients who might otherwise be considered "difficult" or "stuck"
  - Psychosocial rehabilitation including Intermediate Care Centres
  - Clinical supervision
- That SALHN and SMH executive support the planned implementation of a SFBT model of care at Morier Ward, Noarlunga Hospital, by providing time and resources to allow for education, training, supervision, and on-going professional development required when implementing a new program. That Morier Ward staff include research on the effectiveness of their new program.
- That on-going training for beginner and advanced SFBT clinicians be supported and formalised.
- As a part of training and staff development, services should support staff to attend/observe live therapy sessions. Consideration should also be given to creating a policy that allows recorded sessions which can be used for teaching purposes (with client consent).
- That the mnemonic ISBAR be changed to promote a more respectful, positive, strength-based, client-centred health care. Possible examples include:
  - PISBARS (start with a positive, end with a strength)
  - PISBAR-PS (P for "person-centred", PS for "positive and strengths")
- That ward rounds, case conferences, case reviews, and clinical discussions all incorporate the language associated with SFBT i.e. positive, forward-looking, and strength based to incorporate client-centred principles.
- That consideration be given to client-led case conferences using SFBT principles and language.

Background

In Australia the 4th National Mental Health Plan (2009-2014) dictates the implementation of a consumer led, strengths based, recovery model. Since then local mental health services have attempted to incorporate these principles into the provision of care however this has predominately been in the sub-acute and rehabilitation areas. In the acute mental health area there has been somewhat less focus on the above in preference for a more traditional approach of medical-based treatments to assess and stabilise illness and

then refer the consumer to sub-acute care. Nursing care has also tended to follow this medical model in the acute area.

Currently within Mental Health Nursing in S.A. there is no one preferred therapeutic approach to nursing practice/treatment. Furthermore, within the Mental Health Service, there is only limited recognition of the effectiveness of brief or ultra-brief therapies, with preference being for medium and long term psychotherapy. The aim of this study tour was to observe practice currently being used in Canada that incorporates an approach to brief therapy both as a stand-alone treatment plus a therapeutic approach that incorporates principles and aspects of the therapy into its model of care. My overall aim was to assess its effectiveness and the possibility of using it in an Australian context to create a person centred, strength based nursing model.

Solution-Focused Brief Therapy (SFBT) originated in the USA in the 1980's. While it was originally developed and used in the area of family therapy, it is now proven to be effective in a broad range of both clinical areas (including emergency departments, psychiatric inpatient units, community mental health, public health, general practice) and non-clinical fields (such as corporate coaching). Its effectiveness has been proven in working with a wide variety of illnesses and situations such as anxiety, depression, eating disorders, suicidal thinking, psychosis, substance abuse, chronic illness and terminal illness, and in addition has proven to be a very cost efficient psychological therapy (Gingerich and Peterson 2013). SFBT is a positive approach to therapy, focusing on strengths and potential rather than focusing on the problems and deficits that have brought the consumer to seek help.

It has been argued that SFBT is consistent with nursing's core values and philosophical foundations (Webster et.al. 1995, McAlister 2003, McAllister et.al. 2009, Wand 2010). I propose that incorporating SFBT into nursing practice (similar with what McAllister 2006 calls "solution-focused nursing") that it will fit neatly with state government strategic priorities including the SA Health (2014) Nursing and Midwifery Professional Practice Framework and the SA Health (2016b) Nursing and Midwifery Strategic Commitment. McAllister (2010) and Wand (2013) clearly articulate the potential role of a solution focused approach to mental health nursing in the public health system; to expand and promote the role of the nurse, to engage with consumers, and to bring/promote a positive health approach. Most importantly though, a solution focused nursing model offers to provide a truly client-centred approach to nursing care.

While the therapy is used around the world, it is in Alberta, Canada where the therapy appears to be most widely used and reported in the literature within acute adult mental health and psychosocial rehabilitation. Investigation of the current literature, plus personal communication, had identified areas of the public health service in Alberta that have effectively used SFBT across a wide variety of mental health settings in an integrated service approach. The initial pilot project of the Calgary Zone Addiction and Mental Health Service (Alberta Health Services 2012a and 2012b) reported:

* improved satisfaction and outcomes for clients (98% client satisfaction)
* ease of teaching the model, improved staff understanding and acceptance
* that adopting a singular theoretical framework and associated toolset was preferable as it allowed

increased access to training, live observation, coaching and mentoring through a community of practice

* a decrease in waiting times for other therapies and services (related to improved efficacy and the efficiency of a briefer service)
* financial savings using the approach

Expansion of the service has demonstrated both a replication of the above across different clinical areas, as well as a sustained efficiency and efficacy (Alberta Health Services 2014).

Over recent years I have conducted many full-day workshops teaching SFBT to mental health clinicians and non-government employees. There has been overwhelmingly positive feedback from clinicians, with most attendees saying that it was easy to learn and understand the therapy and that they planned to include this therapy into their daily clinical work. However a criticism has been that the structure of the current acute service (based on a medical model) did not allow for a positive strength based paradigm. It was hoped that through the study tour I would be able to identify and plan how to incorporate solution-focused concepts into a nursing model for the whole of the acute mental health service. My desire is to create a truly client-centred approach to mental health care starting with, but not limited to, nursing for a whole of service approach.

Summary of the study tour's itinerary:

5/10/16 Short Stay Unit, Peter Lougheed Centre, Calgary

- Orientation to the Alberta Health Service
- Tour of Hospital and mental health units
- Most of the day spent observing the processes in the Short Stay Unit

6/10/16 Woods Homes Eastside Clinic, Calgary

- Observe full day walk-in single session therapy clinic
- Discuss the implementation and 20 year history of the clinic
- Discuss the various therapy modalities used by the multi-disciplinary team

7/10/16 Airdrie Addiction and Mental Health Clinic, Airdrie

- Observe live SFBT sessions
- Discuss history of SFBT service
- Discuss research and data collection

10/10/16 Emergency Department, Peter Lougheed Centre, Calgary

- Discuss service with mental health team to compare to FMC and SA

11/10/16 Cochrane Addiction and Mental Health Clinic, Cochrane

- Observe single session walk-in SFBT

12/10/16 South Calgary Health Centre, Calgary

- Observe live SFBT single session with expert clinician in a team training event
- Observe walk-in single session clinic

13/10/16 Good Health Medical Centre, Westbrook, Calgary

- Observe ultra-brief therapy sessions in Primary Health Care Clinic

14/10/16 Sheldon M Chumir Addiction and Mental Health Clinic, Calgary

- Meet and discuss emergency mental health service in inner-city

16/10/16 Meeting with Professor Jeff Chang from Athabasca University

- Discuss some of the history of SFBT in Alberta, including the original Eastside Clinic SFBT model

17/10/16 Mental Health and Addictions Clinic, Red Deer

- Orientation to service
- Observe SFBT group work

18/10/16 Centennial Centre for Mental Health and Brain Injury, Ponoka

- Attend advanced SFBT training workshop
- Observe live Recovery Review session (i.e. SFBT version of a case conference)

19/10/16 Centennial Centre for Mental Health and Brain Injury, Ponoka

- Attend advanced SFBT training workshop

20/10/16 Centennial Centre for Mental Health and Brain Injury, Ponoka

- Attend Marion House Rehab Unit to observe and discuss SFBT practices

21/10/16 a.m. Emergency Department, Red Deer Hospital

- Observe emergency/intake assessment using blended traditional and SFBT approach

21/10/16 p.m. 49th St. Addiction and Mental Health Team, Red Deer

- Observe walk in intake clinic and assessments using blended traditional and SFBT approach

24/10/16 a.m. Marion Rehab Unit, Centennial Centre for Mental Health and Brain Injury, Ponoka

- Observe SFBT based group work
- Observe SFBT individual therapy session with key worker

24/10/16 p.m. 49th St. Addiction and Mental Health Team, Red Deer

- Observe SFBT group work

25/10/16 49th St. Addiction and Mental Health Team, Red Deer

- Observe SFBT walk in single session therapy clinic

26/10/16 Kentwood Place Supported Housing, Red Deer

- Observe SFBT based programs in a transitional housing environment

Total: 17 days where site visits and activities occurred
12 different sites/locations visited

Aim and Objective

Objectives 1-7 were from the original Premier's Nursing Scholarship application

Objective 1: Observe the practice/use of SFBT within a wide variety of settings in the Alberta Health Service, including emergency departments, inpatient and outpatient settings.

Objective 2: While in Alberta observe and discuss SFBT training, including what has worked and what has not worked in establishing a Solution Focused Model.

Objective 3: Observe the consumer-led case conference in Ponoka, Alberta, and discuss the implementation, function, benefits and disadvantages with clinical staff, management and consumer representatives.

Objective 4: Observe and study the single session walk-in SFBT clinics in Calgary and Red Deer, Alberta.

Objective 5: Examine the use of SFBT based assessment tools (including risk assessment) in various clinical areas of Alberta Health Service.

Objective 6: Meet with lead clinicians and managers to discuss data collection, KPIs, and tools to measure the success of implementing a new program based on SFBT principles.

Objective 7: Establish strong international links between SALHN and various North American clinicians and organisations not limited to Alberta Health Service.

Additional objectives – established after the original scholarship application

Objective 8: Examine other models of care and brief therapies currently being used in Alberta that do not relate to SFBT and make comparisons to SF based models within the Canadian context.

Objective 9: Meet with the Red Deer SFBT Community of Practice to examine how they run their support group and obtain ideas for the South Australian SFBT Community of Practice.

(Note – the planned meeting of the Community of Practice was cancelled as most of the group were attending the advanced training workshop in Ponoka. I was able to meet most of the group through the workshop and site visits. After completing the scholarship tour I was able to attend a meeting of the Solution Focused Brief Therapy Association of North America to discuss the establishment and structure of groups throughout USA.)

Discussion & Analysis

Site Visits

5/10/16: Peter Lougheed Centre, Calgary. Mental Health Short Stay Unit, Emergency Department, Inpatient (long stay) Psychiatry

The Peter Lougheed Centre is a 600+ bed tertiary hospital in the north-east area of Calgary. In many ways it is similar to the Flinders Medical Centre in respect to size and services offered. Most of my day here was spent in the Mental Health Short Stay Unit. This site was chosen as my first site to visit mostly so I could get an orientation to the mental health service from a speciality area that I mostly work in. I was aware before arriving that the short stay unit previously ran a program based on SFBT (Jessen and Maclean 2008)

however I knew that they did not maintain the model as it was originally intended. While SFBT was mentioned on a couple of occasions in conversation there was actually little evidence of its use. This is not an uncommon situation as many services are known to call themselves “solution focused” without actually using SFBT (Durrant 2016).

My initial orientation to the service was with Roberta Corea, nursing manager of the acute mental health service, who gave me information about the hospital and health service. Alberta Health Service was previously divided into many local health networks but now this has been discarded and the whole province runs as one large network. The short stay unit is the only one of its kind in Alberta and as such can take patient transfers from any other hospital or mental health clinic however in reality would not normally take patients from more than 100km away. The unit was established 15 years ago based on a model used in Halifax, Nova Scotia. Originally established in a temporary home of transportable “trailers”, after 4 years it was relocated into its current position which was formally a forensic psychiatric unit. The unit has 16 beds, twice as big as the SSU at Flinders. While it accepts patients from across the Calgary region and surrounds, unlike Flinders it works purely as a short stay unit. That is, patients arrive with the goal of discharge within 72 hours. Patients will not be transferred into SSU if they are assessed as requiring a longer stay ward. If required however patients can be transferred to a long stay unit if the SSU has not met their needs.

The formal part of the day in the SSU starts with an intake meeting led by Psychiatrist and Clinical Director Dr. Lloyd Maybaum. The meeting consisted of 3 psychiatrists, psychiatry trainees, a general physician, social worker, family counsellor, and nurses. The clinical discussion was such that I could have closed my eyes and imagined that I was at the FMC SSU. Patients have already had an assessment in their place of origin but will be allocated to a SSU psychiatrist for further assessment. Compared with the FMC SSU there was actually a higher concentration of Psychiatrists in the unit.

Immediately after the clinical discussion I met briefly with Dr. Maybaum to discuss the model of care. He advised that they have an eclectic approach, loosely structured around Maslow’s hierarchy of needs, using techniques predominately based in cognitive behaviour therapy (CBT) but also incorporating dialectical behaviour therapy (DBT), psychodynamic psychotherapy, and “some SFBT”. Using a multi-disciplinary approach and a strong commitment on brief care he believes that “the unit can do more in 3 days than an inpatient unit would normally do in 3 weeks”. This struck a chord with me as it is a comment that I often use at FMC. I was to witness this in observing their interviews with a patient that had been admitted overnight. While I was there the patient had a full multi-disciplinary assessment led by a psychiatrist (with nurse and social worker present and participating), he was referred to an seen by the dietitian to assist with unstable diabetes, a meal plan was organised and discharge planning commenced with a referral to the diabetes clinic, he was referred to the Addictions Counselling Service, he was reviewed again by the social worker and information was provided for him to self-refer to further drug rehabilitation services and housing services (which he initiated later), and educational material was provided in the form of CBT-based “skill sets” as well as diagnostic information all for him to read and work through with nursing staff.

The skill sets were information that could be printed off as required. The primary document was a CBT-based information sheet describing the relationship between thoughts, emotions and behaviour, with an

associated exercise sheet to identify “rewarding behaviours”. Patients were also given information sheets to explain their diagnosis in layman’s terms. These were only given after the psychiatrist assessment. Ward nurses would provide further information or assist patients to complete activities.

Observing a psychiatrist complete an assessment of a patient, as well as do a follow-up of another, there was an obvious contradiction in the approach which was later matched by ward nurses. There was obvious discussion with the patient about getting them to make choices, and several comments from the psychiatrist such as “I am working for you … you are my boss”. On face value this might suggest a person-centred approach and an attempt at collaboration, however I noticed a sense of (medical) expert and (patient) victim. While it is difficult to come to a conclusion based on observation of a sole psychiatrist, it was not quite the person-centred/collaborative approach that SFBT would aspire to. Furthermore, there was a lot of talking coming from the psychiatrist, and not much listening to the patient, more fitting to a medical model than a patient-centred one. In addition to this, a focus on diagnosis and identification of personality styles is also not a solution-focused way of working.

As a side note, the following Friday I met with Darcy Jessen in Airdrie who had originally established the SFBT model in the PLC SSU (Jessen and Maclean 2008). She expressed bitter disappointment that the model did not continue. We speculated as to why the model did not continue:

- Lack of managerial support after Darcy left the unit
- Lack of senior SFBT clinician to maintain the clinical focus
- Lack of acceptance by psychiatrists who all maintained the medical model and focus on problems and deficits.

One of Darcy’s concerns were very evident to me as I observed the ward, and it is a problem that can be common in inpatient psychiatric units. That is, the lack of engagement of nursing staff and the lack of empowerment that working under a medical model often presents. On observation, the nurses spent a significant amount of time sitting at the desk and appeared to have little interaction with patient unless the patient approached them. Their extent of therapy was selecting the correct paperwork and giving it to the patient to read. The original model was for the nurses and allied health to provide most of the care and therapy, while the psychiatrist worked purely in a consultation role. It would appear that the psychiatrists did not want to hand over their lead role, and the remaining nurses (after Darcy left) did not want to continue their therapeutic role and neither were they supported by the remaining management. It wasn’t until I later headed to Ponoka before I understood what this model looked like.

Later in the day I met briefly with Marci, manager of the Psychiatric Emergency Team. She provided a brief overview of their service including referral pathways into and out of the department. As with other parts of the MH service at PLC, I am surprised at how similar their service is to FMC. The Psych Emergency service will be discussed further below as I returned there on the following Monday. I note however that there is no emphasis on therapy in the emergency, simply a requirement of doing standard assessments and planning for disposition.

Objectives that were met: 7, 8
Key points:

- Overall a lot of similarities to the services at FMC and across Adelaide
- Even stronger emphasis on the medical model compared with FMC ED/SSU
- Disempowerment of nurses
- Staff paid lip-service to SFBT but there was no evidence of its use
- No restrictions or goals in decreasing length of stay in the ED (unlike the National Emergency Access Target in SA)

6/10/16: Woods Homes Eastside Family Centre, Calgary.

Woods Homes is a not for profit family mental health centre which has been running for over 100 years (Woods Homes 2016a). The Eastside Family Centre, open since 1990, runs a drop-in counselling service for free of charge single session therapy (Woods Homes 2016b). When established it was the first service of its kind in Canada to offer walk in therapy (Clements, McElheran, Hackney and Park 2011). At Eastside I was hosted by their manager Janet Stewart.

The single session therapy team is a multidisciplinary team consisting (in various combinations) of psychologists, social workers, psychiatrists, general counsellors, and students of various disciplines. While their service was initially strongly influenced by a solution focused framework, the therapy can consist of a variety of approaches and techniques depending on the therapist. The structure of the session is based on the Milan Model (Boscolo et.al. 1987) which strongly aligns with a solution focused structure (Slive, McElheran, Lawson 2008).

Clients arrive without booking and are seen on a first in first served basis. They can self-refer or they may be referred from a variety of sources including General Practitioner, mental health services, and school. On arrival clients are asked to complete a selection of paperwork including demographic information, consent form (for observed therapy), a pre-session questionnaire, patient health questionnaire (PHQ-9), and the Generalised Anxiety Disorder Scale (GAD-7).

The therapy team (whoever is available) will discuss the pre-therapy forms and allocate the session to a therapist. The team will then discuss the presentation and plan for the session. The therapist then conducts the session in one room while the rest of the team sit in an adjoining room to listen and watch through a one-way window. The team can interrupt at any time and phone into the therapy room if they have any questions or ideas to put to the therapist. After approximately 40 minutes the therapist pauses the session for a break. The therapist joins with the rest of the team to discuss the session and plan for the conclusion which will include a summary, feedback, and plan. At the end of the session the client is also asked to complete a feedback form. Where time permits, the team will review the feedback form and will further discuss the session (Slive, McElheran, Lawson 2008). Therapists commented that they felt supported by the team

approach, as it didn't matter what the session was about or if they struggled as they knew there was a team watching and supporting them.

The Eastside team is passionate about their approach to single session therapy. Woods Homes has a large research focus and have written extensively about their service. Their approach to single session walk-in therapy has proven to be effective, with high levels of client satisfaction (Miller 2008), and a decrease in client distress (McElheran et.al. 2014).

Further, the nature of the service is inherently client-centred. That is the client can attend whenever they wish, there is no referral waiting list or intake assessment, there is generally only a short waiting time when they arrive, the client identifies their main concern and the therapy addresses this specifically, there is no cost, the client can return at any time in the future for another session. Stronger use of SFBT would only enhance this as a client centred approach through the nature of the therapy (as discussed earlier).

It is also noted below (meeting with Professor Jeff Chang) that the documentation was developed with the assistance of Insoo Kim Berg, one of the founders of SFBT.

Objectives Met: 5, 7, 8
Key points:

- My first opportunity to observe single-session therapy
- Strengths-based and client-centred but not SFBT
- Originally established with SFBT as one of its primary approaches
- Strong emphasis on observed team sessions so that effectively it is a team therapy session
- Strong emphasis on the educational aspects for staff in group/observed sessions

7/10/16: Addiction and Mental Health Clinic, Airdrie.

The Airdrie Mental Health Clinic was my first real SFBT stopover and a destination that I have been planning to attend since first making contact with my host, Darcy Jessen, almost 3 years ago. Darcy leads a team of several therapists all committed to the delivery of a SF model. In fact, she insists that all new employees train in SFBT if they haven't already. While there are several different programs running out of Airdrie, my visit and consequently this discussion, will focus on the use of SFBT.

The day started with meeting 3 of the clinicians (Rob, Anise and Lesley) for a general discussion and then preparation for an assessment. As with the Eastside Clinic one clinician took the interview while the others watched in another room via a computer monitor. Patients first consented to the use of the monitor, however it was explained that the benefits to them was that there would be more than one therapist involved in the interview and subsequent treatment plan. Unlike the Eastside Clinic this method of observation did not happen on every session but rather a couple of times a week, booked in advance so that all could attend,

and used for a training opportunity for the team. The culture of observation is fully supporting the lead therapist. Observers commented on the interview in a positive fashion and only to assist the therapist in the therapy. There was no critic of the therapist and their approach unless the therapist specifically asked. The aim was to create a "safe" environment for clinicians to practice and grow, while having the support of colleagues to interject with questions (via a phone link) and assist with discussion in the break period.

After several years of practicing SFBT this was the very first occasion that I was able observe a live SFBT session anywhere. In Adelaide SFBT practitioners are isolated, with most being very junior and inexperienced practitioners, so there are very few people in South Australia who are practicing SFBT at a competent level. The Airdrie team was amazed at this. My initial thought was that it would be a luxury for this to occur in South Australia. That is, there is no funding available so that the one interview can be watched by several other people. However, the efficiencies and benefits of this system should not be underestimated. For example, currently in the SALHN community MH teams the initial assessment and often follow up appointments are undertaken by 2 clinicians. The following day the patient is presented to the clinical team which may consist of several psychiatrists, registrars, other clinicians and management. The assessment would be discussed in detail and then a plan of treatment/care discussed. In relation to staff time and resources it would take approximately the same time for the team to observe an interview and discuss it on the spot as it would to discuss it the following day. However, the benefits of observation would be 1. That the whole team sees the assessment first hand, and the information is not lost or interpreted incorrectly in the team discussion, and 2. There is a built-in teaching and learning opportunity both for the clinician and the team. This second point was later reiterated at several different sites where managers stated that the benefits of this included staff development, team cohesion, and therefore benefits to the client from having highly skilled practitioners.

A second interview was observed in the afternoon, however this one was the 5th session for the client who was a 13 year old girl attending with her mother. The novelty of this for me (in respect for my current employment) was 1. I do not assess/treat consumers under the age of 18, and 2. I do not usually have the opportunity to do 2nd or follow-up sessions with the same consumer. However it was a chance for me to realise that the approach and techniques used are the same as in the initial session, as well as the same as I would use with adults.

Further discussion was had with Darcy and her team (at various times) regarding their team and approach. Darcy is very committed to maintain a team dedicated to SFBT. A big part of this is because she knows it works. The reader is directed to the "background" section of this paper and the evaluation of the Calgary Region SFBT programs (Alberta Health Services 2012a, Alberta Health services 2012b, Alberta Health Services 2014). For her, as with SFBT services elsewhere, the reasons for this are clear (as highlighted in the above reports):

- Clinically effective interventions, highly rated by clients
- Positive and strengths based approach
- Client centred i.e. the client determines the goals and directions of the therapy, and the client and therapist are in a collaborative relationship

- The walk-in therapy has the advantage of providing the therapy at the time the client requires it by not having a waiting list
- SFBT is appropriate in single session therapy as much of the therapy would happen in the first session anyway
- Clinically effective in both single session and brief (few) sessions
- Easy to teach to clinicians, and clinicians appreciate the positive nature which in turn reduces clinician fatigue
- Has shown to be effective in reducing the waiting lists for other services (e.g. clients start to feel better and withdraw from other longer term therapy waiting lists)

Objectives met: 1, 2, 5, 6, 7
Key Points:

- My first observation of a live SFBT session
- Cohesive team all committed to the use of SFBT
- More effective and cost efficient training as all therapists share the same model and language
- Proven to be an effective and efficient therapy

10/10/16: Emergency Department, Peter Lougheed Centre, Calgary

The 10th of October is both World Mental Health Day and also Canadian Thanksgiving, a public holiday in Canada, and therefore there were very few services open. My original plan was to return to the Eastside Family Centre on the Saturday however they were closed for the duration of the long weekend. Therefore I returned to the Peter Lougheed Centre and spent a short time with the Psychiatric Emergency Team. Unfortunately (but not unexpected) they were busy doing clinical work so my time there was brief to avoid too much interruption to their clinical work. I was hosted by mental health nurses Gail and Christine, both of whom are casual employees. My time there only confirmed that there are many similarities between what they do and what I would normally do at FMC ED.

The team covers the ED from 0700 to 0200. They will sometimes wait for referrals from the ED team, but sometimes will take a more proactive approach and "parallel process" with the ED, depending on the nature of the presentation. They will not see patients intoxicated with alcohol until they are at the legal driving limit. Both Gail and Christine lamented the fact that there was more expectation on doing write-ups and other work on the computer therefore taking longer than it previously did to do each assessment (a comment I often hear from South Australian clinicians).

I note from my previous visit to the PLC and discussion with Marci (Psych ED team leader) that there is little in the way of "therapy" practiced by the team. They appear to view themselves as there to primarily complete assessments and "process" patients. This in itself is not unusual as it may be considered the core business of most ED clinicians. However it should be noted that there are fewer time pressures i.e. there is no time limit in the ED so they are not under anything similar to the NEAT of 18 hours that we currently have in SA.

Patients can spend several days in the PLC ED awaiting an inpatient bed and they will be reassessed each day. There is no specific psychological therapy provided, and once under the psychiatric bed card the patient is essentially in a holding pattern awaiting transfer. I was hoping to see some sort of structured therapy or model, even if it wasn't solution focussed based, but this was not to be. I was hoping it will be different in Red Deer where I was to attend later in my tour. I accept that lengthy delays in the ED used to be the norm in SA but fortunately no longer.

It was inappropriate for me on the day to view assessments. I was also aware that the 2 nurses had clinical work to attend to which made it difficult for me take too much of their time to attain further information.

Objectives met: 8
Key Points:

- Nurses working under a medical model however only limited medical support
- No use of SFBT or other brief therapies
- Nurses present were both casual employees and could not comment on service issues in detail
- Patients can often spend several days in the ED while waiting an inpatient bed. Similar situation to where SA EDs were a few years ago.

11/10/16: Addiction and Mental Health Clinic, Cochrane.
12/10/16: South Calgary Health Clinic, Calgary.

As the teams I visited from these 2 clinics had very similar function I will write about them in the same section but providing basic information from the individual sites.

Tuesday the 11th had me driving West to Cochrane to visit Tara Perry and team at the Addiction and Mental Health Clinic. Tara is a Social Worker and the team Clinical Supervisor. She is an avid devotee of SFBT and uses this as her sole therapeutic modality. I have been in contact with Tara for almost 3 years while I planned my initial application for the Premier's Nursing Scholarship. The initial plan for the day was that Tara was employing new staff members and I was going to join them for their orientation to the service plus a discussion (education) of SFBT. Unfortunately the hiring process had not been completed so the orientation was cancelled and Tara had to cover the walk-in clinic for the day. This was OK by me as it meant I could observe another very experienced solution focussed practitioner in action. There were only 2 clients present for the clinic, and I was able to watch from the adjoining room. For the first client I was joined by another team member, Dan, a non SFBT practicing psychologist. Tara uses a pure SFBT approach. Time before and after the sessions were spent discussing the client, the therapy session, the therapy, the local service (focussing on the walk-in service), as well as Tara's role as a manager and her use of a solution focused approach to managing the team. We also discussed the increasing interest in SFBT in South Australia including a current project in the Noarlunga Hospital in an attempt to elicit suggestions in how to establish a new service with a solution focused model.

On Wednesday October 12 I visited the South Calgary Health Service and was hosted by Monica Barnes, a Mental Health Nurse and the Clinical Supervisor with the therapy team. The team runs 2 services; the walk in single session clinic as well as the adult mental health “change orientated therapy” team which provides up to 12 session of therapy. They have a multi-disciplinary team of 8 clinicians, but only 2 of which practice SFBT. The history of the walk-in SFBT clinic was been reported by Harper-Jaques and Leahey (2011).

My original invitation was to attend the single session walk in clinic in the evening however prior to this Monica had organised a team observation day with experienced SFBT practitioner Janet Wilson. Janet is one of the most experienced solution focused practitioners in the Calgary region. A client on the waiting list for therapy was invited in for a single session of SFBT while the rest of the team (12 including students and myself) watched from the adjoining room. Janet’s therapy session was purely solution focused and included a pre-session discussion, 45 minutes of therapy, a 10 minute break where the therapist could discuss the session with the team and formulate the conclusion, and 5 minutes to present the feedback, conclusion and post session task. The team then spent another 30 minutes in discussion about the session and the approach to therapy. Interestingly in this session the number of non-solution focused therapists greatly outnumbered the solution focused therapists who were hosting the event. Great care had to be taken by both Janet and Monica to ensure the pre and post session discussions remained solution focused as clinicians tended to want to discuss the case through the eyes of their preferred modality. The remainder of my time at South Calgary was spent with Monica observing other clinicians in the walk in clinic. While the other clinicians were not solution-focused, Monica and I were able to offer solution focussed input to the sessions.

The teams I visited at Cochrane and South Calgary were both very similar. Both were run by experienced SFBT practitioners but the teams consisted of a lot of non-SFBT practitioners. Both Monica and Tara, while being completely dedicated to their approach, welcomed practitioners who used other modalities. However as Tara pointed out, she was not concerned that clinicians practiced other modalities, but rather she wanted to know what approach they used and why they used it. She believed it was more important that clinicians were sure of what they were doing and why, otherwise they needed to go and find out. Her thought was that a belief and passion for one approach would lead to increased knowledge in that approach, which in turn would lead to improved outcomes in their clinical work.

Tara particularly had interesting insights to the use of SFBT programs within the broader service, especially in reference to single session walk in clinics, such as:

- Clinically effective
- The nature of the positive approach and the focus on strengths rather than deficits/problems meant that it was more likely that a client was feeling better at the end of the session, and therefore less likely that they would require referral to hospital or acute/urgent mental health services
- Single sessions, offered at the time the client wants it (rather than being on a waiting list for a while) meant that waiting lists for other services could be decreased. Clients have often reported “it’s all I needed” and withdrew from waiting lists for other services

Objectives met: 1, 2, 4, 5, 6, 7

Key points:

- Individual therapists could choose and work with their own approaches
- No common therapy language within the team
- Both teams were led by experienced SFBT clinicians who are passionate about the modality
- Difficulties with whole of team training due to the individual approaches
- While there was a potential richness of knowledge in having different therapeutic modalaties, there was also a lack of cohesion and a variety of language in clinical discussions which could lead to confusion

13/10/16: Good Health Medical Centre, Calgary.

The original plan for this day was to be hosted by Sherry Harris, Clinical Supervisor of the Shared Care Team, however Sherry was out of the province due to an urgent family illness. I was therefore unable to attend this team but Sherry kindly arranged me to meet a clinician at their partner team the Behavioural Health Consultation Service (BHC). Psychologist Zane Webber kindly agreed to allow me to attend his brief therapy clinic at the Good Health Medical Centre. This privately run General Practice has 4 Family Doctors and runs both with appointments and with a drop in clinic.

The BHC is a brief therapy service and a part of the Alberta Health Service. They have approximately 150 clinicians of various disciplines throughout Calgary working with General Practitioners in the Primary Health Network. The service runs clinics at various GP practices throughout the city. GPs refer patients suitable for brief therapy to the sessions run in their own clinic, which could be 1 or 2 days a week. The clinic GPs are the only referral source. Counselling sessions run for 30 minutes. There is no limit to how many sessions that a client can attend but Zane suggests the average is about 5-6. The aim of the service is to provide counselling but not case management or referrals. Clients that require case management, psychiatry, or other services may be directed to Access, the 24 hour mental health intake and information service (similar to the South Australian Mental Health Triage Service). The service is free. I am not aware of the business arrangement between the Clinic and the Health Service, but I was told the GPs find it beneficial to have a clinic on-site to refer their own patients to. The waiting time at this clinic for a BHC appointment is approximately 2-3 weeks, but at other clinics can be as long as 4-6 weeks.

While it was a pleasure to attend the clinic with Zane, the day had a full list of appointments so our discussion was somewhat limited as I did not want to interrupt his clinic work. Furthermore, Zane is a clinician and has no involvement in a management role so he could provide information as a clinician but not detailed service information.

Zane's clinic consists of 30 minute sessions. He would usually run 2 sessions and then have a 30 minute break to write his case notes and prepare for the next sessions. I sat with him to observe 3 sessions (the 4th person did not attend). 2 of these clients were follow-up appointments, and 1 was a 1st appointment. Zane has a background in psychology and works at several different practices. He works from a variety of

modalities but knows little of SFBT. We had little time to discuss the merits of any one particular approach. Zane described the difficulty of working within a strict 30 minute time frame. There is little time for small talk, engagement (must be virtually instant), assessment, problem analysis, or outcome/rating tools. Sessions must be very strictly focused on a narrow goal and to be successful must stick to this focus. Zane described the service as “A little bit of help to a lot of people.” This approach potentially fits in with theory of Milton Erikson which was used by Steve de Shazer and team as a basis for developing SFBT. That is, that clinicians do not have to do assessments, do not have to diagnose, that smaller change can lead to bigger change (the clinician just helps to start the process), and that therapy can be brief (Visser 2013). It was easy for me to see how SFBT would work very well in a clinic such as this, however I would personally struggle with the time restraints of 30 minutes. I questioned Zane on this, stating I would see benefit for an initial 60 minute session under the belief that 90% of SFBT can happen in the first session and therefore there is potential to reduce the number of contacts for many clients down to just 1. Zane could understand my rationale, and explained that at a similar paediatric clinic the first session will be booked for 1 hour.

Zane explained that while he works for the AHS, the clients belong to the GP practice. He records interactions onto the GP electronic medical record. He is not required to complete a formal assessment or risk assessment, but if he becomes aware of an urgent or high risk need he will refer the client immediately back to one of the GPs who are present on that day. There is an expectation that the GP has completed their own basic risk assessment and suitability assessment prior to referral to the team.

While the BHC and the Shared Care Teams collect basic data relating to the service, Zane was not aware of any recent formal assessment of the service or data collection regarding their effectiveness or efficiency. However it is his belief that the BHC provides the following benefits to patients and the health service:
For patients:

- Short waiting lists
- Free service
- Brief targeted therapy
- Maintenance of the primary care model with the GP in a “one stop shop”

For the wider Alberta Health Service:

- Decreased referrals to urgent and not-urgent mental health services
- Decreased referrals to Emergency Departments and Urgent Care Centres
- As with walk-in services that I had visited there was a speculation that by meeting the client’s needs in a timely manner meant that they did not need to wait on other lengthy waiting lists for longer-term therapy (it was reported at Cochrane, Airdrie and South Calgary that some clients who were on the waiting list for longer therapy actually withdrew their names from waiting lists after they had attended brief therapy).

In some ways this model is similar to the original brief therapy model established approximately 14 years ago in the Noarlunga Emergency Department. I am unaware if anything similar is currently being run in the Southern Adelaide Primary Health Network.

There was only a little opportunity to discuss SFBT at this site, where Zane and I were able to discuss techniques that may be appropriate for use. I had been previously advised by Sherry Harris that she was planning to implement SFBT training within the service and promote its use however this has not been commenced and unfortunately I was not able to discuss this any further with Sherry.

Objectives met: 8
Key points:

- Effective ultra-brief therapy
- Clients happy with the service (short waiting lists, free)
- No use of SFBT however I speculate that the therapy would be successful in this setting
- The service plans to implement SFBT training in the near future

14/10/16: Sheldon M Chumir Addiction and Mental Health Clinic, Calgary.

This visit also required a slight change from my original plans. I had originally arranged to meet Cheryl Gardner, manager of the mental health services in the Sheldon M. Chumir Health Centre in downtown Calgary but unfortunately Cheryl became unavailable for the day. Instead she arranged for me to shadow Reyna Dawes, a social worker with the mental health Mobile Response Team, who has an interest in SFBT but does not actively practice the therapy. I was again limited in my time with the team as I was aware that Reyna and the team had clinical work to attend to, however she was gracious with her time to discuss the services in the building.

The Sheldon M. Chumir building is a large and modern inner city community health clinic with a variety of services including an emergency care centre but it does not have an attached hospital. There are a variety of mental health teams including; Psych Emergency team, Mobile Response Team, Police and Crisis Team (PACT), Community Mental Health Team, and the Indigenous Mental Health Service.

The Mobile Response Team describe themselves as an “urgent” service but not an “emergency” service. That is, they will take urgent referrals from triage teams (e.g. Access Mental Health, or the NGO Distress Centre Crisis Line) and respond within 48 hours depending on the urgency. They are a very short term service where they will do an initial assessment and a very limited number of follow-up phone calls or visits. They are the only mobile urgent MH team in the region. All emergency calls are sent to police or ambulance services. They are a multi-disciplinary team focused on crisis intervention and referral rather than therapy. However one interesting form of brief therapy that the team was involved in is Critical Incident Stress Management. The team will be involved when a person of a group of people go through a traumatic event and provide immediate debriefing and counselling with the aim of preventing or limiting the development of post-traumatic stress disorder.

At Sheldon M. Chumir I was also introduced to the PACT team which is unlike anything that we have in South Australia. PACT runs from 0600 to 2400 over 7 days a week. Each shift consists of a partnership of one mental health clinician and one police officer who will attend urgent and emergency mental health referrals where there is an element of high risk. The team travels in a standard police car. The police officer has a full kit including gun and Taser, and the clinician wears a bullet proof vest. On call-outs the clinician does the assessment (including documentation) however the police officer is also involved in the conversation and gathering of information. Under Alberta legislation mental health clinicians do not have the power to "apprehend" or force someone to go to hospital but the police do, so it is handy to have presence for both safety and also apprehension of a person for assessment and treatment. I spent a period of time discussing the service with the police officer on duty. The police officers must have an interest in mental health and apply for the position, however they have very little specialty training after finishing their basic police training. While to some it would appear to be a heavy-handed approach to emergency mental health, it was pointed out that compared to the alternative (i.e. general police attending, who have neither the training, the time, and often the empathy) it was an effective front line response.

There was no opportunity to discuss SFBT at this site. I had been previously advised by Cheryl Gardner that she was also planning to implement SFBT training within the service and promote its use however this has not been commenced and unfortunately I was not able to discuss this any further with Cheryl.

Objectives met: 8
Key points:

- The service plans to implement SFBT training in the near future The clinicians present on the day had little or no SFBT skills
- Unique partnership between police and the mental health service

16/10/16: Meeting with Professor Jeff Chang from Athabasca University, Alberta.

After arriving in Calgary a colleague in Sydney, Michael Durrant, put me in touch with Professor Jeff Chang. As my plans for the 2 weeks in Calgary were already fairly full, Jeff offered to meet me for a discussion over lunch on Sunday which was my last formal day in Calgary. Jeff is the Associate Professor of Psychology and also runs a private consultancy business in various areas. He is an avid devotee of SFBT although he admits that he has been criticised by SFBT "purists" that his practice and ideas have become corrupted by Narrative Therapy and other modalities. But having said that, Jeff has been using and teaching SFBT almost as long as anyone in Alberta. Furthermore he has researched and written extensively on the subject (Chang 2016), including a recent review in the Australian published Journal of Solution Focused Brief Therapy (Chang 2015). Jeff's current main interests are in teaching, clinical supervision, family therapy, and high conflict divorce.

Jeff provided interesting insights into the early days of SFBT in Calgary, including his work in helping to establish the Eastside Family Centre with Arnold Slive and team. Eastside was originally a volunteer

organisation and the initial sessions were mostly assessment/intake and referral. It was Jeff who had the idea of switching to single session therapy over 20 years ago. Along with guidance from Insoo Kim Berg (via assistance of a student) they developed the intake/pre-session questionnaires using SFBT.

From Jeff's website and research I was particularly interested in his work with clinical supervision and a recent paper on a support group for people who support family members who have had a stroke. Jeff stated that approximately 85% of his clinical supervision work is done through SFBT. There is much written about the use of SFBT in supervision (e.g. Thomas 2013) and this is of note to me as I have volunteered to offer myself as a supervisor after the scholarship. Jeff's research into the use of SFBT in non-psychiatric settings (Plosker and Chang 2014) is also of interest as I have recently had enquiry from services within SALHN who support people with chronic medical illness.

Objectives met:6, 7
Key points:

- There is a long history of the use of SFBT in Alberta
- SFBT is applicable in a wide variety of clinical situations and settings

17/10/16 49th Street Addiction and Mental Health Clinic, Red Deer

Monday saw me turn my back on Calgary and drive north to Red Deer, a city of about 80 000 people famous for little except being half way between Calgary and Edmonton. Phil Wright was the very first contact that I made in Canada almost 3 years ago when I started enquiring, investigating and planning an application for the Premier's Nursing Scholarship. I was able to meet with him for a short period on arrival. Phil is the manager of the community Mental Health and Addiction Clinic and a devoted solution focused practitioner. Furthermore he works hard to encourage and support his various teams to train in and use the therapy. Phil is enthusiastic about the approach however accepts that not everyone is.

The background to the service and the introduction of SFBT can be read about in several places such as Taylor, Wright and Cole (2010).

In our brief discussion he spoke about the divisions in the service between those who do and don't practice SFBT. Phil explained that part of his battle is to keep the service unified! For example the psychiatrists in the team do not follow the model, and in reality stick to a very typical medical model (I did not meet any psychiatrists today and did not have the opportunity to discuss what therapies they might use in what settings).

Phil briefly outlined the various parts of the service and discussed some of the options for my time there. The community mental health services can be broken down into 3 parts: intake, therapy, and "nursing" (as Phil called it, but what amounts to general case management of long term clients including medication and treatment orders). In addition to this there is the drug and alcohol team that has recently come under his

management. We loosely planned out our schedule for the coming 10 days which will include SFBT therapy groups, walk-in SFBT single session therapy, time with the psych emergency team (some of whom practice SFBT in what sounds like a similar way to me i.e. a balanced therapy/assessment). Other time will be spent in Ponoka, a 40 minute drive to the north.

In the evening I observed 2 SFBT-based therapy groups, both of which are run weekly and last for 1.5 hours. The first was a walk-in group titled “Creating Solutions”. This group was open to anybody for any mental health related reason. Clients did not need to book in and they could come as many times as they would like. Of the 8 attendees, 6 had been there before and 2 had not. Given the solution focused nature of the discussion I did not know the reasons for attending. Participants completed a brief questionnaire before the session which included a single question on risk: “Are you currently a risk of harm to yourself or others?”. If participants answered yes to this it would be discussed briefly in private after the session. The form was also later used as the case note where the facilitator completed a couple of summary lines. The session was divided into the following sections:

- Introduction of facilitators and participants, and introduction to the session
- Ice-breaker question (today, as it was recently the start of the cold weather, the question was “describe 1 thing that you like to do in the winter”. This question in itself is not especially solution-focused but in many ways it set the tone for a positive discussion).
- There were 3 questions written on the white board, and participants took turns answering all questions. Todays were:
    a. Describe your most positive quality or character strength
    b. How did it come to be?
    c. How does that impact on your life today?
- The facilitator (Kyle) encouraged everyone’s participation and ensured that the focus remained on the future, strengths and solutions rather than problems, deficits and history. He did this by asking very solution focused type questions such as:
    - When this strength is evident, how does that make a difference in your life?
    - How have you learnt these skills?
    - How would this group know that you are continuing to do it?
    - What will be the benefit to you if you continue to do it?
    - What will people notice?

    All the time Kyle continued to use other popular SFBT techniques such as language matching. Kyle provide me with a list of 50 solution focused questions that he refers to when planning the groups.

- Participants were given the opportunity to provide feedback to others however the nature of the group and the way Kyle approached them ensured that the feedback remained positive.

At the end of the session the group were invited to provide feedback for the whole session including their plan for the immediate future. Responses were overwhelmingly positive such as:

- “You come [to the group] and take it [support] as you need it”

- "I wish my psychologist would come and sit in on these sessions, it is a very different approach … more positive"
- "A sense of relief"
- "I'm not alone"
- After the group one participant stated that she had planned to attend the walk in therapy clinic the following day however during the group she decided that she didn't need to anymore and would wait until her next appointment with her psychiatrist next week.

The following group, run by Lisa from the addictions team was titled "Ongoing recovery". This was a closed group and participants had been attending from 2 months to 3 years. All participants were dedicated to the group, and those that couldn't come for whatever reason would usually phone through their apologies. This group was run slightly differently and although the facilitator apologised to me that it wasn't as solution focused as the previous group, I disagreed. The meeting was divided into the following sections:

- Introductions (to myself and another new clinician at that group)
- Apologies
- "Check in" questions
    - Any left over issues from last week
    - This week's question was "What is working week right now in your recovery?"

    Participants were each given time in turn to answer these questions, and others were given time to provide feedback. Again the facilitator assisted the conversation by interjecting with more solution focused questions where required.

- "Check out" questions including:
    - "what did you enjoy/appreciate about today's group?"
    - "anything else?"
- Participants were asked to complete a 4 point rating scale & questionnaire which would serve as their case note.

These 2 groups will be repeated next week, so I will plan to see them again. Once again the client feed back, both verbally and on the form, was extremely positive.

Objectives met: 1, 2, 5, 6, 7,

Key points:

- Team manager Phil Wright is very dedicated to the promotion, training, and use of SFBT
- My first exposure to SFBT groupwork – it appears to be easy to do using the same language and techniques to general SFBT sessions. No extra training would be required
- Clients were very positive about the sessions and the approach, and this was supported by their willingness to return regularly (I note that it was a Monday night and sub-zero temperatures!)

18-19/10/16: Centennial Centre for Mental Health and Brain Injury, Ponoka

Day 1 SFBT Advanced Workshop

To coincide with my visit to Alberta, several of the senior SFBT clinicians decided to host a 2 day advanced practice workshop which would combine both a training opportunity with the chance for me to meet many of the SFBT clinicians in Alberta. The event was coordinated by Dene Shipowick, a senior psychologist at the Centennial Centre in Ponoka, about 50km north of Red Deer. Dean was my 2nd contact in Alberta. The Centennial Centre is an old psychiatric institution, similar to Glenside Hospital, that has been redeveloped and modernised however unlike Glenside it has maintained its expansive property. There are several solution focused programs running in Ponoka, mostly in the area of psychosocial rehabilitation (long stay inpatient rehabilitation). There is a formal review of their service and SFBT approach each year and find that it is clinically effective with clients who report it is a positive and empowering approach (Alberta Health Service 2014).

The workshop had 25 participants who had travelled from all over Alberta. As the workshop was designed to be “advanced”, participants must have been experienced in the use of SFBT. Participants came from a wide variety of areas including Ponoka rehabilitation units, Community Mental Health and Addiction teams, emergency department, community residential facilities, prison, and private practice. The lead clinician for the workshop was Lance Taylor. Lance is the elder statesman of SFBT in Alberta and one of the most experienced teachers and clinicians in North America. He initially learnt the approach with the founders of SFBT at the Brief Family Therapy Centre in Milwaukee. He has researched, written and published extensively on SFBT.

Day 1 included a mixture of theory, observation of a live session, group exercises, and lots of live discussion. However of special note to me was that it incorporated both discussion and observation of a live “Recovery Review” which was one of my original goals. The Recovery Review is a unique solution focused spin on what would traditionally be called a case conference. We were able to observe a session via video link in a nearby room.

The Recovery Review is unique in a number of ways:

1. The patient chairs the meeting
2. The meeting follows a solution focused outline
3. The patients’ “key worker” assists the patient to run the meeting only where required
4. There is an expectation that all involved staff attend the meeting
5. It is perhaps the most extreme example of client centred care that I am aware of

As this was a 12 week rehabilitation unit, the Recovery Review for each patient will not occur very often, perhaps half way through their admission and again near the end. The patient is given a form to complete to record their recovery plan and up to 3 of their goals. They are given the form up to a week in advance. They have the choice of completing it alone or with the aid of their key worker who will also provide a little instruction on how the meeting works. Under each goal there are 7 questions for the patient to answer:

a. What have you noticed about yourself that is better since you started working on this goal?
b. Skip this question if this is your first Recovery Review. What has changed for you since your last Recovery Review?
c. Where would you rate yourself on a scale of 1 to 10 with achieving this goal with 10 being fully achieved and 1 being not at all?
d. If you have gone up in your rating since you started working on this goal, please describe how you were able to do this or what has helped you move up?
e. If you have not gone up on the scale what are you doing to get yourself unstuck?
f. What have others (friends, family members, co-patients) noticed about you since you started to make progress on this goal?
g. What groups have you been attending that have been particularly helpful with this goal? How are they helping?

Patients have the opportunity to identify their strengths, establish new goals, arrange further support, and plan for their discharge.

The session provides the opportunity for the patient to identify what is working well for them in their recovery. The patient and the team have the opportunity to ask questions of each other, however staff are all aware that the questions must remain positive, future focused, strengths based, under a SFBT model.

The session usually lasts for approximately 45 minutes. This includes about 35 minutes of client-led discussion. The team will then have 5 minutes of reflection where the patient remains in the room and the team discuss the session as if the patient was not there. The final 5 minutes will be a team summary and usually includes a task for the patient to complete based on the session.

It was reported that patients overwhelmingly find the Recovery Review a positive experience where they are given the opportunity to develop their own goals and direct the team as to how they can assist to get there. One staff member reported that her patient stated the experience was like “swimming in chocolate” (i.e. very good). Furthermore staff also report the positive experience of the review such as:

- “refreshing”
- “refocussing the team to a forward focus”
- “orientated to change”
- “a celebration of success and strengths”

At the end of the Recovery Review and after discussion within the workshop it was hard for me to believe that there could be a more client-centred approach to care. For me the term “client-centred care” is often used throughout the health care service however is often translated to meaning that we will provide the best care that we can using our knowledge, experience and skills. The Australian College of Nursing (2014) talks of; individual approach, protecting dignity, respecting rights, and therapeutic relationships. Similarly the South Australian Health Service includes collaboration with patients, family and support networks (SA Health 2016). The Australian Commission on Safety and Quality in Health Care (2010) define patient centred care as “… an innovative approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families” (taken from Institute for

Patient and Family-Centred Care 2016). However the use of SFBT in general, and the innovative way the therapy is used in a case conference, means that an absolute person-centred approach is used. That is, the person is literally put in the centre of the health care provision.

- The patient defines their own goals
- These goals are used to guide the service in provide care
- The language used in discussions replicates (where possible) the patients language
- The patient is seen as the expert in their lives
- The clinicians take a very non-expert and non-hierarchical, collaborative stance

It is hard to imagine a more client-centred approach to health care. This radical change to a traditional case conference appears to be unique, as no one involved was aware of anything similar occurring anywhere in the world. Amazingly the staff from the Centennial Centre who were in the workshop then had a discussion on ways that they might be able to make the approach even more client-centred!

While I have a copy of slides used in a conference presentation (Schultz and Camp n.d.) the approach has not yet been formally written and published. I have encouraged Dene to do so.

Day 2 SFBT Advanced Workshop

The second day of the workshop consisted of more theory, more discussion, and more live observation. The first section was a discussion on a way to document a session and also monitor progress which was originally developed by two of the world leaders in SFBT Teri Pichot and Yvonne Dolan. Secondly there was a live therapy session conducted by one of the workshop attendees which we observed via a monitor. This session was later reviewed via video the first section micro-analysed. Following this we did an exercise titled “10 minute interview” where we got into pairs and interviewed each other. After lunch there was discussion about the use of SFBT with psychotic patients, and then Lance Taylor interviewed a patient with schizophrenia who was an inpatient in a long stay ward.

At the end of the workshop there was discussion about the highlights and takeaway learnings from the 2 days. For me it was a unique opportunity to be with a group of experienced mental health clinicians from a variety of disciplines and workplaces who are all committed to SFBT. This is an extremely rare situation in Australia, and has never occurred in South Australia. For me, these are people who take the theory and the therapy into the real world and into situations that I would have never imagined. While they were all amazed and even honoured that someone had come from Australia to participate, I thought that this alone was almost worth the trip here. (I should note that I didn’t come to Canada for the workshop, rather Dene and Lance used my visit as motivation to host a long overdue advanced training workshop.) The skills learnt at this workshop will take my knowledge and its application to a higher level. That is, so far I have been an isolated practitioner in South Australia. Because of this I have had to learn the skills alone, and practice them in a way that I thought was consistent with the therapy. After participating in a workshop with advanced practitioners I now realise that I too am an advanced practitioner, reaffirming that I am on the right track.

Through the workshop I was able to make several contacts in Red Deer and Ponoka to assist me in the next few days of the scholarship tour. Furthermore after the scholarship tour has finished I will meet some of them again at another workshop run by Lance Taylor on SFBT "train the trainer" which will hopefully increase my skills and knowledge in teaching the therapy to others in South Australia.

Objectives met: 1, 2, 3, 5, 6, 7, 9
Key points:

- There is a relatively large concentration of SFBT practitioners in Alberta
- The Recovery Review is a unique SFBT based approach to the traditional case conference, and perhaps the ultimate in client centred care
- It was shown that the best way to teach SFBT was to use the same principles, language, and techniques as you might do in doing the therapy
- Observation of live sessions is a powerful way to teach

20/10/16: Centennial Centre for Mental Health and Brain Injury, Ponoka.

Red Deer and Ponoka are the places to be to see SFBT in mental health settings. There is a lot happening here. Today I spent my time mostly with psychologist Dene Shipowick. Initially we discussed which parts of the service were Solution Focused based, which parts weren't, and why not. Dene is a very strong believer in the use of SFBT. He explained that most of the psychiatrists, particularly those in the acute areas, are not. The acute areas predominately follow a traditional medical model and the psychiatrists are not interested in changing that in any way.

This morning after discussions with Dene I spent my day in Marion House, a 16 bed psychosocial rehabilitation unit where the length of stay is approximately 12 weeks. Every Thursday morning the team does a full ward round where they discuss the progress and plans of every patient. As most of the staff in attendance were at the SFBT workshop, the whole language of the meeting was very solution focused. The meeting was chaired by a senior ward nurse. A psychiatrist attended for most of the meeting but had very little to contribute. I then went with Dene to sit in on a discussion with one of his patients who was being discharged the following day. It seems like every discussion is based on SFBT; "what will you be doing … what will be different … how will that help … what else …".

The afternoon was spent observing a referral assessment, again based on SFBT practice; "what would you like to achieve while you are here … what has been working so far … what do you hope will be different … on a scale of 1 to 10 …" etc.

Patients are referred to Marion house from a variety of sources including psychiatrists, community mental health teams, and general practitioners however the potential client must complete a significant part of the referral. All referrals are checked and if deemed appropriate the client is invited to a referral assessment as was observed today. It is then discussed with the team to consider if a bed is offered. As this is a voluntary

program all clients must have a large amount of motivation to change and must be able to be self-directed to a certain extent to complete the groups and workbooks. But as evident today, psychotic symptoms do not exclude someone from doing this. The man assessed today had significant chronic psychotic symptoms however had a reasonable insight and understood that the program was significantly different from the acute wards that he had been in several years ago. He was able to identify several goals such as increased socialisation and activity in the community. It was explained that goals can be further developed after arriving. Furthermore the recovery Review (as seen on Tuesday) would be scheduled somewhere in weeks 4-6 and this would be an opportunity to review and change goals if needed. Documents obtained relating to the referral and admission process will be used on return to Adelaide to develop a nursing care plan and goals booklet for use in acute mental health areas.

Marion House runs several groups every day starting with an exercise group at 0900. There is an expectation that all patients attend most of the groups unless they are granted exemption. There is also an expectation that workbooks will all be completed. The workbook in its current form has 5 chapters and is 120 pages long. It is a mixture of reading material and worksheets. There is a regular workbook group and patients have the time to all work on their own book at the same time. The books are designed that patients would generally be working in the same chapter at the same time. That is, it doesn't matter when you are admitted you can start the book where the others are up to, work to the end, and then start again at the front. The work book is not actually reviewed by the staff although staff can talk to patients about their progress. The patient keeps the book and none of it is entered into the case notes. Copies of the workbook have been obtained with the aim of developing them for local use.

Objectives met: 1, 2, 6, 7
Key points:

- Psychosocial rehabilitation in Ponoka has successfully used SFBT for several years
- Virtually all aspects of treatment in Marion House are based on SFBT
- It would appear that the success for the model is reliant on several factors including:
    - The use of SFBT in the intake process
    - The use of SFBT in workbooks, groups, and most interactions with patients
    - The use of the language of SFBT in all team and clinical discussions
    - Support from management to practice, further develop the approach, and train at an advanced level
    - Monitoring of the service through yearly data collection

21/10/16 Red Deer
a.m. Emergency Department, Red Deer Regional Hospital
p.m. 49th Street Addiction and Mental Health Clinic

Today was my first opportunity to meet with and shadow Chloe Cole, a registered psychiatric nurse and one of the most experienced SFBT Practitioners in Alberta. I was aware of some of Chloe's work through both

professional literature and reputation. Today Chloe was on the intake team covering the Emergency Department and when not busy there would assist the intake team at the clinic. Our morning was spent completing 2 assessments in the ED and then returning to the clinic to complete another. Chloe is a wealth of experience in using SFBT and it was a pleasure to watch her work. She was able to blend a traditional assessment with a solution focused approach so that she could both obtain the "traditional" information plus include solution focused questions and comments to bring a therapeutic nature to the conversation (Wright, Badesha and Cole 2014).

Between seeing clients Chloe and I were able to discuss the SFBT service and the implementation of the therapy into the team. Taylor, Wright and Cole (2010) describes in detail the history behind the service as well as the initial benefits including:

- Decrease in waiting times from intake assessment to therapy
- Decrease in drop out rates after initial intake and referral
- Benefits of maintaining 1 therapeutic modality in reference to training and learning
- Benefits of combining therapy and training through live demonstration, observation and coaching
- Streamlined approaches to booking appointments, administration, paperwork etc.
- Clinical effectiveness
- Positive feedback from clients post session
- Later expanding the walk in service allowed clients to access therapy when they needed it rather than wait on a waiting list (this was evident to me with a client I observed at the clinic, where she was having an acute exacerbation of a chronic problem and was able to attend a session within 3 hours of the problem arising, having not been in therapy for several years and having few other immediate options for support.)

Objectives met: 1, 2, 4, 5, 6, 7,

Key points:

- The addiction and mental health clinic at Red Deer have a manager and many clinicians dedicated to the use of SFBT.
- Phil Wright is committed to promoting the use of SFBT through education and training
- The Tuesday SFBT Walk-in clinic is a mixture of therapy, training, staff development. Most staff in the team stated that it was the one day of the week that they most look forward to
- The SFBT approach has proven to be a success in several clinical and administrative levels

24/10/16 – Groupwork day

a.m. Centennial Centre for Mental Health and Brain Injury, Ponoka

p.m. 49th Street Addiction and Mental Health Clinic, Red Deer

After seeing some group work in Red Deer last week I was inspired and intrigued. The concept of using SFBT in a group setting had previously only entered my mind briefly and it certainly was not on my list of goals to see. However after a taste for it last week I wanted to see more. I was invited back to Marion House in Ponoka to observe a group titled “skills for life”. This particular group is run twice a week for 12 weeks. There is a set program for the 24 topics and then the program is repeated. It does not matter what stage the patient is in for their admission as the groups are all individual topics and not dependant on previous sessions. Marion is a voluntary psychosocial rehab unit where there is an expectation that patients participate in the majority of groups and activities otherwise they would be questioned on whether they should stay or be discharged. However on this day there appeared to be a strong sense of wanting to be there. 9 out of the current 16 inpatients attended, and most of them arrived 10 minutes before the start. On arriving they sat and read or worked on their folder of activities. At 1000 the door is shut and no latecomers are allowed in to avoid disruptions. Their early arrival and discussions indicated an enthusiasm to be there.

The meeting was run with questions consistent with the SFBT approach. The topic for this session was motivation. There was a mixture of questions and group discussion/brainstorming along with some very brief psychoeducation. The 2 facilitators had the job of ensuring that all attending had equal opportunity to talk, and that the group remained on topic and solution-focused. In reality they had to do little except pose the questions and allow the group to go for it. However throughout the session there were subtle questions woven into the conversation e.g. “how did you do that” which were all very consistent with the solution focussed approach. Feedback provided by participants, both during and after the group, was universally positive. Once again there were comments such as “this is such a positive way to talk” and “I come here because it is good fun, not because I have to”.

After the groups, I sat with one of the key workers and clients on a “keyworker session”. Each patient is awarded a key worker who is the lead clinician for that person. The keyworker will meet with the patient at least twice a week and it is their responsibility to:

- Monitor progress of the patient
- Monitor their attendance at groups and activities
- Loosely supervise their workbook
- Ensure there are no specific problems
- Plan for the recovery review including assistance with establishing and developing goals
- Assist discharge planning
- Coordinate the rehab team and hospital services

Interestingly the keyworker is not the “therapist” as this role could be taken by Dene or someone else to work on a specific problem. However, the keyworker is constantly doing “therapy” with virtually every conversation having solution focused elements. It should also be noted that the key worker is unlikely to be a nurse. While there are nurses who do that role, the general ward nurse has other roles such as the day to day running of the ward, medication, observation, and other roles. There are 4 nurses to the 16 patients. I questioned Dene about this and he stated that most of the nurses accepted the solution focused approach but were not interested in doing the therapy. Dene did not have an answer as to why although he stated they are running

an introduction training program on SFBT in November and he has received a lot of interested from nurses in the hospital. I was able to share some research from Australia about the education of nurses in SFBT which he said he will forward to staff and incorporate into training.

In the afternoon I returned to Red Deer to the same groups that I had seen on the previous Monday. The first group had 8 attend, 6 of whom had been there last week. The second group had 9 attend, 6 of them from last week. The people that I had not met last week were all very apologetic that they did not attend. Once again the groups were positive, strengths based, and solution focused in structure. There were again only a couple of questions put to the group but the facilitators inserted solution focused questions in the discussions. Again participants quoted many reason why they returned.

During my time so far in Alberta the groups have been a real highlight. I had not planned to attend groups while I was here as group work is not a part of my normal work however colleagues at Noarlunga Hospital had asked me to enquire about them. Now I have seen what a solution focused approach can do in a group I am enthused to take the concept home. There is no reason that I can think of as to why they would not also work in an acute area. Despite the fact that acute patients naturally tend to be more unwell, the therapy has been proven to work in an acute area so therefore there is no reason why the same conversation in a group setting cannot work.

Objectives met: 1, 2, 5, 6, 7,

Key points:

- SFBT is easily incorporated into group work
- Clients are universally enthusiastic about the approach

25/10/16 49th Street Addiction and Mental Health Clinic, Red Deer

Today was the long anticipated SFBT single session walk-in clinic. Not only was I anticipating it but also the whole therapy team as many of them stated it was the highlight of the week. There were 15 clinicians involved. All sat together in the conference room awaiting walk-in referrals. The first client arrived at 7am and the clinic doesn't actually open its doors until 8 and the clinic starts at 8.30. The Tuesday clinic has become increasingly popular with the community. There can be up to 25 clients during the day. At one stage there were 5 rooms being used at the same time. The clinic has a couple of observation rooms where teams of 2-4 can observe a session. Alternatively clinicians may be alone or in pairs.

The sessions were run in typical solution focused style. Clients completed a brief information sheet on arrival including demographic information, a brief explanation as to what they would like to achieve, and a very brief risk assessment. This information is read in the conference room and the client is allocated to a clinician. The session runs for about 40-45 minutes, there is a break to discuss the session, and the session is finalised with feedback and a task or plan.

The clinicians were a mix of disciplines and experience. There was an expectation that the services provided would be solution focused even if the clinician is not very experienced in the model. The day would equally be about teaching, supporting and gaining experience. Manager Phil Wright said that this was the only way of getting the clinic to work. That is, it would be unrealistic to think that it was cost effective for 15 clinicians to see 25 clients in one day, however to incorporate training and professional development into the one day means that clients get an exceptional service and clinicians (and the team) improve their knowledge, skills and service.

It was during my last observation of a session that I had a personal revelation regarding both the therapy and the service provision. Both today and during other SFBT sessions I couldn't help thinking that only the "nice" clients came to walk-in therapy, and I wondered why these "nice" patients didn't come to my emergency department? The last client that I observed was a young man training to be a chef and was preparing for an international competition in Hong Kong. He was not happy about some things in his life that were quite stressful, in particular his relationship with his partner. The therapist was very skilled in identifying his strengths and plans in attempt to assist him. In the break we discussed his session, assembled feedback, and this was provided to the client. Both the client and the therapist appeared to be uplifted and encouraged by the session. It was only after this that I realised it was only the type of questioning that influenced the outcome and the perception of the therapist. That is, to take a solution focused approach the client appeared positive, resourceful, proud of his achievements, and determined. I was wondering why guys like this did not come into my ED. But then I realised that this type of presentation often does come to the ED. The client had described a recent situation where he and his partner got drunk, they had a fight, his partner assaulted him, he then smashed a beer bottle in his hands causing large lacerations that required suturing. When he arrived in the ED he would have been assessed and treated in a traditional approach. I expect that he would have been diagnosed with alcohol dependency, antisocial personality, and an anger and impulse problem. Assessments would have been focused on his problems and deficits, he would have been given a diagnosis to match, he would have been discharged without any form of hope or long term assistance, and unlikely to be inspired to make any changes in his situation.

My conclusion is that it is the approach that makes the clinician discover the "good" side of the client rather than the "bad" side. The nature of the therapy highlights the strengths and resources of the client and amplifies them, rather than identify the problems, deficits and weakness and trying to treat it. The principle is that by focusing on the good the good gets bigger, but a focus on the bad makes the bad appear bigger. The potential for clients to change is then amplified.

Objectives met: 1, 2, 5, 6, 7

Key points:

- This was a SFBT walk-in clinic on a grand scale
- Both clients and clinicians were enthusiastic about the positive approach
- Management identified the learning opportunities and professional development associated with the clinic
- There was a unification of the team through the common approach

- Walk in clinics provide an opportunity for clients to access therapy when they actually need it

26/10/16 Kentwood Place transitional housing, Red Deer

The final official day of my study tour was spent at Kentwood Place. I was hosted by Amanda Anderton, an Occupational Therapist who I met at the SFBT workshop in Ponoka. Amanda works for the Alberta Health Service. Kentwood Place is a partnership between the Schizophrenia Association and the AHS. The Schizophrenia Society supplies a 2 story house for the 15 residents plus the general staff including cooks and cleaners. The AHS supplies all of the clinical staff.

The facility is essentially a slow stream community based psychosocial rehabilitation home. Approximately half of the residents are in the “fast” stream where they can remain for up to 2 years. The rest of the residents are essentially permanent residents there and will remain until age or disability prevent them from caring for themselves. All residents must be independent with ADL’s and able to live in the community however they receive a great deal of on-site support which includes most meals.

I was invited to Kentwood by Amanda to view their home and program as several of the clinicians practice SFBT. Staff run daily groups which are mostly voluntary although there are 2 groups per week that are mandatory. On this day I observed a group about healthy sleep which was run using SFBT principles and conversation. The interesting thing for me was that most of the residents there have a psychotic illness, and some of them have chronic psychotic symptoms, however the staff still engaged them using solution focused conversations. There was a discussion in the Ponoka workshops about using SFBT with psychotic clients but this was something that I had never really considered as a possibility until this study tour. Here at Kentwood was an example of how it can be done. I will now need to revisit a well-known book (Macdonald 2011) to review the use of SFBT in an acute psychiatric ward with acutely ill patients.

It was fitting in many ways to end my scholarship here. Over the last 3 and a half weeks I have observed SFBT being used in emergency, single session walk-in clinics, short term therapy, medium term rehabilitation and now in slow stream rehabilitation. I have seen for myself that the therapy can be used across different settings and situations. The remarkable thing is that the therapy is essentially the same no matter who you are talking to or whatever the setting. The techniques and the conversations are only changed in minor ways.

Objectives met:
Key points: 1, 7

- SFBT can be used to great effect within slow-stream psychosocial rehabilitation
- There is very little modification required to adapt SFBT across various clinical situations

Implementation of new learnings

While the acceptance of the S.A. Premier's Nursing Scholarship mandates that the recipients promote and disseminate the learnings within the South Australian health service, prior to the study tour I was already promoting the use of SFBT within the mental health service. Both prior to finishing this document I have already established some plans/opportunities to implement learnings from the study tour including:

- Morier Ward in Noarlunga Hospital are planning to implement a new model of care based on SFBT and I have been consulting with them for several months. While on tour I have been seeking knowledge and resources to assist the implementation of the project including information on group work, documentation, workbooks, and research. On 18/11/2016 I attended a meeting at Morier to present my learning and ideas to staff. I will continue working with them to establish and monitor the new model. We hope to present research findings at the 2017 Conference (below).
- The Australasian Association of Solution Focused Brief Therapy has agreed to hold their 2017 Conference in Adelaide to promote the use of SFBT in the mental health context. I have volunteered as the convener of the conference which will be held at the University of South Australia (city east) on 14-16 July. Part of my role will be to assist establish the program including the invitation of key note speakers, and promote the conference within the mental health service and other services. I will also assist the staff at Morier Ward to present their preliminary findings. On 18/11/16 I was asked be Association President Michael Durrant to present my findings from the study tour at the conference.
- On 10/11/16, the day after my return to Australia, I had a meeting with Michael Durrant who is the president of the AASFBT and the most experienced SFBT practitioner and teacher in Australia. We discussed many things including the conference, my findings on tour, how to implement learnings within the clinical area, expanding my teaching/training opportunities, research including opportunities in Morier Ward and how to obtain ethics approval. Michael has also invited me to assist in the writing of a book on the use of SFBT within mental health areas. In addition Michael has made the rare but prestigious offer of formally endorsing me as an associate of his business The Brief Therapy Institute of Sydney. This will provide resources to assist me with teaching and training, as well as opportunity to expand my training work in South Australia.
- While in Alberta I had 2 offers to be involved in developing literature. The first was to join with Phil Wright (from Red Deer) and Lance Taylor to write a paper on how to blend a traditional psychiatric assessment with a therapeutic intervention using SFBT. The second was from Dene Shipowick (from Ponoka) who was planning to write a book on the use of SFBT in mental health settings and he has requested support to write on acute areas including the emergency department. I am hoping that the work in Morier Ward can be included.
- While in Alberta I was approached by 2 services in Adelaide to provide SFBT training. The Glenside Learning Centre has asked me to increase the number of workshops that I run and dates have been set for 2017. Also the Intermediate Care Team at Noarlunga Hospital has also asked me to run training for their staff in February 2017. This will provide an opportunity to take the learnings outside of the mental health service. Since my return to Adelaide I have also been contacted by the Mental Illness Fellowship of SA to expand the training that I have previously run at their organisation.

- In 2016 I established the South Australian SFBT Community of Practice enabling anyone with an interest in SFBT to meet on a regular basis for education, group supervision, to share experiences, and to promote the use of SFBT. I currently have a list of 80 people who want to keep in touch and learn more about SFBT. At the next meeting on 5/12/2016 I will be presenting my findings and experience from the study tour to the group. Future meetings will be held every 3 months. (See https://www.mhpn.org.au/NewsArticle/483/New-networks---New-opportunities#.WCkc3vp97IU and also http://www.solutionfocused.org.au/localgroupnews.html)

In addition to these opportunities I also plan to expand the use of SFBT in the following ways:

- Expand the use of SFBT within FMC. Several of my team members have attended training with either myself or Michael Durrant but we do not have a formal SFBT program. One of the most significant learnings from the tour was the use of observed sessions and discussions within the clinical area. While we no longer have a functional observation room in the FMC ED, there are opportunities to do joint or observed sessions. On return to work I plan to meet with the Mental Health Clinical Director and the Director of Nursing to develop a plan for the expansion of the brief therapy service in the ED and Short Stay Unit. This may also include options for a brief therapy program or single session clinic within the Inner South Community Mental Health Team.
- Discussions will be required with regard to the use of electronic equipment to either “live stream” a session to another room or to record sessions for teaching purposes. Modern wireless technology such as GoPro could potentially enable this to easily occur.
- Develop closer links with the Flinders University School of Nursing. I had previously been approached to develop a training package for SoN staff but at the time I did not feel that I had the expertise to do so. Since the scholarship tour I believe I now do have the knowledge to do this, and have already been in discussion with the SoN and have made arrangements to meet with them in January 2017 to develop plans.
- Develop advanced SFBT training – up until now I have only offered introduction SFBT workshops. I now have the knowledge to develop follow-up and advanced training.
- Clinical supervision – prior to the study tour I had volunteered to host supervision and my plan is to start this after attending a training session at the Glenside Training Centre. SFBT skills and knowledge can easily be adapted for supervision. I envisage this will also have a significant part to play in developing the project in Morier Ward.

Reflections

The study tour, along with the post-study tour conference that was funded by the Southern Adelaide Health Service, has given me the opportunity to observe and learn of the use of SFBT in a wide variety of clinical areas. This, along with meeting practitioners who have been using the therapy for many years, as well as some of the pioneers and world leaders in the therapy, was an opportunity that I would not have been able to have in South Australia. Until now I have not have an opportunity to even observe SFBT practice in SA.

While the use of SFBT is beginning to expand in SA, this tour has given me the education, skills, knowledge, and motivation to expand its use further, both in my own practice as well as in the health service.

Key points:

- SFBT is successful as a therapeutic approach in a wide variety of settings
- SFBT is transferrable to new settings with very little modifications. Process, practice, and language is all similar whether it be inpatient, outpatient, supervision, management, team leadership, or non-clinical areas
- SFBT can be used anywhere from a long term inpatient service to a 5 minute conversation, and any place can be the place or the conversation that can bring about change
- SFBT is easily taught, but perhaps is best taught by using and modelling the therapy within the education. You do not need specialist qualifications to do SFBT
- There are many benefits in having the same approach and language used across teams
- When trying to implement the therapy within a traditional "medical model" environment it may be best to role model, allow your interventions to be observed by others, and incorporate positive and strength based language within meetings, ward rounds, and clinical discussions
- SFBT is a positive, strength based, and client centred approach, therefore compatible with the National Mental Health Plan, the SA Health (2014) Nursing and Midwifery Professional Practice Framework, and the SA Health (2016b) Strategic Commitment 2016-2018

The Premier's Nursing Scholarship has been a fantastic opportunity for personal education and development, however I have gone to Canada as a representative of the South Australian nursing workforce. Therefore I now have a responsibility to share the knowledge that I have brought back to improve and assist both the nursing workforce and the South Australian health service.

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Appendices

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   - Michael Durrant, president of the Australasian Association for Solution Focused Brief Therapy, for his support of the solution-focused community in Australia

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3. Travel Diary - attached

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