
Systematic review of Solution Focused Brief Therapy (SFBT) with children and families

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Background to the review

This systematic literature review of Solution Focused Brief Therapy (SFBT) arises from the second Serious Case Review (SCR) of the death of Peter Connelly (Haringey Local Safeguarding Children Board, 2009), in whose case SFBT was being partially used within children's social care services. The Peter Connelly SCR Overview Report included the recommendation to examine whether any models of practice had an influence on the way in which Peter's case was managed. The Peter Connelly SCR Overview Report concluded that:

- whilst emphasising the strengths of parents is important, SFBT is not compatible with the authoritative approach to parents in the protective phase of enquiries, assessment and child protection conference (Haringey Local Safeguarding Children Board, 2009, paragraph 3.16.7); and
- the local authority should review its use of SFBT with families (Haringey Local Safeguarding Children Board, 2009, paragraph 5.13).

SFBT is a strengths-based approach, emphasizing the resources that people possess and how these can be applied to a positive change process. SFBT focuses on strengths and 'life without the problem' rather than a detailed analysis of problem dimensions. As a flexible approach, SFBT has been enthusiastically received and applied across a range of contexts and client groups, including school and family settings, with professionals and community members, both in groups and as individuals (Corcoran and Pillai, 2009; Kelly, Kim and Franklin, 2008). Recent published reviews of studies of SFBT effectiveness with children and families have suggested its effectiveness in improving children's behaviour and academic results. It is acknowledged, however, that the evidence base is insufficiently robust and comprehensive (Corcoran & Pillai, 2009; Gingerich & Eisingart, 2000; Kim & Franklin, 2009).

Objectives of the review

Against this background, the objectives of this review are to identify:

1. What is the evidence for the effectiveness of SFBT in relation to work with children and families?
For what types of child and family problems is SFBT found to be most effective?
2. What are the cost-benefits of SFBT in relation to work with children and families?
3. What are the implications of the findings for the use of SFBT within the English context where children are considered to be suffering, or likely to suffer, significant harm?
4. What are the implications of these findings for Local Safeguarding Children Boards (LSCBs) and for the training, supervision and management of staff in particular those working in local authority children's social care services?

Methodology

A six-stage process was adopted in this review:

Stages 1 and 2: Literature searching and reference harvesting to locate relevant research studies

Stage 3: Filtering of research studies according to inclusion and exclusion criteria

Stage 4: Development of a coding framework for evaluation of SFBT research studies

Stage 5: Coding of included research studies

Stage 6: Presentation and description of review findings.

At Stage 6, a pool of 'best evidence' was identified as those studies which were evaluated as being of reasonable methodological quality and appropriateness to the purpose of the review.

Best evidence on the effectiveness of SFBT

The reasonably reliable evidence base relevant to the general effectiveness of SFBT with children and families is relatively small, with only 38 studies being included in the pool of 'best evidence'. However, several limitations are apparent within the current small evidence base on the effectiveness of SFBT, including the absence of control or comparison groups, limited use of reliable and valid outcome measures and limited information about how different elements of therapy may be utilized and combined with different problem areas, client types and complementary interventions.

***What is the evidence for the effectiveness of SFBT in relation to work with children and families?
For what types of child and family problems is SFBT found to be most effective?***

Within the pool of 38 best evidence studies, 34 studies indicate at least some positive outcomes for the therapeutic target group and eight studies found that SFBT intervention yielded some outcomes that were better than treatment-as-usual or a control condition.

Eight best evidence studies which combined SFBT with another intervention programme all produced positive outcomes. Of the 38 best evidence studies in this review, only two studies focus directly on child protection issues (Antle et al., 2009; Corcoran & Franklin, 1998), though almost all studies are relevant to the category of 'children in need'.

The majority of best evidence from this review shows improvements following SFBT intervention in:

- children's 'externalising' behaviour problems (for example, aggression, co-operation, truancy) (Cepukiene & Pakrosnis, 2010; Conoley et al., 2003; Corcoran & Stephenson, 2000; Emanuel, 2008; Enea & Dafinoiu, 2009; Franklin et al., 2001; Franklin et al., 2008; Hurn, 2006; Kowlaski, 1990; Moore, 2002; Newsome, 2005; Shin, 2009; Vostanis et al., 2006; Wilmshurt, 2002; Window et al., 2004; Yarborough & Thompson, 2002; Zimmerman et al., 1996)
- children's 'internalising' problems (for example, shyness, anxiety, depression, self esteem, self-efficacy) (Daki & Savage, 2010; Franklin et al., 2008; Frels et al., 2009; Georgiades, 2008; Grandison, 2007; Green et al., 2007; Korman, 1997; Kvarme et al., 2010; Seagram, 1997; Smyrniotis & Kirkby, 1993; Springer et al., 2000; Wilmshurt, 2002).

Further to this, there is some emerging evidence from one or two studies, in each of the following areas, that indicates SFBT's effectiveness in:

- reducing recurrence of child maltreatment (Antle et al., 2009; Corcoran & Franklin, 1998)
- providing a supportive structure for first sessions with parents of children with learning disabilities and improved goal setting for families of children with behaviour problems (Adams et al., 1991; Lloyd & Dallos, 2008)
- improving children's listening comprehension and reading fluency (Daki and Savage, 2010)
- improving coping of families undergoing divorce (Ziffer et al., 2007)
- improving functioning for young people with developmental impairments, for example, improved signing of a hearing impaired child (Murphy & Davis, 2005; Thompson & Littrell, 1998).

The review highlights several limitations within this emerging evidence base. Although the evidence for SFBT is stronger in some areas, for instance externalising behaviour, gaps remain in relation to specific groups such as older children or those with Attention Deficit Hyperactivity Disorder (ADHD). The paucity of high quality research reports found in the current review, including limited fidelity monitoring, also makes it difficult to confidently attribute positive outcomes to SFBT as the main factor instrumental in changes. The role of core SFBT therapeutic elements in relation to outcomes is also unclear: some apparently successful studies only used two core therapeutic components but in some less successful studies more elements were used.

What are the cost-benefits of SFBT in relation to work with children and families?

None of the 38 best evidence studies report on the cost benefit of the SFBT intervention, though the reviewers' proxy cost estimates suggest that group delivered SFBT, where possible, may be more cost effective than individually delivered SFBT. The omission of cost-benefit considerations within the evidence base limits the evaluation of the feasibility of SFBT intervention.

What are the implications of the findings for the use of SFBT within the English context where children are considered to be suffering, or likely to suffer, significant harm?

Only two studies within the best evidence on SFBT effectiveness focus directly upon child protection issues where children are considered to be suffering, or likely to suffer, significant harm. Furthermore, one of these two studies (Corcoran & Franklin, 1998) is a case study of a single child and parent case, which, whilst informative, adds little to the weight of evidence in this area. Antle et al. (2009) offer promising results with a larger sample; however, SFBT was used in combination with other approaches. The authors do not provide any detail about the relative contribution of the SFBT element within their framework or account for why their approach was unsuccessful in some cases. The reports of both these studies, whilst showing positive outcomes, show methodological weaknesses which limit their utility as research evidence. Therefore, further research is needed into the effectiveness of SFBT in cases where children are considered to be suffering, or likely to suffer, significant harm.

The Munro Review of Child Protection (Munro, 2011) explains evidence-based practice within social work as integrating best available evidence with the social worker's own understanding of the child and family's circumstances and their values and preferences. Outside the research included in this review of SFBT, there are some descriptions of the use of SFBT in the context of child protection work (for example, Dudley Metropolitan Borough Council, 2006; Turnell, 2006). It is possible that, on the basis of a thorough knowledge and understanding of a particular child and family, a social worker may consider SFBT to be potentially useful in some cases where, in spite of the likelihood of significant harm to the child through other factors, the parent shows competencies that may be utilised to impinge upon, or change, the problem behaviour.

It is important at this point to consider the integration of SFBT within child protection work. SFBT is essentially a client-centred approach to intervention, in which 'the problem holder' is the client (George et al., 2006); furthermore, SFBT is often a short-term intervention. Therefore it is well suited to the work of practitioners with 'voluntary' client groups to address specific single issue problems. However, statutory social work intervention where children are considered to be suffering, or likely to suffer, significant harm, defines clients as 'mandated' and the local authority professional is, in effect the problem holder. Whilst statutory child protection work may include some specific issues amenable to SFBT intervention (for example, management of child behaviour), families subject to statutory intervention often have a multiplicity of difficulties which require longer term intervention. This disparity of stance between longer-term statutory and shorter-term client-centred approaches must be reconciled before a practitioner and case manager employs SFBT with a family where there are child protection concerns. It is significant that Antle et al. (2009) showed the use of SFBT with child maltreatment cases when used in combination with other more directive and authoritative intervention strategies as part of the broader-based Solution Based Casework, which includes a case planning framework with safety plans and both family and individual objectives (see also Antle et al., 2008).

For all children in need, ongoing professional assessment of the child's health, development, well-being and likelihood of harm, is inextricable from all interventions and support being provided, including SFBT. SFBT however, does not have a focus upon problem analysis (George et al., 2006). In the high-stakes work of protecting children suffering significant harm it is essential that no approach to intervention or support should compromise the comprehensive and ongoing assessment and plan to prevent the child suffering future harm. Where SFBT is used local authority governance should guide social care practitioners' choice and integration of SFBT methods. Such governance should include provision for training, supervision, and management of SFBT practice within social care.

What are the implications of these findings for Local Safeguarding Children Boards (LSCBs) and for the training, supervision and management of staff, in particular those working in local authority children's social care services?

With an evidence-based approach to practice, the use of SFBT in the case of a 'child in need' may be appropriate, particularly to address some externalising or internalising behaviour problems experienced by children and young people.

It is acknowledged however that there may be considerable variation within particular types of problems experienced by children and families, and that many children and families may evidence degrees of multiple problems and differing circumstances. These factors mean that a social worker's individual case is not likely to fit perfectly with the effectiveness research with specific types of child/ family problems. In relation to social work practice, Munro (2011) points out that evidence-based practice is not simply a case of taking an intervention off the shelf and applying it to a child and family. Therefore, research evidence on

the effectiveness of an intervention such as SFBT with particular types of child and family problems, provides a starting point, rather than the final word, for effective and safe practice.

Munro (2011) recommends that local authorities take responsibility for deciding the range of children's social care services they will offer, defining the knowledge and skills needed, and helping workers to develop them. Where SFBT is being used, this governance should include the provisions for both general and specific training, supervision and management relating to all SFBT practice within social care. The nature of this provision is complicated by the fact that those delivering SFBT may have different initial and post-qualification training in psychological therapy in general, and in SFBT in particular. It is important to identify what competencies are needed to deliver good quality SFBT. Whilst competences may be identified, however, evidence on potentially relevant criteria, such as the necessary level of therapist training, or the amount of direct/ indirect supervision, was not found in this review.

Implications for training, supervision and management of staff in local authority children's social care services

1. **Local authority governance:** Where children are considered to be suffering, or likely to suffer, significant harm and if SFBT is being used, local authority governance should guide social care practitioners' choice and integration of SFBT intervention methods. Such governance should include provision for training, supervision and management of SFBT practice within children's social care.
2. **Pre- and post-qualification training:** Practitioner training at pre- and post- qualifying levels, should incorporate the development of skills for evidence-based practice. This is so that social care practitioners can effectively evaluate and integrate available research with practitioner expertise in the context of service user characteristics, culture, and, where appropriate, individual preferences (see Munro Review of Child Protection, 2011, recommendation 11, p.12).
3. **Training:** Where SFBT is being used, local authority governance arrangements are advised to include a stipulation that SFBT practice within children's social care services be undertaken by staff whose training provides them, at minimum, with:
 - a primary professional qualification
 - generic competences in psychological therapies
 - specific competences in SFBT
 - meta-competences, including:
 - an understanding of why SFBT may be useful in a particular case and how SFBT may be safely integrated to other necessary elements of

comprehensive and longer-term assessment, planning and intervention for the child and family

- the ability to evaluate the research base on the effectiveness of SFBT
- the ability to evaluate the effectiveness of SFBT as part of the intervention with an individual child and family.

4. **Specialist training:** Applications of SFBT when undertaking statutory interventions with children suffering, or likely to suffer, significant harm will require additional in-service specialist training/ development from experienced specialist practitioners with a track-record of success in safely implementing SFBT interventions within the field of child protection.
5. **Supervision:** Practitioners using SFBT intervention within child protection work should have appropriate levels of professional SFBT practice supervision by another experienced and trained SFBT practitioner.
6. **Use of records.** All SFBT practitioners should keep comprehensive and appropriate records of all therapeutic sessions. In child protection cases, such records should be available to the child's allocated social worker and the case manager who should regularly review the case and evaluate the relevance of information from therapeutic sessions to the assessment of the child's needs and the subsequent plan.
7. **Management:** As part of regular case review where SFBT is being used, case managers should consult with SFBT case practitioners and their SFBT practice supervisors to evaluate the effectiveness and appropriateness of the SFBT intervention.
8. **Competence to practise:** Any practitioner's SFBT intervention during the statutory phases of child protection work should follow a period of competent SFBT practice with a voluntary client group.

Implications for research

9. Further research on the effectiveness of SFBT with children and families is warranted in order to develop a more comprehensive view on its likely effectiveness with different problem types, client groups and age groups, using different modes of delivery. In particular, further research in the following areas would address significant current knowledge gaps: SFBT use with teachers to improve child behaviour difficulties; SFBT use with parents and family groups to reduce recurrence

of maltreatment where children are considered to be suffering, or likely to suffer significant harm; SFBT use with children and young people to support improvements in functional skills such as reading.

10. In order to support effectively the evidence-based practice of SFBT, future qualitative and quantitative research on the effectiveness of SFBT should follow guidelines for high quality research control and reporting. In particular, the use of well-defined participant samples and valid and reliable objective outcome measures should be prioritized.
11. Future research on the effectiveness of SFBT should incorporate adequate fidelity monitoring of the intervention, including consideration of the rationale for inclusion or exclusion of specific SFBT therapeutic elements in specific situations.
12. Future research on the effectiveness of SFBT should, where possible, incorporate cost benefit analysis. As a minimum, research reports on SFBT effectiveness should detail all financially relevant human resource factors (for example, training time/ direct costs; direct therapy time and supervision time; professional role of therapist; delivery mode), in order that practitioners can be aware of direct costs of effective SFBT intervention.
13. Specialist practitioners with experience of SFBT intervention in relation to child protection work, should seek to publish evaluations of such work in peer-reviewed journals, in order that an understanding of the impact of their work may contribute to the SFBT research evidence base and support its appropriate use across a range of settings.

References

- American Psychological Association (APA) (2006). Evidence Based Practice in Psychology, *American Psychologist*, May-June, 271-285.
- Berg, I. K. (1994). *Family-Based Services: A Solution-Focused Approach*, New York: W.W. Norton and Company, Inc.
- Beyebach, M. (2000). *European Brief Therapy Association outcome study: research definition description of the treatment*. Available at <http://www.ebta.nu/page2/page30/page30.html>. [Accessed 8th February, 2011].
- Carr, A. (2009). The effectiveness of family therapy and systemic interventions for child focused problems. *Journal of Family Therapy*, 31, 3-45.
- Cleaver, H., Unell, I., & Aldgate, J. (2011). *Children's Needs - Parenting Capacity. Child Abuse: Parental Mental Illness, Learning Disability, Substance Misuse and Domestic Violence*, 2nd edition.
- Cohen, J. (1992). Quantitative methods in psychology: a power primer in psychology, *Psychological Bulletin*, 112(1), 155-159.
- Corcoran, J. (2006). A comparison group study of solution-focused therapy versus treatment as usual for behavior problems in children. *Journal of Social Service Research*, 33, 69-82.
- Corcoran, J. & Pillai, V. (2007). A Review of the Research on Solution Focused Therapy, *British Journal of Social Work*, 39(2), 234-242.
- Department of Health (2004). *CAMHS standard national service framework for children, young people and maternity services: the mental health and psychological well-being of children and young people*. London: DoH Publications.
- Department of Health (2007). *The competencies required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders*. London: DoH Publications.
- Department of Health, Department for Education and Employment and Home Office (2000). *Framework for the Assessment of Children in Need and their Families*. London: The Stationery Office.
- De Shazer, S. (1994). *Words Were Originally Magic*, New York: Norton.
- Devaney, J. (2009). 'Chronic Child Abuse: The Characteristics and Careers of Children Caught Up in the System,' *British Journal of Social Work*, 39, 24-45.
- Dudley Metropolitan Borough Council (2006). *Prevention Intervention Service: Interim Evaluation*. Dudley: Dudley Metropolitan Borough Council.
- Ferguson, H. (2004). *Protecting Children in Time: Child Abuse, Child Protection and the Consequences of Modernity*. Basingstoke: Palgrave Macmillan.
- Ferguson, H. (2011). *Child Protection Practice*. Basingstoke: Palgrave Macmillan.

- Franklin, C., Moore, K & Hopson, L. (2008). Effectiveness of solution focused brief therapy in a school setting. *Children and Schools*, 30, 15-26.
- George, E., Iveson, C. & Ratner, H. (2006). *Briefer: A solution focused manual*. London: BRIEF.
- Gingerich, W.J. & Eisengart, S. (2000). Solution Focused Brief Therapy: A review of the outcome research, *Family Process*, 39, 477-498.
- Gough D (2007). Weight of Evidence: a framework for the appraisal of the quality and relevance of evidence In J. Furlong and A. Oancea (Eds.) *Applied and Practice-based Research*. Special Edition of *Research Papers in Education*, 22(2), 213-228.
- Green, L. (2006). 'An Overwhelming Sense of Injustice? An Exploration of Child Sexual Abuse In Relation to the Concept of Justice', *Critical Social Policy*, 26(1):74-100.
- Green, L. (2005). 'Theorising Sexuality, Sexual Abuse and Residential Children's Homes: Adding Gender to the Equation', *British Journal of Social Work*, 35(4): 453-481.
- Hackett. P. & Ward, J. (2005). Invisible badges and other see through tools, *Journal of Family Psychotherapy*, 16(3), 11-115.
- Haringey Local Safeguarding Children Board (2009). *Serious Case Review. Overview Report: Child A*. London: Haringey Local Safeguarding Children Board. Available at: <http://media.education.gov.uk/assets/files/pdf/s/second%20serious%20case%20overview%20report%20relating%20to%20peter%20connelly%20dated%20march%202009.pdf>
- [Accessed 2nd November, 2011].
- Henwood, K.L., and Pidgeon, N.F. (1992). Qualitative research and psychological theorising, *British Journal of Psychology*, 83(1), 97-111.
- HM Government (2010). *Working Together to Safeguard Children*. London: Department for Children, Schools and Families.
- Kelly, M.S., Kim, J. S. & Franklin, C. (2008). *Solution-focused Brief Therapy in Schools: A 360-Degree View of Research and Practice*. Oxford: Oxford Workshop Series.
- Kim, J. S. (2008). Examining the Effectiveness of Solution Focused Brief Therapy: a meta-analysis, *Research on Social Work Practice*, 18(2), 107-116.
- Kim, J.S. & Franklin, C. (2009). Solution Focused Brief Therapy in Schools: a review of the outcome literature, *Children and Youth Services Review*, 31, 464-470.
- Kraemer, H.C. (2007). DSM Categories and Dimensions in Clinical and Research Practice, *International Journal of Methods in Psychiatric Research*, 16(1), S8-S15.
- Laming, H. (2009). *The Protection of Children in England: a progress report*. Norwich: The Stationery Office.
- Lawrence, A. (2004). *Principles of Child Protection*, Maidenhead: Open University Press.

Levin, J. R., O'Donnell, A. & Kratochwill, T. (2003). Educational/psychological intervention research. In W. M. Reynolds (ed.), *Handbook of psychology (volume 7: educational psychology)*, pp.557-582. New Jersey, John Wiley & Sons.

Mendeley Ltd. (2008). *Mendeley Desktop* (version 0.9.9.2) [software]. Available from <http://www.mendeley.com/> [Accessed 23rd May 2011].

Miller, A. and Frederickson, N. (2006). Generalizable findings and idiographic problems: struggles and successes for educational psychologists as scientist-practitioners. In D.A. Lane and S. Corrie (eds), *The Modern Scientist Practitioner: a guide to practice in psychology*. London: Routledge.

Munro, E. (2011). *The Munro Review of Child Protection (Final Report): a child centred system*. Norwich: The Stationery Office. Available from <https://www.education.gov.uk/publications/standard/AllPublicationsNoRsg/Page1/CM%208062> [Accessed 2nd November 2011].

Newsome, S. (2004). Solution focused brief therapy (SFBT) group work with at risk junior high school students: enhancing the bottom line. *Research on Social Work Practice*, 14, 346-343.

Parton, N. (2006). *Safeguarding Childhood: Early Intervention and Surveillance in late Modern Society*, Basingstoke: Palgrave Macmillan.

Rees, I. (2003). *3-session change programme: Intensive solution-oriented brief therapy*. Cardiff: Unpublished training manual.

Seagram, B.C. (1997). *The efficacy of solution-focused therapy with young offenders*. Unpublished doctoral dissertation, York University, New York, Ontario, Canada.

Solution Focused Brief Therapy Research Committee (2010). *Solution Focused Treatment Manual for working with individuals*. Retrieved February 9 2011, from <http://www.sfbta.org/>.

Spencer, L., Ritchie, J., Lewis, J. & Dillon, L. (2003). *Quality in Qualitative Evaluation: a framework for assessing research evidence*. London: Strategy Unit (Cabinet Office).

Squires, G., & Dunsmuir, S. (2011). Embedding cognitive behaviour therapy training in practice. *Educational Psychology in Practice*, 27(2), 117-132.

Stalker, C.A., Levene, J. & Coady, N.F. (1999). Solution focused brief therapy – one model fits all? *Families in Society: Journal of Contemporary Human Services* 80(5), 468-483.

Thomas, J., Harden, A., Oakley, A., Oliver, S., Sutcliffe, K., Rees, R., Brunton, G., & Kavangh, J. (2004). Integrating qualitative research with trials in systematic reviews. *British Medical Journal*, 328, 1010-1012.

Turnell, A. (2010). The signs of safety. A comprehensive briefing paper. Available at: http://www.signsofsafety.net/sites/files/imagecache/product_full/Signs-of-Safety-Briefing-Cover-Image-Web_0.jpg [Accessed 5th May 2011].

Wolpert, M., Aitken, J. Syrad, H., Munroe, M., Saddington, C., Trustam, E., Bradley, J., Nolas, S. M., Lavis, P., Jones, A., Day, C., Fonagy, P., Frederickson, N., Humphrey, N., Meadows, P., Rutter, M., Tymms, P. Vostanis, P. & Croudace, T. (2009). *Review and recommendations for national policy for England for the*

use of mental health outcome measures with children and young people. DCSF Research Report 2008/56A. Nottingham: DCSF Publications.

Yardley, L. (2007). Demonstrating validity in qualitative research. In Smith, J. (ed.), *Qualitative psychology*, pp.235-251. London: Sage.

Zimmerman, T.S., Jacobsen, R.B., Macintyre, M. & Watson, C. (1996). Solution focused parenting groups: An empirical study, *Journal of systemic therapies*, 15, 12-25.

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