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

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Executive summary

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 & Einsengart, 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; Smyrnios & 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 the 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.

Chapter 1 Introduction

1.1 Background to the review

Solution focused brief therapy (SFBT) is a flexible approach, which has been applied across a range of contexts, including work with families, individuals and schools (Corcoran and Pillai, 2007; Kelly, Kim and Franklin, 2008). It is based upon principles of focusing on strengths, exceptions to the problem and future goals, rather than problems and deficits (Rees, 2003). SFBT interventions are usually very short-term and it is not unusual for therapy to consist of a small number of sessions or even a single session (Corcoran and Pillai, 2007).

This systematic literature review arises from the second Serious Case Review (SCR) following the death of Peter Connelly (Haringey Local Safeguarding Children Board, 2009). It is set against a background of government reports and recommendations for safeguarding and protecting children, which emphasise the need to ensure professionals' decision-making is based upon sound professional judgements (HM Government, 2010; Laming, 2009; Munro, 2011). The terms of reference of the SCR relating to the death of Peter Connelly included an examination of whether any models of practice had an influence on the way the case was managed (Haringey Local Safeguarding Children Board, 2009).

This SCR Overview Report suggests that SFBT may have had some indirect influence on the outcome in the case as it was being piloted within the social work team that was working with Peter's family in 2007 (Haringey Local Safeguarding Children Board, 2009, paragraph 3.16.6). The Peter Connelly SCR Overview Report recommends that: '*The SFBT approach has a place in family work and emphasising the strengths of parents is important, but it is not compatible with the authoritative approach to parents in the protective phase of enquiries, assessment and the child protection conference if children are to be protected'* (Haringey Local Safeguarding Children Board, 2009, paragraph 3.16.7). The Peter Connelly SCR Overview Report recommends that social workers and their managers should be trained and supported '*to purposefully and authoritatively drive forward child protection plans with the support of other members of the core group'* (Haringey Local Safeguarding Children Board, 2009, paragraph 5.12). Accordingly, the broad aims of this review are to scope the empirical evidence on the effectiveness of SFBT with children and families and to consider the implications of such evidence for policy and professional practice in the

safeguarding of children from harm. Understandings of evidence-based practice are central to the review (American Psychological Association, 2006; Munro, 2011).

1.2 Solution focused brief therapy in practice

SFBT is a strengths-based approach, emphasizing the resources that people possess and how these can be applied to a positive change process. SFBT developed from clinical practice at the Brief Family Therapy Centre in Wisconsin during the early 1980s. It was developed by Steve de Shazer and Insoo Kim Berg, who emphasized the importance of enabling clients to do more of what works well for them (Berg, 1994; de Shazer, 1994; Kim, 2008). There are increasing numbers of SFBT practitioners and trainers in the United Kingdom (George, Iverson & Ratner, 2006).

SFBT focuses on strengths and `life without the problem' rather than a detailed analysis of problem dimensions, although some forms of solution focused practice, such as Solution Oriented Brief Therapy may encourage some exploration of problem dimensions (Rees, 2003). Attempts have been made to specify the core components of SFBT in order to increase treatment fidelity (Beyebach, 2000; Solution Focused Brief Therapy Association (SFBTA) Research Committee, 2010). Key elements that are common to these frameworks include focusing on client's goals, eliciting exceptions to the problem and identifying client's strengths and resources. Tools used by therapists to elicit client skills and potential for changes include the miracle question[1], coping questions and scaling. SFBT practitioners are encouraged to adopt a respectful and cooperative stance towards clients and to see the client as having the solutions and potential for change. Sessions usually last about an hour and end with complimenting the client, identifying whether a further session would be helpful and setting homework tasks. SFBT interventions are usually very short-term, sometimes only a single session, which may have presented difficulties in developing an evidence base for SFBT (Corcoran & Pillai, 2007).

As a flexible approach, SFBT has been enthusiastically received and applied across a range of contexts and client groups, including schools and family settings, groups and individuals, professionals and community members, voluntary and mandated groups (Corcoran & Pillai, 2007; Kelly, Kim & Franklin, 2008). Early practitioner evaluations of SFBT were very positive, but these studies often used subjective outcome measures and were not high quality reports (Gingerich &

[1] The miracle question, which may be variously phrased, asks the SFBT client to begin to imagine and describe the interactions, resources and settings at a time following the occurrence of a 'miracle' through which the problem about which the client has sought consultation has been removed.

Eisengart, 2000). Reviews by Gingerich and Einsengart (2000) and Corcoran and Pillai (2007) have identified research studies, deemed to be good quality, which suggest SFBT effectiveness for areas such as parenting skills (Zimmerman, Jacobsen, MacIntyre & Watson, 1996) antisocial adolescent offenders (Seagram, 1997) and child behavior problems (Corcoran, 2006). A meta-analysis of 22 studies by Kim (2008) found small effect sizes with the use of SFBT with child and adult populations. Kim (2008) concluded that this was reasonable evidence for effectiveness, given that these were not highly controlled experimental studies. A recent review by Kim and Franklin (2009) focused specifically on the use of SFBT in schools and found some evidence for the effectiveness of SFBT in relation to improving academic results and in dealing with 'externalizing' behaviours, such as aggression, co-operation and truancy (Franklin, Moore & Hopson, 2008; Newsome, 2004).

In all of the above reviews of SFBT effectiveness, the researchers were able to attest to the popularity of SFBT by identifying many studies which reported the use of SFBT but relatively few studies were sufficiently clearly reported to meet the reviewers' criteria for inclusion in the reviews. Methodological limitations, variable effect sizes and significant gaps in the evidence base led Corcoran and Pillai (2007) to conclude that the evidence base relating to SFBT effectiveness within social work practice was both equivocal and sparse. Further to this, a more recent review by Carr (2009) indicates that for many specific family and child problems there are more targeted approaches with a more established evidence base, for instance parent training programmes for child behaviour problems.

Given its flexible, collaborative, strengths focused approach SFBT is likely to appeal to children's services staff, including social workers and family support workers. Corcoran (1999), Dudley Metropolitan Borough Council (2006) and Turnell (2010) describe the potential and actual application of SFBT by social work teams in resolving complex family problems involving child protection issues. Although these evaluations suggest promising potential of SFBT intervention within child protection, they have not been subject to the scrutiny of independent peer review, for example through the process of external publication.

Critics of the application of SFBT within social work, such as Stalker, Levene and Coady (1999) argue that the brief nature of SFBT may make it less effective with more severe problems; also, its tendency to neglect broad based contextual assessment may obscure the analysis of significant problems, such as the parenting and care that children are receiving. In short, SFBT is an approach

that may allow a client-centred intervention with parents, with little or no objective assessment of the problem for the child. Accordingly, the Peter Connelly SCR Overview Report concluded: '*The SFBT approach has a place in family work, and emphasising the strengths of parents is important, but it is not compatible with the authoritative approach to parents in the protective phase of enquiries, assessment and child protection conference if children are to be protected'* (Haringey Local Safeguarding Children Board, 2009, paragraph 3.16.7).

The Peter Connelly SCR Overview Report goes on to indicate that where there is confidence that the parents are being genuinely co-operative with staff, then a family support approach alone is appropriate, as long as there is continued awareness that the assumptions about co-operation may be mistaken (Haringey Local Safeguarding Children Board, 2009, paragraph 3.16.7). It is of course important to recognise that such 'co-operation' extends beyond SFBT intervention within family support, to encompass the four key processes of work with children and families: assessment, planning, intervention and reviewing, as set out in *Working Together to Safeguard Children* (HM Government, 2010).

1.3 Issues in the evaluation of solution focused brief therapy

The reviewers identify eight main issues which are relevant to the evaluation of SFBT effectiveness. First, the wide variety of problem areas and client groups to which SFBT is applied. Even within a defined field of practice such as 'children and families', it is possible that extrapolation from evaluation of SFBT practice with one client group, experiencing particular kinds of difficulties, may not be valid. For example, evidence of an effective SFBT intervention with teachers of children with behaviour problems may not indicate that such intervention would be similarly effective with the parents of such children.

Second, SFBT is practised by a wide variety of practitioners from differing professional backgrounds which may have a bearing upon the form and process of its delivery. Within a local authority this may also lead to consideration of which professional groups can, do, or should deliver SFBT. Similar considerations can be identified in relation to other psychological therapies and in the case of cognitive behavioural therapy these have been addressed through development of a competences framework (Department of Health, 2007).

Third, the initial training level of SFBT practitioners is variable. Some initial training is provided by a specialist external agency whilst other training is provided 'in-house', without a fixed benchmark standard (for example certification, diploma) across contexts. Therefore careful evaluation of practitioner competence is required in evaluating SFBT effectiveness.

Fourth, the experience of practitioners in using SFBT and supervision received while delivering it are also variable, making it difficult to ensure equivalence of intervention. Effective supervision for practitioners delivering therapeutic interventions is crucial in ensuring fidelity and ethical practice (Department of Health, 2004; Squires & Dunsmuir, 2011), which also has implications for professional delivery within a local authority context.

Fifth, there is variability in the modality (for example individual/group delivery) and average number of sessions of SFBT delivery which requires caution when comparing the effectiveness of different SFBT interventions.

Sixth, although clarity regarding the core components of SFBT is emerging (SFBTA Research Committee, 2010), descriptions of SFBT components delivered by practitioners are variable, making difficult the comparison between different interventions similarly described as SFBT.

Seventh, as one method of intervention, SFBT may be used in combination with other intervention strategies by the same or different practitioners, which raises the question of the extent to which it is SFBT that has been instrumental in producing certain effects as part of the combined approach.

Lastly, standards of evidence may be affected by variability in quality of reporting across empirical studies, including use of appropriate outcome measures, clearly defined participant sampling and intervention setting, fidelity monitoring and inclusion of a control group (American Psychological Association, 2006).

Further to these issues relating directly to SFBT evaluation research is the broader issue of the utility of such research to evidence-based practice (American Psychological Association, 2006; Munro, 2011). The American Psychological Association (APA) (2006) defines evidence-based practice as the integration of the best available research with professional expertise in the context of service user characteristics, culture and preferences. The APA goes on to explain that multiple

research designs are relevant to best available research evidence, with different research designs being better suited to different kinds of question. For example, randomised controlled trials (RCTs) are the standard for drawing causal inferences about the effects of interventions, whereas process-outcome studies are valuable for identifying the mechanisms of change. Similarly, single case experimental designs are particularly useful for identifying causal mechanisms in the context of an individual, which may be particularly relevant where the client group in practice may have a variety of multiple problems.

Munro (2011) points out that evidence-based practice is sometimes used in a narrow sense to refer to using methods of helping service users that have research evidence of some degree of effectiveness in some places where the methods have been tried and evaluated. In the context of social work, Munro (2011) employs the term in a broader sense of 'drawing on best available evidence to inform practice at all stages of the work and of integrating that evidence with the social worker's own understanding of the child and family's circumstances and their values and preferences' (para 6.34, p.92). Munro (2011) also cautions against the uncritical acceptance of findings from research, including consideration of cross-cultural transferability of interventions, and underlines the importance of research methods training for social workers.

1.4 Safeguarding children legislation and policy

A background understanding of safeguarding children policy is relevant to the structuring of this particular review of SFBT effectiveness. Society's concern with child protection, however, has been subject to many philosophical, legal, policy and practice changes (Ferguson, 2004, 2011; Lawrence, 2004; Munro, 2011; Parton, 2006). Furthermore, legislation, policy, thresholds and cultural norms, and professional social care practice are known to vary between countries and so caution is required in extrapolation of child protection theory and research between different countries (Munro, 2011).

In the UK, specific terms (such as 'child abuse', 'child protection' and 'safeguarding') have evolved in tandem with increasing legal intervention during the late 20th and early 21st century. For example, in the 1970s the notion of abuse being predominantly physical was prominent but sexual abuse came to the professional and societal forefront in the 1980s and witnessed abuse, such as being party to adult domestic violence, was not legally categorized as child abuse until 2002. Research emerging since the latter part of the 20th century also highlights that child abuse occurs in many different environments, including institutional settings such as children's homes and schools, and

electronically, for example via the internet (for example Green, 2005). It may be inflicted by adults familiar to the children, such as neighbours, babysitters and a range of child professionals, as well as by parents and other relatives, other children, including siblings, and far less commonly than previously thought, by strangers. Institutionally, child abuse may be perpetrated not only through the opportunistic or organized acts of individuals or groups of children or adults, but additionally through institutional processes and systems which in themselves could be construed as being abusive to children (for example Green, 2006).

Section 17(10) of the Children Act 1989 defines a **child in need** as:

(i) a child unlikely to achieve or maintain or to have the opportunity of achieving or maintaining before a reasonable standard of health or development without the local authority providing specific services or resources;

(ii) a child whose development or health is likely to be significantly or further impaired without the provision of such services;

(iii)a child who is disabled (i.e. a child who is blind, deaf or dumb, suffers from a mental disorder or is severely and permanently handicapped by illness, injury or congenital deformity).

The Children Act 1989 also introduced the concept of **significant harm** as the threshold which warrants intervening in family life in the best interests of the child. Harm is defined as ill treatment or impairment of health or development. It includes physical, sexual, and emotional abuse, and neglect. A section 47 enquiry requires an assessment which must be initiated when there is 'reasonable cause to suspect' a child is suffering or likely to suffer significant harm; or, is the subject of an emergency protection order (EPO); or, under police protection; or, is under 10 and is in breach of a curfew order.

A **Care Order** or **Supervision Order** may be made if the child has suffered or is likely to suffer significant harm and this 'harm' is attributable to either (i) the child being out of parental control or (ii) the care they received prior to the order not being what would be judged as 'reasonable care'.

The term 'looked after' relates to all children who are cared for by the local authority whether they are (i) accommodated under section 20 of the Children Act due to a voluntary arrangement between the local authority and where the parents retain full parental responsibility; or (ii) under a care order

which gives the LA parental responsibility in addition to the parents. Such children may be placed in their family home with their parents or live with relatives, in foster homes, in residential children's homes or elsewhere. A child may be accommodated or the subject of a care order up until the age of eighteen.

Section 120 of the Adoption and Children Act (2002) (implemented in January 2005) amended the definition of significant harm to include 'impairment suffered from seeing or hearing the ill-treatment of another', domestic violence being the key example here. Notwithstanding these legal definitions, there are no absolute criteria which professionals can rely on when judging what constitutes significant harm or likelihood of significant harm (Lawrence, 2004). The implication for this review is that a research sample specified as having suffered significant harm may not be entirely homogeneous.

Working Together (HM Government, 2010) more broadly defines **safeguarding** and **promoting welfare** as:

> '*the process of protecting children from abuse or neglect, preventing impairment of their health and development, and ensuring they are growing up in circumstances consistent with the provision of safe and effective care that enables children to have optimum life chances and enter adulthood successfully'* (p.27)

In order to integrate understandings of child protection to the present review of SFBT effectiveness, identified studies are evaluated for their relevance to the legal definitions of 'children in need' and/or 'significant harm'.

It is particularly relevant to the evaluation of SFBT in the context of child protection that where statutory intervention is necessary, the adults and families concerned often have a multiplicity of difficulties; there are clear links between child abuse/ neglect and family characteristics such as mental illness, alcohol and illicit drug misuse, domestic violence, learning disabilities, poor physical health, financial problems and poverty (Cleaver, Unell & Aldgate, 2011; Devaney, 2009). It follows that conclusions from this review about the *general* effectiveness of SFBT with particular kinds of child or family problems would need clear contextualisation within the *specific* family and social

context, including the availability of resources for other necessary assessments or interventions (American Psychological Association, 2006).

1.5 Objectives of the review

The broad aims of this review are to scope the empirical evidence on the effectiveness of SFBT with children and families and to consider the implications of such evidence for policy and professional practice in relation to the protection of children.

To meet these Review aims, the specific questions posed by this Review are:

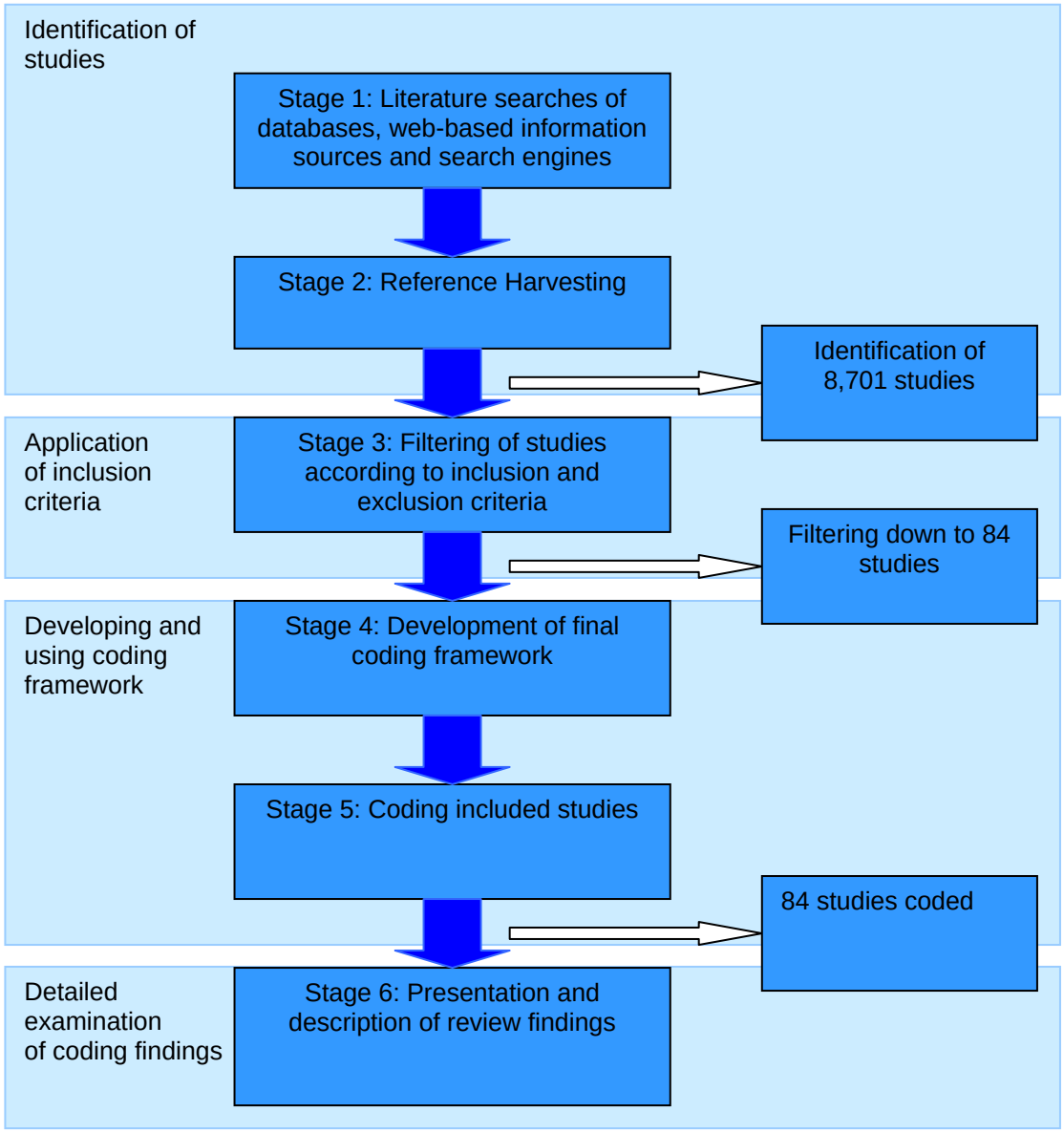
1. What is the evidence for the effectiveness of SFBT in relation to work with children and families? For what types of child and family problems is SFBT found to be most effective?
2. What are the cost-benefits of SFBT in relation to work with children and families?
3. What are the implications of the 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?

Chapter 2 Review methodology

2.1 Overview of the review methodology

The review process is summarised in Figure 1 below:

Figure 2.1 – Stages in the systematic review process.



2.2 Review stage 1: literature searching

Before beginning the literature searching, the types of document that should be included in the review and the search terms that should be used to locate them were established. With regard to the former, it was decided that a document could be included if it had been published externally and/or was peer reviewed. Thus, peer-review journal studies, magazine studies, and PhD dissertations would be included, whilst self-published and/or internally reviewed documents, such as Masters level dissertations would not. Using this criterion, books and book chapters could be included, although they were not systematically searched for. A book chapter was considered for review if it was (a) located during literature searches and (b) reported a primary study that (c) was described in enough detail to complete the coding framework.

Once the types of document to be included had been determined, search terms were developed to locate them. The search terms were divided into three categories:

a) terms relating to solution focused brief therapy
b) terms relating to the population under study (children, young people and families) and,
c) terms relating to interventions.

In the next step, a list of words and/or phrases was generated to capture terms in each of these three categories (see table 1 below). The search terms were trialled to ensure they were capturing all relevant studies. To do so, the search terms were used to see if they would return four relevant studies already known to the review team. As a result of this exercise, the term 'children' was replaced with 'child*', and the terms 'foster*' and 'implementation' were added. Subsequent searching also led to the inclusion of 'working on what works', as 'WOWW' alone did not capture relevant studies; also, 'solution orientated schools' was added, as its acronym 'SOS' sometimes resulted in a large number of irrelevant hits. The final list of search terms is shown in Table 2.1 below.

Table 2.1 – Categories of interest and related terms for the systematic review.

Category	Related Terms
1) Solution focused brief therapy	Solution focused brief therapy OR brief therapy; solution focused therapy; solution focused family therapy; solution focused brief family therapy; solution oriented; three session change; three-session change; working on what works; WOWW; SFBT; BT; solution orientated schools; SOS; S.F.B.T.
2) Children and families	Child* OR adolescents; family; families; carer(s); parents; community; communities; pupils; students; young people; teenagers; school(s); single-parent(s); siblings, foster*
3) Intervention	Programme OR evaluation; intervention; strategy; initiative; programme effect; impact, implementation

Initial searches focused on electronic databases in the following subject areas: Counselling; Education; Community and Youth Work; Sociology; Psychology; Nursing, Midwifery and Social work. This included a number of large databases, such as PsychInfo, ISI Web of Knowledge, ASSIA, British Education Index, Medline and Scopus. In total, 44 databases were searched.

Searches of relevant web-based information sources were also conducted. These were: Education-Line, OECD Education at a Glance, Office for Standards in Education, Department for Education, International Review of Curriculum and Assessment Frameworks Internet Archive, National Foundation for Educational Research, Office of National Statistics, Evidence for Policy and Practice Information Centre and Eurydice. Extensive web-searching was also conducted using Google and Google scholar.

2.3 Review stage 2: reference harvesting

Studies found during the initial searches were used to identify other studies that might be relevant to the review, through a process of reference harvesting. Throughout this process, researchers who had conducted a number of research studies in this area were also identified and were contacted personally with the aim of sourcing further relevant studies from them.

If any studies returned during the initial searches, or during reference harvesting, could not be accessed, they were sourced through the document supply facilities at the University of Manchester, which requisitions texts from the British Library. PhD dissertations were ordered via ProQuest's online ordering system 'dissertation express'.

2.4 Review stage 3: application of inclusion criteria

Throughout the searching process, the resulting hits were filtered to select studies to be included in the review. In order for a study to be retained, it had to meet the following inclusion criteria:

- Published in the English language
- Published in the period 1990-2010
- Primary study reporting on the effectiveness of SFBT with/without cost effectiveness and/or child protection implications of SFBT
- Sample(s) including children and young people (0-18) and/or their families.

Conversely, a study was not included within the review if it met the following exclusion criteria:

- Published in a language other than English
- Published outside of the period 1990-2010
- Does not report/review a primary study relating to the effectiveness of SFBT with/without cost effectiveness and/or child protection implications of SFBT
- Sample does not include children and young people (0-18) and/or their families.

Studies that met the inclusion criteria were transferred and saved into a bibliographic application (Mendeley Desktop, 2008). Studies that were a review or meta-analysis, rather than a primary study, and met the rest of the inclusion criteria, were not included in the review. However, these studies were used for reference harvesting. Following this, there was a consultation with members of the SFBT review Advisory Group who were able to identify any potential omissions in the pool of included studies, which were then sourced and evaluated against the inclusion criteria.

A total of 84 relevant studies were identified from 8,701 hits which had been identified from across all the databases searched (including Google scholar) or through the process of reference harvesting. Table 2 outlines the number of hits returned from each subject area and the number of studies that were included in the review.

Table 2.2 – Studies included for coding within the review framework

Database (subject for example education)	Number of databases searched	Initial Hits	Studies passed inclusion criteria
Counselling	6	2,163	7
Education	13	446	5
Community and Youth Work	3	1,918	14
Sociology	4	3,363	55
Psychology	6		
Nursing, Midwifery and Social Work	12	811	3

2.5 Review stage 4: development of coding framework

Studies selected for inclusion in the review were subsequently coded using a purpose-made and fully trialled framework. The coding framework was devised by the research team with the aim that it would accurately describe the approach, focus, methods, quality and findings of each study in a systematic way. The framework collected both descriptive and evaluative information about each included study.

Descriptive information included: the study's author; year of publication; type and number of participants included in the study (for example children and/or parents); the nature of the presenting problem; the SFBT used (for example the specific model of SFBT, the components of SFBT utilised, the number and length of session received); the therapist's characteristics (for example amount of SFBT training and experience).

Evaluative information came from the coders' assessment of the primary relevance of the study to the general effectiveness of SFBT and/or safeguarding/child protection implications and/or cost benefit. Evaluation was also made on the quality of the research. The reviewers acknowledge that these evaluations reflect only what was available within the published review study and that the primary research may indeed have contained many features of high quality research. However, quality evaluations of the available evidence are essential to building a sound evidence base for SFBT practice. For example, where an SFBT evaluation shows the intervention to be effective it is important for another practitioner to have sufficient information to be able to replicate that

intervention faithfully. Similarly, an SFBT evaluation requires a clear focus on a well-defined problem area/participant sampling, since 'community sampling' may mask the effectiveness (or ineffectiveness) of the intervention with certain sub-groups, which may mislead the practitioner as to the likely effectiveness of the intervention with particular client subgroups.

Criteria on which the quality of a quantitative study was judged were drawn from American Psychological Association (2006) and gave a 1 point credit for the presence of each of the following criteria:

- Use of a randomised group design
- Focus on a specific, well-defined disorder or problem
- Comparison with treatment-as-usual, placebo, or less preferably, standard control
- Use of manuals and procedures for monitoring and fidelity checks
- Sample large enough to detect effect (from Cohen, 1992)
- Use of outcome measure(s) that have demonstrable reliability and validity (2 point weighting given for more than one measure used).

The criteria on which the quality of a qualitative study was judged were drawn from Spencer, Rithie, Lewis & Dilton (2003), and Henwood & Pidgeon (1992), and gave 1 point credit for the presence of each of the following criteria:

- Appropriateness of the research design
- Clear sampling rationale
- Well executed data collection execution
- Analysis close to the data
- Emergent theory related to the problem
- Evidence of explicit reflexivity
- Comprehensiveness of documentation
- Negative case analysis
- Clarity and coherence of the reporting
- Evidence of researcher-participant negotiation
- Transferable conclusions
- Evidence of attention to ethical issues.

From the evaluation of quality, each study was categorised as being a report of high, medium or low quality. For each quantitative study, a total points score of 0-2 attracted a categorisation as low quality research, 3-4 as medium quality research and 5-7 as high quality research. For each qualitative study, a total points score of 0-4 attracted categorisation as low quality research, 5-8 as medium quality research and 9-12 as high quality research. Each mixed methods study was 'dual coded' and evaluated as both a qualitative and quantitative study and, in the case of evaluation disparity, awarded the higher quality rating.

Also, from Gough (2007) each study was evaluated as 'high', 'medium' or 'low' in relation to its 'methodological appropriateness' and 'relevance of focus' for the review questions. Methodological appropriateness evaluations took account of:

(i) Having a clearly defined participant sample and some measure of outcome

(ii) The soundness of the SFBT model used, to include appropriate theoretical grounding *and* inclusion of at least two core SFBT components

(iii)The use of objective outcome measures relating to children/ families[2].

Relevance of focus evaluations took account of the study's focus upon general SFBT effectiveness and/or child protection, and/or cost-benefit[3]. Each research study was evaluated for its relevance to 'children in need' and/or the 'significant harm' threshold (see section 1.4 above).

The trialing of the coding framework included training, moderation and framework modification followed by an inter-coder reliability check. Across qualitative and quantitative studies, an overall Cronbach's alpha inter-coder reliability co-efficient of .92 was calculated (with the lowest framework element at alpha value 0.76) indicating very high inter-coder reliability. Following the inter-coder reliability check, final minor modifications were made to the coding framework. In total, there were ten versions of the coding framework before the final version (version 11) was established. The development of the framework is detailed at Appendix 2.

2.6 Review stage 5: using the coding framework

All of the 84 studies included in the review were coded using version 11 of the coding framework. Studies were coded as they were added to the Mendeley database (Mendeley Ltd., 2008). Coding

[2] (i) + (ii) = MEDIUM level evaluation; (i) + (ii) + (iii) = HIGH level evaluation.
[3] Focus on any one of the three areas = MEDIUM weighting, unless SFBT model is weak

included reading the study thoroughly and seeking out the information relevant to the review. As far as possible, information was recorded verbatim, to minimise any bias in interpreting the data. Any information that was considered to be potentially significant, but that did not fit the categories of the coding framework, was placed in a separate 'notes' column at the end of the framework. Any concerns about a study (for example whether the study used an acceptable model of SFBT) were recorded in Mendeley and followed up with other team members. Weekly checks of the coded data were conducted, to ensure that the framework was being completed correctly, and any apparent discrepancies or inaccuracies were discussed with the coder and amended if necessary.

2.7 Review stage 6: presentation and description of review findings

Once all of the studies included in the review had been coded using the framework, the information from the coding exercise was used to:

- Describe the range of quality, appropriateness and relevance of the review studies
- Identify within high, medium and low quality studies, the design, target sample, therapeutic methods, measures and outcomes of each study, together with an evaluation of its relevance to child protection and safeguarding
- Identify a pool of 'best evidence' for the review from which reasonably confident conclusions may be drawn about the general effectiveness of SFBT in relation to types of child and family problems. In this review, a study is included as best evidence if it is reported as being at least medium quality, and has at least medium level appropriateness to the main purpose of this review to evaluate the effectiveness of SFBT with children and families
- Identify and evaluate cost benefit reports.

Chapter 3 Findings

3.1 Overview of the quality, appropriateness and relevance of the review studies

3.1.1 Quality of review studies

Each of the 84 studies included in the review was evaluated according to the quality criteria for research reporting outlined in section 2.5 above (Gough, 2007). Quality evaluations were summated into one of three categories to identify the review study as being 'high quality', 'medium quality' or 'low quality'.

Table 3.1 – Quality of reporting within the review studies (n=84)			
Quality of reported study	HIGH QUALITY	MEDIUM QUALITY	LOW QUALITY
Number of studies	5	37	42

Half of the studies in the review were evaluated as reporting at least medium quality research, suggesting that a reasonable level of confidence may be placed in their findings. It is disappointing, however, that half of the studies in the review were evaluated as reporting low quality research, diminishing the level of confidence that can be placed in their findings. The design, focus, therapeutic methods, measures and outcomes of each of the high and moderate quality studies are summarised in Appendices 3 and 4 respectively. A summary of the methods and outcomes for the low quality reported studies is provided in Appendix 7.

3.1.2 Methodological appropriateness of the review studies

A judgement was made on the methodological appropriateness of each study to the main purpose of this review to evaluate the effectiveness of SFBT with children and families. These judgments were made according to the criteria outlined in section 2.5 above, with particular emphasis upon clearly defined participant sampling, use of objective outcome measures and clear utilisation of a 'good-enough' model of SFBT intervention. Table 3.2 below shows the range of appropriateness of the review studies to the review purpose.

Table 3.2 – Methodological appropriateness of studies for the review (n=84)			
Methodological Appropriateness	HIGH	MEDIUM	LOW
Number of studies	5	50	29

Well over half of the studies included within the review were evaluated as being of least medium level methodological appropriateness to the purpose of the review. These studies are eligible to be included in the 'best evidence' on the review questions, provided that they are reported as being at least medium quality studies. Thirty-eight of the review studies which report the study as being at least medium quality also have at least medium level methodological appropriateness to the purpose of the review. This pool of 38 studies is taken as being the 'best evidence' to provide clear conclusions about whether SFBT is effective and for whom (see section 3.2 below).

Over one third of the included studies were of low methodological appropriateness to the review with the most commonly identified limitations being the lack of clearly objective outcome measures relating to children/families and/or clear definition of participant sample. The reviewers note the high proportion of practitioner researchers (56%) reporting across the set of review studies, and propose that the inherent constraints of fieldwork practice upon research (for example participant sample determined by service priorities; resourcing and ethical feasibility of administering particular outcome measures) may account for these apparent limitations in methodological appropriateness to the review's purpose of evaluating SFBT effectiveness.

3.1.3 Focus of review studies

Each study was evaluated for its relevance of focus in relation to this specific review, according to the criteria outlined in section 2.5 above, with particular emphasis upon relevance for child protection and SFBT cost benefit, as well as SFBT general effectiveness. Table 3.3 below shows the range of focus relevance of the review studies:

Table 3.3 – Focus relevance of review studies (n=84)			
Focus relevance	**General effectiveness**	**Cost benefit**	**Child protection**
Number of studies	80	2	3

A general consideration relating to the focus of the studies is that of country of origin since cultural norms and professional practice may vary between countries. Of the 38 best evidence studies, 22 originated from the USA, 6 were within the UK, and 10 were from a variety of countries including Australia, Canada, Cyprus, Lithuania, Norway, Romania, Sweden, Hong Kong and Korea. In relation to this particular range of countries it is assumed that, notwithstanding indicated inter-cultural differences (for example Georgiades, 2008), child protection descriptions are likely to evidence a considerable degree of similarity.

Only two review studies report directly upon cost benefit of the SFBT intervention, one further study does report the direct costs of the SFBT intervention allowing some non-benchmarked evaluation of its cost. The reviewers note however that several studies provide some specific time cost information. Therefore the reviewers have estimated, for the positive outcome high quality studies only, direct financial costs of provision of SFBT, which may then be related to the reported positive outcomes to provide a 'proxy' cost benefit (see section 3.4 below).

3.2 Best evidence on the effectiveness of SFBT

Following the methodology outlined in section 2.7 above, 38 studies were identified as the 'best evidence' on whether SFBT is effective, and for whom. The design, focus, therapeutic methods, measures and outcomes of each of the 38 best evidence studies is described within the summaries in Appendices 3 and 4 respectively.

Of the 38 best evidence studies, most applied SFBT directly with individual or groups of children/young people, with group delivery used not just for shared environmentally-based concerns such as divorce and dealing with parental incarceration, but also for personal issues such as self-efficacy, aggression and behavioural difficulties. Several studies applied SFBT with family groups (parents and children together) for concerns such as behaviour problems, coping with child's hospitalisation, and, in two cases, child maltreatment issues directly (Antle et al., 2009; Corcoran & Franklin, 1998); all these studies took outcome measures relating to children/ young people. Two studies applied SFBT with parents and one study applied SFBT with both parents and family groups; these three studies took outcome measures relating to parents.

It can be seen from Appendices 3 and 4 that best evidence from the review provides at least reasonable evidence of SFBT's effectiveness in the following areas:

Improving internalising problems in children (for example shyness, anxiety, depression, self-esteem, self-efficacy) (Daki & Savage, 2010; Franklin et al., 2008; Frels et al., 2009; *Georgiades, 2008; Green et al., 2007; *Grandison, 2007; Korman, 1997; Kvarme et al., 2010; Seagram, 1997; *Springer et al., 2000; Smyrnios & Kirkby, 1993; Wilmshurt, 2002).

Improving externalising behaviour problems in children (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).

Providing a supportive structure for first sessions with parents of children with learning disabilities (Lloyd & Dallos, 2008).

Reducing recurrence of maltreatment (*Antle et al., 2009; Corcoran & Franklin, 1998).

Improving children's listening comprehension and reading fluency (Daki & Savage, 2010).

Improving coping of families undergoing divorce (Ziffer et al., 2007).

Improved goal setting by families with children with behaviour problems (Adams et al., 1991).

Functional improvements (signing/cognition/ affect) for young people with developmental difficulties (hearing impairment/learning disabilities) (*Murphy & Davis, 2005; *Thompson & Littrell, 1998).

Eight of the best evidence studies (*) applied SFBT as part of another intervention approach and, notably, all of these studies produced positive outcomes; one of these studies (Antle et al., 2009) concerned child protection. However, for reasons such as absence of a control group, uncertain equivalence between control and intervention groups, non-specified control group intervention or the presence of extraneous variables, it is not possible in any of these studies to identify with certainty the contribution of SFBT per se to the positive outcomes.

Antle et al. (2009) used solution focused interview techniques to develop a child welfare practice model, Solution Based Casework (SBC), which also incorporates considerations of family life cycle theory and relapse prevention. Georgiades' (2008) intervention was based upon empowerment philosophy and solution-focused strategies, entailing extensive email support to the client over a period of years, which is unusual within normally brief SFBT practice. Springer et al. (2000) combined solution focused, interactional and mutual aid approaches to address the needs of children of incarcerated parents; Window et al. (2004) combined solution focused approaches and behavioural approaches to support families with a variety of presenting problems, finding that behavioural issues improved most and the behavioural aspects of the intervention were particularly well received; Grandison (2007) used solution focused approaches to support the delivery of an eye movement desensitisation and reprocessing (EMDR) intervention; Murphy and Davis (2005) individualised their Solution Focused (SF) intervention by including a video behavioural modelling element; Thompson and Littrell (1998) added a more directive 4-step process to support young people with learning disabilities to achieve their individual goals and Enea and Dafinoiu (2009) combined SF with motivational interviewing to reduce truancy. Where SFBT is applied in combination with other intervention methods, careful evaluation should be made of the rationale and relative contribution made to outcomes.

Thirty-four of the 38 best evidence studies within the review, including the two studies relating to child protection, found some positive outcomes following SFBT, although over half of these studies did not report any fidelity monitoring of the SFBT intervention (see Appendices 5 and 6), lessening confidence that in those cases the SFBT intervention was delivered as described/ planned. Twenty-five best evidence studies reported unequivocally positive outcomes. Furthermore, 8 of the best evidence studies found evidence that at least some of the measured

outcomes following SFBT were better than for control or treatment-as-usual groups, though 5 of these studies did not report fidelity monitoring (see Appendices 5 and 6). Two best evidence studies found some negative effect following SFBT (Corcoran & Stephenson, 2000; Lloyd & Dallos, 2008), and four other studies provided neutral evidence on SFBT effectiveness (for example Cook, 1998; Geil, 1998; Lam & Yuen, 2008; Triantafillou, 2002).

Against this generally positive picture of SFBT effectiveness, several studies identified caveats. Wilmshurst (2002) found that improvements in children's behaviour and social competence were no greater for the SFBT intervention group than for a control group who were receiving a cognitive-behavioural intervention. Daki & Savage (2010) found that the control group, as well as the SFBT intervention group, showed some language/literacy skills improvements. Smyrnios and Kirkby (1993) identified a slightly better outcome at follow-up for a comparison intervention.

Appendices 5 and 6 show the core and additional elements of SFBT process reported, together with a level of reported fidelity monitoring of the SFBT intervention, for all of the high and medium quality studies respectively. In the 34 best evidence studies which reported some positive outcomes following SFBT, between 2 and 5 SFBT core elements were reported as having been used, with 4 being the modal number of core therapeutic elements used. The most commonly reported SFBT core elements used are 'looking for strengths/solutions', 'client goal setting', 'use of scaling questions', 'use of the miracle question', and 'finding exceptions to the problem'. The most frequently used additional/non-core SFBT elements used are 'giving compliments' and 'setting homework tasks'.

Notwithstanding the generally positive evaluations of the quality and appropriateness of the 38 best evidence studies, the following range of methodological limitations were identified across the best evidence pool:

- Small sample size (for example Wilmshurst, 2002; Daki & Savage, 2010; Springer et al., 2000; Shin, 2009; Conoley et al., 2003)
- Lack of control groups (for example Corcoran and Stephenson, 2000; Emmanuel, 2008; Thompson & Littrell, 1998)

- Absent fidelity monitoring of SFBT intervention (for example Daki & Savage, 2005; Antle et al., 2009; Green et al., 2007; Ziffer et al.; 2007, Korman, 1997; Springer et al., 2000). Appendices 5 and 6 show that a variety of full and partial fidelity monitoring procedures are reported and that 21 or the 38 best evidence studies did not report any fidelity monitoring of the intervention, lessening confidence that the intervention was delivered as planned/described.
- Limited triangulation of outcome data (for example Wilmshurst, 2001; Window et al. 2004)
- Reliance upon participant self-report (for example Green et al., 2007; Thompson & Littrell, 1998)
- Participant self-selection (for example Green et al., 2007; Vostanis et al, 2006 and Window et al, 2004)
- Extraneous factors not evaluated (for example Cepukiene & Pakrosnis, 2010; Springer et al, 2000)
- Community samples without a clearly identified target group (for example Franklin et al., 2001; Window et al., 2004)
- Lack of long term follow up (for example Springer et al, 2000, Shin, 2009; Corcoran & Stephenson, 2000)
- Gender skewed sampling (Wilmshurst, 2002; Franklin et al., 2008).

From the summary at Appendix 7, there is some indication within the low quality studies of the possible effectiveness of SFBT with externalising behaviour problems, post abuse work and physical health issues. Further research using more robust research designs, is needed to validate the tentative findings suggested by the low quality studies.

Appendix 10 shows a 'mapping' of the review evidence on SFBT outcomes against mode of delivery and area of focus (concern), showing positive evidence of SFBT effectiveness across a range of areas using a range of treatment modalities. The mapping does however suggest a need for further research on the evidence base for SFBTs use with teachers to improve child behaviour difficulties, on its use with parents and family groups to reduce recurrence of child maltreatment,

and on its use with children and young people to support improvements in functional skills such as reading.

3.3 Studies focusing upon children in need and child protection

Two of the best evidence review studies focus upon child protection, involving children, or issues, clearly related to 'significant harm'. Antle et al. (2009) report using solution focused interview techniques to develop a child welfare practice model, Solution Based Casework (SBC). The SBC practice model was developed in the United States with front-line practitioners. It emphasises partnership with the family in the assessment of problems within the specific family context and targets specific skills required to reduce the level of risk. Although framed from a positive perspective the SBC model does not exclude formal risk assessment and incorporates other more 'instructional' and directive intervention strategies based upon relapse prevention and family life cycle theory. Although the study by Antle, Barbee, Christensen and Martin (2008) is not included within the best evidence pool, this research paper provides more detail regarding SBC case planning with families. The SBC approach provides a case planning framework which includes the use of safety plans and family and individual objectives. Solution Focused interviewing is used throughout the SBC process to highlight what is working in order to help families engage with the process and to work through setbacks.

Antle et al., (2009) report the use of SBC with 339 child maltreatment cases as being effective in reducing the recurrence of maltreatment, particularly for families with a history of involvement with the child welfare agency. The model was also most effective in strong child welfare teams, where supervisors and team members worked closely and were receptive to new practice. Whilst this study provides some positive evidence of the potential utility of SFBT as part of intervention package for children identified as having suffered significant harm it is necessary to bear in mind the following limitations:

- The authors of the study acknowledge that their maltreatment recurrence monitoring period of six months is relatively short and that longer term follow-up of between two to five years would be advisable
- Although Antle et al.'s (2009) SBC intervention group showed approximately 30% less recurrence of maltreatment compared to the comparison intervention group, the SBC

intervention group still evidenced a level of maltreatment recurrence. Whilst potentially effective for some types of child protection cases, it may be, therefore, that SFBT is ineffective, or even counter-productive for some types or severity levels of maltreatment

- Within the short research report, the description of the SBC model provided lacks sufficient detail for confident replication. Practitioners wishing to adopt this model would need to undertake further research and training in order to establish its utility within their local settings and child protection procedures
- The report by Antle et al. (2009) does not fully detail the comparison group intervention and so it is not possible to be certain that the outcome difference between the SBC intervention and comparison intervention groups is most likely to be due to solution-focused elements of difference between the two groups.
- Although the review includes the Antle et al. (2008) precursor study, this did not meet criteria for inclusion within best evidence. The review found no replications of the study by Antle et al. (2009), meaning that this study is the only reasonable quality report of a large scale evaluation of SFBT incorporated to child protection work. As such, it is also specifically limited by the particular child protection definitions and social care policy/ norms within its country of origin (USA) (see section 1.4 above).

Corcoran and Franklin (1998) report upon a single case study of a solution focused approach to a case of physical abuse by a mother to her 13 year old son. The young person was initially referred following a court appearance for drug possession. During the initial interview he reported feeling suicidal and that he was fearful of his mother, reporting numerous episodes of his mother physically abusing him by repeatedly hitting him with her fist and slapping him in the face and head. The use of physical punishment was confirmed in an interview with his mother. The authors report that following SFBT with the mother, which focused on alternative strategies she used for disciplining her children, the young person reported that the physical abuse by his parent, and his suicidal thoughts, had ceased. Again, this study does provide some positive evidence of the potential utility of SFBT for children who have suffered significant harm but it is necessary to bear in mind the following limitations:

- As a single case study with no other intervention comparison, and no direct client report on how the intervention may have worked, it is more difficult to confidently conclude in

this case that it was elements of SFBT, rather than more general elements of the intervention or extraneous factors, which were instrumental in bringing about the positive change. Similarly, it is not clear that the apparent success of SFBT with this young person would generalise to a range of cases of other individuals of different presenting difficulties, ages, backgrounds or abilities.

- As a medium quality case study report, it is noteworthy that Corcoran and Franklin (1998) do not provide a clearly detailed and data-driven analysis of the mechanisms by which SFBT applications were instrumental in bringing about cessation of physical abuse. Neither is any longer-term follow-up of the case specified.

One further study by Georgiades (2008) is set within the context of child protection issues though its focus relates to the young person's adjustment and relationship to the perpetrating parent rather than to the cessation of abuse. Georgiades (2008) reports a case study of a four-year intervention with a 13 year-old Greek-Cypriot boy who had witnessed domestic violence, and was later the victim of severe violence (kicking, throwing, hair pulling) perpetrated by his father. A combined intervention using empowerment philosophy and solution-focused strategies, through both face-to-face and email communications, was evaluated using three standardised measures over five time points in a four year period. The intervention is reported to have helped to produce remission of the young person's depressive and post-traumatic symptoms, improved academic attainments and improved father-son relations, though the young person was not resident with the abusing parent during the latter phases of the intervention which may have been a specifically facilitative factor in the boy's positive adjustments and improved relationship with his parent.

Notwithstanding the two best evidence SFBT studies which are relevant to child protection, the reviewers have acknowledged the broad spectrum of 'children in need' and the scope of safeguarding work (see section 1.4 above). It is it is noted that 34 of the 38 best evidence studies within the review are considered to be relevant to 'children in need' (see Appendices 3 and 4). Studies by Green et al. (2007) (see Appendix 3) and by Zimmerman et al. (1996) (see Appendices 3 and 4) are regarded as not being clearly relevant to either children in need or child protection as defined in section 1.4 above.

3.4 Cost benefit of SFBT

Two review studies (Seagram, 1997; Wake et al., 2009) reported directly upon the cost benefit of the SFBT intervention. Seagram (1997) calculates a $50,000 benefit for each young offender successfully remediated using SFBT intervention.However Seagram's (1997) study, whilst finding some positive benefits (for example increased guilt) did not show a significant difference in recidivism between the SFBT intervention group and comparison group. Wake et al. (2009) concluded that provision of an SFBT intervention ('LEAP2') represented '*a marked increase in costs for no real improvement in the primary or secondary outcomes* [body mass index, activity levels, nutritional and health-related quality of life measures]' (Wake et al., 2009, p.5). This study, however, used a weak SFBT intervention and is not included as best evidence in this review.

Nowicka et al. (2007) report the direct costs of the SFBT intervention allowing some non-benchmarked evaluation of its cost benefit. The researchers reported that expenditure of €2,300 per family resulted in significant improvements in children and young people's self-esteem and reductions in body mass index. The study by Nowicka et al. (2007), however, did not report its outcome measures comprehensively and so is not included as best evidence in this review.

In addition to this, five of the best evidence high quality studies provide specific time cost information which allowed the reviewers to calculate estimated direct financial costs of the positive benefits obtained by providing the therapy, which could then be related to the reported outcomes to provide a 'proxy' cost benefit. The notional tariff by which estimate costs of a high quality report of an SFBT intervention were calculated is shown in Appendix 8. Appendix 9 shows the 'unit cost' calculation of the benefit provided to clients in each of these five high quality studies (See Appendix 3 for '+/-/0' notation on reported outcomes/ benefit of study). Estimated unit costs are made without reference to economies of scale/cost reductions that might obtain after the period of the research, for example by continued utilisation of SFBT trained staff. Data in Appendix 9 show the mean estimate unit cost of providing a successful SFBT intervention to be approximately £248 per client (child/parent) per intervention, with,

predictably, the mean estimate for individually-based SFBT (£319) being higher than estimates for group-based SFBT (£144) or one-session SFBT (£138).

Chapter 4 Discussion and implications

4.1 Introduction

The final section of this review report sets the review findings in the context of the specific review questions, drawing out implications for practice and future research.

4.2 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?

The reasonably reliable evidence base relevant to the general effectiveness of SFBT with children and families is relatively small. This review found only 38 appropriate studies of at least medium level quality within which a reasonable level of confidence could be placed in the reliability of findings. Within this small pool of 'best evidence', however, the great majority of studies indicate at least some positive outcomes for the therapeutic target group. A very small number of studies with appropriate research design (8), demonstrate that SFBT yields some measures of outcome which are better than treatment-as-usual or a control condition.

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; Green et al., 2007; Grandison, 2007; Korman, 1997; Kvarme et al., 2010;

Seagram, 1997; Springer et al., 2000; Smyrnios & Kirkby, 1993; 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 (Lloyd & Dallos, 2008; Adams et al., 1991).
- 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 difficulties, for example improved signing of a hearing impaired child (Murphy & Davis, 2005; Thompson & Littrell, 1998).

Of the 38 best evidence studies in this review, only a very small proportion (2 studies) is directly relevant to children suffering significant harm, though almost all (34 studies) is relevant to the category of 'children in need'.

The Munro Review of Child Protection supports the implementation of evidence-based ways of working with children and families (Munro, 2011, recommendation 13, p.13). However, several limitations are apparent within the current small evidence base on the effectiveness of SFBT:

- Incompleteness of the evidence base across the range of different problem types, client age groups and therapeutic delivery modes (see section 4.3 below); for example, though there is some evidence that SFBT reduces classroom behavior problems in middle childhood (Franklin et al., 2008), it is not clear whether such benefits would obtain for older children. Similarly, whilst there is a collection of evidence relating to SFBT effectiveness in relation to children's internalizing and

externalizing behaviours (see section 3.2 above and Appendices 3 and 4), the range of research (summarized in section 3.2 above) includes some, but not all specific subgroups; for example, the review found no evidence focusing specifically on children with Oppositional Defiant Disorder (ODD) or Attention Deficit Hyperactivity Disorder (ADHD) types of problems and so it is not clear whether SFBT intervention might be similarly effective with these types of behaviour problems.

- A relatively small proportion of the available best evidence (less than one in six studies) is judged to be high quality research, with most research being judged to be medium quality. For example, the absence of use of control or treatment-as-usual comparison groups, and limited use of reliable and valid objective outcome measures, means that it is difficult to conclude with certainty that SFBT has been instrumental in effecting valid changes or improvements. Two factors may be relevant: first, research quality may be compromised for practitioner researchers, who formed the majority of researchers across the review, by the inherent constraints of fieldwork practice (for example limited resources for selecting and taking appropriate outcome measures; service delivery constraints on participant sampling strategy); and second, some academic/practitioner journal outlets may effectively restrict researchers' capacity to fully describe their research methods by requiring authors to emphasise other aspects, such as detailed explanations of therapeutic process or context, or implications for practice.

- Incomplete understanding of how different elements of therapy may be utilized and combined with different problem areas, client types and complementary interventions. There is variation in the number of SFBT therapeutic elements that are reported to be used, though the rationale for this is unclear. Some SFBT interventions are apparently successful by using only two core therapeutic components (for example Antle et al., 2009), whilst others using as many as five components are not successful (for example Triantafillou et al., 2002).

- Absence of reporting of fidelity monitoring is a problem in half of the best evidence. This leaves open the possibility that therapists may modify the initially intended SFBT structure and/or combine the SFBT approach with other intervention approaches available within their practice. This possibility diminishes the confidence that any observed outcomes have been effected by the SFBT intervention as described.

Implications for research

4.2.1 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 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.

4.2.2 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.

4.2.3 Future SFBT 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.

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

Only one of the review studies reports on the potential cost of the SFBT intervention, though in that study actual benefit to clients was not reliably found. 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. This omission of cost-benefit considerations within the evidence base limits the evaluation of the feasibility of SFBT intervention, particularly in the context of other intervention options which may have demonstrable potential cost-effectiveness in relation to particular problem types.

Implication for research on costs

4.3.1 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.

4.4 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?

Of the best evidence in this review, only a very small proportion (2 studies) focuses directly upon child protection issues and children who are considered to be suffering, or likely to suffer, significant harm (Antle et al., 2009; Corcoran & Franklin, 1998). Both studies show positive outcomes but one of these two studies (Corcoran & Franklin, 1998) is a case study of a single child and parent case which, whilst informative, has necessarily limited general implications. The case report of Corcoran and Franklin (1998) also has a relative weakness by not showing exactly how SFBT was instrumental in bringing about the reported cessation of physical abuse (see section 3.3. above).

The report of Antle et al. (2009) shows several methodological weaknesses which limit its utility as research evidence (see section 3.3 above):

- No follow-up of child protection cases beyond 6 months after intervention
- Lack of negative case analysis. Although Antle et al.'s (2009) Solution Based Casework (SBC) intervention group showed less recurrence of maltreatment than the comparison intervention group, the SBC intervention group still evidenced a level of maltreatment recurrence. Negative case analysis would therefore be important to understand for which child maltreatment subgroups SFBT intervention may be ineffective, or even counter-productive
- Insufficient detail in the description of the SBC model to allow confident replication (including time spent on SBC and proportion of SFBT work within SBC). Practitioners wishing to adopt this model would need to undertake further research and training in order to establish its utility within their local settings (Notably, Antle et al. (2008) provide more detail regarding SBC case planning with families)
- Inadequate detail of the comparison group intervention, so it is not possible to be certain that the outcome difference between the SBC intervention and comparison intervention groups is most likely to be due to solution-focused elements of SBC.

The review found no replications of the study by Antle et al. (2009), meaning that this study is the only reasonable quality report of a large scale evaluation of SFBT incorporated to child protection work. As such, it is also specifically limited by the particular child protection definitions and social care policy/norms within its country of origin (USA) (see section 1.4 above).

More generally, both the reports of Antle et al. (2009) and Corcoran & Franklin (1998), like others within the review, are unclear on the following points, which obscure their relevance to a specific child protection case:

- deciding how to choose to use SFBT with some cases rather than others
- explaining how SFBT is integrated alongside longer term broad based assessment, intervention and child protection planning

- explaining why some, but not other, SFBT components were included in the intervention
- explaining required SFBT practitioner training, experience and supervision levels, and choice of therapeutic modality.

Such variables within a research study may be significant in fully understanding the likely effectiveness of SFBT within the practitioner's specific case.

The evidence from this review therefore indicates that the use of SFBT within the child protection field is relatively under-evidenced, i.e. not 'tried and tested'. Further research is needed on the effectiveness of SFBT in cases where children are considered to be suffering, or likely to suffer, significant harm (see 4.2.1 above).

Munro (2011) sets out a broad view of evidence-based practice within social work of integrating best available evidence, such as that may be, with the social worker's own understanding of the child and family's circumstances and their values and preferences. She points out the role of the social worker's analysis of family strengths and difficulties, particularly in the context of the complexity of a family which may have multiple difficulties affecting parenting capacity**.** It is noteworthy then that outside of the scope of this review there are some non-peer-reviewed reports of the effective use of SFBT in the context of child protection work (see section 1.2 above) (for example Dudley Metropolitan Borough Council, 2006; Turnell, 2010).

It is possible that a social worker may, on the basis of a thorough knowledge and understanding of a particular child and family, consider there to be potential utility of SFBT in those cases where the parent, notwithstanding the degree of severity of problem behaviour, appears to show some areas of relative social, personal or parental competence that may be developed as a 'resource' 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); it is often a short-term intervention. Therefore it is well suited to the work of practitioners with 'voluntary' client groups (for example family support or parent training as part of safeguarding work) to address specific single issue problems. However, statutory social work interventions 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 who are the subject of 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 uses 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 SBC, which includes a case planning framework with safety plans, family objectives and individual objectives (see also Antle et al., 2008).

For the local authority child protection practitioner, the SFBT problem focus needs to be mutually, not unilaterally agreed, and to have some bearing upon their professional concern for the child's welfare. Furthermore, SFBT practice does not emphasise the therapist's analysis of the client's problem areas, whether self-defined or otherwise, which runs counter to an authoritative approach on the part of local authority professionals (Haringey Local Safeguarding Children Board, 2009). For all children in need, ongoing professional assessment of the child's development, welfare and likelihood of harm, is inextricable from all interventions and support being provided. Indeed, Antle et al. (2009) emphasise that their SBC model incorporates SFBT, together with more directly instructional intervention strategies, whilst 'not excluding the assessment of deficit-based criteria for risk' (p.1347), which would relate directly to criteria for significant harm (see also Antle et al., 2008).

In the high-stakes work of protecting children from suffering significant harm it is essential that no approach to intervention or support should compromise the comprehensive and ongoing assessment and interventions to protect these children. Against this background, and with due regard to the place of professional expertise and service user characteristics within evidence-based practice (American Psychological Association, 2006; Munro, 2011), the evidence of this review must balance the findings that:

- it is plausible that in some cases, SFBT may, as part of a comprehensive package of ongoing assessment and intervention, facilitate positive change in parenting where children are considered to suffering or be likely to suffer significant harm, with the finding that
- the evidence on the effectiveness of SFBT is insufficient to provide a mandate for its general use to facilitate positive change in parenting where children are considered to be suffering or likely to suffer significant harm.

To safely balance these findings in the best interests of children suffering significant harm, the use of SFBT by social workers should be subject to local authority governance mechanisms which stipulate the training, supervision, and management requirements for social workers using SFBT. Given the paucity of research evidence on the effectiveness of SFBT in child protection, some local authorities may decide upon governance arrangements to stipulate that SFBT should not be used in cases where a child may be suffering or likely to suffer significant harm. Munro (2011), however, points out the general paucity of intervention evaluation in the UK and additionally this review has found that a significant proportion of the available research evidence on SFBT appears to originate from within a practitioner, rather than commissioned, research setting. Local authority governance mechanisms could provide a safe framework for the development of the evidence on the effectiveness of SFBT by social workers in cases where a child is considered to be likely to suffer significant harm.

Implications for the use of SFBT where children are considered to be likely to suffer significant harm

4.4.1 **Local authority governance:** Where children are considered to be suffering or likely to suffer significant harm, local authority governance should guide social care practitioners' choice and integration of SFBT intervention methods. Such governance should include the provisions for training, supervision and management of SFBT practice within children's social care.

4.4.2 **Research:** 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.

4.5 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?

A first implication of the evidence on the use of SFBT is that, within the context of considerations about evidence-based practice outlined in sections 1.3 and 1.4 above, 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. There may, however, be considerable variation within identified problem types (Kraemer, 2007), reducing the generalisability of research findings within a specific group of a practitioner's clients. In addition, many clients of child and family practitioners may evidence degrees of need in relation to multiple problems (Munro, 2011), which may or may not be identified within the relevant research sample. Furthermore, clients viewed as having similar types of problem may be subject to differing contextual factors and circumstances (for example availability of support from family members; employment status). Therefore, the practitioner's individual child or family case does not fit perfectly with the effectiveness research on specific types of child/ family problems (Miller and Frederickson, 2006; Munro, 2011).

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' (p.92). Munro (2011) conceptualises evidence-based practice as 'drawing on the best available evidence to inform practice at all stages of the work and of integrating that evidence with the social worker's own understanding of the child and family's circumstances and their values and preferences' (para 6.34, p.92). Therefore, research evidence in relation to 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.

Implications for training of staff in children's social care services

4.5.1 **Pre- and post-qualification training:** Practitioner training at pre- and post-qualifying levels, should incorporate the development of knowledge and skills for evidence-based practice so that children's social care practitioners can effectively evaluate and integrate available research with practitioner expertise in the context of service user or client characteristics, culture, and, where appropriate, individual preferences (see 'Munro Review of Child Protection', 2011, recommendation 11, p.12).

It is relevant at this point to consider general issues relating to the governance of therapeutic practice. For example, in considering the competent delivery of cognitive and behavioural therapy, the Department of Health (2007) points out that identifying individuals with the right skills to deliver therapy is not straightforward since there is no single profession of psychological therapist and since those delivering therapy may have different initial and post-qualification training in psychological therapy in general, or in any one particular approach (see section 1.3 above). Therefore, it is more important to identify what competencies are needed to deliver good quality therapy, rather than simply rely upon job title. Furthermore, whilst competences may be identified, potentially relevant criteria, such as the therapist's level of training, or the necessary amount of direct/indirect supervision of therapy, are most often not stipulated or evidenced

(Department of Health, 2007).

Section 4.4 above outlines the rationale for local authority governance of social care practitioners' choice and integration of SFBT intervention methods where children are considered to be suffering, or likely to suffer, significant harm (see 4.4.1 above). The Munro Review of Child Protection 'asks local authorities to take responsibility for deciding the range of services they will offer, defining the knowledge and skills needed and helping workers to develop them' (Munro, 2011, p.8). If a local authority decides to support use of SFBT by its social care staff, it's governance arrangements should stipulate the provisions for both general and specific training, supervision and management for all SFBT practice within children's social care.

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

4.5.2 **Training**: Where SFBT is being used, local authority governance arrangements are advised to stipulate 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 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 (see 4.5.1 above).

4.5.3 **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.

4.5.4 **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.

4.5.5 **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 line 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.

4.5.6 **Management:** As part of regular case review where SFBT is being used, line managers should consult with SFBT case practitioners and their SFBT practice supervisors to evaluate the effectiveness and appropriateness of the SFBT intervention.

4.5.7 **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.

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Appendix 2 – Process description of development of the review coding framework

Version of framework	Action
1-3	The framework was discussed in detail by the review team. Sample studies were coded to establish both the ability of the framework to capture relevant information, and its utility. As a result of this exercise, further detailed categories were added, such as the type and extent of fidelity monitoring used.
4-5	The coding framework was piloted by the review team using four studies that met the inclusion criteria. Of the four studies, two were quantitative, one was qualitative and one used a mixed methods design. The user-friendliness and appropriateness of the framework was assessed through a formative inter-rater reliability exercise. Amendments were made to the framework as a result, for example removing any spurious items and allowing for more open coding for example when identifying the nature of presenting problems.
6	Three research assistants were trained in the use the framework, and they each coded a quantitative and a qualitative study. They provided the review team with feedback, and the coding framework was amended accordingly.
7	The coding framework was turned into an excel database, and the research assistants were provided with standardised guidance notes on how to complete each category. They then coded another two studies (one quantitative, one qualitative) and inter-rater reliability was formally assessed. An overall Cronbach's alpha inter-coder reliability co-efficient of .92 was calculated (with the lowest framework element at alpha value 0.76) indicating very high inter-coder reliability. Where the research assistants differed in their coding, discussions were held until consensus was achieved. As a result of the exercise minor modifications were made to the coding framework and the guidance notes.
8-10	The amended framework was piloted by the research assistants again, who each coded approximately four studies that had been found during the database searches. As a result of this exercise, it was found that three categories were irrelevant to the majority of the studies, and thus they were removed, and an additional category was added to record any important information that may not have been captured by the other categories. Other minor modifications were made.
11	The final version of the framework was used to code the remaining studies.

Appendix 3 – Summary of methods and outcomes for high quality studies

Key for Appendices 3 and 4	
++	Positive SFBT intervention outcome better than control group
+	Positive SFBT intervention outcome no better than control group, or in absence of control group
-	Negative SFBT intervention outcome
0	Neutral SFBT intervention outcome
Best evidence	Study evidenced at least medium level methodological appropriateness for the review

Summary of methods and outcomes for high quality studies				
Research study	**Research design/ methods**	**Focus and target sample country of study**	**Therapeutic methods**	**Outcomes**
Daki, J., & Savage, R. (2010). **++/ 0**	Quantitative Randomised Controlled Trials **Best evidence**	Reading difficulties, motivation and social/ emotional/ behavioural difficulties 7 children, aged 7-14 years Canada	SFBT 5/7 SFBT core components 2/4 SFBT additional components With individual children By school psychology Masters level students	SFBT group showed improvement in attitudes to school and teachers, listening comprehension and reading fluency, and a reduction in anxiety; control group participants showed gains in phonological awareness and spelling skills relative to the intervention group.
Franklin, C., Moore, K., & Hopson, L. (2008). **++**	Quantitative Quasi-experiment **Best evidence**	Classroom behavioural problems 30 children, aged 10-12 years USA	SFBT 5/7 SFBT core components 2/4 SFBT additional components With individual children By Masters level therapists	Child Behavior Check List (CBCL) Teacher Report Form (TRF) showed improvements in both internalising (effect size .61) and externalising child behaviour (effect size 1.4) in the SFBT intervention group, as did the Youth Self Report (YSR) form for externalising behaviour (effect size 0.86).
Green, S., Grant, A., & Rynsaardt, J. (2007). **++**	Quantitative Randomised Controlled Trials **Best evidence**	Hope, hardiness, depression, anxiety and stress 25 young people, aged 14-18, with non-clinical scores on baseline measures	Coaching programme based on a SF and cognitive behavioural framework 2/7 SFBT core components 0/4 SFBT additional components With individual young people. By teachers.	Trait Hope and Cognitive Hardiness Scales both showed significantly greater increases in the coaching group than the control group. Depression, Anxiety and Stress Scale shows significant reduction in depression score not seen in the control group.

		Australia		
Kvarme, L.G., Solvi, H., Sorum, R., Luth-Hansen, V., Haugland, S. & Natvig G.K. (2010). **+/ 0**	Quantitative Quasi experiment **Best evidence**	Socially withdrawn children 144 children aged 12-13 years allocated to control or experimental groups Norway	Solution Focused Approach (SFA) Re-teaming intervention (Furman and Ahola) 6 x 1hour weekly sessions 3/7 core components 1/4 SFBT additional components Groups of 3-7 young people By school nurses	General self-efficacy increased for girls (moderate effect size) post intervention but not for boys. At 3 month follow up general self-efficacy had improved for boys, girls and controls, with more change in the experimental group. The programme had less impact on specific self-efficacy domains.
Lloyd, H. & Dallos, R. (2008). **+/ -**	Qualitative Interviews **Best evidence**	Service users' experiences of initial SFBT sessions 5 mothers of children with moderate/ severe learning disabilities England	SFBT 5/7 SFBT core components 2/4 SFBT additional components With parents By clinical psychologist	SFBT provides useful structure for first session by building therapeutic relationship, self-efficacy and coping styles. Miracle question, however, seen as unhelpful way to consider preferred future.

Appendix 4 - Summary of methods and outcomes for medium quality studies

Summary of methods and outcomes for medium quality studies				
Research study	**Research design/ methods**	**Focus and target sample country of study**	**Therapeutic methods**	**Outcomes**
Adams, J.F., Piercy, F.P. & Jurich, J.A. (1991). **+**	Quantitative RCT **Best evidence**	Impact of initial first session structure on outcomes 60 families, child behaviour problems USA	SFBT for up to 10 sessions. 2/7 core components 1/4 SFBT additional elements Family group By Doctoral therapy students	Families receiving Formula First Session Task (FFST) completed task more readily and were clearer about their goals than those receiving Problem Focused Task. No differences between group outcomes after 10 sessions.
Antle, B.F., Barbee, A.P., Christensen, D.N., & Sullivan, D.J. (2009) **++**	Quantitative Quasi-experiment **Best evidence**	Child maltreatment cases 339 children/ young people, ages unspecified. USA	Solution Based Casework (SBC) drawing upon Solution Focused Family Therapy (SFFT). 2/ 7 SFBT core components 1/ 4 SFBT additional components With family groups/ parents By social workers	SBC group had significantly fewer recidivism referrals for child maltreatment than the comparison group ($p<0001$).
Cepukiene, V. & Pakrosnis, R. (2010). **++/ 0**	Quantitative Quasi experiment **Best evidence**	SF with adolescents in foster homes 92 young people aged 12-18 years Lithuania	Maximum of 5 sessions SFBT 3/7 core components 0/4 SFBT additional Individual By therapists	On the Standardised Interview for the Evaluation of Adolescents' Problems the intervention group reported significant progress in relation to behaviour difficulties compared to controls post intervention. Change was not significant for somatic or cognitive difficulties.
Conoley, C.W.,	Quantitative	Aggressive and	4-5 sessions of SF family therapy	By end of 4-5 sessions all 3 families that had

Graham, J.M., Neu, T., Craig, M.C., O'Pry, A., Cardin, S.A., Brossart, A.F. & Parker, R.I. (2003). **+**	Single case experiment **Best evidence**	oppositional behaviour 4 children aged 8-9 years USA	5/7 core components 3/4 SFBT additional components With families Doctoral students with 6 or more months SF experience	met inclusion criteria felt issues that had lead to seeking therapy had been resolved. Parent Daily Report, Behaviour Assessment System for Children (BASC) scores, teacher and family reports corroborated this. At follow up one family requested further therapy.
Cook, D.R. (1998). **0**	Quantitative Quasi experimental **Best evidence**	Self concept 68 7-10 year olds allocated to experimental/ control group USA	SF intervention, 5-6 weeks 4/7 core components 2/4 SFBT additional elements Group	On Piers-Harris Self Concept Inventory no significant difference between experimental and control groups pre-post and no significant change in scores for either group.
Corcoran, J. & Franklin, C. (1998). **+**	Qualitative Case Study **Best evidence**	Child abuse case Parent (non-voluntary) and 13 year old juvenile offender USA	2 sessions SF therapy with young person and 1 with parent 3/7 core components 1/4 SFBT additional components. Individual session(s) with parent and young person Experienced practitioner (author)	Young person reported physical abuse had stopped and his suicidal ideation had ceased.
Corcoran, J. & Stephenson, M. (2000). **+/ - / 0**	Quantitative Single group phase change	Behaviour problems (externalising) 56 parents and children. Children aged 5-17 years.	Solution focused therapy. 4-6 sessions. 4/7 core components 0/4 SFBT additional elements Family group.	59% drop out rate. Feelings Attitudes and Behaviour Scale for Children (FAB-C) showed improved self image scores at post test but unexpected increase in conduct problems and no change in lying, worrying, negative peer relations and anti-social attitudes. Conners Parent Rating

	Best evidence	USA	By masters level social work students	Scale at post test showed significant positive change in all areas except anxiety.
Emanuel, C. (2008). +	Qualitative Semi-structured interviews **Best evidence**	Anger problems 5 children aged 7-10 years England	SF group intervention, 8 weeks 5/7 core components 1/4 SFBT additional elements Group. School counsellor	Reduction of aggression, higher self esteem, higher self perception reported by children and noticed by parents, less by teachers.
Enea, V. & Dafinoiu, I (2009). ++	Quantitative RCT **Best evidence**	SF and motivational techniques to decrease truancy 38 14-18 year olds (treatment or control) Romania	Less than 7 weekly 1 hour sessions 5/7 core components 2/4 SFBT additional elements Individual	Significant decrease in truancy rates for experimental but not control group.
Franklin, C., Biever, J., Moore, K., Clemons, D. & Scamardo, M. (2001). +	Quantitative Single case experiment **Best evidence**	learning disabilities and classroom behaviour problems 7 children aged 10-13 years USA	5-10 sessions SF therapy 4/7 core components 1/4 SFBT additional components Individual sessions Doctoral students, 3yrs or more clinical practice	Positive changes in 5/7 cases. At least one of two teacher raters indicating positive changes on at least one subscale of the Conners Teacher Rating Scale.
Frels, R., Leggett, E. S., & Larocca, P. (2009). +	Qualitative Case Study **Best**	Hospitalised child 7 year old girl USA	Creative SF sessions enabled child to manage pain and envisage preferred future 4/7 core components	Author reports improved coping skills of child following intervention.

	evidence		0/4 SFBT additional elements Family group By counselling intern	
Froeschle, J.G, Smith, R.L., Ricard, R. (2007). **++/ 0**	Quantitative Quasi experiment	School based drug prevention programme 80 girls aged 13-14 years old USA	SFBT and action learning theory 1 hour for 16 weeks 0/7 core components 0/4 SFBT additional elements Group programme By school counsellor	Decreased drug use in intervention group. Significant difference between intervention group and controls on 5/8 assessed domains.
Geil, M. (1998). **0**	Quantitative Single case experimental **Best evidence**	SF, behavioural and no consultation model comparison 8 young people with externalising behaviour problems (3 in SF group) USA	3-4 weeks consultation with teachers only 3/7 core components 1/4 SFBT additional elements Teachers By school psychologists	Code for Instructional Structure and Student Academic Response (CISSAR) indicated mixed results. Researcher concluded no consistent difference in behaviour across the 3 conditions. Behavioural slightly more impact on behaviour and SF slightly more impact on environment.
Georgiades (2008) **+**	Quantitative Single case **Best evidence**	Witness and victim of domestic abuse One, 13 year old Greece	4-year evaluation of an empowerment and SF correspondence intervention 2/7 core components 0/7 SFBT additional Individual intervention By therapist	Child Attitude Towards Father Scale (CAF), Depression Self Rating Scale (DSR) and Child Report of Posttraumatic Symptoms (CROPS) showed pattern of response to traumatic events with eventual decline in symptoms post intervention.
Grandison, P.	Qualitative	Shy, anxious	6 sessions EMDR within SF	All children reported increased confidence.

(2007). +	Interviews **Best evidence**	children 5 children aged 9-11 years UK	framework 4/7 core components 2/4 SFBT additional Group intervention By educational psychologist	Teacher and parent interviews confirmed this.
Hurn, R. (2006). +	Qualitative Case study **Best evidence**	Behaviour problems (externalising) 9 year old boy UK	SF board game intervention alongside family work 4/7 core components 0/4 SFBT additional Individual/family	Positive reports from parent and child at end of intervention.
Jordan, K. & Quinn, W.H. (1994). **0**	Quantitative RCT	Service users experiences of 2 SFBT sessions 37 adults and 3 children age 10-16 years USA	2 session comparison of SF vs problem focused first session therapy 3/7 core components 0/4 SFBT additional Individual/couple/family sessions By doctoral level counselling students	High adherence to session protocols. No significant differences between the two treatment approaches overall, but some differences indicate utility of different approaches for different client groups.
Korman, H. (1997). +	Qualitative Case study **Best evidence**	Psychosomatic presentation 11 year old girl Sweden	SFBT 4/7 core components 3/4 SFBT additional Child and mother By psychiatrist	Young person able to walk again and no problems reported a year later.

Kowalski, K. (1990). **+**	Qualitative Case study **Best evidence**	Concentration and cooperation in class 12 year old girl USA	SFBT, 4 sessions 5/7 core components 3/4 SFBT additional Young person/mother/father	At end of therapy parent and young person reporting problems resolved and mother reporting resolution continuing 5 weeks later.
Lam, C. & Yuen, M. (2008). **0**	Qualitative Case study **Best evidence**	Disruptive classroom behaviour 1 child aged 6 years Hong Kong	4 x 20 minute weekly sessions of SF 6/7 core components 0/4 SFBT additional With child By teacher	Progress towards goals noted by deliverer, no formal evaluation.
McCallum, Z., Wake, M., Gerner, B., Harris, C., Gibbons, K., Gunn, J., Waters, E. & Baur, L. (2005). **0**	Quantitative RCT	Training of GPs in LEAP and BMI trial 163 Obese 5-9 year olds (in experimental or control group) Australia	4 SF and education sessions over 12 weeks 4/7 core components 2/4 SFBT additional Family By GP	Part of wider study and outcome data limited. GPs were positive about the programme and how it could support them in managing children's weight. Attendance of families for intervention also 63% for 3 of 4 sessions.
Moore. K. (2002). **+**	Quantitative Quasi experimental **Best evidence**	Classroom behaviour 59 10-12 year olds allocated to control and experimental groups USA	5-6 SF sessions and staff training 4/7 core components 3/4 SFBT additional elements Individual Doctoral level students	On Achenbach experimental group showed significant improvement for externalizing on pupil report and significant improvement on teacher report for internalizing and externalizing. Children started above clinical cut off levels.

Murphy, J, & Davis, M. (2005). **+**	Quantitative Single case experiment **Best evidence**	Developmental difficulties/ hearing impairment 9 year old child USA	Combined SF and behavioural modelling approaches. Positive video examples used daily for 5 days 2/7 core components 0/4 SFBT additional Individual sessions Doctorate counsellor and psychologist	Significant increase in target behaviour (signing). Child and teacher also provided positive reports.
Newsome (2005) **+**	Quantitative Quasi experimental pre-test post-test **Best evidence**	children at risk of academic and attendance problems 26 children 11-13 year	SF group programme 7-8 weeks 5/7 core components 1/4 SFBT additional Group Graduate students, doctoral student and social worker	Statistically significant group improvement on Homework Problem Checklist, Behavioural and Emotion Rating Scale and Social Skills Rating System from pre to post
Seagram, B. (1997). **+/ 0**	Quantitative RCT **Best evidence**	SF with secure custody young offenders 40 young people (treatment or control group) USA	SF >7 sessions 5/7 core components 0/4 SFBT additional elements Individual Author	Jesness Behaviour Checklist: Recidivism Scales – trend towards greater anger control, less chemical abuse and more optimism in SF group post. Control group more progress in problem solving. No significant changes on teacher report and no significant difference in reoffending rates at 6 months.
Shin, S-K. (2009). **++**	Quantitative RCT **Best**	Aggression and social adjustment in juvenile delinquents 40 young people	6 weekly SF sessions of 2 hours 2/7 core components 0/4 SFBT additional	Buss-Durkey Hostility Inventory (B-DHI) showed significant decrease in aggression for intervention group and also significant improvement on researchers social adjustment scale.

	evidence	(average age 17yrs) on probation for 1 year or more Korea	Group sessions By clinical social workers	
Smyrnios, K.X. & Kirkby, R.J. (1993). **+/ 0**	Quantitative RCT **Best evidence**	Comparison of minimal contact, brief and time unlimited therapy for children with emotional problems 30 children aged 5-9 years and parents USA	Brief therapy for 12 or less sessions 3/7 core components 0/4 SFBT additional Family group By therapists (authors)	Pre-post treatment all groups showed progress on Goal Attainment Scaling (GAS) and Target Complaints Scales (TCS). At 4 year follow up all groups significantly improved on GAS but only minimal contact significantly improved on TCS.
Springer, D.W., Lynch. C. & Rubin, A.R. (2000). **++**	Quantitative Quasi experiment **Best evidence**	Children of incarcerated parents 10 Hispanic/American children aged 7-10 years USA	Combination of SF, interactional and mutual aid approaches 3/7 core components 0/4 SFBT additional components 6 group sessions By social work practitioners/academics (authors)	On the Hare Self-Esteem Scale the 5 children in the experimental group showed significant progress compared to 5 control group children. Moderate effect size .57.
Thompson, R. & Littrell, J. M. (1998). **+**	Quantitative Single group phase change **Best evidence**	Adolescents with learning disabilities 12 young people 16-18 years. USA	4-step Solution Oriented brief counselling. 3-4 sessions 4/7 core components 0/4 SFBT additional elements Individual sessions By counsellor with Masters in brief	Counsellor Rating Form (CRF) Students perceived the counselor as having a high degreee of expertness, trustworthiness and interpersonal attractiveness. All but one made progress towards goals and 90-100% achieved. All reported more positive affect and cognition.

			therapy	
Triantafillou, N. (2002). **0**	Mixed methods Quasi experiment / interview **Best evidence**	SF with foster parents to reduce behavioural difficulties 30 young people (treatment or control) Canada	5-6 weeks SF 5/7 core components 2/4 SFBT additional elements Group programme Therapists	Serious incident reports higher for experimental than control group at post-test but not significant difference.
Vostanis, P., Anderson, L. & Window, S (2006). **0/ +**	Quantitative Quasi experiment **Best evidence**	Service delivery models for children with behaviour problems 140 families UK	Solution focused therapy family support 4/7 core components 1/4 SFBT additional elements Home visits by family support teams	Family support groups and controls all showed decrease in child behaviour problems. Family support interventions offered earlier response and significant improvement on SDQ (Strengths and Difficulties Questionnaire) and HoNSCA (Health of the Nation Outcome Scales)
Wake, M., Buar, L.A., Gerner, B., Gibbons, K., Gold, L., Gunn, J., Leviekis, P., McCallum, Z., Naughton, G., Sanci, L. & Okoumunne, O.C. (2009). **0**	Quantitative RCT	Overweight and mildly obese children 258 children aged 5-11 years allocated to control/exp groups Australia	4 consultations over 12 weeks using SF and stages of change models 1/7 core components 0/4 SFBT additional elements Child and parent By GPs	Primary care screening plus brief counselling did not improve BMI, physical activity or nutrition of intervention group. No significant differences between experimental and control groups.
Wilmshurst, L. (2002).	Quantitative	Children at risk	SFBT residential and home-based.	For the SFBT group, externalising difficulties and behaviour difficulties decreased

+	Randomised Controlled Trials **Best evidence**	27 young people, average age 11 years, and their families. USA	4/7 SFBT core components 1/4 SFBT additional components With family groups. By variety of child/ youth specialists	significantly, but no more than the control group. Similarly, social competence improved significantly, but not significantly more than did that for the control group.
Window, S., Richards, M., & Vostanis, P. (2004). +	Qualitative Post intervention interviews **Best evidence**	Wide range of referral concerns 100 parents 22 children aged 5-12 years UK	6-8 sessions of SF combined with behavioural techniques 4/7 core components 3/4 SFBT additional With families By family support workers	Most improvement reported in school and child problem behaviour domains. Emotional or peer problems reported as less likely to be resolved. 44% reported behaviour management advice was most useful component.
Yarborough. J. & Thompson, C. (2002). +	Quantitative RCT **Best evidence**	Use of SF/RT for primary aged children displaying off task behaviour Two 7-10 year olds USA	5-6 sessions SF or Reality Therapy 5/7 core components 2/4 SFBT additional elements Individual Researcher	Both children achieving tasks and GAS scores over 50 by sessions 3-4. RT slightly more effective.
Ziffer, J., Crawford, E.,& Penney-Wietor, J. (2007). +	Qualitative Interviews **Best evidence**	Families experiencing divorce 5 families with parent group and children's groups of 5x 3-7 year olds and 7x 8-11 year olds USA	SFBT 3/7 core components 3/4 SFBT additional elements Group programme By family therapists and 1 school counsellors	Interviews 3 years post programme. All parents reported positive impact.

Zimmerman, T.S., Jacobsen, R.B., MacIntyre, M. & Watson, C. (1996). **+/ 0**	Quantitative RCT **Best evidence**	Adolescent problem behaviour defined by parent self-referral 42 parents of adolescents USA	Family Strength Programme. 6 week programme, half hour sessions 4/7 core components 1/4 SFBT additional elements Parent group By graduate students	Drop out rate from control group 18/30. Parenting Skills Inventory showed 4/8 significant positive subscale differences between intervention and control groups at post-test. Family Strengths Assessment no significant differences between intervention and control groups at post-test.

Appendix 5 – SFBT process elements reported in high quality studies

Key for Appendices 5 and 6

++	Positive SFBT intervention outcome better than control group
+	Positive SFBT intervention outcome no better than control group, or in absence of control group
-	Negative SFBT intervention outcome
0	Neutral SFBT intervention outcome
*****	SFBT component present in the intervention
Best evidence	Study evidenced at least medium level methodological appropriateness for the review

Appendix 5 – SFBT process elements reported in high quality studies

Research study	Study Outcome	SFBT components											
		Pre-treatment change	Miracle/ preferred futures question	Coping question	Scaling questions	Looking for strengths/ solutions	Exceptions to the problem	Client goal setting	Evaluation of client potential for change	Consultation break	Giving compliments	Home-work tasks	Fidelity monitoring
Daki & Savage (2010) ***Best evidence***	**++ / 0**		*	*	*	*	*				*	*	Not reported
Franklin et al. (2008) ***Best evidence***	**++**		*	*	*	*	*			*		*	Full (by video analysis)
Green et al. (2007) ***Best evidence***	**++**					*		*					Not reported
Kvarme, et al. (2010). ***Best evidence***	**0/+**		*		*			*				*	Partial (by supervisio n)
Lloyd & Dallos (2008) ***Best evidence***	**+ / -**		*		*	*	*	*			*	*	Partial (by transcript analysis)
		Pre-treatment change	Miracle/ preferred futures question	Coping question	Scaling questions	Looking for strengths/ solutions	Exceptions to the problem	Client goal setting	Evaluation of client potential for change	Consultation break	Giving compliments	Home-work tasks	Fidelity monitoring
Total		**0**	**4**	**2**	**4**	**4**	**3**	**3**	**0**	**1**	**2**	**4**	**3/5**

												partial or full

Appendix 6 - SFBT process elements reported in medium quality studies

Table 3.7 – SFBT therapeutic process elements reported in medium quality studies

Research study	Study outcome	SFBT component											
		Pre-treatment change	Miracle/ preferred futures question	Coping question	Scaling question	Looking for strengths/ solutions	Exceptions to the problem	Client goal setting	Evaluation of client potential for change	Consultation break	Giving compliments	Home-work tasks	Fidelity monitoring
Adams, Piercy & Jurich (1991). ***Best evidence***	+					*	*					*	Partial (by video)
Antle et al. (2009). ***Best evidence***	++					*		*			*		Not reported
Cepukiene & Pakrosnis (2010). ***Best evidence***	++/0		*		*		*						Partial (by manual)
Conoley et al. (2003). ***Best evidence***	+		*		*	*	*			*	*	*	Full (by supervision)
Cook (1998). ***Best evidence***	0		*		*		*	*			*	*	None

Corcoran and Franklin (1998). ***Best evidence***	+					*	*	*			*		None
Corcoran& Stephenson (2000). ***Best evidence***	+/-/0		*		*		*	*					Partial (by video and supervision)
Emanuel (2008). ***Best evidence***	+		*		*	*	*	*			*		None
Enea & Dafinoiu (2009). ***Best evidence***	++		*		*	*	*	*			*	*	None
Franklin et al. (2001). ***Best evidence***	+		*		*	*	*					*	Full (by video)
Frels, Leggett & Larocca (2009). ***Best evidence***	+		*	*	*		*						Full (by supervision)
Froeschle, Smith & Ricard. (2007).	++/0												None
Geil (1998). ***Best***	0					*	*	*				*	Partial (by supervision)

evidence													
Georgiades (2008) ***Best evidence***	+			*		*							None
Grandison (2007). ***Best evidence***	+		*		*	*		*			*	*	None
Hurn (2006). ***Best evidence***	+		*		*	*		*			*		None
Jordan & Quinn (1994).	**0**		*			*	*						Full (by video and supervision)
Korman, (1997). ***Best evidence***	+		*		*	*		*		*	*	*	None
Kowalski (1990). ***Best evidence***	+		*		*	*	*	*			*	*	None
Lam & Yuen (2008). ***Best evidence***	**0**		*	*	*	*	*	*					None
McCallum et al. (2005).	**0**		*			*	*	*			*	*	None
Moore (2002). ***Best evidence***	+		*	*	*		*			*	*	*	Partial (by co-worker)

Murphy & Davis (2005). ***Best evidence***	+					*	*						None
Newsome (2005) ***Best evidence***	+		*		*	*	*	*				*	None
Seagram (1997). ***Best evidence***	**+/0**		*		*	*	*	*					Full protocol
Shin (2009). ***Best evidence***	++					*		*					Full (by co-worker)
Smyrnios& Kirkby (1993). ***Best evidence***	**+/0**			*		*		*					None
Springer et al. (2000). ***Best evidence***	++		*		*			*					None
Thompson & Littrell (1998). ***Best evidence***	+		*			*	*	*					None
Trianta-fillou et al. (2002). ***Best evidence***	**0**		*		*	*	*	*			*	*	Partial (by co-worker)

Vostanis, Anderson & Window (2006). ***Best evidence***	**0/+**		*	*		*		*	*				Full (by supervision)
Wake et al. (2009).	**0**					*		*					None
Wilmshurst (2002) ***Best evidence***	+		*	*	*	*						*	Partial (by manual and case notes)
Window et al. (2004). ***Best evidence***	+			*		*	*	*			*	*	None
Yar-borough & Thompson (2003). ***Best evidence***	+		*		*	*	*	*			*	*	Full (by video)
Ziffer, Crawford & Penney-Wietor, (2007). ***Best evidence***	+	*				*		*	*		*	*	None
Zimmer-man, Jacobsen, MacIntyre & Watson (1996). ***Best evidence***	**+/0**					*		*				*	None

		Pre-treatment change	Miracle/ preferred futures question	Coping question	Scaling questions	Looking for strengths/ solutions	Exceptions to the problem	Client goal setting	Evaluation of client potential for change	Consultation break	Giving compliments	Home-work tasks	Fidelity monitoring
Total		**1**	**24**	**8**	**20**	**30**	**23**	**26**	**2**	**3**	**16**	**18**	**15/37 partial or full**

Appendix 7 - Summary of methods and outcomes for low quality studies

Table 3.8 – Summary of methods and outcomes for low quality studies			
Externalising behaviour			
Focus	**Method/aim**	**Sample**	**Outcome**
Watkins & Kurtz (2001).	Mixed SF to reduce problem behaviours	One, 8 year old boy	Positive teacher report during intervention . Re-referred one year later. Overall outcome **+/0**
Allison, Roeger, Dadds & Martin (2000).	Quantitative SF with emotional and behavioural difficulties	55 children (average 9yrs). Moderately severe emotional and behavioural problems	Moderate improvements on Child Behaviour Checklist at post-test. Overall outcome **+**
Banks (1999).	Mixed SF to reduce bullying	8, 11-13 year olds identified as bullies in group intervention	Class reports of bullying decreased by 50% and only 2/8 still identified as bullies. Overall outcome **+**
Young & Holdorf (2003).	Quantitative SF as part of Anti-bullying project	92 children being bullied at school	92% progress on rating scales. Overall outcome **+**
Burns & Hulusi (2005).	Qualitative Establishing centre for social and emotional learning using SF	4, 11-16 year olds referred for challenging behaviour.	All pupils gave positive reports of the group and their progress towards goals. Overall outcome **+**
Houlston (2009).	Mixed methods Evaluation of 1:1 peer counselling intervention to reduce bullying	Y7-8 group recipients and Y10 group counsellors	No significant changes in outcome measures. Overall outcome **0**
Atkinson &Amesu (2007).	Qualitative Use of SF and motivational interviewing to improve behaviour and attendance	1, 11-13year old received 1 session of SF/MI and school interventions	Teacher and parent reported behaviour and attendance improved. Overall outcome **+**
Wheeler, J. (1995).	Quantitative	73, of which 34 had	Significant reduction in withdrawal with

	Psychiatric social workers evaluation of SF with caseload of young people with behaviour difficulties	received SF intervention	outcome unknown, less referral to other services and high satisfaction reported. Overall outcome +
Corcoran (2006).	Quantitative Children with school behaviour problems	239 children 5-17 years allocated to intervention or treatment as usual groups	High drop-out, 85 families completed programme. No significant differences between SF and comparison groups. Both made progress on parent and child reports. Overall outcome 0/+
Demmons (2003).	Mixed methods Effectiveness of SF with primary school children (range of presenting needs)	5 x 9-11 year olds received the intervention	On the Behaviour Assessment Scale for Children (BASC) 3 children showed statistically significant improvement, but no improvement on parent and teacher scales. All children reported goal attainment. Overall outcome +/0
Mental health			
Focus	**Method/aim**	**Sample**	**Outcome**
Worrall-Davies, Cottrell & Benson (2004).	Quantitative Effectiveness of SF in Tier 2 to Tier 3 referrals	149 young people	High drop-out rate. 75/92 completers showed significant reduction in HoNSCA scores especially social/ behaviour scales. Overall outcome +
Selekman & King (2001).	Quantitative SF effectiveness with self-harm	1 young person and family	Therapist observed changes in self-harming behaviour. Overall outcome +
Pakrosnis (2008).	Quantitative SF and mental health	51, 14-18 year olds who completed intervention.	High drop out rate. No clear results on researcher devised measures. Intervention group reported significant decrease in severity of problems. Overall outcome **0/+**
Kvarme, Eboh, Tejlingen & Love (2008).	Qualitative Training school nurses to use SF with children who had been bullied	1, 11-13 year old and 5 friends	Group continued until young person said she was happier and had friends. Overall outcome +
Gostautas, Cepukiene, Pakrosnis &	Young people in foster care	133, 12-18 year olds (SF or	Therapist rated 86% improvement in problem

Fleming (2005).	or attending 2 health institutions.	control group)	solving skills. Problem severity reporting significantly reduced in SF group.
Perkins (2006).	Quantitative SF effect on mental health difficulties	216, 5-15 year olds (allocated to treatment or control groups)	Devereaux Scales. Parent reported significant improvement for SF group. Teachers less change as low level of concern initially. Overall outcome +
School attendance/ achievement			
Focus	**Method/aim**	**Sample**	**Outcome**
Newsome (2004).	Quantitative Use of SF to improve Grade Point Average of at risk students	52, 11-13 year olds allocated to intervention and control groups	SF intervention improved GPA but not attendance. Overall **+/0**
Cook & Kaffenberger (2003).	Quantitative SF to improve academic outcomes	35, 11-17 year olds with falling grades/economic disadvantage	Just over half improved their Grade Point Average post intervention. Overall outcome **+/0**
Franklin, Streeter, Kim & Tripodi. (2007).	Quantitative SF drop out prevention programme	46, 14-18 year old young people allocated to control/intervention groups	Higher graduation rate in control group, grades and credits higher in intervention group. Overall outcome **0**
Yarborough, J.L (2004).	Quantitative SF to improve assignment completion in underachieving pupils	6, 10-11 year olds received 5-6 weeks of individual work	Work completion rates improved in all cases. Overall outcome **+**
Leggett, M.E.S. (2004).	Quantitative SF to improve achievement	67, 7-10 year olds treatment group received 8 weeks solution focused group counselling	No significant differences on Hope scales for treatment and controls at post test. Teachers and students in treatment group did rate environment more positively. Overall outcome **0/+**
Family problems			
Focus	**Method/aim**	**Sample**	**Outcome**
Sudman (1997).	Quantitative	382 families and single	Mixed results.

	Use of SF to improve social worker and family relationships	people	Overall outcome **0**
Lee (1997).	Quantitative Effectiveness of SF based on client report	59 children (4-17 years) and families	64.9% reported success rate with range of presenting problems. Overall outcome +
Williams (2000).	Qualitative Use of SF in school	1 family - parents and 2 children	Parental relationship improved. Overall outcome +
Forrester, Copello, Waissbein, & Pokhrel (2008).	Mixed Improve family functioning and reduce need to enter care	279, 11-13 year olds on child protection register/plan allocated to intervention or control groups MI and SF family intervention	Intervention did significantly not reduce likelihood of entering care, or number of days in care. Did take longer to enter care. Significant cost savings. Overall outcome **0**
Lee & Mjelde-Mossey (2004).	Qualitative SF intervention to reduce generational conflict	1 family	Authors report increased family harmony through use of SF Overall outcome +
Brown & Dillenberger (2004).	Quantitative Effectiveness of Sure Start SF and parent behaviour programme	10 children under 4 years and parents in 5 families Social services involvement.	Some children improved on Child Behaviour Checklist and some reports of improved parenting but not in all cases. Overall outcome **0**
Ventura, D. (2010).	Quantitative Review of families that had received SF for problem child behaviour	56 families	Session rating scales showed significant improvement. Child discipline reports decreased pre to post-test. Overall outcome +
Marianaccio, B.C. (2001)	Quantitative School based family therapy project	60 mothers, 60 teachers, 48 children SF with family group for 3-4 sessions	Students did not report increased positive perceptions of self but teachers and parents did. Significant difference between control and treatment groups. Overall outcome **0**/+
Shennan, G. (2003).	Mixed Families receiving SFBT	101 of 415 families followed up after 3-4 family group sessions. Presenting problems not specified	81% of parents reported improvement and 75% improved coping at post-test. Overall outcome +

Simm, Andrew, Brogan & Slinger (2010).	Mixed Audit of SF practice with families by clinical psychologists	14 families with 5-16 year old children, wide range of presenting problems	SDQ only significant change at post-test on impact category. 64% of parents reported improvement. Overall outcome **0**/+
Abuse			
Focus	**Method/aim**	**Sample**	**Outcome**
Antle, Barbee, Christensen & Martin (2008).	Quantitative	Study 1: 48 families allocated to Solution Based Casework (SBC), intervention or control. Study 2: 100 families allocated to intervention or control.	A wide range of outcome measures were used. Intervention groups showed higher levels of compliance and higher levels of case planning. Workers delivering the SBC intervention took less legal action and were less likely to remove a child from the family. The effect size for family goal achievement in the intervention groups was large in both studies. The model was effective across a range of categories of abuse and was particularly effective for families with a history of child protection concerns. Overall outcome: ++
Kruczek & Vitanza (1999).	Quantitative Effectiveness of SF group intervention	41, 14-18 year old girls	SF Recovery Scale for Survivors of Sexual Abuse showed adaptive functioning increase at post-test and follow up. Overall outcome +
Care placement			
Focus	**Method/aim**	**Sample**	**Outcome**
Koob & Love (2010).	Quantitative Comparison of SF and CBT in improving foster placement stability	31 (11-13 year olds)	Failed placements decreased for intervention group. Overall outcome +
Myers (2006).	Qualitative SF with LAC young person displaying	1, 14-18 year old	Went from 9-2 on GAS. Behaviour improved and problem touching resolved. Overall outcome +

	sexually harmful behaviours		
Physical health			
Focus	**Method/aim**	**Sample**	**Outcome**
Viner, Taylor & Hey (2003).	Quantitative SF and motivational interviewing intervention	77 diabetic children, 11-17 years	Significant improvements in self-efficacy and blood sugar levels for intervention group. Overall outcome **+**
Nowicka et al (2007).	Quantitative SF and systemic family therapy	44 obese children 6-17 years and parents	Self-esteem on 'I think I am' and family functioning on Family Climate Scale improved. BMI decreased post intervention. Overall outcome +
Other			
Focus	**Method/aim**	**Sample**	**Outcome**
Littrell, Malia & Vanderwood (1995).	Quantitative Comparison of single sessions of SF counselling and 2 other approaches	61 young people allocated to each of 3 interventions Mostly academic concerns	All 3 approaches equally effective in enabling achievement of goals. SF quicker. Overall outcome **0/+**
Taylor, Wright & Cole (2010).	Quantitative Community Counsellors SFBT service delivery evaluation	554 children and adults	Client satisfaction questionnaire 98%. Overall outcome **+**
Coyle, Doherty & Sharry (2009).	Mixed SF game to increase client engagement	22 children aged 11-13 years (range of presenting difficulties)	Positive questionnaire feedback from 5/22 clients and 19/22 therapists. Overall +
Perkins (2008).	Quantitative Mode of delivery of SF effects after 18 months	72 children aged 5-15 years	50% drop out rate. Mean group improvements maintained irrespective of intervention type. Overall outcome 0
LaFountain & Garner (1996).	Evaluate SFBT training workshop	311 children control and experimental groups	Significant differences between control and experimental groups. 81% of experimental group achieved goal.

			Overall +

Appendix 8 – Notional tariff for calculation of direct costs of SFBT intervention in five high quality studies

Appendix 8 – Notional tariff[4] for calculation of direct costs of SFBT intervention in five high quality studies	
Costs for trainer or bought-in therapist	£40 per hour or £300 per day
Costs for externally attended three day training course	£450 (£150 per day) + £250 expenses per therapist
Costs for in-house therapist	£22 per hour or £165 per day
Supervision costs (one hour supervision time for four hours of therapy)	£22 per hour

[4] Notional hourly and daily rates within the tariff were derived from the reviewers' knowledge of Children's Service commissioning rates within Greater Manchester. Transparency of calculation in Appendix 9 allows notional rates to be substituted for locally relevant values.

Appendix 9 – Estimated unit costs of benefits of five best evidence high quality studies

Appendix 9 – Estimated unit costs of benefits of five best evidence high quality studies					
Best evidence high quality study	**Outcomes**	**Therapy training costs***	**Therapy direct costs***	**Supervision costs***	**Total unit cost**
Daki, J., & Savage, R. (2010). Solution-focused brief therapy: impacts on academic and emotional difficulties, *Journal of Educational Research,103*(5), 309-326.	++/ - SFBT intervention group showed gains on the control group in 26 out of 38 academic and emotional competence measures Control group showed gains on the intervention group on 10 out of 38 measures SFBT group showed larger effect sizes than the control group	**Time E** **Cost E** Attended the 2007 Conference on Solution-Focused Practices in Toronto £300+£250 expenses = £550 x 1(therapist)/7 (units)= **£79**	**Time S** **Cost E** Therapy delivered individually to 7 children. Average of 4 hours of therapy per child £22 x 4 = **£88**	**Time E** **Cost E** £22 x 1hr per four hours = **£22**	**£255**
Franklin, C., Moore, K., & Hopson, L. (2008). effectiveness of solution focused brief therapy in a school setting, *Children and Schools, 30*(1), 15-26.	++ Improvements on child behaviour checklist compared with a control group	**Time S** **Cost E** 30 children per therapist £1200/ 30 = **£40**	**Time S** **Cost E** Average 3.5 hours individual therapy per child Estimated as £22 x 3.5hrs = **£77** Plus a teacher training session + teacher consultations = £22 x 5 + £22 x 8/ 30 + £22 x 1 = £198/ 30 = **£138**	**Time E** **Cost E** 0.9hrs x £22 = **£20**	**£275**
Green, S., Grant, A., & Rynsaardt, J. (2007). Evidence-based life coaching for senior high school students: building hardiness and hope,	++ Significant increases in hope and cognitive hardiness in the solution-focused coaching group, but not in the control group Significant decreases in depression in the solution-	**Time E** **Cost E** 10 therapists. Each therapist saw approximately 3 children	**Time E** **Cost E** Therapy delivered individually to children. Average 7 hours per child	**Time E** **Cost E** 1.75 hrs x £22 = **£39**	**£426**

International Coaching and Psychology Review 2(1), 24-32	focused coaching group, but not in the control group	£450 + £250 = £700/ 3 = **£233**	£22 x 7 = **£154**		
Kvarme, L.G., Solvi, H., Sorum, R., Luth-Hansen, V., Haugland, S. & Natvig, G.K. (2010). The effect of a solution-focused approach to improve self-efficacy in socially withdrawn school children: a non-randomized controlled trial. *International journal of nursing studies*, *47*(11), 1389-96.	**+/ 0** Moderate size increase in general self-efficacy for girls post-intervention. Increase in self-efficacy for boys, girls and controls at 3 month follow-up, but with greater increase in experimental group	**Time E** **Cost E** Each therapist worked with a group of 6 children. £450 + £250 = £700/ 6 = **£116.67**	**Time S** **Cost E** 6 one hour therapy sessions delivered in groups to children Estimate average 1 hour per child. £22 x 6hrs/ 6 children = **£22**	**Time E** **Cost E** **1.6** hrs x £22 = £33/ 6 = **£5.50**	**£144.17**
Lloyd, H. & Dallos, R. (2008). First session solution-focused brief therapy with families who have a child with severe learning disabilities: mothers' experiences and views, *Journal of Family Therapy*, *30*(1), 5-28	**+/ -** The experiences of mothers suggest that SFBT is a useful structure for initial therapy sessions, particularly as it seems to build a useful therapeutic relationship, highlights self-efficacy and may encourage helpful coping styles The miracle question was perceived as irrelevant by the mothers, and was the most frequently cited unhelpful event	**Time S** **Cost E** 1 therapist saw 5 clients Advanced training from BT practice (£300 per course + £250 expenses) = £550 /5 = **£110**	**Time S** **Cost E** Therapy delivered in family groups 1 hour per family £22 x 1 = **£22**	**Time E** **Cost E** 1hr / 4 = £22/ 4 = **£5.50**	**£137.50**

Appendix 10 – SFBT outcome, mode of delivery and area of focus across the review's best evidence studies

Key for Appendix 10	
++	Positive SFBT intervention outcome better than control group
+	Positive SFBT intervention outcome no better than control group, or in absence of control group
-	Negative SFBT intervention outcome
0	Neutral SFBT intervention outcome

Appendix 10 - SFBT outcome, mode of delivery and area of focus across the review's best evidence studies					
Focus area	**Mode of delivery**				
	Individual CYP[5]	**Group CYP**	**Family group**	**Parents**	**Teachers**
Externalising behaviour difficulties	++/++/++ +/+/+/+/+ **0/ 0**	++ +/+	+/+/+/+/+/+/+ **00** **-**	+ **00**	**0**
Internalising behaviour difficulty	++/++ + **0**	++ +/+ **0**	+/+/+ **0**		
Reducing recurrence of child maltreatment			++	+	
Providing a supportive structure for first sessions with parents			+/+ **-**		
Improving listening comprehension and reading fluency	++				
Improving family coping in divorce		+[6]			
Functional improvements re developmental difficulties	+/+				

[5] 'CYP' denotes 'children and/ or young people

[6] Intervention was with CYP group in tandem with a separate parents' group

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