Unleashing the solution-focused power of the Ormskirk Model by minding your language

Dominic Bray, Mark Guyers, Sze May Ng

A solution-focused approach engages and motivates patients and their families, resulting in positive clinical outcomes and better healthcare professional–patient interactions. It requires a change in language used by healthcare professionals, however, which can be a challenge for some when it comes to turning worthy principles into day-to-day practice. This article provides grounded, real-life examples illustrating how to 'speak solution-focused' and outlines how common challenges can be successfully overcome in paediatric diabetes practice.

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Article points

1. Solution-focused language shifts focus from biomedical targets and critical terminology (fix-it mentality) to what the patient wants and how they can be helped to achieve it.
2. It is useful to ask questions, such as 'Where would you like to be?' and 'What is going well?' to identify what is important to the child/young person and their family.
3. Persist with this new language – the discomfort, self-doubt and challenges you may initially experience will diminish and your ability to effectively apply solution-focused practice will improve over time.

Key words

- Language
- Ormskirk Model
- Solution-focused brief therapy
- Solution-focused practice

Authors' details

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Elsewhere, we have written about what a solution-focused (SF) approach looks and sounds like using words and pictures, and suggested significant benefits accrue from engaging with children/young people and their families in this way (Guyers et al, 2020). Such psychologically-informed practice should not be the sole preserve of psychologists. When everyone – families, teams, whole communities – engages in this enterprise, the benefits are magnified. Many of these benefits will be lost if the parties involved do not speak, or understand, the language being used. In this article we consider what lies behind change in language. We look at what it takes for healthcare professionals (HCPs) to move from heavy reliance on a problem-focused model towards a largely SF one. We also address one of the apparent paradoxes of SF practice, namely how it is that something so apparently easy and simple to describe can be so difficult to apply in practice.

Solution-focused approaches in brief

SF approaches claim to make significant contributions to health, social work, education and organisational wellbeing through application of the related principles of: relentless interest in what matters within those contexts; and what expertise already exists within these contexts towards those ends. Guyers et al (2019a) gives examples of how SF-style questions can be applied specifically within the paediatric diabetes arena. Such questions you might ask yourself/your patient include: What are XXX's best qualities? What does s/he *already know* about diabetes? What *really* motivates him/her? What would s/he be *most pleased* to be telling you about next time you meet? The Queen, in her COVID-19 broadcast to the nation and Commonwealth on 5 April 2020, invited us to harness the power of the future in just this way: "I hope in the years to come everyone will be able to take pride in how they responded to this challenge. And those who come after us will say that the Britons of this generation were as strong as any. That the attributes of self-discipline, of quiet good-humoured resolve and of fellow-feeling still characterise this country. The pride in who we are is not a part of our past, it defines our present and our future."

'"We Scare, Because We Care" can remain the motto for employees of Monsters, Inc., not the NHS; if the right conversation/approach is employed, favourable results will follow'

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As well as being a predominantly verbal approach, albeit with craft-based adjuncts such as the Tree of Life, taking a graphical approach in the clinic may yield great results. We have suggested replacing the usual 'problem-saturated' thermometer of the glycaemic index – with its associated messages of impending pathology – with a more motivationally-informed scale we called the Ormskirk Model (Guyers et al, 2020).

Solution-focused approaches as countercultural to standard practice

Historical hangovers

SF practice de-emphasises biomedical targets and the use of scare tactics along the lines of "if you don't comply, you will be ill, go blind and die young". *We Scare, Because We Care* can remain the motto for employees of energy-producing factory Monsters, Inc., not the NHS. (Interestingly, the moral of that film is that laughter – in comparison to screams – provides more energy and in turn makes the job easier.)

The assumption is made that if the right conversation/approach is employed, favourable results will follow. Experience seems to bear this out with evidence of good biomedical outcomes following SF practice. For example, significant quality improvements were seen in the National Paediatric Diabetes Audit between 2016 and 2018, which reported a median HbA_{1c} of 62 mmol/mol (7.8%) for our unit – significantly better than the national average (RCPCH, 2020). In addition to this:

- 35% of all patients achieved HbA_{1c} targets of <58 mmol/mol (7.5%) and 17.5% achieved <53 mmol/mol
- The non-attendance rate improved from 22% to 11% (5% for <10-year-olds)
- The length of hospital admissions due to diabetes has been reduced by 1.8 days in the past 2 years (Guyers et al, 2019b).

However, as is likely apparent, for many medical doctors, nurses and associated care professionals, SF practice is decidedly not business as usual. Undergraduate (and, in the case of clinical psychologists, post-graduate) training is decidedly not of this hue. HCPs are generally trained and acculturated into a Positivist "identify the problem and fix it" model to such an extent they are frequently unaware they are applying it. Such positivistic cause–effect philosophies first became pre-eminent in the 18th Century, when the practice/philosophical assumptions of medicine became elided with the principles of engineering. In short: there's a problem with the machine; identify problem, rectify; job done. Now this appropriation of an engineering metaphor has many merits when the challenge is straightforward, as in the case of curable infectious diseases, broken limbs and so forth: X + Y = Z. But what of ailments that do not permit a straightforward, one-hit fix? What of messy human beings that have ideas of their own and appear to be irrational? We would argue that irrationality is in the eye of the beholder.

The good news is that far older philosophies are also available, for example the Stoicism of the Ancient Greeks and Buddhism. SF shares many ideas with Buddhism, for example the assertion that change is constant, implying that any given problem is not a fixed, immutable monolith but a transitory event that will come and go in intensity, coexisting with 'un-problems' – or solutions, as we might call them. We would argue that it is particularly helpful to look at our clinical practice through more than one lens. Ultimately, "there's nothing more dangerous than an idea… when it's the only one you have" (Émile Chartier [Alain], 1868–1951, *Libres-Propos*).

We all have an agenda

It is obviously not the sole preserve of patients to bring their messy humanity into the consulting room. We all do, and run the risk of doing our clientele a serious disservice if we believe otherwise. There is evidence of at least some doctors being 'dangerously mistaken' because they assume they know what a patient's preferences actually are (Mulley et al, 2012). The Health Foundation has written about the anxiety present in both parties to a consultation, resulting in the creation of a medically-imposed 'glass maze' to manage concern about 'cans of worms' or over-running. In an observational study, Walsh et al (2000) wrote about the temptation for the medic to assume the mantle of 'hero', only to become a 'zero' when the wished-for miracle fails to materialise. Hence,

there is emerging evidence that not only does it matter what the HCP construes the patient, but how they construe themselves and their general self-awareness can be important factors in the success – or otherwise – of the consultation, and by extension outcomes.

From our own observations and colleagues' spontaneous self-report, some self-construal may be at play and be a mediating factor in whether HCPs are willing/able to adopt a different consultation model. Put simply, they do not feel like they are doing a proper job if they are not following a standard biomedical approach. HCPs experience associated fears about professional vulnerability to criticisms of negligence or 'going feral'. Furthermore, their self-esteem as a HCP – and potentially their whole sense of self-worth – may be bound up with this medical model as it puts them in a one-up position as an expert or rescuer (Walsh et al, 2000). If a HCP's very vocation, from the start, was 'to make people better', giving up the one-up, expert position is potentially costly, and certainly risky.

Unfortunately, assuming the role of expert in this manner has significant downsides. Whose fault is it if things do not go to plan? In no time, hero becomes zero. Even in less dramatic scenarios, do children and families really 'own' what needs to be done or is the HCP making a lot of the running? What *compliance* can be hoped for when comparatively little attention has been paid to building *concordance*? (For a helpful explanation of those terms, see www.rpharms.com/resources/quick-reference-guides/medicines-adherence.) Are scare tactics effective beyond possibly encouraging children/young people and families to 'toe the party line' at appointments? In this case, how do we know we – as HCPs – are being told the truth? (I [DB] vividly remember sitting in on many renal appointments and witnessing the bemusement of the physicians as to why patients' blood results were so poor given the prescription. Afterwards, I found out what they were really taking.) In the longer term, does paternalism – whether cosseting or anxiogenic – lead to self-sufficient young adults as they engage with the very different culture of most adult teams? And all the while, does the HCP have a sustainable future in their chosen profession or are they heading for burnout?

The conclusion to the above is that for better outcomes for children/young people and their families as well as themselves, the HCP's behaviour needs to change.

What does it take?

What is really required is a deliberate effort on the part of the HCP to talk a new language. This, in turn, is underpinned by a necessary act of faith; namely allowing oneself to test the hypothesis that giving up control, or perhaps in some cases the illusion of control, will lead to better results. HCPs need to choose literally to mind, ie bring to consciousness, their language and their reasons for why they are using a (largely) new one. This also applies to HCPs' associated actions. For example, being excited with the patient about their fully-owned plans for achieving good glycaemic control but then repeatedly checking up on them will be counterproductive. Our mantra would be believe the patient unless and until proved otherwise. Doing the opposite brings the relationship straight back to one-up-expert and passive patient.

Tackling scepticism

Einstein is widely reported as saying, "The definition of insanity is doing the same thing and expecting different results", whereas what he actually said was, "We cannot solve our problems with the same thinking we used when we created them". Hence if every clinical, psychological and social metric is excellent in your service, and you have compelling reasons to believe these continue through transition to adulthood, congratulations! Keep doing what you are doing. If not, maybe it is time to take one small step.

One set of reasons for change pertains to extrinsic motivation. For want of a better phrase, to be seen to be working towards the patient's family's agenda ticks boxes. The NHS has long been replete with guidance on patient-/person-centred practice (NHS England et al, 2014). The paediatric diabetes peer review process mandates it (RCPCH, 2019). Intuitively it seems reasonable to suggest that conspicuously engaging with parents is more likely to 'get them off you back' than not doing it.

However, HCPs are intrinsically motivated; helping people is what they want to do and in

Page points

1. Consider what concordance can be hoped for if little attention is paid to building concordance.
2. If a one-up-expert stance is taken or scare tactics used, how can we be sure patients are telling the truth rather than telling us what they think we want to hear?
3. What is required is for the healthcare professional to make a deliberate effort to talk a new language.
4. Consider using the mantra: believe the patient unless and until proved otherwise.

Box 1. Putting it into practice: example from Dr May Ng, April 2020.

As a consultant in paediatrics who has been looking after children with diabetes for over 20 years, I was trained in a medical model that involves trying to fix a problem. However, having more recently been trained in solution-focused brief therapy I came to realise that in many consultations I was focusing on the numbers instead of the patient and that trying to fix the problem was not working. I realised I needed to be interested in the patient as a whole, to listen to what mattered to them and allow them to come up with their own solutions. I was a facilitator and sometimes a motivator. The consultation evolved over time – it did not happen overnight.

Each time I practise solution-focused brief therapy approaches with a patient, it gets better and works more effectively. I have, on some occasions, spent a majority of the clinic time playing Pokemon cards with a young patient or simply learning about a patient's hobbies and interests. Somehow it works; it is what matters more to them and they come up with their own solutions to improve self-management of their diabetes.

many cases who they are. It has been said that "Integrity is doing the right thing even when no one is watching" (CS Lewis, 1898–1963). Most HCPs, in our experience, are 'wired' that way.

So, how can practice be improved? Perhaps it is worth seeing what works elsewhere; not only in the Ormskirk Service, which gets demonstrably and consistently good results, but other services of your acquaintance. What are they doing that seems to work well that you could be doing? Perhaps best of all, on the principle that "Nobody can give you wiser advice than yourself" (Marcus Tullius Cicero, born 106 BC, assassinated 43 BC), ask yourself (de Shazer et al, 1986):

- What are we already doing that's working?
- When are we even minimally successful?
- When *is* there 'energy in the room'?
- When do children/young people and their families get excited and come back next time proud of what they do? What have you and your colleagues done that has contributed to that change?
- Are you learning the patient's language, learning their steps?

As you notice those things and reflect on them, you will be in good company. This is how SF practice started in a Milwaukee family therapy centre. Steve de Shazer and colleagues (1986) noticed they got better results and faster when they asked about what people wanted and what they were good at. People sat up straighter and smiled just a little more. Hence, the roots of SF practice are not fundamentally philosophical but pragmatically empirical:

- Notice what does not work (and stop doing it)
- Notice what does work and keep doing it/do more of it.

In the end, this is exactly what we are suggesting to our patients; it is good to 'practice what we preach', see *Box 1*.

Keeping the faith: Top tips

Expect change

This article was written in the midst of the COVID-19 crisis. Currently, the Ormskirk team is not only piloting the Attend Anywhere virtual consultation software (www.attendanywhere.com) in its hospital, it is also utilising it to maximise opportunities for best-possible SF consultations (results to be analysed). For those unfamiliar with Attend Anywhere, the patient/family clicks on a link sent via email that lets them in to a virtual waiting room from the comfort of their own sofa. Members of the multidisciplinary team then 'invite' them into virtual consultations. With the developing Ormskirk approach to Attend Anywhere, a 'host' initially welcomes the patient/family when they 'arrive' at the virtual waiting room and asks them questions, see *Box 2*.

Expect pain

Changing professional habits can be just as challenging as changing personal ones, perhaps harder; at work we are publicly on show. Expect fluency to be an issue. Expect to feel disempowered. Expect anxiety; it will feel like 'flying by the seat of your pants' or a high-wire act. Paradoxically, all of these feelings can be very helpful in building the HCP–patient working relationship. This is because it brings you psychologically closer to patients and where they are at. You are in it together. And, paradoxically from our experience, they work *harder*.

Expect challenge: impossibilities

The more outlandish, the better. Patients may say to you: "What do I want?' I want you to take the diabetes away!'" This is not a cue to go back into

biomedical mode. Try saying, "Yes, of course you'd want that. Good answer! And if we did, what would you be doing with your life?" You might be surprised by how quickly the patient will volunteer that they know full-well that diabetes cannot be cured, while they begin to share examples with you of how they are, however transitorily, experiencing some of that wished-for life even now. Why would they not want to cooperate with you? They are the ones with the problem and you are there to help. And you have earned their cooperation.

Expect challenge: negativity

Sometimes we all need a good whinge. In the case of our patients, some have good reason to complain. It is common for consultations to start with an arc of hope on our part and plummet as we hear a lot about what is wrong, see *Figure 1*. The trick is to stay with it. Most appointments will last 42 minutes or fewer. Over the course of the conversation, what is right will emerge – usually when the patient trusts you enough to share success without fear of being prematurely shown the door. This is not limited to consultations. Sometimes SF conversations happen in a quiet corridor, in the carpark or in the supermarket. And all the while, you have an opportunity to hear directly, or infer, what matters.

Expect self-doubt

There are situations in which we have an agenda, an obvious example being concern about harm. Should we not be a responsible HCP and switch to 'expert' mode to protect the vulnerable? The HCP must never be naïve and should seek the full story.

Invoking legislation to protect children and young people from themselves or others – particularly by hospitalising or removing them – has a very high bar. Other reasonable efforts must be tried first, as dramatic action is rarely supported by courts. The exception is in scenarios where significant harm is evident or is likely to happen imminently. In these circumstances, responsible HCPs would be acting quickly anyway.

There is a better reason to think first rather than act first. Cooperation won from empowered children/young people and their families is a more credible long-term strategy. If the child/young person is to be permanently hospitalised or removed, s/he will at some point need to be independently safe and some level of contact with family is likely. In both cases, cooperation is unlikely to be engendered by a prior adversarial stance of control first and seek buy-in later.

Box 2. Examples of questions asked in the virtual waiting room

- Do you have any particular concerns you wish to discuss?
- What are you hoping will come from today's appointment?:
  - o What things are you hoping will stay the same?
  - o What are you hoping will be different because of it?
- What's already going well?

There is SF literature relating to the prevention of self-harm (Henden, 2017) and child protection (Turnell and Edwards, 1999), the latter known as Signs of Safety – a validated approach embraced by the Australian State Government. At this point it is worth considering some illustrative questions relating to self-harm, see *Box 3*, and child protection, see *Box 4*.

It is important for SF practitioners to hold their nerve; there are great gains to be made by bolstering/affirming patients' and families' inherent strengths before any precipitous,

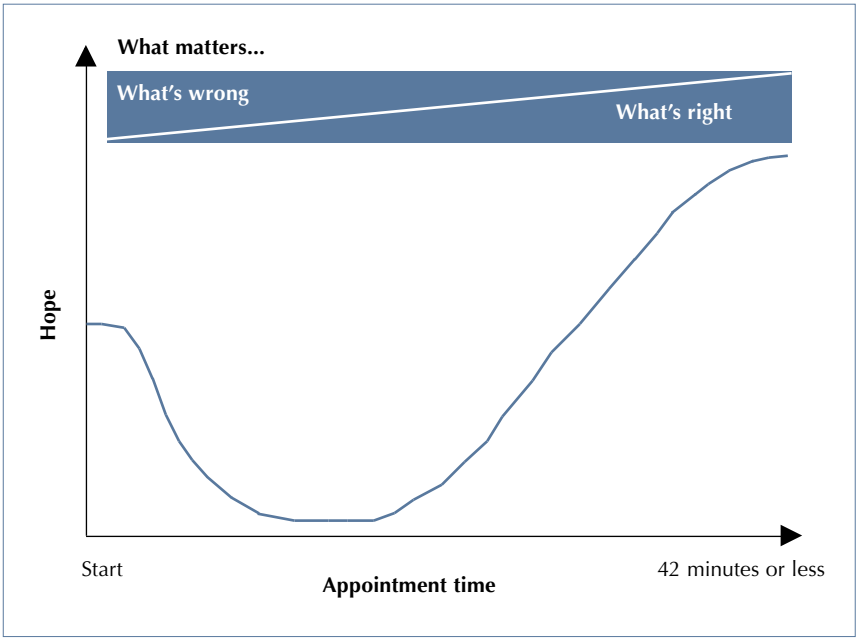

Figure 1. Healthcare professional hopes for an appointment in relation to patient unburdening

Box 3. Questions relating to self-harm

- On a scale of 0–10, 10 being completely safe, where are you?
- What makes it that number (and not lower)?
- What did it take to get there at all?
- How are you managing to keep it there?
- Who would be least surprised you're still doing those things that keep it there and why?
- Who would be least surprised if you did more of those things that keep you safe and why?
- How much confidence have you got that you will be doing more of those things and why?

Box 4. Questions relating to child protection

- How will we [healthcare professionals] know that we don't need to worry about XXX [your child/young person]?
- What would it mean to you if we didn't worry about XXX [your child/young person]?
- What times, as parents and as a family, have you managed to do those things before?
- What qualities have other people seen in you, as parents and as a family, before?
- What else are you doing to look after XXX [your child/young person] well?
- What else would you like to be sharing with us when we meet again [short timescale]?
- How much confidence do you have that you will be sharing those things… and why?

controlling action is taken; not to do so misses a great opportunity to build sustainable benefits. Being blind to harm or potential harm is dangerous, but so is any knee-jerk action driven by fear rather than reason and good practice. Controlling practice should be invoked when it is the only thing that works; doing so prematurely potentially breaks what could yet be a fruitful working relationship.

Utilise the power of community (yours)

It is particularly helpful to have like-minded colleagues working to the same model within your particular multidisciplinary team and wider circle of associated colleagues, eg housekeepers, porters, administrators, healthcare assistants and student nurses. We have written about this elsewhere (Guyers et al, 2020). All colleagues need to practice psychologically. SF principles and practice are a powerful way to 'be on the same page' where, in effect, the patients' story – ie what matters to them and their expertise – is understood and consistently forms the backbone of the help they receive from your teams.

Furthermore, the judicious use of SF questions pertaining to strategy can in themselves bolster best practice within any team in a conducive way. Ask any HCP, and most employees for that matter, which management style they prefer (and which works, eg Dyer, 2019): command and control or leading by trusting the motivation and competence of staff? This has seldom been more evident than during the COVID-19 crisis, which is possibly the NHS's finest hour (in the vein of Winston Churchill's speech, delivered to the House of Commons on 18 June 1940). Classic SF questions that elicit both what matters to teams and teams' expertise are given in *Box 5*.

Utilise the power of community, near and far

It takes a village to raise a child (see also Guyers et al, 2019a) and if you are working to the good of children and young people by working on your language, you will never be alone. Beyond our extended multidisciplinary teams, consider formal and informal parent-run groups that could be talking SF language, and in fact probably do and did before HCPs. Who could be more motivated to build and share expertise, being focused on what matters to them; namely the health and wellbeing of their children and mutual support? Schools (Kim and Franklin, 2009), local authorities (see Rankin (2007) for empowerment and Ree (1998) for SF approaches), clubs/societies and whole communities (Blickem et al, 2018) all want good for their children. What positive stories could be and are being told that we need to hear and could contribute to? What of other diabetes teams who have developed SF expertise that could be shared (see examples from a recent ACDC conference in *Box 6*)?

Concluding thoughts

As diabetes professionals we have much in common, not least wanting maximum health and wellbeing for 'our' children. The motto *Nil Satis Nisi Optimum* (nothing but the best is good enough) can and should be our minimum standard. It is possible to achieve this using SF-focused language, which places an emphasis on the best. By a determined effort to mind our language, choosing each and every word with the care of skilled crafts people, HCPs are at our best. We can build powerful and sustainable working relationships with children, young

people and families that deliver benefits that can last a lifetime. ■

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Box 5. Solution-focused questions that elicit what mattes to teams and teams' expertise

- If we were sat here in 6 months' time, what would we want to be most pleased about?
- What would children, parents, colleagues, commissioners notice about what we were doing?
- If we were to put that on a scale of 0–10, with 10 being everything has been achieved, where are we now?
- What makes it that number? What else?
- How would we (and other stakeholders) know we'd gone up a point?
- How much confidence (0–10) do we have that will happen? And why?

Box 6. Summary of great practice from a solution-focused workshop at the 14th Association of Children's Diabetes Clinicians' Annual Conference, 2020

- 'What works is having psychology [support] through the service, for the staff and the families. It makes a big difference not having to refer elsewhere, we all share the same approach... there is a consistency to it which is good to work in and I think the families appreciate that too.'
- 'Group education has worked very well, it's a nice meeting [...] all of the skills people have are shared.'
- 'We get alongside people instead, rather than shoving them a direction they don't want to go – families know what's best for them.'
- 'Leaflets in the waiting room have helped. We have called them "my agenda" and allow the families to think about what they want out of an appointment – it keeps it about what they want.'
- 'Keeping an ear out for what works or helps [for that family] and simply dropping what doesn't.'
- 'It's all about personalisation. We have young people living with diabetes who enjoy dogs, we do a walk and talk with the dogs on Saturday mornings – a nice check-in with the family, comfortable place. We can answer any questions they have and offer support. Why not?'
- 'I enjoy waiting my turn... you know... I shut up and listen! [...] It revolves around them, nothing else.'

The Ormskirk Model is free for all diabetes teams to use with the source acknowledged whenever used.

To download a pdf of the Ormskirk Model, go to www.diabetesonthenet.com/resources/details/language-matters-image-matters-too-ormskirk-model

Translations in over 20 languages are available at www.diabetesonthenet.com/diabetes-care-for-children-and-young-people/ormskirk-model