

Using a solution-focused approach to education in paediatric diabetes clinics

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Article points

1. Children and young people and their families often need additional support in the form of education to achieve good glycaemic control.
2. Solution-focused approaches can help young people with diabetes recognise their successes and, through positive engagement, improve their knowledge.
3. Highlighting successes and reflecting in a non-blaming manner can reduce a young person's anxiety and motivate them to break the cycle of avoidance and disengagement.

Key words

- Children and young people
- Education
- Glycaemic control
- Solution-focused approach
- Type 1 diabetes

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The benefits of maintaining good glycaemic control in children and young people (CYP) with diabetes are well established, but achieving it requires self-management knowledge and skills. This is difficult for CYP and their families, and there can be many barriers to overcome, including negative feelings that can result in the individual focusing on problems and avoiding situations that cause them worry. Additional support, often in the form of education, is frequently required. With the help of an example, this article outlines a solution-focused approach that healthcare professionals can adopt in clinics to promote meaningful and active learning. The approach involves highlighting successes rather than problems, and recognises the importance of building relationships so that tailored plans and goals can be formulated with CYP.

Achieving good glycaemic control in type 1 diabetes requires self-management knowledge and skills, with the child or young person and family reviewing and adjusting medication and lifestyle to achieve blood glucose targets. It is important for diabetes healthcare professionals (HCPs) to recognise that concordance is difficult, both for the young person and their family. The list of tasks involved includes regularly monitoring blood glucose levels, carbohydrate counting for all food and drink consumed, injecting insulin as appropriate and adjusting the amount if required, managing the effects of exercise, stress and illness, and monitoring blood ketones.

Education

The management of children and young people (CYP) with a high HbA_{1c} at Alder Hey Children's Hospital in Liverpool reflects current national guidelines (NICE, 2004). Additional support, which is often in the form of education, is offered to CYP when their HbA_{1c} is greater than

75 mmol/mol (9.0%). The aim of additional support is to address needs and barriers to improved control.

The form of education is important to consider. According to NICE guidance on the use of patient-education models for diabetes (NICE, 2003), there is insufficient evidence to provide specific guidance relating to this, but it is recommended that educational programmes “should use a variety of techniques to promote active learning” and that they are “adapted wherever possible to meet the different needs, personal choices and learning styles of people with diabetes”.

Caring for CYP with diabetes is markedly different from caring for adults (Christie, 2008) and so, when thinking about how to adhere to this guidance, we understand that it is important to tailor education to children depending on their developmental stage and time since diagnosis. For example, cognitive skills and academic ability develop over time and can, therefore, affect how information is received, processed and understood. We must also consider

how factors other than concordance can interact with each other (e.g. hormone levels affecting blood glucose levels). Education that takes this into account helps us to provide relevant information.

We also understand that the reasons behind poor glycaemic control are multifactorial and will vary from child to child. For example, CYP may feel anxious regarding aspects of their diabetes, such as fear about hypoglycaemia, insulin needles or blood glucose tests. Some may also feel alienated from their peers due to the need to manage their diabetes in school and in public. Furthermore, family systems and relationships can impact on glycaemic control, as can developmental issues such as pushing boundaries and risk-taking behaviours (Delameter et al, 2012).

Promoting self-efficacy has been shown to be effective in engaging CYP (Viner et al, 2003). Education that does not recognise the personal, environmental and social factors that affect concordance is unlikely to target high HbA_{1c} readings effectively.

Furthermore, diabetes management is “subject to the capriciousness of human behaviour” (Shaw, 2011). This can mean that negative feelings experienced by CYP can result in the individual focusing on problems and avoiding situations that they feel worried about, including aspects of their diabetes management.

A solution-focused approach

A solution-focused approach recognises the importance of the HCP building a relationship and formulating treatment plans and goals with the child or young person. It involves looking for solutions rather than attempting to take a problem away (interested readers may refer to de Shazer [1988]). The use of this approach is a fluid process and can, therefore, be adjusted to suit the situation if needed. Within the approach, the HCP is able to tailor education to the individual which, in turn, promotes meaningful and active learning – often managing to bridge the gap between the focus of the HCP (biomedical outcomes) and child or young person (managing treatment in everyday life).

This article illustrates the use of this approach in the clinical context with an example.

Example of the approach

Sam is a teenage boy who has just gone into his final year at secondary school. He was diagnosed with type 1 diabetes when he was 5 years old. He has attended clinic with an HbA_{1c} of 92 mmol/mol (10.6%), but has previously achieved readings within target. Sam says that he does not take his insulin at school.

It could be assumed that Sam requires education on the importance of taking insulin. A solution-focused approach, however, might reveal that there are more factors influencing his behaviour and, as such, this education would do little to tackle the cause of the issue.

Problem-free talk

Engaging the child or young person and family in talk that focuses on their skills and resources sets the scene for positive change and allows the professional to get to know the individual (Christie, 2012). Whilst the approach allows for some flexibility, problem-free talk (i.e. time spent getting to know the individual outside of the problem) can often be a good starting place for conversation.

Problem-free talk can focus young people's attention on something that is meaningful to them, and may sometimes open up conversations about what might be affecting their diabetes management.

The team asks Sam what he likes to do. Sam says that he enjoys playing football. He is the captain of his school football team. He also plays at weekends and scored a goal last week. He often plays with his older brother in the garden.

Goal clarification

The aim of clarifying goals is to find out what motivates the young person (Christie, 2012). This is important because the aim is concordance between appointments. If the young person does not feel motivated, they are less likely to implement change once they are home.

It could easily be assumed that a goal for Sam may be to lower his HbA_{1c} when, in fact, Sam's goal is “to avoid hypos whilst playing football at lunchtime”. As well as explaining why Sam is not taking insulin at school, this information can help to focus his diabetes education.

Page points

1. Promoting self-efficacy can be successful in engaging children and young people in their diabetes management.
2. A solution-focused approach recognises the importance of building a relationship with the individual so that treatment plans and tailored education can be developed.
3. Talking about aspects of an individual's life that are not problematic may open up conversations about what is affecting their diabetes management.

Page points

1. Inviting young people to describe their “preferred future” can help clinicians understand what defines “success” to them.
2. Asking a scaling question can be a way of showing where a child or young person is in relation to their goal and of monitoring progress.
3. Discussing the times when an individual was closer to their goal can help them think of subsequent steps they can make towards achieving it.
4. Asking an individual to think of small steps or changes that they can make towards a larger step can make their preferred future seem more achievable.

At times, the individual may respond with “I don’t know”. In some cases, a lack of concordance can be caused by apathy and so they may struggle to define what motivates them. In addition, young people may be facing a cycle of struggling to manage their diabetes and experiencing low mood as a result of this; they cannot see a way out and seldom want to talk about it (Riekert and Drotar, 1999). In circumstances where an individual cannot define a goal for themselves, it can be beneficial to revert back to problem-free talk to gauge what is important to them and collaboratively formulate a goal based on information from this. Alternatively, the HCP may ask: “Who brought you here today and what might they think is your goal? Do you agree?” (Christie, 2012).

Preferred future

According to de Shazer (1988), asking people what they want to do is unhelpful. When people are asked to think about steps to “solve a problem” it brings about obstacles that could hinder resolution (Christie, 2012). As an alternative, inviting young people to describe their “preferred future”, for example through the lens of “describe a future where (goal) has happened”, can lead clinicians to better understand what defines “success” to the young person.

This kind of question is also useful when working with younger children, such as by asking “if a fairy waved a magic wand in the middle of the night, how would you be able to tell (...) had changed?”

We may need to clarify how Sam will know when he has reached his goal. Sam tells us that he would be feeling confident that he is taking the right amount of insulin and would enjoy playing football without worrying that he will have a hypo.

Scaling

Scaling, where a response to a question is chosen from a range of values, can be a useful method of showing a child or young person where they are in relation to their goal and of monitoring progress. According to Christie (2012), when a child or young person is asked a scaling question, they will rarely say they are a “0” (the lowest rating). This gives an opportunity to ask how they managed to get to where they are and about things they are

already doing that are helping them towards their goal. Scaling can also help identify what might help them to reach the next “step” towards their preferred future.

Sam is asked to rate on a scale of 0 (not confident) and 10 (very confident) how confident he is when working out how much insulin to take. Sam rates his confidence at “3” because he is aware he needs to take some insulin with his lunch, even on days when he is playing football, and has a rough idea of how much he should take. He says he would like his confidence to be at “8”.

Exceptions

No problem happens all of the time. Exceptions refer to times when the young person has been closer to their goal or preferred future. This can help them to think of subsequent steps they can make in their progress.

Exceptions can highlight skills that the young person possesses and that can help them to manage their diabetes.

Sam says that he is more confident at home (6 out of 10) because he can check his “carb” counting and reassure himself that he is taking the correct amount. He also has easy access to his meter when playing football in the garden.

Small changes

The discrepancy between where the young person is and where they want to be on the scaling question can sometimes feel overwhelming. Asking the young person to think of small steps or changes they can make to get themselves “one step” towards their preferred future can feel more achievable.

Reflecting on the effect of change in subsequent clinics is rewarding for the young person and provides measurable outcomes for the clinician.

Some days Sam has a packed lunch at school. He thinks that a small change might be to learn how much insulin he needs for this meal and how he should adjust this amount when playing football.

Conclusions

Solution-focused approaches have the potential to help young people with diabetes recognise their

skills and improve knowledge and concordance through positive engagement. Highlighting successes and reflecting on what could be done in a positive (non-blaming) manner can reduce anxiety that CYP may feel coming to clinic, thereby motivating them to break the cycle of avoidance or disengagement.

Furthermore, solution-focused approaches respond to the modern NHS ethos of “patient-centred care” (Department of Health, 2000). They recognise that concordance can be affected by many personal factors, as well as the patient’s level of knowledge. They also promote Lord Darzi’s vision of a “21st Century NHS” that “gives patients more rights and control over their own care” (Darzi, 2008: p. 33), as scaling and goals help define what is important to the young person.

In many instances, professionals working in paediatric diabetes teams can feel “stuck” when education alone is not wholly effective in improving CYP’s concordance. Whilst using a solution-focused approach in clinics does not replace the need for psychological support, less complex issues may be tackled by asking a selection of questions that provide the HCP with ideas for tailoring education.

In an attempt to apply a solution-focused approach to improve education in the paediatric diabetes clinics at Alder Hey, we first identified a clear goal. This was to create a patient-centred approach to education for CYP. On a scale of 0–10, we were at a 5. We identified some small steps, such as team training in solution-focused approaches. Ideally, a next step would be to provide evidence of the use of this approach. This would help us towards our preferred future of paediatric diabetes clinics that improve outcomes by responding to the needs of CYP and their families. ■

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