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Implementing the Solihull Approach

A study of how the Solihull Approach is embedded in the day to day practice of health practitioners

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Executive Summary

1. Introduction and background

The intended outcomes of this study, commissioned through Newcastle upon Tyne Hospitals NHS Foundation Trust, are to make recommendations to promote more consistent implementation of the Solihull Approach, by Health Visitors and professions aligned to Health Visiting, and to encourage a more evidence based culture, in order to ensure care of the highest standard with a focus on continuous improvement.

The Solihull Approach was developed in the late 1990s and is a psycho-therapeutic approach to working with children and families. The theoretical underpinning has three strands: containment, reciprocity and behavioural management drawn from psycho-analytical thinking, child development research and learning theory, respectively. The initial evaluations have been positive with evidence of some Health Visitors feeling more positive about their jobs, an impact upon referral processes and an improvement in Health Visitors working in partnership with other professionals. However, concerns are still raised about the consistency of implementation and the need for further support. In Newcastle, the Solihull Approach has been implemented with roles created for Solihull trainers and a specific strand of supervision embedded into the overall supervision structure but perceptions related to lack of consistency in implementation mirror the findings in the published literature.

2. Aims of the study

- To carry out an initial questionnaire across the staff group aligned to Health Visiting (Health Visitors, School Nurses and Nursery Nurses) to get a broad understanding of attitudes towards the Solihull Approach and implementation in practice.
- To generate in depth qualitative data from the perspective of Health Visitors and related professionals to identify how they have been embedding the Solihull Approach into their actual practice.
- To code data, identify emerging themes and key categories and explore the relationship between categories.
- To identify any barriers to working with the Solihull Approach in practice.
- To identify detailed practice scenarios to illustrate different ways that the Solihull Approach had been adopted into the actual practice of Health Visitors and other professionals.
- To make recommendations to the Trust to promote more consistent implementation of the Solihull Approach and to encourage a more evidence based culture.

3. Methods and data collection

A mixed methods approach was used combining a questionnaire survey with in depth qualitative interviews. The proposal for the study went through the Trust approval processes and it was authorised under the category of service evaluation as opposed to research. Therefore full ethics approval was not sought.
The questionnaires were analysed to give descriptive statistics and a grounded theory approach was used in relation to the qualitative in depth interviews (Glaser and Strauss 1967).

3.1. Questionnaires

The questionnaire was designed to cover questions related to job role, recording, supervision, knowledge, understanding and application of the Solihull Approach, and barriers to using the approach. From a sample of 100 there was a 22% response rate.

3.2. In depth interviews

14 interviews were carried out 8 Health Visitors, 2 School Nurses, 1 Nursery Nurse, 1 Community Psychiatric Nurse, a senior parenting counsellor from a local authority and a team leader for Barnardos Family Support Team. All participants were guaranteed anonymity. Detailed coding was undertaken on transcripts as they became available and emerging themes identified. These were then organised into broader conceptual categories (see Appendix 1, Table 1).

4. Findings

4.1 Analysis of data from questionnaires.

The analysis of data suggests an almost universally positive response, across occupational groups, to the merits of the Solihull Approach as a general model or approach to working with children and families. There are, however, ambiguities in the responses in the extent to which it has had an actual impact on standard health visiting practice and how consistently it is being implemented in terms of both therapeutic and behavioural management elements encompassed within the approach. A key barrier to implementation was identified as perceptions of the time involved and one area that has been flagged is the relatively low value that has been given to level of opportunity to share practice with colleagues. One explanation could be that there are ample opportunities available that are fully utilised but it could alternatively be the case that Health Visitors and related professionals do not sufficiently value their own professional expertise and the extent to which they can learn from and be a resource for others. There appears to have been a minimal impact on referrals and this also needs further exploration as there could still be a number of processes related to referrals that have changed whilst overall numbers of referrals remain the same.

4.2 Analysis of qualitative data from interviews

The broader categories identified are as follows:

4.2.1. Category 1: Engaging families and building relationships

There was evidence that the Solihull Approach had helped both novice and experienced practitioners to gain fresh insights into understanding the importance of emotional and relationship building aspects of their interactions with families and of creating a ‘space’ for a therapeutic relationship to develop. Practitioners gave examples of how they had encouraged a ‘story telling’ approach in order to explore the impact of family histories and current family dynamics on parenting practices. Applying the Solihull Approach appeared to deepen their practice knowledge and understanding of why certain parenting practices and children’s behaviour patterns occurred and also developed practice skills such as active and productive listening. There were some examples that indicated it helped to increase sensitivity to cultural differences, although the analysis of the
quantitative data indicated this as one of the areas that was least enhanced by application of the Solihull Approach (55% disagreed that it had helped in this respect).

4.2.2. Category 2: Applying theories to practice – looking deeper and wider

It was evident from analysis of the transcripts that the Solihull Approach was seen as both a philosophy of care and as a package of resources, part of the professional toolbox, which enabled practitioners to apply theory to practice. Participants described how a greater understanding of the theoretical underpinning to the Solihull Approach, and integration of the three theoretical strands, gave a deeper understanding and ‘systemised’ their knowledge. There were many illustrations of how utilisation of the approach helped to uncover hidden and more complex problems. This could result in more time needed for some families but overall it helped to get to the root of the problem and assisted in ensuring there was appropriate referral if necessary. Participants were able to describe case scenarios of how they had integrated the three strand of the Solihull Approach in their practice and how a greater understanding and application of concepts such as containment and reciprocity enhanced their practice and enabled them to explore behaviour management strategies in the context of greater understanding of family dynamics and an emerging therapeutic relationship with parents and families.

4.2.3 Category 3: Re-defining professional practice

This section illustrates the benefits in terms of Solihull Approach providing a professional language and vocabulary for validating professional practice, strengthening professional identity and increasing the willingness of participants to undertake further professional development. Additionally it provided a ‘common language’ that facilitated work across professional boundaries and promoted a whole service approach. There was evidence about increased professional confidence in managing less complex cases and in explaining and giving an evidence based rationale when formal referral was necessary. There was some reference to a sense that they could advocate better and more fairly for children and families from a stronger professional basis which was less influenced by personal values and opinions.

4.2.4 Category 4: Promoting reflective practice and reflective parenting

Promoting reflective parenting as a means of developing family resilience occurs implicitly as a cross cutting theme in all of the categories and appears to be at the heart of the Solihull Approach. Reflective parenting enables parents to think about their own life histories and how they might have impacted on their parenting practices as well as considering the immediate context and how this might be having an impact on the family. This type of reflection was seen to be promoted by a ‘partnership approach’ to working between practitioner and parent and different methods were uses such as encouraging ‘story telling’. There were numerous case examples given of ‘light bulb’ moments leading to clients identifying and analysing problems and coming up with their own solutions. Practitioners also gave examples of how they allayed anxieties by ‘normalising’ behaviour.

4.2.5. Category 5: Overcoming resistance

Although it isn’t possible to quantify resistance this section highlights some possible reasons for it that feed into the recommendations made (see section 6). Both quantitative and qualitative data pointed to fear of the time it would take to embed the Solihull Approach in practice. The qualitative data, however, gave a lot of in depth case scenarios where initial time input paid off in terms of families developing resilience and increasingly being able to resolve their own problems and issues with minimal professional input. Most of the participants interviewed were themselves Solihull trainers and therefore had confidence in their own knowledge base and skills. However, there were indications that others might feel they had insufficient skills, particularly in managing a more
therapeutic type of relationship, and that low attendance at supervision might partly be due to risk of exposure of ‘not knowing’. A high percentage of respondents in the questionnaire felt that they were using the Solihull Approach in a common-sense way prior to training. This in itself might build resistance to ‘deeper learning’ and engagement with a lesser impact on practice. Participants also pointed to resistance to changing established practices.

4.2.6. Category 6: Leadership, organisation and management

Effective training and supervision were identified as key functions necessary for embedding the Solihull Approach and therefore important in any strategic plan mapping out a vision for the service. Further facets of organisational embedding related to paperwork, facilitation of parenting groups and use of the Solihull Approach by team leaders to develop team resilience. There were risks of loss of momentum if left to enthusiastic and committed individuals to take forward without strategic commitment and allocated resources.

5. Discussion

The themes identified during the coding and analysis of transcripts were clustered into the categories described above. There were some themes which cross cut all the main categories. Family resilience was explicit in some and implicit in all categories and could therefore be seen as one of the key outcomes of successful embedding of the Solihull Approach. Language was another theme, or sub-theme, that cropped up in all main categories and this highlights that the crux of the initiative to embed the Solihull Approach more consistently in the practice of Health Visitors and other professionals is in essence an endeavour to translate research based knowledge and theory into practice based actions. This knowledge to action process has been the subject of much debate and enquiry in the health arena and concerns about the theory to practice gap well-articulated. It has been noted that research findings often take a very long time (if ever) before they are effectively embedded in actual practice.

This study has illustrated that embedding the Solihull Approach is complex because processes need to happen at different levels. Practitioners not only have to apply theory to practice but they also have to translate academic concepts into everyday language to encourage parents to translate theory into their parenting practice. In some scenarios described the Solihull Approach was also embedded in supervisory, management and leadership processes so this involved articulating theory with different organisational functions and practice contexts.

In addition to these multi-layered knowledge to action processes the theory underpinning the Solihull Approach is itself complex and multi-stranded with some tensions between the more therapeutic and behavioural components of the approach. Reported examples of poorer practice, privileging the “quick fix”, tended to launch straight into top down professionally driven behavioural advice without putting in the ground work to generate client driven solutions and the development of family resilience. There is a risk that a superficial understanding of the approach reduces it to the immediately observable behaviour management strategies and completion of the assessment documentation without the development of a therapeutic relationship with parents and families. This is a particular risk when individuals are under workload pressure and there is a perception that applying the Solihull Approach will be much more time consuming.
6. Recommendations

There were a number of areas that emerged from the in depth interviews suggesting where specific changes could be made to build on existing good practice and ensure more consistent implementation and embedding of the Solihull Approach. The areas are listed below and detailed recommendations can be seen in the main report.

- Training and training the trainers/supervisors
- Supervision
  - Solihull group supervision
  - Clinical supervision
- Documentation
- Skills development
- External
- Leadership and developing teams
- Measuring quality
- General promotion of Solihull Approach

7. Conclusion

The recommendations above are based on detailed analysis of the finding from this collaborative piece of work and are focused on minimising barriers and maximising benefits of embedding the Solihull Approach more consistently across the whole health and social care workforce. It is recognised that many may be already in place or in the early stages of being implemented.

A key concern is that a superficial understanding of Solihull Approach and formulaic application could lead to fragmentation across occupational groups with behaviour management strategies being implemented in a more professionally driven top down way outside the framework of a developing therapeutic relationship with families. This would impact on the key benefit at the heart of the Solihull Approach i.e. developing family resilience. Ongoing refresher training and mandatory Solihull supervision sessions are necessary to enable practitioners to have a deeper understanding of the Solihull Approach and the central importance of a ‘partnership approach’ and promotion of ‘reflective parenting’. The main resistance to this is perceptions of time input and the corollary is the ‘quick fix’ approach - which can in fact be more time consuming in the long term. The benefits of holistic practice and potential efficiencies in use of time need to be stressed in both training and supervision.

To address this concern on-going effective leadership and management is essential with key individuals tasked with taking a strategic plan forward in order to achieve a critical mass of practitioners, across professional boundaries, with an in depth understanding and level of skills to fully embed the Solihull Approach. One of the risks identified is that with reorganisation and changing personnel the momentum becomes lost and embedding the Solihull Approach becomes fragmented both in terms of its holistic philosophy and inter-professional potential.
Main report

1. Introduction and background

The Open University and NHS Newcastle and North Tyneside Community Health\(^1\) have had a history of shared project work since 2009 and have developed a model of academic-practitioner enquiry that encompasses elements of knowledge transfer and exchange. The outcomes from this work include two written reports based on evaluative research with Health Visitors and Community Nurses and three published papers\(^2\). The intended outcomes of this study, commissioned through Newcastle upon Tyne Hospitals NHS Foundation Trust, are to make recommendations to promote more consistent implementation of the Solihull Approach and to encourage a more evidence based culture within the Health Visiting profession, in order to ensure care of the highest standard with a focus on continuous improvement. This relates to the Health Visiting Service Specification (2012-2013) which states that part of the role of the Health Visitor is to, ‘to promote parental attachment and positive child mental health through the use of evidence-based approaches such as the Solihull Approach, Preparation for Pregnancy and Beyond Triple P’

The Solihull Approach has been used by Health Visitors in work with children and families since the late 1990s. It was originally utilised for children with sleep difficulties but its scope has since been broadened and applied to children with a range of behavioural difficulties and supporting resource pack materials have been developed. The scope has also been extended to encompass accident prevention, child protection and children with special needs. Additional resources have also been developed to go beyond the first five years and provide practical support for professionals working with school aged children and young people. Alongside these developments is an increased emphasis on multi-agency work and using the approach across a range of professional groups. It is a psycho-therapeutic approach and the theoretical underpinning has three strands: containment, reciprocity and behavioural management drawn from psycho-analytical thinking, child development research and learning theory, respectively.

The initial evaluations of the implementation of the Solihull Approach were positive with some evidence that more routine behavioural difficulties were dealt with successfully by putting the approach into practice rather than resulting in referrals to child psychology services (Douglas and Ginty 2001). Health Visitors have also responded very positively to the resources but this positive response is arguably not matched by the level of transformation of practice that might be anticipated by such an extensively promoted approach to working with children and families that is well supported by theory and evidence. This is indicated in the published work in the intervening years where the Solihull Approach continues to dominate the literature with many examples of attempts to embed the approach through work with individual families and group work with parents and children. For example, Whitehead and Douglas (2005) outline how the Solihull Approach has led to changes in practice: Health Visitors feeling more positive about their jobs, an impact upon referral processes and an improvement in Health Visitors working in partnership with other professionals.

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\(^1\) NHS Newcastle and North Tyneside Community Health was dismantled following the Health and Social Care Act 2012. The collaborative relationship has been maintained via Newcastle upon Tyne Hospitals NHS Foundation Trust.

\(^2\) The reports are: 1) Leading in practice: A case study of how Health Visitors share and develop good practice in the context of national policy and local organisational change (Brigham, L., Maxwell, C., Smith, A) 2) Turning with the Tide: An exploration of challenges facing recently qualified nurses based in the community (Brigham, L., Logan, J., Maxwell, C., Smith, A). See reference list for papers published from these reports.
However, concerns are still raised about the consistency of implementation and the need for further support.

In Newcastle, the Solihull Approach has been implemented with roles created for Solihull trainers and a specific strand of supervision embedded into the overall supervision structure but perceptions related to lack of consistency in implementation mirror the findings in the published literature.

2. Aims of the study

- To carry out an initial questionnaire across the staff group aligned to Health Visiting (Health Visitors, School Nurses and Nursery Nurses) to get a broad understanding of attitudes towards the Solihull Approach and implementation in practice.
- To generate in depth qualitative data from the perspective of Health Visitors and related professionals to identify how they have been embedding the Solihull Approach into their actual practice.
- To code data, identify emerging themes and key categories and explore the relationship between categories.
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3. Methods and data collection

A mixed methods approach was used combining a questionnaire survey with in depth qualitative interviews. The proposal for the study went through the Trust approval processes and it was authorised under the category of service evaluation as opposed to research. Therefore full ethics approval was not sought.

The questionnaires were analysed to give descriptive statistics and a grounded theory approach was used in relation to the qualitative in depth interviews (Glaser and Strauss 1967).

3.1. Questionnaires

The questionnaire was designed to cover questions related to job role, recording, supervision, knowledge, understanding and application of the Solihull Approach, and barriers to using the approach. A draft questionnaire was piloted with three members of staff and amendments made before circulation.

Occupational groups aligned to health visiting were included in the questionnaire but the decision about whether or not to carry out more in depth interviews with other groups was held until after initial analysis of the questionnaire data. Questionnaires were distributed on two occasions to approximately 100 Health Visitors, School Health Nurses and Nursery Nurses via the Professional Practice Forum. There was a short time slot allocated on both of these occasions to explain the background to the evaluative project and to encourage participants to submit completed questionnaires. Out of approximately 100 potential respondents, 22 questionnaires were received so
the response rate was relatively low at 22%. This was sufficient to highlight potential issues and ambiguities to be explored in the in depth qualitative interviews but not high enough to attribute statistical significance to comparative data between different occupational groups, with varied job roles in relation to working with children and families.

3.2. In depth interviews

The analysis of data from the initial questionnaire had not identified that other groups responded to questions differently to Health Visitors but it was felt that a more in depth understanding of a variety of roles in relation to implementation of the Solihull Approach was required. The decision was therefore made to include both Health Visitors and occupational health groups aligned to health visiting to increase the diversity of the sample.

14 interviews were carried out in total but not all were identified at the outset. These initially included 8 Health Visitors, 2 School Nurses, 1 Nursery Nurse, 1 Community Psychiatric Nurse. Participants were identified through the Health Visitor Practice Co-ordinator and follow up of those who had completed the initial questionnaire and indicated that they were willing to be interviewed.

The interviews ranged from 35 minute to an hour in length and all were transcribed in full. Prior to the start of each interview every participant was asked to complete a consent form which gave an outline of the study and confirmed that any information they gave could be used in the final report and any subsequent publications but that all contribution would be anonymous.

Detailed coding was undertaken on transcripts as they became available and emerging themes identified. These were then organised into broader conceptual categories (see Appendix 1, Table 1).

As the coding and analysis of transcripts progressed there was a theme emerging related to multi-professional working across health and social care and two participants outside health were therefore identified for interview – a senior parenting counsellor from a local authority and a team leader for Barnardos Family Support Team.

It became apparent from early on in the interviewing process that those who were willing to be interviewed tended to be enthusiastic advocates of the Solihull Approach so it could be argued that this lack of representativeness skewed the study. However, qualitative studies in general, and grounded theory in particular, work within a model of ‘theoretical sampling’ rather than ‘representational sampling’ (Charmaz 2008) and from the sample interviewed it was possible to build up a rich picture and insights into the benefits of implementing the Solihull Approach in practice as well as barriers to implementation.

4. Findings

4.1 Analysis of data from questionnaires.

In the following analysis, response by number of respondents has been translated to percentages in some cases to give a clearer descriptive picture of the results but actual numbers can be ascertained by reference to the charts. The full questionnaire can be seen in Appendix 2.
4.1.1 Job role (questions 1-3)
The respondents included 15 Health Visitors, 4 Nursery Nurses, 1 Staff Nurse, 1 School Nurse and 1 Public Health School Nurse. All but one of the respondents had been trained by attending structured workshops in the use of the Solihull Approach. None of the respondents had registered for module assessment or received academic credit for this training. 4 of the respondents were involved in training others in the use of the Solihull Approach.

4.1.2 Recording (questions 4-6)
Only 2 of the respondents were involved in piloting the new documentation so the majority of respondents were only familiar with the current documentation.

![Chart 1: Usefulness of current system of documentation]

The majority of respondents (12) found the current system of documentation not very helpful with only 2 respondents finding the system very helpful.

When asked if they explicitly referred to key concepts of the Solihull model (containment, reciprocity and behaviour management) in recording of practice the most frequent response of respondents (10) was ‘sometimes’. The 2 respondents who had found the current system very helpful stated ‘very frequently’ and ‘frequently’ for reference to Solihull concepts.

![Chart 2: Reference to Solihull concepts in recording]

4.1.3 Supervision (questions 7-9)
Attendance at Solihull supervision sessions was variable with the most frequent responses being attendance at most or approximately half of supervision sessions available to them. 32% of respondents had attended less than half or never attended so uptake of these sessions is lower than might be anticipated.
Chart 3: Attendance at Solihull supervision sessions

Of those who had attended opinion was divided about the extent to which the sessions had influenced the way they thought about and approached practice. 55% of respondents agreed or strongly agreed that it did but 36% disagreed or strongly disagreed that they had been influenced.

Chart 4: Influence on practice

When participants were asked about their use of Solihull Approach to reflect on practice in clinical supervision sessions there was an interesting relationship to the previous question on influence on practice. Of the 2 respondents who strongly disagreed about influence on practice one made frequent use of the Solihull model to reflect on practice in supervision whereas the other respondent never made reference to Solihull in supervision. Of the 2 who strongly agreed both made frequent use to Solihull in clinical supervision. The 6 who disagreed made occasional reference or never made reference to Solihull Approach in supervision.

One possible answer to the broad split between agreement/disagreement about influence on practice might be that some respondents felt they were already working within the broad framework of Solihull principles and therefore training and subsequent supervision did not change their practice. This would explain the seemingly anomalous result of strong disagreement to influence on practice yet frequent use of Solihull concepts to enable reflection on practice in clinical supervision.

4.1.4 Knowledge and understanding (questions 10-15)

Questions in this section were designed to assess the extent of impact of the Solihull Approach in different areas; listening to parent/child experiences, understanding different development stages, clarifying what is done in practice. Questions constructed negatively were also included such as
knowledge and understanding not enhanced and not helpful in observing and making sense of child/parent interactions.

From the above charts it can be seen that the area where there was most consensus was 91% of respondents feeling that they were already using the Solihull Approach in a common sense way with 50% strongly agreeing and 41% agreeing with this statement. The majority of respondents (82%) acknowledged that it helped to give them a more in depth understanding of what they did in practice. There were more respondents who agreed that it had changed attitude to importance of listening to parent/child experiences to those who disagreed (68% positive) and likewise understanding of different developmental stages (59% positive). Where statements related to Solihull were constructed in a negative way there was a greater tendency for respondents to strongly disagree. For example 64% of respondents disagreed with the statement that Solihull had not enhanced their knowledge and understanding and of those 23% strongly disagreed. There was also strong disagreement that Solihull had not helped in observation of parent/child interactions (73%) with 5 of those respondents strongly disagreeing. Apart from one instance, where
respondents strongly disagreed that it had not enhanced knowledge and understanding they also strongly disagreed or disagreed that it had been of little help in observing child/parent interactions.

The distribution of agreement/disagreement raises questions about whether or not the Solihull Approach has been taken on board sufficiently. One interpretation, supported by data in Chart 8, suggests that its seemingly limited impact is because practitioners feel that their practice has been closely aligned in a ‘common sense’ way with the Solihull Approach prior to formal training and supervision.

The question set to assess actual rather than perceived knowledge included a list of six statements related to baby brain development and respondents had to identify which ones were true. Four out of the six statements were true and only one respondent got all the true/false responses correct. This result was skewed by one of the statements, ‘the cortisol level is more likely to be raised in a crying child than a passive child’. This statement is in fact false but 21 out of 22 respondents ticked it as correct. If this question is omitted 45% of respondents got all of the remaining responses correct. All but one respondent recognised that the first two to three years are critical in establishing normal brain development but with two respondents believing that any early damage can be fixed with love and affection later. Other true statements: the limbic system regulates emotional behaviour and is not fully formed at birth; development of the orbital frontal cortex around 3-6 months has been linked to attachment; early pre verbal experiences affect us because we store emotional experiences in the brain even when we can’t remember them, were flagged as correct by 73%, 82% and 91% of respondents respectively.

4.1.5 Application of the Solihull Approach (questions 17-24)

Statements related to application of Solihull Approach generated more positive than negative responses. For example, in terms of being helpful in generating and negotiating practical suggestions related to behaviour management, 82% of respondents agreed or strongly agreed that this was the case.

![Chart 11: Generating practical solution re behaviour management](image)

When calculated in the same way other criteria were rated less positively but consistently; increased confidence and skills (64%); being empathetic and non-judgemental (64%); helpful in evaluating interventions (64%). In terms of increased confidence in working with families from diverse cultures the balance shifted with more negative than positive comments. Only 45% agreed or strongly agreed that Solihull Approach has been helpful in this respect with 37% disagreeing and 18% strongly disagreeing.
There was a high level of consensus that Solihull Approach was more time consuming. When asked to respond to the statement that ‘using the Solihull Approach does not increase the time required for assessment and intervention’, 73% of respondents disagreed with this and there was no strong agreement.

In terms of impact on referrals, no respondents thought that using Solihull Approach decreased the number of referrals with 68% stating that it made no difference and only 18% saying that it increased the number of referrals.

![Chart 12: Impact on referral](chart.png)

Responses to a related statement, ‘I do not have time to make full use of the Solihull Approach but do refer families for further input from other professional groups’ mirrored this with 64% disagreeing and 34% agreeing.

4.1.6 Barriers to using the Solihull Approach (question 25)

When asked to rank barriers to their own use of the Solihull Approach criteria were clustered into the following types of category: knowledge and skills (1-2); management support (3-4); peer support (5-6); time related (7-8); personal motivation (9); disagreement with model and approach (10).

Respondents were asked to rank 10 statements describing possible barriers to using the Solihull Approach in order of significance, with 1 being high and 10 being low. The figures in the bar chart relate to the cumulative scores for each item. Lack of time (7-8) was clearly seen as the most significant barrier to implementation with personal motivation (9) and disagreement with the model (10) ranked as the least significant barriers. Respondents also ranked extent of opportunity to share practice with peers as of relatively low significance. Individual factors such as gaps in knowledge and understanding and skills in applying the principles of Solihull Approach to practice were ranked as less important than limitations in management feedback and supervision.
In summary, the analysis of data suggests an almost universally positive response, across occupational groups, to the merits of the Solihull Approach as a general model or approach to working with children and families. There are, however, ambiguities in the responses in the extent to which it has had an actual impact on standard health visiting practice and how consistently it is being implemented in terms of both therapeutic and behavioural management elements encompassed within the approach. A key barrier to implementation was identified as perceptions of the time involved and one area that has been flagged is the relatively low value that has been given to level of opportunity to share practice with colleagues. One explanation could be that there are ample opportunities available that are fully utilised but it could alternatively be the case that Health Visitors and related professionals do not sufficiently value their own professional expertise and the extent to which they can learn from and be a resource for others. There appears to have been a minimal impact on referrals and this also needs further exploration as there could still be a number of processes related to referrals that have changed whilst overall numbers of referrals remain the same.

4.2 Analysis of qualitative data from interviews

4.2.1 Category 1: Engaging families and building relationships

   i. Creating ‘space’ for a therapeutic relationship to develop

Data provided indications of ways in which the Solihull Approach has increased understanding and how that has been translated into practice so practitioners are able to engage with and foster
therapeutic relationships with families. Even for those with long practice experience, the approach has given them ‘permission’ to ‘sit on their hands’ in order to create a space for a relationship to develop and consequently more considered action. Experienced practitioners reflected on this:

‘We’re all doers..... If someone had taught me or given me permission to have a decent relationship which is the predictor of outcomes, I would have spent more time at that stage, knowing that behaviour would sort itself out in some respects.’ (13)

I do a lot of listening, most students have said that I don’t say very much sometimes, whereas they are wanting to rush in and give ideas. I think I’ve always been the sort to sit back and listen to what’s going on and that’s exactly what Solihull is about listening, containing and that reciprocal relationship with families and then being able to help them think about what’s happening. (2)

ii. Exploring emotions

The Solihull Approach was seen by the participants interviewed as a useful framework within which emotions can be explored and problems identified:

Solihull gets you to touch on people’s feelings, what they feel about this or that. It also gets you to talk about how the child feels so I think it’s a great tool for me. (1)

Talking about feelings enables parents to see problems in a different light:

Listening to the parents and seeing how they feel about the child, why they feel he’s naughty, why they feel this isn’t appropriate and then they say, ‘Well actually it’s not that bad. It’s in that moment of time I think it’s horrible but actually he’s a lovely boy.’ So it’s getting them to off-load, I think that helps. (12)

iii. Active and productive listening

Data highlighted a tension between form filling which is structured and active listening. This was also highlighted by Mitcheson and Cowley (2003) who flagged that structured assessment instruments can be in tension with client involvement and inter-personal relationships and communication (Mitcheson and Cowley 2003). The participant quoted below felt this tension could be off-set by familiarity with the assessment documents and being confident and flexible in your approach:

There’s the paperwork but you know if you feel less confident you might feel you have to write all the time ... I might glance at it and I might write the occasional note but I wouldn’t just sit filling it in, question by question.. which then gets in the way. (2)

A recently qualified participant described how the Solihull questions helped to enhance her listening skills and provided a guide for gaining more information:

Beforehand I used to go into a family thinking what am I going to do here? You know they told you they had a problem and there was no set answer to the problem and I’d think, what am I going to do? I was there listening to them and Solihull gives you the questions to ask. Before you know it most of the time the problem’s solved. (8)
iv. Building trust and sensitivity to differences

Overall, the data reflected fresh insights into an understanding of the impact of social and environmental factors on behaviour even for those with wide practice experience:

It’s sort of opened a new window I think. It’s increased my understanding a lot of why people behave the way they do and you’re taking people’s – I guess we’ve always taken people’s background into account but looking at it and realising the impact it has on children has been quite enlightening. (5)

There was evidence that the conceptual framework of Solihull was in line with expected professional behaviour. For example one participant described how she applied the concepts to ensure sensitive and non-judgmental practice:

You’ve got to be careful that you’re not putting your personal opinions on to a situation that you’re looking at, particularly if there are cultural issues going on; but the concept of containment, being able to contain and give people space and being able to comment on and observe the reciprocity gives you the knowledge, gives you the language, that can transcend over many different avenues of people you’re working with. (10)

From the evidence presented, creating a partnership of trust enables practitioners to ask sensitive questions concerning ways in which the parent’s own experience of childhood may be affecting behaviour. This is consistent with the published literature as Maunders, Giles and Douglas flag the centrality of the quality of the mother/professional relationship in successful interventions (Maunders, Giles and Douglas 2007). The following extract illustrates that building relationships of trust can be challenging:

It (Solihull) helps in fixing the problem. Whereas before it seems as if you’re going backwards and forwards to these families and thinking ‘I’m not getting anywhere. They’re not listening to the advice I’m giving them anyway because they just think the child should be referred on to someone’ and that’s often the answer they’re looking for .... whereas I think this is a good way in making them see, yes I have had a bad childhood and this is affecting the way I’m parenting and the way my child is behaving. (8)

However, judging the right time to approach such sensitive issues is an important skill:

I didn’t say that to her on that occasion because there was someone else there and I don’t think mum was wanting to – and you’ve got to think about that relationship between you and the family as well and the right time. (2)

v. Getting and using stories to develop shared understanding

There is an emphasis with the Solihull Approach on helping parents to think about parenting through telling their own stories. One participant described how she visited a mother who had a ‘naughty child’. In spite of her own scepticism about asking about the mother’s pregnancy history, she found that this uncovered useful insights which were shared by both mother and practitioner and consequently helped to inform action:
With this particular Mum it was very useful because she actually identified herself why her little girl was having problems. She said, ‘I think I know why we’re having problems with her’. She said ‘it’s because I had 2 miscarriages before I had her - they were quite late in my pregnancy so when I had this particular child she was very precious and she’s been babied.’ (1)

vi. Translating the Solihull concepts into practice.
Participants highlighted some difficulties with the abstract language of Solihull but found ways in which they could translate the concepts into understandable language:

You’ve got young mums who struggle with normal everyday things and if you start using the word reciprocity they’d just switch off... I talk about relationship cues, trying to understand what your child’s feeling ...I talk about brain development and why that’s important. (6)

There is evidence from the transcripts that different forms of knowledge acquired from Solihull training increased understanding of the physiological impact of relationships on the developing child and therefore had an impact on practice:

The brain development helps me to understand all the more about the impact of relationships on the baby and be able to explain to parents so they can understand. That’s changing as we learn more about baby brain development. (7)

Summary of Category 1: Engaging families and building relationships
There was evidence that the Solihull Approach had helped both novice and experienced practitioners to gain fresh insights into understanding the importance of emotional and relationship building aspects of their interactions with families and of the impact of family histories and dynamics. Data reflected the perceived influence of these factors in terms of deepening their practice knowledge and skills.

4.2.2. Category 2: Applying theories to practice – looking deeper and wider

i. Solihull as a philosophy of care and as part of the professional toolbox
All participants acknowledged the impact learning about Solihull had on them even if they had at first approached it with some scepticism. It had not only provided an expanding ‘toolbox’ of strategies and resources but also a philosophy of care which made them review their whole approach to practice:

It makes you think more about the experience of the parents because that’s one of the big things of the Solihull assessment you’re looking at how parents parent and what experiences they’ve had of parenting. Although I was aware of that even before I had the training it just became more useful if you like when I had had the training myself. It gave me a greater understanding of the relevance of it. (7)

For some the introduction of Solihull appeared to have re-energised them:

It’s worked for me because it is, I hate using this word, a religion, but it’s a thinking way for me. Every time I go to see someone I have my Solihull head on. (9)
This data reflects findings of a study by Whitehead and Douglas (2005) which highlighted changes in overall approach to work and increases in job satisfaction.

**ii. Systemising knowledge and raising awareness**

Even if some of the concepts drawn on in Solihull were familiar to participants, these were revisited during training and their relevance reconsidered. In addition the integration of knowledge gained from different academic fields (psychodynamic field, child development research and behaviourism) combined with an emphasis on relevance to practice was seen as a great strength. It provided a rational and evidence-based approach:

*A lot of it just clicked and made sense.* (10)

*It systemised my knowledge; it helped me to put things together.* (12)

The three key concepts helped participants consolidate and reconsider what worked in practice and why:

*The training gave me words to use for the work that I did. Although it was good and interesting to hear about the concepts, there wasn’t anything I think that I hadn’t been using but it gave it a name I suppose. Thinking about families, you go in and you don’t do anything and you go back and things have resolved. I used to think why has that happened with that family? It gave me the knowledge to know why it has worked on that occasion.* (2)

These findings are in line with Douglas’s assertion (2010) that the Solihull Approach provides a useful lens through which to gain clearer view of relationships (including that of practitioner and family members) and their influence on the development of emotional health and well-being.

A participant explained how her analysis of observations between parent and child had reached a deeper level through her understanding of containment and reciprocity, particularly as the interaction progressed and the child relaxed:

*I’m looking a lot more at the facets of the communication between parent and child. I think before I would have taken it for granted... he would go to his Mum initially and feel contained. [ ] Once I had been in the room for 15 minutes and he completely relaxed [ ] he actually showed very little reciprocity with his Mum and actually was quite argumentative with her so I thought there’s containment at a basic level but not on a deeper emotional level. She was saying things and he was saying ‘That’s not what I said’, ‘That’s not what I did.’ Mum wasn’t really reading his cues and he sat with his back to her.* (1)

It was apparent there was an increase in breadth as well as depth of understanding:

*It builds your confidence once you’ve learned about baby brain development and know why we do things. .... There’s that light bulb moment when you go, yes I do know why I need to know about this.* (9)

**iii. Uncovering hidden more complex problems**

Data indicated that participants perceived that Solihull created an environment for a deeper level of analysis as it was likely to uncover underlying issues. Some participants were concerned at first about opening *‘a large can of worms’* although those who said this felt that these fears were
lessened once they had implemented the approach. For others the relevance of the Solihull assessment questions were also queried but again understanding was increased by application:

\[
\text{I think if I'm honest I thought what relevance these questions had. I didn’t understand... I felt a bit awkward asking some of the questions but then the more I've used the tool, the more I’ve realised the relevance and I’m not worried because you never know what you’re going to uncover when you go into a house anyway, so I don’t think I've been scared of that. (8)}
\]

The uncovering of hidden aspects of problems was viewed both positively (in terms of quality of care) and negatively (in terms of unexpected extra time needed) although it was acknowledged that this might involve less time overall.

\[
\text{I think sometimes it brings up things that you think ‘Oh I didn’t come for that!’ but obviously you have to follow through whatever it brings up [ ] I explained to Mum why I was doing the assessment and the questions – I think, just the way the questions are - it brought out domestic violence. It was domestic violence that was historic but also ongoing so that led to referral because the Mum in question was assessed as high risk. (4)}
\]

One participant pointed to the usefulness of additional questions posed within the assessment documentation which can lead to a more considered approach:

\[
\text{Often when we go into a family, particularly if they may be at crisis point or at a point of high anxiety, they are absorbed into that and if we jump into behaviour management we’re also joining the crisis [ ] so I think the questions are really poignant about the quality of the relationship before the crisis rather than diving into the crisis as a goal. (13)}
\]

iv. Applying the concept of containment to practice

Participants were able to define containment and its value in their work with parents:

\[
\text{One of the biggest parts of our job is containment so that is going to increase their capacity to parent because we’re acting as containers [ ] it’s allowing them to get more space in their heads to be able to cope with what they are dealing with, which is what containment is all about. (7)}
\]

This involved helping parents to identify key influences on behaviour including their own:

\[
\text{Containment isn’t about taking on all their problems but it’s about listening and sort of giving it back to the parent in a way that they can use. Often the parent will say ‘Actually it’s me isn’t it, it’s me that’s the problem’. (2)}
\]

There was evidence of how containment affected outcomes. This was illustrated by a participant who was informed by a mother with a 2 ½ week old baby that she was giving up breast feeding and had given the baby formula:

\[
\text{I just listened to the Mum’s problems, I mean her perception of the problem, how she felt tired, overwhelmed by it all, how she thought she couldn’t cope, how she thought the baby hadn’t had enough milk [ ] I gave her all the information about how to safely feed the baby. I then explained the normal feeding pattern of the baby, how it’s OK and normal to feel tired and for the baby to be hungry every hour. I turned the perspective on how the baby was feeling ..we talked about different ways of soothing the baby. She just had the opportunity to listen to me and then she said}
\]
‘Well I just can’t do it.’ So I said ‘Fine it’s your decision. I’ll come back tomorrow and see how you’re doing.’ And I just left her and she never gave her baby any more bottles and breast fed this baby till she was 14 months. She became a breast feeding supporter after that.... She said ‘I felt great because you didn’t judge me, you gave me all the advice but you also helped me realise that it was all right and normal and things were getting better’ (12)

v. Applying the concept of reciprocity to practice

The concept of reciprocity had been unfamiliar to most participants before Solihull training but they were able to provide clear examples of how lack of it might be recognised and positive bonding encouraged:

*I think sometimes there is a problem because this dance isn’t really working, the reciprocity isn’t there between them. Sometimes just pointing and showing, sometimes by modelling, by me playing with the child and telling them ‘Oh, he’s not interested in that anymore’ and just turning away whereas the parent would probably go on trying to play with the child. ... sometimes it’s just telling or trying to be their child’s advocate and saying something like – maybe she could try a different toy or do something differently.* (12)

Data provided information concerning how use of the Solihull Approach enhanced parents’ sensitivity to cues and their understanding of parent/child reciprocity:

*I talk about baby cues and baby brain development, how important it is to pick babies up and talk to them, stimulate them and how sometimes they’re overwhelmed, they might cry, they might look away. It’s interesting because the next time I visit they often say, ‘Do you know he did that, I noticed him doing that’.* (9)

Data also demonstrated how the conceptual framework was useful in giving a deeper understanding about what was observed:

*Years ago I will have observed it and not necessarily done anything about it whereas I can think of something recently where I made that observation in a family where I wasn’t expecting to see it. I could see it actually and it was the lovely nurturing care for the baby. I can remember going back to the office and talking about the relationship that those parents had with that baby and using reciprocity almost slightly laughingly. But it does give you that kind of terminology to explain what you observe that years ago I wouldn’t have had.* (3)

vi. Applying behaviour management strategies in practice

The participants described ways in which their views of behaviour management had changed. All described how the Solihull Approach encouraged them to see behaviour in context and of not necessarily ‘rushing in’ with interventions before trying to establish underlying reasons for behavioural issues:

*Someone going to do intensive work around bedtime routines won’t help when the issues are underlying and they’ve never been – it’s like sticking a plaster on something, it works for so long and then it falls off - the problem’s still there.* (6)

The importance of all categories of staff understanding the need to put behaviour into context was apparent:
I thought it was a physiological problem but actually there were lots of things Mum was talking about around stress and the family [ ] Solihull is a holistic approach. It goes away from bedwetting as an isolated thing. (1)

Evidence emerged of changes in attitude to behavioural problems because of this approach:

There were multiple issues going on with Mum which even by the first session she was acknowledging the links between how she was feeling herself and what the little boy was demonstrating. So in the space of an hour that was what was coming out of her, about her feelings of anger and emotional distress. And she said ‘Actually I think he’s angry. He’s kind of behaving like I’m feeling.’ (11)

There was positive feedback about the advantages of doing this:

I think I can give you an example of a child who wasn’t eating. Before-hand I would probably have gone out with a food diary and those sorts of things. I just went out and did the assessment and got the dietary questions as well. I ended up taking a star chart to go along and within a couple of weeks this child was eating fine and to be honest because I’d asked about the parent’s childhood, it was all there all their anxieties came out and it was them who turned round to me and said ‘it’s us isn’t it? It’s not her it’s us!’ It was really this sort of thing. Had I not used the Solihull Approach I would never have gotten that information out of them. I would have been going down a behaviour management route.

Summary of category 2: Applying theories to practice – looking deeper and wider
It was evident from the transcripts that the Solihull Approach was seen as both a philosophy of care and as part of the professional toolbox which enabled practitioners to apply theory to practice. Understanding the theoretical underpinning to the Solihull Approach and integration of the three strands gave a deeper understanding with subsequent impact on practice. Data related to the application of the conceptual framework of Solihull in practice pointed to its effects on the quality of care provision and outcomes.

4.2.3 Category 3: Re-defining professional practice
Analysis of the interview transcripts identified a number of themes that have been categorised as re-defining professional practice.

i. Developing a common language
Language is a theme cutting across categories and in relation to redefining professional practice there were frequent examples given of how the Solihull Approach helped practitioners to re-frame their practice in terms of a new conceptual framework. This both validated their existing practice and gave them a professional language and vocabulary to sharpen and expand understanding and to communicate to other professionals about their practice with children and families:

So instead of going, oh yes I went round for a cup of tea and we had a chat, blah blah blah you can say ‘I felt the session was very good containing for mum and the family.’ Sometimes it gave
people that – oh that’s what I’ve been doing. I also think there’s something round sharpening people’s understanding of what they’re doing [] about doing something more consciously. (13)

I’ve got a lady at the moment who has personality problems and I’ve referred her to Claremont House [ ] I’ve been able to include a sense of her inability to contain and her reciprocity with her daughter in that referral which I think has been helpful for the psychoanalysts to pick up [ ] my confidence to have put that down before would have been based on my personal values which isn’t really research based. (10)

Having a ‘common language’ to build bridges across agencies and facilitate inter-professional working was seen as important and examples were given that demonstrated a positive impact on a more joined up service provided to children and families:

Just having that shared language is fantastic with other agencies. I’m blowing my own trumpet here but we work brilliantly together. We both found that we’ve done a much better job with a client because we’ve both been working with the Solihull Approach. It’s made a huge difference, just looking at things in a different way and using the same language, understanding what we’re both doing, rather than her coming from her speciality and me coming from mine, working with the family but not knowing what the other one’s doing. (7)

Practitioners valued the fact that Solihull Approach is evidence and research based. This legitimised their practice and it also positioned them more strongly to advocate for children and families, “it’s almost like at least they’re representing the family in a fairer way and people understand what they’re trying to say” (13). This manifested itself in their dealing with other professionals, case reviews, writing reports for court and advocating for additional resources. This sense of fairness was related to an ability to stand back and be more impartial and objective and less influenced by personal values and opinions.

ii. Patterns of Referral

There was no definite pattern in terms of quantitative measures of referral from the analysis of the questionnaires. The qualitative evidence, however, gave examples of much more considered reasons for referral. Health Visitors and other practitioners were more confident about the boundaries of their professional roles and willing to work with families with support from other professionals, accessed through their networks, rather than formally referring on. This was sometimes double edged as in some instances applying the Solihull Approach opened up issues that would not have been apparent from a more directive way of working and therefore increased the likelihood of referral. In other instances early intervention led to quick resolution of problems and therefore reduced the likelihood of referral:

It’s probably reduced the amount for CAMHS referrals, hopefully we’ve been able to nip the problems in the bud and we’ve been able to deal with them before they’ve needed referral to CAMHS. (5)

I think that as Health Visitors we have a lot of skills that perhaps we don’t always think we have and we can actually manage a lot of behaviour management in our practice rather than referring on and I think for some Health Visitors it’s probably given them the confidence to do that. (2)
In addition to direct referral there was also evidence of informal communication, sometimes because of working in the same vicinity, and formal communication through documentation between different service areas promoting continuity of care:

> When the child goes into school those notes are handed over to school health, so they get those notes and they would see all the work that we’ve done and all the answers, everything that the parents have said in that assessment. (8)

### iii. A sense of professional identity

In general there were strongly positive comments about inter-professional working and there did not seem to be any anxieties about loss of Health Visitor professional identity:

> I think social workers should use the Solihull Approach and I think they should be integrated. Health Visitors and Social Workers for instance are integrated in Norway and they work very well together [ ] we need to do more interagency working because they need to be talking the same language as us. (9)

> We’ve got good relationships and I think it’s really helpful but as I say it’s the commonality. When you’re sitting in a room we’re all singing from the same hymn sheet. (10)

Full engagement with the Solihull Approach was linked to a stronger sense of identity as a professional and willingness to undertake on-going continuing professional development. Findings mirrored those of Douglas, Delaney, Cabral and Rheeston (2009) in that engagement with the Solihull Approach and its theoretical basis appeared to whet the appetite and create a ‘virtual circle’ for learning and development:

> That’s definitely grown over the years of using Solihull and I’ve also done the infant mental health training which is recommended in Newcastle to go alongside Solihull [ ] as part of that course you go out and do observations on a family that you don’t know and write it up and you take it back to the course group and discuss what you’ve actually seen, what you’ve witnessed. (7)

Having the appropriate tools for the job was also inter-related with what it is to identify as being a professional person:

> I think it’s a toolkit, it’s a bit like having a bag of spanners, you’ve always got it in your kit and you need it in your kit. (9)

### iv. Delegation and skills mix teams

Re-defining professional practice was associated with when to delegate and how to work in mixed skills teams and was also associated with ‘tools of the trade’:

> If the Health Visitor knows the family quite well, is reasonably confident that there’s nothing complex going on within that family, there’s not any safeguarding factors. Do you know we’ve got the risk assessment, the red, amber, green risk assessment, so for example if they’re confident it’s a green family, so a low risk family, and they know the family well they may be quite happy to ask the Nursery Nurse to go out and carry out a Solihull Assessment with a view to that being early intervention, that’s how the tool is marketed but with the red families that would never happen. (11)
There were some related instances where Health Visitors said they did not “do Solihull” but “delegated it to the nursery nurses”. On further questioning, however, it was apparent that this was because a narrow definition of the Solihull Approach was being used that was restricted to the behaviour management dimension and this was what was being delegated. When Health Visitors actually described their practice they invariably gave detailed and in depth examples of working therapeutically with parents and families to contain anxieties and used knowledge of Solihull to shape how they carried out initial assessments. One participant discussed using Solihull as a “way of life in health visiting” in which you “always have your Solihull head on” and compared this with its use in a more clearly defined targeted intervention:

*There are two ways of using Solihull. One is interwoven with your work and the way you use the words, the way you talk to parents and the way you question parents and the other way, if you talk about delegation, maybe a staff nurse or a nursery nurse is doing a piece of work like toileting or feeding and they will go away and use the Solihull Approach.* (9)

v. A whole service approach

A whole service approach refers to working across different roles within skills mix teams in health but it also relates to different parts of the service working together. One participant described how Solihull can be used effectively alongside other tools to co-ordinate multi-agency work:

*Each tool complements the other and allows decisions to be made about which is the most helpful in individual situations. These can feed into the CAF (Common Assessment Framework).* (14)

There was some evidence that having Solihull Approach as a common approach to working with families helped to break down silos and facilitate working across professional boundaries to deliver more family centred care and support. The following narrative illustrates this alongside the benefits of networking through multi-agency training:

*She came to us when she was having her second baby, very traumatised and very anxious about what her experience was going to be like with this new baby. We got the perinatal team on board and it was one of the girls that I’d trained in Solihull and so we were both working from the Solihull Approach.. [describes a piece of joint work with the mother].. and it worked really well. She got a lot out of that and became a lot more relaxed around her second child and the bond was more easily attained if you like. It was really lovely to see. It was a really satisfactory piece of work.* (7)

Individuals in different parts of the service demonstrated awareness that Solihull Approach was increasingly being used across health and social care and the following example illustrates the benefits to a mother who had lost confidence in herself:

*On Tuesday, she went to the infant massage session and she was really upset, she feels she’s not doing the best for her children but she said that one of the workers in the Sure Start centre had commented on the reciprocity. She didn’t use that word reciprocity [ ] she was reporting the good feelings that she’d got from that [ ] She said to me that baby had been talking to her on the mat and was, you know, just babbling at her, he’s about 31/2 to 4 months, and that he’d been looking at her and she’d been responding to him through talking to him .. but had also been physically
touching him and that she (the Sure Start worker) had said ‘that’s a really lovely interaction, isn’t it lovely the way you’re handling your little boy, look at the way he’s speaking to you, look at the way that you’re then responding to him’ and had just observed and picked up on that short interaction. (10)

These findings indicate the value of Solihull Approach in promoting multi-agency approaches to ensure continuity of care and approach and provide some evidence that the requirement for embedding whole family approaches is being met (Department of Health 2013).

Summary of category 3: Re-defining professional practice
This section illustrates the benefits in terms of Solihull Approach providing a professional language and vocabulary for validating professional practice, strengthening professional identity and willingness to undertake further professional development. Additionally it provides a ‘common language’ that facilitates work across professional boundaries and promotes a whole service approach. There was evidence about increased professional confidence in managing less complex cases and in explaining and giving an evidence based rationale when formal referral was necessary.

4.2.4 Category 4: Promoting reflective practice and reflective parenting
In depth analysis of the interview transcripts identified a number of themes that relate to a way of working where Health Visitors and other practitioners reflect on their own practice and also develop a relationship with parents that promotes facilitated reflection on the parenting process. This joint therapeutic and problem solving approach could be described as a partnership approach to reflective parenting.

i. Reflection on and in practice
Health Visitors and other professionals used the Solihull Approach to help them reflect on their own practice in formal situations such as Solihull supervision sessions:

Yes, you say well we’ve got little Bobby, he’s age such and such, mam’s here, dad’s there – the problem’s this you know and we don’t know which way to tackle it. We use De Bono’s Thinking Hats – they use those and that’s a good way of deconstructing the problem..(1)

I hadn’t really appreciated that was where I was using containment. It’s just that sort of clarifying what it means and maybe being able to think about where they’re using it in their practice outside a formal assessment tool. (10)

As well as retrospectively reflecting on practice it also became part of their embedded practice. For example, there were many instances where practitioners described using the Solihull conceptual framework in a way that enhanced their observation and analytical skills when they were present during parent and child interactions. This relates to category 2, applying theory to practice (see section 4.2.2 v) and has been well documented as a way in which professionals think in action, a process of ‘reflection in practice’ (Schön 1983)

ii. Promoting reflection through story telling
Practitioners also described how they utilised story-telling to encourage parents to reflect on their parenting practice. This relates to category 1 (see 4.2.1 v) as using story-telling to develop shared
understanding in the initial relationship building phase can set the scene for on-going facilitated reflective parenting. The following is an extract from a scenario where there was a complex family situation with multiple issues for a mother.

I was helping through the story telling process and using containment [ ] I went back the following week and it was one of those families and you think, ‘Oh I’m going to be coming forever to this house’ and within a week she’d shifted massively in terms of how she viewed the little boy and also what she was doing with both children on a daily basis. From having been sort of ‘I can’t go anywhere, can’t do anything, he’s just a nightmare, the family don’t want to be anywhere near him because he’s such a nightmare’, and having implemented lots of stuff within that week in just the house setting, partly because of the time of year, her perception of him had changed significantly. (11)

Evidence from transcripts illustrated how parents moved from helplessness to increased confidence in putting strategies in place to manage situations and behaviour.

iii. Client identified problems and solutions- opening their eyes wider
This partnership approach to working with parents generated examples where insights and ways forward were suggested by parents themselves. When anxieties were contained and parents had space to talk more generally about issues without problematising situations the emphasis changed to parent driven rather than professionally driven solutions.

Quite often I don’t concentrate on the problem itself, I kind of talk about other issues, and then the problem gets solved itself really so it’s like getting to the bottom of it, why things are happening and is it really a problem. And then the parents open their eyes wider and think well we could change this and that. (13)

iv. Developing family resilience
Developing family resilience was at the centre of this therapeutic and reflective style of working. One participant who had a school nurse role said:

I’ll just say, ‘You can do this you know’. There’s not a family I see that hasn’t got a problem. I try to build them up and with the Solihull Approach you can point out the resources they do have. So you’re getting the balance. It’s not all you know, ‘Oh its terrible, we never get any sleep’. You can say ‘Right what could we do, how could we do it, what could we look at’ and you’re giving them, you’re putting strategies forward – you’re not prescribing it - you’re putting strategies and you’re letting them decide. You’re suggesting things but you’re basically letting them make the decisions. You’re letting them get to the eureka moment when they can say what they need to do. (1)

Getting to the eureka moment encapsulated a turning point where families moved from feeling overwhelmed and helpless to taking control and drawing on their own resources to resolve situations.

21
v. Normalising behaviour

The following extract from a nursery nurse demonstrates the informal and ubiquitous use of the Solihull Approach to supporting parents and giving them the confidence to find their own solutions to problems. It also illustrates a strategy that was frequently used by health visitors and other professionals i.e. ‘normalising’ behaviour. In this instance developmental stages are used to illustrate realistic expectations but there are other examples where behaviour is re-framed (see previously in ii):

“They might just come to the health clinic... or if I do a developmental review. So there are two situations where I might meet the families without a referral and the family might say ‘everything’s fine, everything’s fine but...’ and they start saying, ‘he’s not sleeping, he’s not eating, weaning isn’t going very well’ and then it starts coming out, so that’s when I will use the Solihull Approach to talk to the parent about it, to make it easier for them to understand why things are happening, to make them have realistic expectations of a child at a certain developmental age, of changes in the family - because often they cause a disturbance. And then quite often by just talking to them but also by containing them (using the Solihull word) things are solved within a couple of weeks so there is no need for further intervention, for further going in and doing a further assessment and doing a full six week programme of support. Just often that’s enough for them, being able to tell somebody their problems and just off-load. (12)"

Summary of Category 4: Promoting reflective practice and reflective parenting

Promoting reflective parenting as a means of developing family resilience occurs implicitly as a theme in all other categories and appears to be at the heart of the Solihull Approach. Reflective parenting enables parents to think about their own life histories and how they might have impacted on their parenting practices as well as considering the immediate context and how this might be having an impact on the family.

4.2.5. Category 5: Overcoming resistance

As discussed in the methods section, there was a tendency for it to be Solihull enthusiasts who came forward to be interviewed. This enabled a whole range of benefits to be identified of utilising the Solihull Approach, with an in depth and rich picture of practice scenarios. It was, however, also possible to identify a number of themes relating to resistance of others in the transcripts.

i. Fear of the time it will take

Perception of the time it would take to implement the Solihull Approach was identified as a key barrier in the analysis of the questionnaire responses. This wasn’t borne out in the in depth interviews where participants tended to stress the benefits of the initial investment in time. It was acknowledged that using the approach could uncover ‘a can of worms’ (see section 4.2.2 iii) but there was also recognition that underlying issues would get in the way of interventions anyway so it was better to have things out in the open so they could be addressed. Paperwork was an area that was identified as a potential issue but, again, participant felt that there were efficiency benefits in passing on assessment documentation to other professionals to ‘join up’ the service. In general, the
approach of Solihull in developing family resilience should reduce the overall amount professional input and therefore reduce time commitment.

ii. Fear of not having skills and knowledge
This was identified as only a medium level barrier in the analysis of questionnaire responses. However, participants in the in depth interviews did refer to some of their own initial anxieties when implementing the approach such as being expected to be a ‘mini-counsellor’ and not having the requisite level of counselling skills to deal with some of the more complex issues that were uncovered. In general, this did not prove to be an issue in practice but it is possible that fear of not having skills and knowledge, in general, is an on-going anxiety for individuals who are less confident. A high percentage of participants in the in depth interviews were also Solihull trainers and this gave a level of confidence in knowledge and skills in implementing the Solihull Approach that might not be present to such an extent amongst others.

There were some comments that the relatively poor attendance at Solihull supervision sessions might be because of individuals feeling exposed about their lack of knowledge and skills, “So I think maybe some people are afraid of not knowing”. (13)

iii. Not seeing the value
Analysis of the questionnaire responses revealed an almost universal agreement with the general model and approach of Solihull. However, this was an ambiguous response as a significant percentage also thought that they were implementing the Solihull Approach anyway in a ‘common-sense’ way and that training had not significantly affected their practice. There were some in depth examples from the interviews where this was certainly the case and Solihull enabled individuals to put a name to their practice. However, there could be elements of resistance where individuals are not using it as a tool (based on an integrated approach combining psychoanalytic, child development and behavioural theoretical insights) to really develop and build on existing practice. “Depending on how open you are to your own self-awareness and your own level of development, supervision can just feel like an intrusion into your practice”. (13)

iv. Changing established practices
This was identified as a barrier particularly in the context of a whole raft of change initiatives where individuals might hang on to the safety of established practices, “ it’s very difficult to get people to take on board things..people are quite resistant to change”. (1) One school nurse reflected:

“I think there needs to be more done generally about nurses’ attitude to change. [ ] as a group of people I think they can be frustrated by their hands being tied by one thing and another. I think a lot of change is just seen as a hassle – they haven’t got the time for it or they’re already overburdened. I think you’ve really got to sell what they are going to get out of it.”(1)

Another participant (a health visitor) commented:

“I think there are a lot of resistant Health Visitors and other staff in health visiting. People tell me they’re not using it and they don’t come to supervision.” (6)
There was also some commentary about established practices of a fire-fighting coping strategy in the face of heavy workload:

*If somebody comes in to the clinic and they’re worried about their toddler’s behaviour they’ll just give them 5 minutes of advice and tell them to get in with it rather than say, ‘I’ll come and see you next week and we’ll spend some time talking about it’. That’s what they should be doing and using the Solihull assessment or principles of Solihull but they don’t, they’ll just give this quick fire – because it’s easier I think and they can get more done that they need to do. (6)*

This type of ‘custom and practice’ of privileging the quick fix relies on short term gain for the Health Visitor, or other professional, rather than longer term benefits to families and could undermine rather than promote family resilience therefore creating more work in the long term.

v. Family resistance

There were some instances of family resistance identified. These related to hostility to professionals and fear of stigmatisation and general chaos and disruption in the family setting making it difficult to implement the approach. Some participants also identified instances where it was clearly very painful and difficult, “too much to bear”, for parents to talk about their own parenting experiences.

**Summary of Category 5: Overcoming resistance**

Although it isn’t possible to quantify resistance this section highlights some possible reasons for it that feed into the recommendations made (see section 6).

### 4.2.6 Category 6: Leadership, organisation and management

This was included as a category because there were a number of key themes where an organisational approach with strong leadership and management processes to implement changes was desirable.

i. **Training as a process of embedding the Solihull Approach**

Whilst the knowledge gained from the Solihull Approach during the training sessions was viewed positively, there were criticisms of the amount of information packed into the first two sessions with insufficient time for reflection on application to practice:

*The material is so substantial [ ] you need time with the material to explore it, what does it mean to you, where do families fit in (13)*

*There’s a lot packed into 3 days. I think that was overwhelming because you really have to go and read round the concepts. You don’t pick up on reciprocity and the buzz words immediately – you need time to process that information and I think the first 2 training sessions are really hard going. It begins to click when you start to understand what you’ve heard and relate it to what you see in practice. (1)*

Those participants who were trainers themselves acknowledged this, one highlighting the problems faced:
There’s no getting away from it, we do an hour and a half on baby brain development and infant mental health and I think that’s actually the section people struggle with and find most challenging particularly about their own experience of either being parented or being parents themselves [] it becomes very subjective for most people in the room. (11)

A need to reinforce learning gained from initial training was identified:

There is ongoing training for new members of staff. . Hopefully the refresher training will be rolled out..if they had a refresher it would probably reinvigorate them to use it. (2)

This was seen as particularly important to overcome possible resistance to utilisation of the approach, particularly if participants went in to training with preconceptions of what might be involved:

I think we all went to training thinking it was probably going to focus on behaviour management but in reality the behaviour management bit is very short. Really it’s looking at the other bits because behaviour almost manages itself if you get the other bits right. So once you’ve got over the language, once you’ve got used to it and had time to read it, people are usually fine. It’s just that first day – whole new ideas to take in – whole new terminology and everything. (5)

Trainers found resistance challenging especially amongst experienced staff:

I think with everything you’re always going to get people who embrace this with enthusiasm, you get the ones who are not quite as enthusiastic and then you get the ones who just don’t want to know. It’s change management and eventually it’ll work its way through I would imagine and become ingrained as people retire and the workforce changes. (7)

One participant described her appreciation of having Solihull training early in her career post qualifying since it provided her with a clear framework for practice and useful guidance on specific actions. She indicated that would have found it useful if she could have been taught about it even earlier:

To be honest I think it would have been of great benefit to have had it in our Health Visitor training because we’re managing a small case load then and I think we could have started it from qualifying. I think it would have been better to have had it embedded in training. (8)

Participants (who were all positive about the benefits of the Solihull Approach) related difficulty in ‘selling’ the approach to some experienced staff. They were clear that the training provided them with useful advice, guidance and increased understanding but they also reported pressures related to the amount and content of theoretical knowledge presented over a short period of time. These were mainly related to their introduction to key Solihull concepts and baby brain development. The advantages of introducing Solihull training in Health Visitor undergraduate training should not be at the expense of missing out on continuing a multi-professional approach, particularly in view of the aspirations of the Health Visitor Implementation Plan (Department of Health 2011).

The benefits of multi-agency training were flagged as leading to to greater understanding of professional roles (health and social care) and opportunities to share perspectives and compare use of Solihull, thus becoming a learning situation for all. The multi-professional approach became an
opportunity to learn from and give to the group in a dynamic and reflective partnership mirrored in the approach with families, “That's what I like about Solihull, everything's got to be two ways or it just doesn’t work.” (14)

Training together was therefore not only seen as positive in gaining knowledge and in sharpening the application of skills but it also facilitated continuity of care across professional areas. This was described by one practitioner as follows:

I think that’s one of the biggest things, you’ve got Sure Start staff, you’ve got CPNs, you’ve got Health Visitors, we’ve all got the same training so we’re all singing from the same hymn sheet. (10)

ii. Supervision as a process of embedding the Solihull Approach

Groups who trained together stay together for Solihull group supervision. The trainers facilitate this with the aim of creating a non-threatening, restorative model that promotes confidence building and the opportunity to share experiences and learn from each other. There is evidence that this was effective for most participants in the study:

It just keeps you enthusiastic when you can see a group of people who are all committed and thinking the same way and the support’s there for you. (1.)

I found it helpful because you’re talking to the group so you can listen to how other people have used it and things that they’ve done as well. You can also get feedback about things you’ve done. I found it quite useful. (8)

There were however observations that group participation in the sessions might be limited:

I think it feels like something that’s been forced on us – that we have to go rather than actually our choice because we’re not going, a lot of us aren’t going, and I have to say the session I went to wasn’t very helpful [ ] I think it comes down to experience. I’m not saying I’m – I feel like I’m still learning every day...actually I didn’t learn anything from my supervision session. I didn’t say anything. It was two people – two people presenting and I didn’t get anything from them presenting. (3)

I think people come to the sessions because they have to [ ] what ideally it is that the session should contain is some sort of clinical practice and that relies on people bringing a case to talk about and that doesn’t always happen. I think there is opportunity for people to reflect on practice but I’m still not sure how much it’s used just by the attendance at supervision and what gets brought to supervision (2)

The non-attendance of staff at Solihull supervision sessions was recognised as a problem and several possible reasons for this were given such as time and workload constraints but participants also pointed to other possible causes:

Solihull expects you to look at your cases, to know your case, to be able to validate your actions and interventions [ ] I think maybe some people are afraid of not knowing. (13)
Maybe they’re feeling they’re not getting a good enough supervision session. They’re not coming away from it feeling that was any good because I’m sitting with people who are the same as me and what does she know! There’s a little bit of that – in fact I know there is because I’ve heard that. (6)

Participants in the study who were trainers were supervised by a psychologist and the form and content of these sessions were highly regarded:

He asks us what topic we want and then he’ll usually send us a couple of research papers to read through first and we just talk generally about the topic and then if anyone has issues around it we’ll talk about that. There’s always time at the end of the talk about cases that you’re struggling with because you learn from other people talking about their cases so that’s really helpful. (5)

This approach was seen as informative but also non-threatening and data from some trainers in the study indicated the need to take care not to make people feel uncomfortable. A two way approach was advocated:

It’s important to discuss what supervisees want to discuss. I may begin with concept such as containment rather than asking them to describe ‘case’ and then ask for examples of when practitioners have used e.g. containment or reciprocity, which then provide openings for discussion re cases. (14)

This kind of approach was perceived as beneficial:

We’re trying to get back to the packs and Solihull on a more formal basis. Today we looked at the concept of containment and we spent an hour talking about that and actually everyone in the group brought something to the table and discussed something so that was really useful .... also one person said ‘I’ve never thought of writing my notes in that way, I hadn’t really appreciated that was where I was using containment’. It’s just clarifying what it means and about where they’re using it in their practice outside of a formal assessment tool. (10)

Data also revealed the importance attached to the confidence and enthusiasm of supervisors and the impact the Solihull framework could have on the way supervision was facilitated:-

I model the model for example using containment when considering challenging cases. (14)

Sometimes they are so overwhelmed with their own work that they are quite happy to listen to somebody else. So it depends on the day, sometimes it’s about containment, you’re containing those stresses that they have in everyday life. Sometimes just talking about it you can see that light bulb moment where they go, ‘Oh, that’s a good idea, maybe I’ll try that! I haven’t thought of that! So it allows other people to go in a non-threatening way – have you thought of that? Have you looked at this? Have you tried asking them that? because they’re all experienced practitioners.

There was evidence of good models of practice in group supervision with the potential for sharing experiences, reducing work stress, widening skills and evidence based, multi-professional practice. However this could be strengthened with more knowledge of why people do not attend supervision sessions and in determining strategies to address this. Recognition and promotion of the value of
peer group learning will also help to further promote and embed the Solihull Approach within practice.

iii. Organisational embedding
Participants reported that new documentation was being implemented which had more emphasis on Solihull Approach and included assessment questions related to aspects of Solihull e.g. attachment and bonding, maternal mental health.

It was seen as an opportunity that we could use because everybody was now trained in the Solihull Approach and found it useful to actually incorporate the good ideas from that into what we were doing. (5)

Participants reported that they used the language of Solihull within general documentation e.g. in report writing but this could not be verified within this evaluation.

A small number of Health Visitors in the study had been trained in delivering parenting groups and one participant described the complexity and valuable insights gained from one group as follows:

You’re dealing with any child who belongs in the family and one of them had a 16 year old boy, a 9 year old and a 3 year old, who she’d come about or with if you like. And then she had a 6 or 7 month old as well but we spent as much time discussing her 16 year old as we did the 3 year old. It was remarkable how similar they were in their behaviour, their ability to communicate or not! She was really struck by that and was able to put a lot of the exercises into play with him. (11)

Increasing the delivery of parenting groups would therefore be another means of embedding the use of the approach with all children and young people in the family and another way of promoting the development of family resilience. The efficacy of parenting groups is well outlined in the literature (Johnson and Wilson 2012; Douglas 2010).

Another aspect of organisational embedding was referred to in the previous section when a participant referred to ‘modelling the model’ in supervision. This came out quite frequently in the transcripts where health visitors and other professionals were explicitly using the Solihull framework for their work with other staff in a formal supervisory, management or leadership context or offering informal peer support with team members. This provided a powerful means of ‘containing’ practitioner anxiety and enabling reflection on difficult and challenging practice situations.

.. so when she (the mother) spoke to my colleague she was extremely angry with her and you know when she (the colleague) came off the phone she was really upset because she felt that she’d missed it (a child’s medical problem that was subsequently diagnosed). (2)

This example illustrated how a team leader was able to contain the anxieties and distress of a team member so she in turn could maintain a functioning relationship with a client and in turn contain her distress.

iv. Leadership without authority
There were some indications from in depth interviews that individuals in team leadership roles did not have the requisite authority to take anything other than a ‘gently-gently’ approach, so
promoting use of the Solihull Approach became dependent on individual motivation and enthusiasm rather than organisational strategy:

**It’s getting down to personalities - you cannot force someone to do it but I do encourage them [ ] it might just be at a team meeting, I get an idea of who’s using what and find out what people’s feelings are and encourage them to go along to the supervision as well. (4)**

There was a risk to consistent embedding if some Health Visitors and other professionals see Solihull as an optional add on to their practice and one set of training amongst other commitments rather than a fundamental philosophy and approach that is part of an organisational strategic plan.

v. Leading change

Economic realities were acknowledged in a context of on-going change and associated risks to driving the embedding of Solihull forward into the future:

**I think it will have a future if someone’s driving it [ ] if you lose someone like that, it tends to drift. I know you can’t always have a person, it’s like a luxury item but I think we have to get better and find some way of driving it forward (13).**

Having named people with leadership and management status with accountability for embedding the Solihull Approach across the whole service built into their roles and job descriptions will therefore be essential.

**Summary of Category 6: Leadership, organisation and management**

Training and supervision were identified as key functions necessary for embedding the Solihull Approach and therefore important in any strategic plan mapping out a vision for the service. Further facets of organisational embedding related to paperwork, facilitation of parenting groups and use of the Solihull Approach by team leaders to develop team resilience. There were risks of loss of momentum if left to enthusiastic and committed individuals to take forward without strategic commitment and allocated resources.

5. Discussion

The mixed methods approach resulted in descriptive statistics from analysis of the questionnaire responses and these results were outlined in section 4.1. This analysis helped to set the framework for areas of questioning for in depth interviews: exploration of role and training, exploration of areas where Solihull training had made a difference (to overall practice, to clients, to individual, to service as a whole), what had supported individuals in implementing the Solihull Approach and what the barriers to implementation were, how helpful or otherwise they had found the model and any specific examples of how they had applied the three main concepts to their practice.

The coding of interview transcripts resulted in identification of emergent themes which were classified into categories (see Table 1, Appendix 1). These categories were conceptualised in diagrammatic form as an interactive set of processes that need to be in place in order to maximise
the development of family resilience (see diagram 1 below). Detailed findings for each category were outlined in section 4.2.

From the coding and analysis of transcripts it became apparent that there were some themes which were interconnected in all the main categories. Family resilience was explicit in some and implicit in all categories and this was therefore placed at the heart of the diagram as one of the key outcomes of successful embedding of the Solihull Approach. Language was another theme, or sub-theme, that cropped up in all main categories ranging from the conceptual vocabulary or theoretical building blocks of Solihull, language as validating professional practice and conferring professional status and identity, use of professional language to enable health visitors and other professionals to act as advocates for families, translation of theoretical concepts to everyday language, developing a common language to facilitate multi-professional and inter-agency working practices, use of language to develop shared understandings and build relationships. The capacity to use language to re-frame problems was also critical in the developing client/professional relationship and use of story-telling to promote reflective parenting.

The centrality of language highlights that the crux of the initiative to embed the Solihull Approach more consistently in the practice of Health Visitors and other professionals is in essence an endeavour to translate research based knowledge and theory into practice based actions. This knowledge to action process has been the subject of much debate and enquiry in the health arena (discussed in Brigham 2012) and concerns about the theory to practice gap well-articulated. It has been noted that research findings often take a very long time (if ever) before they are effectively embedded in actual practice (Graham et al. 2006).

Although the remit of this piece of work was to make recommendations to embed the Solihull Approach more consistently in practice, given this context and the findings it also becomes valid to reflect on why it has been so successful and the reason why so many examples of excellent practice have been forthcoming (the examples here represent a very small proportion of the total). This can be clearly linked to the national status of the Solihull Approach and the development of resources and tools that facilitate bridging of the theory practice gap plus strategies at regional level to roll out an infrastructure of training, supervision and support for the Solihull Approach. However, embedding the Solihull Approach is complex because processes need to happen at different levels. Practitioners not only have to apply theory to practice but they also have to translate academic concepts into everyday language to encourage parents to translate theory into their parenting practice. In some scenarios described the Solihull Approach was also embedded in supervisory, management and leadership processes so this involved articulating theory with different organisational functions and practice contexts.

In addition to these multi-layered knowledge to action processes the theory underpinning the Solihull Approach is itself complex and multi-stranded. The approach is underpinned not by one theoretical framework but several with arguably fundamental tensions in their explanations of human behaviour. The concept of ‘containment’ was coined by Bion (1967) working within the psychoanalytical tradition (Bion 1967). This is closely connected to the concept of ‘reciprocity’ situated in the child development literature and developed by Brazelton et al. (Brazelton, Koslowski and Main 1974). Situated alongside this is behaviour management and the roots of this approach sit within the theoretical tradition of behaviourism founded by Skinner (Skinner 1978). At the risk of
oversimplifying, psychoanalysis tends to focus on conscious and unconscious processes linked to development whereas behaviourism is focused on observable behaviour.

The detailed examples outlined in this study bring together the three key concepts and demonstrate scenarios where containment and reciprocity work is undertaken with families and behaviour management strategies then sensitively aligned in a way that accounts for individual and family differences and histories. Some examples also implied an iterative approach between theory and practice with concepts applied then theory revisited with enhanced understanding from practice deepening understanding of theory. Reported examples of poorer practice, the “quick fix”, tended to launch straight into top down professionally driven behavioural advice without putting in the ground work to generate client driven solutions and the development of family resilience.

There were also some examples where professionals said they “didn’t do Solihull” but delegated to nursery nurses. What was delegated in these instances was the behaviour management work which was seen as relatively straightforward. However, in all instances in the sample interviewed both Health Visitors and Nursery Nurses did in fact still embed the holistic and more therapeutic aspects of Solihull into their practice. The risk is that this is not widespread and a superficial understanding of the approach reduces it to the immediately observable behaviour management strategies and completion of the assessment documentation without the development of a therapeutic relationship with parents and families. This is a particular risk when individuals are under workload pressure and there is a perception that applying the Solihull Approach will be much more time consuming. A previous study has identified tensions in the health visitor role with quantifiable targets and standardised approaches being in tension with qualitative dimensions of work, flexibility and professional autonomy (Brigham, Maxwell and Smith 2012). Health Visitors and other professionals need to have the flexibility and professional autonomy to invest time in the initial visits and building therapeutic relationships with families.
6. Recommendations

There were a number of areas that emerged from the in depth interviews suggesting where specific changes could be made to build on existing good practice and ensure more consistent implementation and embedding of the Solihull Approach. These are summarised as follows with specific recommendations in bullet points.
6.1. Training and training the trainers/supervisors

- Prepare and circulate pre course information to prepare individuals and articulate the benefits of utilising the Solihull Approach in practice. Clear message to be included about the investment of time paying off in terms of building family resilience and reducing overall professional input.
- Prepare and circulate some preparatory material outlining Solihull concepts and enabling individuals to get to grips with more theoretical components of the approach prior to the first training day.
- Review structure of training days and if necessary shift the balance from mechanics of completing documentation to a range of techniques including development of cases studies/scenarios to address application to practice.
- Roll out refresher training schedule for existing staff and induction for new staff.
- Continue and extend opportunities for multi-professional refresher training (and supervision) to enhance the opportunities for dialogue across professional boundaries.

6.2. Supervision

6.2.1 Solihull group supervision

- In subsequent Solihull group supervision session trainers to: initially use anonymous case studies to engage the group and model reflective practice without exposing individuals. Then to gradually encourage individuals to volunteer their own case scenarios.
- Increase utilisation of existing models of good practice e.g. joint selection of topics, research papers circulated in advance, encouragement to share scenarios that demonstrate impact on practice.

6.2.2 Clinical supervision

- Draw upon Solihull conceptual framework in individual clinical supervision sessions to encourage reflection on practice.
- Promote value of peer mentoring and supervision to create a culture of learning from each other and the value of sharing practice.

6.3. Documentation

- Embed Solihull as an approach in all assessment documentation. A new documentation system is already in hand for Health Visitors and this should help to meet this recommendation.

6.4. Skills development

- Provide counselling training to enhance ‘listening visits’ e.g. for post natal depression.
- Provide training opportunities in group facilitation skills to build confidence of trainers/supervisors (and those delivering Solihull parenting groups) and to raise awareness of the value of the professional experience of Health Visitors and other professionals.

6.5. External

- Liaise with University to influence curriculum development and propose that the theoretical dimensions of the Solihull Approach are introduced explicitly in Health Visitor education. If
embedded at this stage Health Visitors would be more confident about using the approach as soon as they are qualified. The Community Practice Teacher could then act as a bridge between the academic/practice divide. (N.B. this would be in addition rather instead of multi-professional training once qualified)

- Develop strategies and an action plan for working more closely with Solihull trainers across social care to widen its application and to promote an inter-professional whole service approach.

6.6. Leadership and developing teams

- Provide leadership training for Team Leaders to enable them to motivate their teams and promote the embedding of Solihull Approach in practice.
- Identify experienced Solihull trainers and advocates to work with multi-skilled teams to identify and promote different levels of application of Solihull Approach: parent: child, practitioner: parent, manager/supervisor/team leader: practitioner.

6.7. Measuring quality

- Carry out audit of how practitioners use Solihull in practice e.g. audit use of resources and use of documentation.
- Invest in research to collect both practitioner and client stories to evidence quality of service.

6.8. General promotion of Solihull Approach

- Promote consistency in uptake of Solihull supervision sessions by making attendance mandatory and building SMART (specific, measurable, achievable, relevant and timed) objectives into appraisal documentation so uptake of sessions can be monitored, reviewed and used as a performance measure.
- Organise half day conference with certificate of attendance.
- Appoint Solihull champions.
- Produce and disseminate posters/leaflets outlining what Solihull can do for parents and families, practitioners and the broader service i.e. to promote Solihull as an evidence-based approach and philosophy with a positive impact on outcomes rather than a narrower focus on completion of assessment forms.
- Consider building increased delivery of Solihull parenting groups into strategic plan.
- Extend the reach of Solihull training to occupational groups outside the immediate health context to achieve a critical mass, shift the balance to a more inter-professional culture and ensure sustainability.

7. Conclusion

The recommendations above are based on detailed analysis of the finding from this collaborative piece of work and are focused on minimising barriers and maximising benefits of embedding the Solihull Approach more consistently across the whole health and social care workforce. It is recognised that many may be already in place or in the early stages of being implemented.
A key concern is that a superficial understanding of Solihull Approach and formulaic application could lead to fragmentation across occupational groups with behaviour management strategies being implemented in a more professionally driven top down way outside the framework of a developing therapeutic relationship with families. This would impact on the key benefit at the heart of the Solihull Approach i.e. developing family resilience. Ongoing refresher training and mandatory Solihull supervision sessions are necessary to enable practitioners to have a deeper understanding of the Solihull Approach and the central importance of a ‘partnership approach’ and promotion of ‘reflective parenting’. The main resistance to this is perceptions of time input and the corollary is the ‘quick fix’ approach - which can in fact be more time consuming in the long term. The benefits of holistic practice and potential efficiencies in use of time need to be stressed in both both training and supervision.

To address this concern on-going effective leadership and management is essential with key individuals tasked with taking a strategic plan forward in order to achieve a critical mass of practitioners, across professional boundaries, with an in depth understanding and level of skills to fully embed the Solihull Approach. One of the risks identified is that with reorganisation and changing personnel the momentum becomes lost and embedding the Solihull Approach becomes fragmented both in terms of its holistic philosophy and inter-professional potential.

8. References


Health Visiting Service Specification (2012-2013)


