
Solution-Focused work in the busy Emergency Department of a large city hospital. An interview with David Hains

Interviewed by Michael Durrant

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Solution-Focused Brief Therapy has experienced something of a resurgence in Adelaide, South Australia — largely due to the influence of David Hains. I invited David to reflect on his Solution-Focused journey.

Can you tell me a bit about what got you into mental health nursing in the first place?

Actually it was partly Professor Nicholas Procter (who is hosting our conference at the University of South Australia in a couple of months). In 1993, I was doing the first year of a nursing degree and Nicholas was one of my tutors. In July, we both ended up at a party where we didn't know anyone else so we sat together and chatted. Nicholas asked me if I had any thoughts about my future nursing career and what direction I might like to go in. Really, I had no idea. He then asked if I had thought about mental health and I replied "I have never thought about it, and I never will". At the end of 1996, I was finishing my graduate year and a 3 month contract became available to work in a mental health ward, There were 20 of us finishing at the same time and we all declined the offer. I then realised that I would be unemployed at the end of the year so I took the position, just so I could say that I had something to put on my resume. Three months turned into nine months, which turned into my career. Since then I have had several jobs where I was the only applicant, jobs that turned out to be absolutely perfect for me but in which no one else was interested. I don't know what that says about me!

My guess is that Solution-Focused wasn't in your nursing training, so how did you come to embrace the Solution-Focused approach?

It certainly wasn't in any of my training. I had been working for several years in emergency departments and I was thinking of doing a project of some sort but didn't know what. I decided that I would try to define the approach that we were using. We had a very small team that consisted of a psychiatrist, a psychiatry registrar, and a nurse. While it was medically led, we weren't really working under a traditional medical model. In fact, I remember one occasion when Prof Kalucy (our psychiatrist) was called into an urgent meeting with the head of surgery, the hospital risk manager and a couple of others to discuss an urgent surgical case with a patient who was also under the mental health act. Prof saw me walk past and called me into to room to ask my opinion. I made a couple of suggestions then left. Later, the head surgeon asked Prof why he had called me into the room and asked my opinion, and Prof replied, "that's just what we do". We had a team with a very flat hierarchy and, without knowing it, we were very "client centred" even though that term wasn't in common use.

Brief Therapy approaches previously had some presence in mainstream mental health in South Australia, in contrast to the rest of Australia — I'm thinking of the Brief Therapy program within child & adolescent mental health in the 1990s and early 2000s (see references). What drew your attention to brief therapy?

Working on this project, I was looking at brief therapy and how our approach might align with other brief therapies. That's when I stumbled upon SFBT — it was nothing like what we were actually doing but it instantly made sense to me. For years I had taken a not knowing stance, mostly because I just didn't know so I couldn't tell someone what to do anyway. Whenever anyone asked me, "What should I do?" I would be thinking, "Hell, I don't know what you should do" so I would just say, "That's tough, I don't know, but what do you think you could do?" SFBT then gave me some more reason and structure to the conversation. Why should I be telling someone what to do, when I can get them to tell me what they should do?

I later discovered that Tim Wand (mental health nurse practitioner, Royal Prince Alfred Hospital in Sydney) was also using SFBT in his ED and out-patient clinic. I had known Tim for several years and he is one of the most respected mental health nurses in the country. Tim put me onto you (Michael) and I later headed over to Sydney to attend a workshop at the Brief Therapy Institute of Sydney and also catch up with Tim in the ED. In the last few years

there has been an increasing number of nurses working in ED and psychiatry liaison positions using SFBT.

Can you think of an example, early in your use of Solution-Focused, that really convinced you of its usefulness in the mental health context?

Yes, absolutely. The very first patient I tried Solution-Focused with. He was a 50-something-year-old man who presented to the ED with shortness of breath. He was divorced and his two adolescent sons lived with their mother 2 hours drive away. He had been diagnosed with terminal lung cancer, was unable to drive any more and was connected to an oxygen bottle 24/7. The man was seen by the ED doctor and referred for a mental health assessment due to possible depression. That was the first "miracle" — that the man presented to the ED because of his trouble breathing, but the ED doctor actually picked up that he might be depressed and that mental health assistance might be helpful!

What made you decide to try out your new Solution-Focused skills with this man?

The reason I chose this man first was that I was looking for someone to experiment on, but I wanted someone that I didn't have to do my normal traditional assessment. I discovered that the man had had a full assessment at another hospital just a couple of weeks before, was diagnosed with dysthymia (I'm not sure why they would call it that but that's another story), and had the appointment to see the hospice psychiatrist already. That was enough reasons to give myself "permission" to experiment.

When I saw him, I simply tried to have a conversation using the little bit of Solution-Focused knowledge that I had. He initially presented as flat, low mood, low energy, low motivation. His self-care was a little poor and he couldn't see much hope for the future. The focus of my discussion was trying to establish both how he has coped so far, as well as his best hopes for the remainder of his life given his circumstances. During our discussion he told me that he was a car enthusiast and had a very nice old car sitting in the shed which he was unable to drive. Without me offering any suggestions, but using SFBT techniques, he was able to work out his desire and hopes. His one desire was to be able to teach his 16-year-old son to drive before he passed away. We explored what this might "look like" — he would contact his ex-wife, who would drop his children off on a Friday night, he would give his son driving lessons and do things like drive to Brighton and get ice cream, and

he would arrange for his wife to pick up the boys on Sunday afternoon. With almost no prompting, he was able to plan and describe this in a lot of detail.

So, what happened?

I didn't see this man again, but always remembered his story. A couple of years later, I was talking about his story while I was running a SFBT workshop. One of the participants told me that she knew this man as she was working as a mental health nurse at the hospice at the time. She asked me, "do you want to know what happened?" and she told me, "He taught his son how to drive."

You currently work in the Emergency Department of a large city hospital.

What does your work involve?

My work in the ED now is more than just doing assessments although that is still a large part of what I must do. I often say that "people don't come to the ED because they are having a good day." While the traditional approach would be to find out all of the reasons why they are not having a good day, I know that doing an assessment will not actually make them feel better. My job is more about trying to turn people around. I might only have one chance or one interaction so I have to make it a good one. Some of the people I met in Canada such as Lance Taylor, as well as the team in Red Deer refer to this as a balanced assessment (Wright, Badescha and Schepp, 2014). This makes absolute sense to me in this environment.

How does using the Solution-Focused approach make a difference in this context?

Incorporating Solution-Focused work into my day has made a huge difference both to the work I do and to my nursing career. I have been in this position for 10 years and it's rare for someone not to have been burnt out in that time. When you spend 12 hours a day listening to, and taking on, people's problems it can really wear you down. On top of that there are the political, environmental and time pressures in a department that sees about 80,000 patients a year, and in being attached to a hospital that is always at capacity. Then I come home to a busy house only to have my wife and kids wanting to tell me all about their problems! The time spent doing Solution-Focused work is more than just time spent not listening to problems. It is a chance for me to do something therapeutic, to help people, to remind me why I got into nursing in the first place. My patients usually walk away feeling good, and so do I!

Tell me about the ED client who best illustrates how SF makes a difference in that context.

Mary was a 50-something-year-old woman from the Adelaide Hills. She was previously a hard working woman in a traditional eastern European family. She was house proud, spent a lot of time cooking, keeping house, raising children, etc and helping her husband on their farm. Mary had an accident and badly broke her leg. She required surgery and internal fixation. Her leg got infected and she remained in hospital for six months on the strongest antibiotics we could serve up. On discharge, she continued on antibiotics and strong analgesia. Mary frequently represented to the ED saying the pain was uncontrollable and that she thought the infection had returned. She would be seen by the ED doctor who would not be able to do anything for her and they would spend the rest of the day trying to discharge her. She would usually refuse to go home as, far as she was concerned, nothing had been done and she was convinced that the infection had returned. The ED became increasingly frustrated with her reappearance. Over her subsequent presentations the "infection" and pain seemed to migrate up her legs, into her back, her abdomen, chest, neck, head ...

How did you become involved?

The mental health team was not involved until she said the magic word — suicide. "I might as well kill myself the pain is so bad". To the ED staff, this was their chance to wash their hands of her as this was now a psychiatric problem. Mary was happy to talk to me but didn't see that I had anything to offer as she believed she needed to be readmitted to the orthopaedic ward and needed stronger analgesia. At our first meeting, I must have spent the first hour listening to her problems and the second hour trying to extricate myself from the room, then referred her back to the ED saying there was nothing I could do. Mary must have had a copy of my roster since she only presented on the days that I was working, and I was usually the one that had to see her. Mary was hard work, and I later discovered that she had already burned through two different psychiatrists. I tried intervening a couple of times without any success. She was absolutely focused on the pain. I describe Mary as being like a black hole — when you were in her presence, all of your energy was sucked out of you and by the time you left the room you would feel completely drained but there was no change in Mary. I decided that I had nothing to lose so I would try to put into practice my new SFBT skills. I checked with her psychiatrist first, not wanting to step on any toes, but she said "PLEASE DO ANYTHING!".

So, what “anything” did you do?

At the time Mary next came to hospital, I was trying to get my head around exceptions and how to ask questions to find them. I knew that the problem couldn't be happening 100% of the time but it was hard because all I knew about Mary so far was that she was housebound (apart from coming to the ED), could not care for herself, could not cook, could not clean, could not keep house, etc. As far as I knew, the only thing she could do was to come to the ED. That is, until during my SFBT conversation, when Mary disclosed that she went to church EVERY DAY. Mary told me that she loves going to church, that she has many friends there, she has a strong faith, that they sometimes have lunch afterwards etc. We were able to identify that the pain was much less at church (or no pain at all) and she was able to cope with life and do activities. I also heard that, after church, many of the women would stay for lunch, and on the way home Mary might do something else such as go shopping. We were able to identify some strengths (e.g. that she could soldier on) and then identify other things that she could do. It was a very positive conversation.

Then the most amazing thing happened. Mary stood up, and for the first time initiated her own discharge. We walked out together, she shook my hand, and we said our goodbyes. Then the second most amazing thing happened: I returned to my office and realised that, for the first time, I had been able to talk to Mary and hadn't left feeling like all of the life had been sucked out of me. I actually felt good. Mary left with a feeling of hope for the future, and I left with a rejuvenation in my nursing career which has carried on and is strengthened every time that I do SFBT with a client.

Did you see Mary again?

I have seen Mary a few times since then, but only bumping into her when she has presented for medical or physical issues. The frequency in her ED presentations decreased straight away. The ED doctors have not seen the need to refer her for a mental health assessment again. I note that a psychiatrist has readmitted her back to the inpatient unit once or twice, but I assume that was because their problem-based approach and focus on medication must have identified something that I didn't see the need for.

You won a South Australian Premier's award for your work as a mental health nurse. What was it that got you that award?

Each year the SA Department of Health offers five scholarships for nurses to travel overseas to study something that might benefit nurses and the health

service in South Australia. I first started planning this in 2013, three years before actually arriving in Canada. My idea was to use Solution-Focused therapy to develop a model of care for nurses in the mental health setting. I can't actually claim this as my idea since I had read work from Margaret McAllister (2007) and Tim Wand (2010, 2013), but there was not much happening in South Australia. The application process involved researching what I wanted to do and where I wanted to go, then making contact with the relevant people around the world, planning the trip in detail and then submitting quite a detailed application, including demonstrating that it would benefit local health services.

So, where did you go?

I was trying to find somewhere that was using SFBT in acute mental health services across various teams. After contacting various people in Europe and North America as well as the online SF List, I received an email from Phil Wright in Red Deer, Alberta saying, “I think we might have what you are looking for”. My first thought was, “Great, but where the hell is Red Deer?”. I went to Google and found the city homepage which told me that it was forecast to be -10°C on that day. I said to Phil that I wouldn't usually get out of bed if it wasn't going to be +10° at home, to which he replied, “If you come here you are going to spend a lot of time in bed”. I held out for a while, waiting for contact from a service on a tropical island in the South Pacific but didn't happen. Phil put me in contact with Lance Taylor, Dene Shipowick, Darcy Jessen and others in Alberta, and I was eventually able to get a plan and an application worthy of a scholarship.

And you ended up in Nova Scotia? That's the other side of the country!

I timed my trip so that it would coincide with the Solution Focused Brief Therapy Association conference in Halifax, Nova Scotia, then asked my boss if I could stay a little longer and attend the conference (conferences were not covered by the scholarship). My boss agreed to pay for part of the expenses, and SFBTA provided a free ticket to the conference. While I was there I was also able to attend a 2 day workshop with Lance Taylor and Heather Fiske, and got to meet some really interesting people like Elliott Connie & Adam Foerer, Frank Thomas, Jeff Chang, Joel Simon, and also Harvey Ratner from the UK and Ella de Jong from the Netherlands and so many others. I never would have imagined meeting so many passionate SF people in one place.

Given that my work in ED often involves working with suicidal people, it

was a privilege to meet Heather, who is probably THE international expert on using SFBT with acutely suicidal people (Fiske, 2008). When I was at Heather's house for the post-conference party, I got to tell Joel of my story with the terminally ill man (above). Part of the reason I was able to talk to this man was because the first SF book I had read (the only one at that time) was Joel's book on using SFBT in end of life and grief counselling (Simon, 2009). I think Joel was on the verge of crying when I told him the story. He said that he wrote the book because he thought it was a good idea and it worked, but it is only after hearing stories like mine that he knows it was all worthwhile.

What was a highlight from the trip?

Amazingly I had been using SFBT for a few years but as I was on my own in Adelaide I had never seen anyone do a live session. In Canada I was able to sit in on many sessions and for me I was about as excited to do this as I was to read about the early days in Milwaukee where people could observe and discuss sessions and learn as they were happening. We just don't have that culture here.

I saw a lot of sessions over a few weeks and really enjoyed it. On my last day in the Red Deer Community Mental Health Clinic it was a Tuesday and they run a solution focused drop in clinic. There were about 15 staff who all met in a room and waited for clients to walk in. We then divided up where one would interview and several would observe. The first client arrived about an hour before the clinic opened — it was about -2° outside and I just could not believe it.

After observing all of these interviews, I was amazed at how all of these clinics seemed to attract all of the nice people. Why don't nice people ever come to my ED? I only ever get to see the ratbags, the PD's, the drunks and druggies, the malingerers, etc, but I never get to see the nice people. The last client in Red Deer was a young man who was brought in by his girlfriend. They were both drinking every day and there was a lot of conflict in their relationship. However doing the interview I heard that this man was training to be a chef, that he had just won a big competition and he as in training to go to Mauritius for a world cooking competition. I heard about his strengths, resources and ambitions, and the clinician was really skilled in getting his vision for his preferred future. I was feeling really positive about this young man's future, and again I was left to wonder why I never saw men like that in my ED.

Then I had a big revelation. The week before this interview the man had attended the Red Deer ED. He was drunk, he had had a big fight with his girl-

friend and in the process had smashed a beer bottle and had ripped open his hand. I imagine he would have been belligerent, perhaps aggressive. We would have identified his alcohol addiction, his impulsive behaviour, domestic violence, and perhaps even a personality disorder. We would have suggested he see the drug and alcohol service and anger management program, and would have been 100% certain that he would not have attended. I then realise that the outcome will be determined by the questions that we ask. If we look for problems, we will only find problems. If we look for solutions we will find solutions.

And what else?

Another highlight was seeing Solution-Focused group work in both Red Deer and Ponoka. I had never been involved in group work, and I wasn't looking for it while I was away, but the things they were doing there were unbelievably simple and yet so very effective. I asked the participants why they would leave their home on a Monday night when it was -1° outside. They unanimously said that they got so much out of it that couldn't miss it. Likewise, in the inpatient rehab unit in Ponoka, I saw the patients turning up to the group 15 minutes early and they sat there with their workbooks on their lap all ready to go. I never would have imagined that patients in a rehab ward would be early for anything, but again they said they got so much out of the group that they wouldn't want to miss it. Since I've returned to Adelaide Solution-Focused groups have been implemented in Noarlunga Hospital with great success.

You are THE key person in organising the 2017 Australian Solution-Focused conference. What are your "best hopes" from the conference?

Coming back to Adelaide and having an offer from you (Michael) to hold the Australasian SFBT conference was just a dream for me. After attending the 2nd AASFBT conference in Sydney I wondered if we would ever have enough interest in SFBT in Adelaide to host a conference, and a couple of years later here we are. By the time this is published the conference will probably be over, so one of my hopes is that we will still be able to talk about the conference in a positive light after July. There are a lot of things I am hoping for with the conference. Firstly, the growth of SF work in Adelaide has occurred mostly in acute mental health areas, so I would love for clinicians here to be able to show that off to the rest of the world, which will in turn inspire the people here to continue their work. Secondly, I would like to see the conference kick-start some growth in SF work outside of the mental health world — such as

schools — I know there is a bit happening with some school counsellors but I would love to see more. On a more personal note, I would like to learn about using Solution-Focused approaches within organisations, so I am really looking forward to hearing about the work of Sophie Giesler and others. Finally, I would like to understand just a little about the philosophical underpinnings of SFBT, that Dan Hutto writes about — his work looks impressive, but I just have absolutely no idea of what he is talking about!

And you've gone on to establish a South Australian SFBT interest group.

A few years ago I was asked if I would run an occasional 1 day workshop on SFBT to staff in the public mental health service here in Adelaide. The workshops seemed to go well and, after a couple of years, I had a few people approach me asking how we could learn more and spread the word on how good this was in the mental health service. We decided to have a meeting and put together a few ideas. There were 5 of us at the first meeting, and we decided to set up a regular get-together for education, support, peer supervision, and promotion of SFBT. We decided to establish ourselves through the Mental Health Professionals Network for the simple reason that they provided money (for catering and expenses) as well as a little admin support (for advertising, attendance lists, and certificates of attendance). We ran our first meeting in April 2016 and have met every 3 months since then. We now have a membership of over 100 names, with people from both public and private health as well as school counsellors and NGO workers. A few months ago, the South Australian SF Community of Practice formally affiliated with AASFBT.

Finally, what's this "Left Turn"?

With a growing interest in SFBT in Adelaide, I was getting enquiries from different organisations to run training. As some of these people could not access the normal training I was offering through the public mental health service I decided to set up a small business so I could provide this training in a private capacity. Hence Left Turn Solutions was born. ("When things aren't going right — turn left"). It's not enough work for me to be able to give up my day job, but the ability to do this has meant more people in Adelaide can access Solution-Focused training. I have run workshops for the Mental Illness Fellowship of South Australia (a non-government organisation) as well as the Southern Adelaide Complex Care Team (a non-mental health team who assist with complex multi-dimensional problems). I have future workshops planned with mental health and non-mental health teams.

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