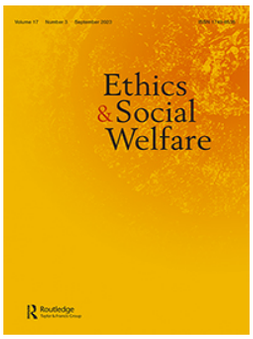

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ETHICS IN PRACTICE

Solution-focused Practice and the Role of the Approved Mental Health Professional

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ABSTRACT

The Approved Mental Health Professional (AMHP) has a pivotal role in a decision to detain an individual under the Mental Health Act 1983. This article is a reflective account demonstrating how a solution-focused approach can enable an AMHP to engage constructively with the person being assessed and apply the values of anti-oppressive practice. Using a solution-focused approach enables a creative and empowering discussion of risk and may lead to a less restrictive outcome. These techniques should be part of the training and ongoing education of AMHPs.

KEYWORDS

Approved Mental Health Professional; solution-focused; Mental Health Act 1983

Introduction

This article explores how the approach and techniques of solution-focused practice can be applied by Approved Mental Health Professionals (AMHPs) to enhance ethical practice when undertaking assessments which, in England and Wales, might result in detention under the Mental Health Act 1983 (MHA 1983). The AMHP intervenes in a crisis, where there may be muddle and confusion, as well as a state of panic (Parkinson and Thompson 1998). Leah (2020) describes the AMHP as having a hybrid role, including mediator, advocate, custodian of social justice and – of relevance to this article – therapist. The AMHP is responsible for assessing and managing risk, whilst protecting the public: described by Thompson (2003) as being between the 'devil and the deep blue sea'. Individuals being assessed should be enabled to think about risk and be open about the dilemmas they face; empowered to take positive risks, and not just required to do things for the '*lack of talking through what might generate hope*' (Sayce 2016, 127). Neither should they be subject to a mechanistic risk assessment that excludes them (Glover-Thomas 2011). Gregor (2010) suggests that AMHPs find the process of coordinating and leading Mental Health Act assessments both complex – in terms of the diverse factors to consider, and the logistical issues to manage – and emotionally demanding.

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The ethical nature of the AMHP role

Good AMHP practice is underpinned by concerns with the ethics of compulsory treatment and the ethical use of power (Bogg 2010). AMHPs are required to demonstrate their commitment to the guiding principles of the statutory guidance provided in the Mental Health Act 1983: Code of Practice (Department of Health 2015) particularly the 'least restrictive' outcome for the person being assessed. Kinney (2009) suggests that the AMHP faces significant ethical challenges in applying the values of anti-oppressive practice. This is increasingly difficult, with a tension between a lack of adequate and least-restrictive alternatives, and societal expectations of mental health services (Warne, Keeling, and McAndrew 2011). There is also a concern that involuntary treatment can be based on the need to maintain social order, with the person in mental distress being seen as inherently 'risky' and not trusted to manage their situation (Vassilev and Pilgrim 2007). Therefore the AMHP must remain focused on the experience of the MHA assessment by the client: that it is as anti-oppressive and person-centred as possible. This article suggests that solution-focused practice can help AMHPs achieve this.

Brief solution-focused therapy (BSFT)

The BSFT approach developed out of a notion that the (presenting) problem did not show itself continuously in a client's life, there were exceptions to the problem (De Shazer 1988). Whilst there was no causal link between problem and solution, a potential solution for the client might be derived from an exploration of the absence of the problem. Much research and practice development followed; in the UK, led by the team at BRIEF. In basic terms, the structure of a BRIEF session (George, Iveson, and Ratner 2013) involves asking about a client's best hopes for the conversation; obtaining detail about their preferred future (via the miracle, or tomorrow question); scaling their current proximity to the preferred future and asking the client to determine which small achievements might indicate graded progress towards either the top of the scale, or the point that is good enough to achieve. Additionally, layered information could be obtained by asking the client what other (figural) people would notice about the impact of the miracle on them – internalised others, as discussed by Tomm, Hoyt, and Madigan (2001)) – and through imagined dialogue between them. A further session might begin with the question 'What has been better?'.

This article will demonstrate the possibility of using solution-focused techniques in parallel with the statutory role of the AMHP. There is a need to be candid about the reason for the statutory interview (often the client is being interviewed under compulsion), and the reality of different parties' concerns about risk, but this should not preclude the possibility of engaging clients around best hopes and preferred futures. With a twin-track (statutory and therapeutic) approach, it is possible to take into account both the history of the problem (usually in the form of the referral documentation and risk assessments) and the history of possibilities (from the client's back-catalogue of capability). It is also possible to promote positive risk management via the work of obtaining detail on the client's preferred future. All the techniques available to the solution-focused practitioner can be utilised within this one-off statutory intervention.

An anonymised practice example

Molly (aged 14) has not been at school for six months. She is exhibiting restricted eating behaviours. She has developed compulsions. She copies her mother – in every detail. Previously she could tolerate her mother leaving the house, and be looked after by her father and grandmother, but when her mother returned to work after the school holidays (she is a teaching assistant) Molly was unable to cope. She began screaming and head-banging. Her parents were so worried that they took her to the nearest hospital.

Molly was admitted to the paediatric ward distressed and agitated: hitting out at staff; screaming so loudly that she could be heard all around the hospital; and banging her head against the walls and the windows of her side-room. She was seen urgently by a children's consultant psychiatrist who prescribed sedating medication, wrote a medical recommendation for detention under Section 2 of the Mental Health Act 1983, and referred her for a Mental Health Act assessment.

The AMHP attended that afternoon, with a second doctor, as required by the Act. Molly had recently been given intra-muscular sedating medication. On arrival in the side room, it became clear that Molly was asleep. Her parents Sue and Don were there and explained some of the background. Don said that he had begun to notice some of Molly's ritualistic behaviours over the past months, and it reminded him of his childhood. There is the history of mood disorder on both sides of the family – both parents' siblings. Molly was too drowsy to answer the doctor's questions and the AMHP agreed for him to come back the next day. The AMHP decided to stay on with the parents (aware that the information shared so far had been focused on problems) to ask some solution-focused questions, with an instinct that Molly might be able to listen …

The AMHP asked each parent about their best hopes for the current situation, starting with dad. Don said that he just wanted to keep Molly alive. His children and his family are his life. Tears rolled down his face. He said that he would like Molly to get some medication that would help her, and he would like her to be able to return home. ***Asked what difference it would make*** if Molly had some medication that would help, and be able to return home, Don said that it might be possible to return to some sort of normal family life: doing enjoyable things together.

Asked about her own best hopes – Sue's were similar. She said that she would like to be able to get her life back – she has needed to comfort Molly so much, and be with her all the time, to manage the distress and agitation. ***The AMHP was able to explain the tomorrow question, and agree a loose contract: a 'more normal family life, where it was possible to do fun things again and for Sue to have more of her life back'.***

Starting with Don, we began describing the next day, where the family was much further forwards towards the best hopes of a more normal family life. Don describes himself waking at about 8.30 am, hearing the sound of Molly being loud in the house and intensely engaged in something that interests her. Sue is already up. Molly says good morning to him and he says good morning back. He goes to go and celebrate this change with Sue. They hug. Don gives more detail on how the day will unfold … He phones his brother about Molly. His brother is pleased for him. He will be able to concentrate better on his work. He will work a normal day until about 6 o'clock and then come back to the house from his office and a happy family meal will be shared. Molly

and her siblings and Sue and Don will chat. They might play a game afterwards. There will be normal bedtimes.

Sue speaks about how the morning will have gone from her perspective – she will have had some time on her own in the kitchen first thing. Molly will come and ask her what is for breakfast. There will be a hug. Sue will choose to cook bacon and eggs as a celebration and Molly will help (as she used to do, and which she enjoys so much). They will all eat together at the table. And then Molly will take charge of getting her 11 year old brother and 8-year-old sister ready for school. There will be noise and chaos, and audible happiness.

Molly will get her things ready, be organised to have a school lunch and meet a friend on the way to the bus. Sue will take the younger children to school (where she also works). The school secretary will notice that there is a change in Sue and when she explains what has happened, the school secretary will be pleased for her. The change in Sue's face is noticed in her lunch break (in the staff room), and by teachers and parents who know Molly. Sue can take the younger children to the park after school and then swing by and pick up Molly from her bus stop on the way home. The family meal is prepared – it is a steak dinner. The steaks for Sue and Molly won't weigh the same, and this will be fine – Molly won't mind, and will be helping with the preparation. Once the children have gone to bed in an orderly fashion, Sue and Don go to bed too – they are exhausted but happy.

Asked to scale their proximity to this imagined day happening, Sue says that she is a 3 out of 10. Asked how she has managed to be at 3 rather than lower, she says it helps to know that having been to the hospital, the family is now more likely to get help. ***Asked how she would know that she has arrived just half a point up the scale***, Sue says that she would know this if Molly agrees to take her night-time medication that evening. She also says that seeing Don able to share his emotions will help her know she has reached 3.5 on the scale. In fact, this has already started to happen, she says, as Don has been emotional during our conversation.

Don feels the same about what would indicate arriving a half a point up the scale – he sees himself at 5 out of 10, but Molly taking her medication will see him a half a point higher. Don talks about being able to be a bit more social, and to see some of his old friends. Sue says that she might be able to take a night away from home with a friend if things were just a little bit better.

The next day, the AMHP returns half an hour before the re-arranged Mental Health Act assessment. Molly is reported to have taken her night-time medication and slept through the night. Sue has also slept through the night. Molly has been up early and has showered. She has asked for tea and breakfast and has shared a relaxed morning with her mum.

When Sue is asked by the AMHP what has been better, she says that Molly taking her medication was wonderful. She says that she is pleased that her daughter has started to help herself; she says that she is proud of her.

Don joins in to say that he is proud of his daughter, and that it has taken courage for her to cooperate with the treatment. The AMHP reports to the family his having heard about these successes from the ward staff and, on this basis, having arranged for professionals from the Home Treatment Team to attend the Mental Health Act assessment. This means, he tells Molly, that going home is still on the table. Molly is not able to engage directly with the AMHP, so an agreement is reached about how the assessment

will proceed. Molly does not have to speak, but she needs (with the help of Sue) to give yes or no answers. Without some interaction with her, the AMHP explains, the assessors will not be able to determine whether or not Molly can return home. Molly is clear that returning home is what she wants.

When the other assessors arrive the AMHP briefs them about the progress that has been made. He also explains the need for questions to Molly to be directed through him, and interpreted, so that yes or no answers can be given. When the assessment resumes, Molly can explain that whilst she still has thoughts of suicide (she wants to be free from her compulsions and this is the only way she believes she can be free) she has no plan. Molly reluctantly appears to accept that she will need to go home not only in a way that suits her, but suits her parents, and suits the services that have a duty of care to them. With irritation, Molly accepts that she will need to stay further two nights in the children's ward to be monitored; that she will need to be compliant with medication; and that she will need to see professionals when she goes home. Molly's parents have anxieties about her returning home. They are reassured that there is a contingency plan: medical recommendations for detention are available. If things are not working out at home, different decisions can be made. Molly complies with the plan as has been arranged. In 2 days, she is discharged from the ward. There are no further incidents of self-harm or violence towards staff.

Conclusion

There is the possibility of using the pre-interview discussion with the client (as suggested in the Code of Practice para 14.49-54) not only for the purpose of explaining the role of the AMHP but also to ask solution-focused questions about best hopes for the outcome of the legal process, and to establish some detail about this. With the prior agreement of co-assessors, solution-focused questions can be used as part of the interview itself. It is our contention that solution-focused questions can be used to address the power differentials that are inevitable between the assessing professionals and a client in a crisis – where the client is often under legal compulsion – and to support an ethical, person-centred approach to AMHP practice. We suggest that focusing on clients' strengths and capabilities will enable them better to take ownership of named, agreed and positive changes to risk-related behaviours. This reflective piece makes the case for the use of solution-focused practice within MHA assessment work; and that training in its techniques is both a significant need, and resource, for AMHPs. The use of these techniques will assist in the convening and delivery of least restrictive, anti-oppressive interventions under the MHA 1983, and they should become a standard part of the training of AMHPs across England and Wales.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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