



EMPIRICAL RESEARCH ARTICLES

Putting the Hope Back In: Making the Case for Solution Focused Practice in AMHP Interventions

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This article explains the structure, progress and outcomes of a training project to introduce warranted Approved Mental Health Professionals (AMHPs) to the core assumptions and techniques of Solution Focused Practice (SFP), so that they might begin to apply their learning to the role of the AMHP. Semi-structured interviews were undertaken before and after the training and the post-training supervision that was provided. Thematic analysis allowed for themes to be derived from interview data. Key findings from the study include the need for increased professionalisation of the AMHP role, located in particular skills and knowledge; the importance of purposeful communication by AMHPs; the value of using Solution Focused Practice when spending time alone with the individual being assessed, in order to prioritise their voice in the assessment; and the impact on broader practice, for example, job satisfaction for AMHPs.

But I just like this [approach] because it puts the hope back in, even when someone's feeling hopeless...

With amendments to the Mental Health Act for England and Wales finalised at the end of 2025 (MHA 2025) and the roll out of the changes planned over the next ten years, there is much change facing Approved Mental Health Professionals, despite their core s13 duty remaining the same.

A new Code of Practice is under construction as this article is submitted, and it is hoped that the findings of the training project reported here will add to the evidence base for new statutory guidance on interviewing ‘in a suitable manner’ (s13(2), MHA 1983 as further amended).

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Down the line, we may also see changes to previous Regulations (2008), which have structured AMHP competence over nearly 20 years. It is in support of calls to train AMHPs in communicative practices, as well as legal expertise, that we submit this paper for publication.

The role of the Approved Mental Health Professional (AMHP)

The successor to the Approved Social Worker, the Approved Mental Health Professional role was introduced in England and Wales by the 2007 amendments to the Mental Health Act 1983. The 1983 Act had in turn replaced the Mental Health Act 1959, and provides the legal grounds for people to be admitted to hospital compulsorily for assessment followed by treatment. It sets out the framework for decision-making in civil situations (Part II) as well as forensic situations (Part III). The professionals eligible to undertake AMHP training are social workers, occupational therapists, mental health or learning disability nurses and psychologists, although 93% of AMHPs still come from the social work discipline (Skills for Care, 2025). Whilst considered to be public bodies (in respect of the Human Rights Act 1998) and required to be independently liable for their decision-making, these workers undertake the role on behalf of local government authorities (s13, MHA); are appointed by these local authorities; and can also be substantively employed by other agencies (such as Mental Health Trusts). The Mental Health Act Code of Practice (2015) informs the way AMHPs should undertake their work: key elements being to provide a social perspective and to undertake a holistic assessment of the person with mental health needs, to ensure the least restrictive, safe outcome (DH, 2015).

The AMHP is expected to act independently of specially approved doctors (s12, MHA), who may provide medical recommendations for detention to hospital about which the AMHP makes the final decision (DH, 2015, 14.52; s13(5) MHA 1983 as further amended). As part of their role in coordinating Mental Health Act work and obtaining relevant views (including from the person, their Nearest Relative - soon to become the Nominated Person - and other significant people in the network), the AMHP must also interview the person 'in a suitable manner' (s13(2); COP, 14.49). It is in the process of gathering this range of relevant views, particularly those of the person being assessed, that an opportunity for the use of therapeutic communication skills arises.

How does Solution Focused Practice lend itself to AMHP work?

Solution Focused Brief Therapy (SFBT) evolved out of 'briefer' approaches to systemic family therapy (Weakland et al., 1974) and the key ideas and questions which have given a structure to this way of talking were designed by Steve de Shazer, Insoo Kim Berg and their colleagues at the Milwaukee Brief Family Therapy Centre, USA, in the mid-1980s (de Shazer et al., 1986).

Over the years SFBT has found its way out of the therapy room and is being used by workers of all backgrounds and descriptions (not just in healthcare settings, but in business, management and coaching) – hence the shift in terminology to Solution Focused Practice (SFP) (Perry & Goldie-McSorley, 2024).

The core assumptions and techniques of the approach that have been honed in different parts of the world over the past 40 years arguably involve most of the following (de Shazer et al., 1986; George et al., 2012; Watzlawick et al., 1974):

- Working collaboratively, and working with the person (or family) rather than the problem
- Believing that it is not necessary to find or hypothesize a causal link with the presenting problem in order to begin working towards solutions
- Looking for strengths, resources and competences rather than deficits
- Looking for exceptions (to the problem that brought the person to the conversation)
- Asking about the person’s best hopes from the talking
- Visualising a preferred future - a life where the best hopes are being lived
- Looking for instances where these things have happened in the past
- Scaling the proximity of the person to a life containing the best hopes
- Eliciting detail about how the person is at that score and not lower, and what they might notice about themselves one point up the scale
- Accessing further detail from ‘other person’ perspectives on the situation at hand.

The above tasks might be seen as a spine for a solution-focused conversation and there are obvious similarities between some of the tasks and other therapeutic modalities, for example CBT and scales, or NLP and visualisation, but there is uniqueness too (Jerome et al., 2023).

Practitioners are not required to hold rigidly to an order of questions and Solution Focused techniques can just as readily be used in unplanned ways (Shennan, 2025) or applied in specific statutory scenarios (Turnell & Edwards, 1999) – and this is how the approach lends itself to the role of the Approved Mental Health Professional.

Whilst the Mental Health Act 1983 (as further amended) and its 2015 Code of Practice require AMHPs to interview ‘in a suitable manner’ (s13(2)) and encourage them to spend time alone with persons being assessed under the Act (COP, 14.54; COP for Wales, 14.45, DH, 2015) there is no detailed guidance (yet) as to how to do this. As a result, whilst it is clear that skilled communicative practices are crucial to the undertaking of the AMHP role, its post-graduate training has retained a broadly legal lens and has not taught AMHPs how best to use time alone, nor how to ensure that their practice embodies the guiding principles of the Code. This is the space in which it has been possible to introduce solution-focused ways of working.

The person-centred and strengths-based nature of SFP is helpful in deriving ‘new’ information from the person, rather than the problem-focused information contained in referral and medical model-based documentation. This information will be key to understanding the person’s hopes for their recovery and their plans for the future they want, as well as in helping assessors to come to more balanced views on risk and what might be the most appropriate and least restrictive way forward (Watson & Perry, 2022). In this regard the approach also identifies itself as an ally to anti-racist practice (Lee, 2003; Perry, 2025; Simon, 2026).

Overview of the research project and the methods

The training project, which received funding from an NHS body, was able to commission an experienced Solution Focused trainer to be part of the project team and to train the participants jointly with a dually qualified AMHP and Solution Focused Practice trainer. The training was delivered entirely online, and taught core assumptions and skills (as referred to in the ‘spine’ above), enabling participants to begin to have solution-focused conversations whilst undertaking their statutory duties.

The project had a steering group which included the Mental Health Lead for Social Work (at the Department of Health & Social Care), representatives of the funding body, the trainers and the researchers, and which supported the planning and timetabling of the work.

A research proposal was submitted, and university ethics approval was obtained. The participant information sheet explained the purpose of the study:

This study will explore whether, and for what purpose, [time alone as recommended by the Code at 14.54] takes place in practice. Based on an earlier pilot study, it will look at whether this is a site for SFP as well as looking at how AMHPs might extend their communication skills through their statutory interview where relevant.

Currently, there is little available evidence as to how AMHPs go about their professional work and this study will add to the emerging evidence and knowledge-base. Overall, this study will build on and develop AMHPs' continuing professional development and distinct professionalism at approval and re-approval.

The 16 participants, all qualified and practicing AMHPs (from across three local authorities), received the following explanation for their invitation to join the project:

You have been invited to take part as you are a qualified, practicing AMHP and we are seeking to understand how, or whether, AMHPs are able to spend meaningful time alone with service users and, additionally, how or if SFP can support this work.

The training was free for the participants, and they were released from work in order to attend the training. The participants were chosen by the AMHP Leads of their respective local authorities and the training will have met the required 18 hours of annual training specified within the AMHP Regulations. The participant information document explained the process of the project. Prior to a total of 24 hours' training, delivered in five sessions over consecutive weeks, the two identified researchers (the AMHP-qualified social work academics) conducted semi-structured interviews with the participants. The trainers were not involved in these interviews; however the AMHP- and SFP-qualified trainer was involved in discussing the findings and co-authoring this paper.

The training itself was experiential, with minimal homework. Orientation to Solution Focused Practice was amplified by video excerpts of real work and participants were able to practice solution-focused questions in small groups and in plenary.

Anonymised written pieces of AMHP work, demonstrating Solution Focused Practice, were shared and discussed. Participants were encouraged to practice the questions outside the training and report back and this became the content for the supervision sessions offered post-training.

Following the completion of the training, online supervision was offered once per month for a three-month period and on completion of the supervision, the AMHP-qualified academics undertook a second semi-structured interview with participants.

Themes and findings

Thematic Analysis (Braun & Clarke, 2024) has been used to elicit themes and findings. Thematic analysis is used to categorise, scrutinise and decode patterns of meaning within a qualitative dataset (Braun & Clarke, 2024) and is an appropriate approach for exploring experience, perception and social interaction. To analyse the data in this study, the social work academics and the AMHP-qualified SFP trainer began by engaging with the interview transcripts to identify initial codes and then looked for relationships between these codes to generate and name themes (Braun & Clarke, 2024). Data analysis was strengthened by a process of triangulation, in which the three

co-authors reviewed the same transcripts and compared coding. Reflective discussion led to the construction of key themes and ensured rigour in terms of clearly demonstrating consistency in coding and the grounding of themes in the data (Braun and Clarke). Identified themes are listed by sub-heading below:

The Approved Mental Health Professional as a distinct professional role

Participants reflected on the need for the professionalisation of the AMHP role, for it to have its own evidence base, knowledge and skills. The debate about the need for the professionalisation of the AMHP role has been ongoing since the 2007 amendments to the Mental Health Act 1983, when nurses, occupational therapists and psychologists joined social workers on the list of disciplines eligible to train as AMHPs (Fish, 2022). Fish (2022) highlights that a key AMHP responsibility is to keep the person being assessed at the centre of the assessment process and to ensure consideration of their circumstances from a social perspective, as per 14.52 of the MHA Code of Practice (2015). Fish (2022) concludes, however, that there has been little consensus as to the skills and knowledge required for AMHPs to fulfil this function. This is congruent with AMHPs in this study who noted that:

We've never talked about ... what you actually do ... We can actually professionalise ourselves ... Theory informs practice, doesn't it? ... Otherwise, we just make it all up!

AMHPs' sense of the role as a profession (rather than simply a qualification) has been further explored in research, with 80% of a sample of 247 AMHPs conceptualising the role in a different way to their background discipline, identifying skills, knowledge, status and power as contributing to their perception of the AMHP role (Hemmington et al., 2021). AMHPs identify that they struggle for professional legitimacy, working as they do alongside medical professionals (Fish, 2022). Participants in this study agreed that other disciplines have achieved a greater level of professionalism for their roles:

[Allied professions] have really professionalised themselves ... Whereas [we struggle] because we've always tried to align ourselves with clients ... [we] can be more professional ... [start having] something in writing.

Despite advanced skills being identified as essential to effective AMHP practice (Morriss, 2016) the absence of an evidence-base for AMHP skills is a significant research interest within the field (Hemmington, 2024). Hemmington (2024) found that a key priority for AMHPs is to improve communication in order to enhance relational practice. Participants in this study also reflected on the AMHP skill base:

... It makes us think ... how to re-do it ... something to hang our skills onto.

Using communication approaches that are planned and purposeful is a key AMHP skill (Hemmington, 2024). One area in which participants in the Hemmington et al. survey felt AMHP training could improve on (2021, p. 45) is '*how the AMHP can involve the person in the assessment with perhaps some modelling as to what this might look like*'. This study contributes to the evidence base for AMHP practice in relation to communication and relationship-based approaches, as participants identified how the introduction of solution-focused skills enhanced their ability to engage people in Mental Health Act work:

Practice has changed over the years ... we've lost the human side ... [the training] has brought back trying to really understand what they want ... looking at a preferred future for them ... it changes the dynamics.

Stevens et al. (2019) consider what motivates mental health professionals to become AMHPs and, conversely, what might deter them. They identify a range of intrinsic and extrinsic factors that contribute to the decision. Congruent with this study, their participants were concerned with relationship-building and a possible negative intrinsic effect for therapeutic relationships with people using services. Alongside this, there was a positive extrinsic effect related to professional esteem and career progression (Stevens et al., 2019), both of which are components that increase job satisfaction and reduce burnout (Evans et al., 2005; Garvey, 2025). Participants in this study are also curious about how the introduction of a solution-focused approach to their AMHP practice might change their experience of the role and enhance job satisfaction:

I was a bit stuck in a rut with the job and was missing ... having those better relationships with people ... although I am still just seeing people maybe once or twice ... there is more of a connection ... that has ... helped with my job satisfaction.

Spending time alone with the person

The AMHP role is complex and multi-faceted, requiring practitioners to occupy diverse spaces whilst undertaking an assessment under the Mental Health Act. Leah (2020) identified eight roles (quasi-judge, detective, legal enforcer, custodian of social justice, advocate, educator, mediator and therapist) to conceptualise the breadth of AMHP practice. However, the experience of the person being assessed is not always one of involvement. Blakley (2023) finds that people being assessed experience a 'barrage of three' in terms of the assessing team, which reduces opportunities for the service user voice to be heard.

14.54 of the Mental Health Act Code of Practice (DH, 2015, p. 122) states that, '*Patients should usually be given the opportunity of speaking to the AMHP alone*'. During the pre-training semi-structured interview, participants discussed their current practice approach with regards to seeing the person alone before the assessment. One participant thought that seeing the person alone was a matter of '*professional curiosity ... asking those questions*' and shared their '*worry that our AMHPs are too busy and won't ask the questions*', continuing, that '*it's becoming a process rather than about the person, and I don't like the way it's going*'.

Another thought that seeing the person alone allowed for an independent view of the person's situation: '*I think it's beneficial for us because we're seeing that person on our own ... We're not with doctors trying to influence the situation*'. However, despite evidence that people being assessed want to feel listened to (Akther et al., 2019; Blakley, 2023; Johansson & Lundman, 2002) participants shared that they did not routinely seek to see the person alone, often citing that this was more likely if there was no prior contact with the person or due to concerns about risk.

Following the training, participants talked again about taking time to speak to the person alone before the assessment. One participant reflected that they were able to engage more with the person being assessed and, through asking about their best hopes, learn more about the person's needs and wishes and understand how the person had felt in previous assessments:

I was able to ... get from her what she wanted from services which she hadn't previously expressed ... It was frustration from her that nobody was listening.

This supports both Hemmington et al. (2021, p. 48) and Blakley (2023) who suggest respectively that AMHPs should be '*allowing those being assessed to tell their stories without imposing prescribed questions on them*', and that negative experiences of assessment and feelings of coercion can be mitigated by the person being assessed feeling heard.

A focus on seeing the person alone also led one participant to reflect that using a solution-focused approach allowed them to re-connect with their professional social work roots in terms of engaging with the person and approaching an assessment from a strengths-based, social model perspective:

I like ... that we're going back to how we practiced as AMHPs when I first qualified.

This study finds that giving AMHPs an approach that empowers them to engage with people being assessed using CoP 14.54 involves the person better in their own assessment, with the consequence of the person feeling heard (Akther et al., 2019; Johansson & Lundman, 2002).

Communication

The evidence here is subdivided under the following headings:

Improved information gathering

Little AMHP research to date has focused on the AMHP's role in communicating with those being assessed under the Mental Health Act (Hemmington, 2024). Leah (2020) highlights the multiple roles that AMHPs adopt and notes therapist as one of these, suggesting that AMHPs use therapeutic skills both to demonstrate care and manage emotional impact during assessments. Watson & Perry (2022) explore the benefit of a solution-focused approach to assessments, concluding that it contributes to a more person-centred and strengths-based way of engaging the person being assessed. In exploring the role of communication in undertaking AMHP duties and the effect of a solution-focused approach on engagement within the assessment, this study supports Watson & Perry's (2022) assertion, as one participant comments:

What's your best hopes from this conversation ... [shows] that you're listening.

Whilst another participant reflected that:

Using a different approach ... I learned quite a lot of different things about her ... without having to ask her about her risk ... It came out naturally.

This last comment suggests that using a solution-focused approach within the assessment allowed the AMHP to connect more authentically with the person and to glean information without the person feeling interrogated, further supporting the Hemmington et al. (2021) point about the imposition of questions. This is significant in relation to what participants reported before the training, as they commented on the continued medical focus of assessments, which mirrors Brammer's (2020) finding that Mental Health Act assessments retain a focus on symptomology at the expense of consideration of personal circumstances. Participants felt that a solution-focused approach allowed them to establish their specific role in the assessment process:

It's advocating for the person ... getting their views and bringing that into the assessment process ... all of that rich information that can help with social perspectives.

Also, supporting the work of Watson & Perry (2022), AMHPs participating in this study reflected on the change in their practice following completion of the solution-focused training, particularly in the move from a deficit to a strengths-based approach:

It was a different stance ... I don't think I would have started with that. I would have looked at what's gone wrong ... gone down more of the deficit route ... And it shows in your interactions with people that it does actually develop that relationship.

Linking back to the use of 14.54 ‘time alone’, participants considered its relevance when considering their s13 duty:

Here the community team are telling me one thing. Family are telling me another. The only way I’m going to find out is ... to see the person alone.

Another participant also linked the changes in their approach to their s13(2) MHA 1983 (2007 & 2025) responsibility in relation to what it means to interview ‘in a suitable manner’:

If we’re not asking the right questions ... are we giving them the best chance? And was it a suitable manner?

Recent research considering the meaning and scope of s13 of the Mental Health Act has challenged AMHPs specifically and mental health services generally, to revisit how AMHPs proceed from referral to decision in applying the Act. Simpson, Lewis & Mitchell (2024, p. 8) talk of the need to slow down the process; for AMHPs to be more empowered to consider the merits of each referral and to decide whether medical examination is appropriate, in order to move away from a ‘getting it done’ approach. The evidence from this study suggests that AMHPs can use Solution Focused Practice to return the person being assessed to the centre of the process and gather information that allows for consideration of alternatives to detention under the Act.

Relationship-based practice

Using solution-focused techniques allowed some AMHPs to feel re-positioned as an advocate for the person in the interview. Participants reflected on benefits for building rapport, relationship and allyship.

You’re building a rapport ... I think it’s them feeling that they’ve listened [to] and heard a lot more ... I’ve lost that practice ... and that’s a really major thing for me.

Hemmington (2024) identifies the need for approaches that empower AMHPs to position themselves alongside the person being assessed, and this study provides evidence that using the recommended time alone to ask solution-focused questions as well as to explain the role of the AMHP has helped the participants to achieve this:

Most definitely allied [to the person] ... if someone is extremely anxious, doesn’t want to talk and you say to them beforehand, this is what’s going on, you’re actually taking the time out to sit with them.

Leah (2020) identifies ‘advocate’ as one aspect of an AMHP role. These findings support the possibility of this, whilst also speaking to Blakley’s (2023) consideration of who truly represents the person being assessed during the Mental Health Act assessment process. Blakley (2023) queries that,

although the role of Nearest Relative exists as a safeguard, it is the AMHP who is central to ensuring that the voice of the person is heard; and that it is the AMHP who has the power to ensure that the person is supported to articulate their point of view.

Improved report writing

In addition to the verbal communication skills AMHPs require to undertake their role, the findings of this study highlight the importance of a strengths-based approach to written communication in reports. One participant notes that:

It made me make sure my reports feel a lot more human.

The use of solution-focused approaches clearly extended beyond the interaction with the person being assessed and enhanced the participants' confidence in taking on the role of advocate (Leah, 2020) with one participant commenting:

I use a lot more verbatim now ... so I'm saying ... why they're in hospital. And then I put quotes: 'I'm fed up with this. I did this. I did the other' ... how they're feeling ... and then always saying 'as to the future, this is what I feel'. So, I've noticed that's how I've changed ... is it because I'm more interested in what they're saying, that I'm actually writing [it] down.

Simpson, Lewis and Mitchell (2024, p. 10) summarise that an area for the development of AMHP practice is in the communication of 'defensible decisions' in MHA reports. This study extends that point to suggest that the representation of the person's voice within the report is paramount in supporting the decision to detain and aligns with the new statutory principles (derived from the Wessely Report: DHSC, 2018).

Service-user experience

Service-user experience of Mental Health Act assessments is an under researched area (Akther et al., 2019; Blakley, 2023). People being assessed under the Act have reported a range of both inclusive and excluding experiences (Blakley, 2023). The Wessely Report (DHSC, 2018, p. 57) concludes that, 'Patients should be treated in a way that respects them in the context of their own lives, recognises their strengths, needs, values and experiences'. Being able to ask questions that derive information about the person's 'preferred future' was viewed by participants as providing a way to engage better with the person being assessed, putting them at the centre of the assessment and facilitating more understanding about their lived experience:

When the bed became available ... I spent quite a lot of time with him because ... I wasn't totally convinced that the criteria for admission was still met ... we had a really good discussion ... we

started to talk about ... a preferred future ... something different ... trying to really inspire some hope. He wasn't happy where he was ... wasn't feeling safe in his environment ... it enabled me to look at that in more detail.

Participants also reflected on how a solution-focused conversation allowed the person being assessed to consider new perspectives:

It keeps very much in mind that this is about the individual. When often we're seeing people that feel like they've gotten lost. It offers that person ... a unique way of looking forward ... looking inside themselves ... Actually, I could have a different future ... that guy said to me, "Oh my God, just through talking, I realised the only person holding me back is me". I didn't do that. He did that.'

Conclusions

In this study the participants' experience of having used solution-focused techniques within their AMHP practice supports Blakley et al.'s (2023) finding that focusing on building relationships and person-centred practice in Mental Health Act assessments can centre the service user's voice. The views of the participants also support Watson & Perry's (2022) argument that AMHPs should make full use of the 'time alone' as encouraged by the Code.

The use of the approach by participants has supported improvements in communication skills, information gathering, report writing, and relationship-based practice in general.

There is further information that the participants have shared in interview about the support needed to maintain the approach, and how to address obstacles to its use in the workplace, which the authors will hope to return to.

For now, we believe this initial tranche of evidence makes the case for the usefulness of SFP in AMHP interventions, as well as for the inclusion of SFP in training opportunities for AMHPs – both as they qualify, and as they seek to develop and then sustain their person-centred, strengths-based practice.

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