Perry, N., & Goldie-McSorley, L. (2024). Suspending Disbelief – Using Solution Focused Practice With Young People in Mental Health Crisis 🇯🇵🇨🇳🇹🇼🇵🇱🇷🇴. *Journal of Solution Focused Practices*, *8*(2). https://doi.org/10.59874/001c.125023

CASE STUDIES

Suspending Disbelief – Using Solution Focused Practice With Young People in Mental Health Crisis 🇯🇵🇨🇳🇹🇼🇵🇱🇷🇴

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This article is a reflective account from two registered social workers who have undertaken extensive further training and accreditation in Solution Focused practice (SFP); have developed their knowledge through frontline work in their respective settings; and have delivered training on applying SFP in different workplace contexts. The article attempts to tackle scepticism from some participants in these training courses that SFP is something that can be helpful when working with young people in mental health crisis.

The two anonymised case studies seek to show how a Solution Focused approach can deliver a successful social work intervention in two very different settings; support risk assessment and anti-racist practice; increase and co-create safety; and prioritise the voice, as well as the agency, of young people at their most stressed and vulnerable. The case studies are written in quite different ways, reflective of the different statutory systems and their reporting requirements. Japanese Chinese traditional Chinese simplified Polish Romanian

Solution Focused practice in a UK context

Those of us who are believers and trainers in Solution Focused practice (SFP) celebrate its flexibility: that the approach can be applied in a variety of settings with a variety of presenting issues – in individual and family therapy, in coaching, in mentoring, in supervision for various disciplines (George et al., 2011, 2012, 2013), in nursing environments (Ferraz & Wellman, 2008) and in specialist health service interventions such as speech and language therapy (Burns & Northcott, 2022).

Although there have been strong steers as to the helpfulness of the approach over the years following the Munro Review (Munro, 2011; Turnell & Edwards, 1999), its take-up in the UK – within child or adult social work – has neither been systematic nor comprehensive.

There are examples of SFP being used by a whole service: the Divisional Based Intervention (DBIT) Service of Essex County Council's Children's Services has, for example, over the past 10 years developed a model of Solution Focused practice which sits comfortably within social work contexts, risk management and family intervention.

There are examples of parts of services being managed by third sector organisations who are using a Solution Focused model – for example Learning Space along with other charities, has helped to provide a Solution Focused triage for Surrey CAMHS since 2021 (www.learningspace.org.uk).

There are randomised control trials such as the SASH study (www.sashstudy.co.uk) training mental health practitioners – some of whom may well be social workers – in the use of SFP with young people who are presenting to emergency departments with self-harm and/or suicidal thoughts and behaviours.

Although not specific to social work itself, the Welsh Government has indicated the benefits of SFP within primary care and educational psychology services (Welsh Government, 2011, 2016).

UK-based Solution Focused practice has had valuable and consistent contributions from social work-trained professionals. The work of BRIEF (George et al., 2012, 2013) developed the model they witnessed first-hand from SFP's American originators: Steve de Shazer and Insoo Kim Berg (de Shazer et al., 1986).

Despite this, the authors – both of whom are currently practising as registered social workers (in CAMHS and adult mental health settings respectively) – have experienced obtaining qualifications and accreditation in Solution Focused practice and then applying this learning, as being on the periphery of mainstream social work practice.

Nowhere has this felt more the case when working with young people in mental health crisis, which for the purpose of this article will be defined as MIND defines it: 'when you feel at breaking point, and you need urgent help' (MIND, 2020).

Solution Focused practice and social work training programmes

Perhaps the absence of SFP within social work education and mainstream practice guidance in the UK makes sense in a cultural context of long-term under-funding of services and increased managerialism, causing social work to become more technical than relational (Ingram & Smith, 2018).

Chronic workforce recruitment and retention difficulties, as well as a focus on risk management and safeguarding (Glover-Thomas, 2011) – processes which themselves are informed by problem-focused information-gathering – have contributed to a social work which is problem(management)-oriented. And within mental healthcare, the prevalence of the medical model of disability (Szasz, 1956) compounds this.

Within children's social work teams, there may be residual concerns about Solution Focused practice due to its focus on strengths, capability, and the expertise of the client regarding themselves (George et al., 2012, 2013). This professional environment has been influenced since the 1970s by successive serious case reviews (CQC, 2009) that have criticised strength-based approaches, and mistakenly targeted them as contributing factors to failure

(rather than targeting inadequate levels of support, supervision, and training, which might have better supported thinking around safe uncertainty (Mason, 1993) and more effective reflexive approaches).

A problem-focused mindset has become so culturally acceptable that when providing SFP training the authors have, on many occasions, come across the question – 'But can you use Solution Focused practice in crisis?'.

In statutory social work in the UK, with all its professional vulnerability – dogmatic and mechanistic approaches to risk management (Glover-Thomas, 2011), often trammelled by the bureaucratic processes of local government (Sheppard, 1995) – an overriding disbelief in SFP should come as no great surprise.

It might be far easier for social workers to consider this approach to be workable for, say, coaching in business, or in the work associated with primary care settings. Perhaps the approach has a weakness in its relatively small (quantitative) evidence base (Jerome et al., 2023), which might explain why Solution Focused practice has not become a key component in social work training in the UK, despite it being a very practical way of implementing anti-oppressive social work values (Dominelli, 1998; Strier & Binyamin, 2013).

Invoking the famous phrase of Sigmund Freud as used by Steve de Shazer (de Shazer, 1994), we want to share some of the magic of our words and stories, to whet social worker appetites for using Solution Focused questions particularly with young people, but also across a range of ages where clients and families are experiencing mental health crisis. We offer this not only because it might provide a glimmer of hope to professionals and clients in a statutory environment which often feels quite hope-*less*, but also, because it works.

The similarities between Solution Focused practice and anti-oppressive practice

SFP conversations are exercises in mindful language. SFP skills relate to the building of questions using the words that clients use. This takes practice, and good training is almost always experiential. When SFP questions are asked well, the approach can and does look easy; clients often enjoy it; and it can be a way of supporting anti-racist practice (Lee, 2003).

A discussion of a client's best hopes will lead to a broad and detailed visualisation of the life that the client would like to have, where the identified difficulties – or crisis – are no longer present (whilst at the same time honouring the challenges that have come before – Connie & Froerer, 2023).

There is a determination within Solution Focused practice not to ask questions about the work that is needed to deliver the client's preferred future; rather, the job of the practitioner is to ask lots of questions about the imagined reality of the client's life when their best hopes are being lived out.

This is where the approach demonstrates its connection to, and roots in, systemic practice: through its detailing of interactions between the important people (in the key places) of the client's life; its use of other person perspectives (Lee, 2003; Tomm et al., 2001); and its acknowledgement of different observable behaviours – all of which provide information about the client as the version of themselves living a life where their best hopes have been achieved.

This is also where the approach lends itself well to the assessment requirements of statutory agencies, and practitioners can obtain 'new' information on client histories of capability, rather than focus on the histories of deficit which are often the content of referral documentation. As George et al (2012) have described, there is the opportunity for the twin-tracking of statutory functions and responsibilities alongside the opportunity to ask Solution Focused questions which end up being useful to the client.

The SFP approach is accessible and fluid, and, as Guy Shennan (2014) has described, can be used – where there is the will to do so – in an 'opportunistic' way. That is to say, particular questions (for example scaling questions) can be used to assist an intervention in a way that does not demand the classical structure of an SFP conversation.

When social workers receive training in Solution Focused practice, they begin to develop a working knowledge of the intention and the structure; and find their practice embodying the core assumptions out of which SFP questions are formed. It is the view of the authors that this is a professional acculturation with similarities to anti-oppressive social work (Dominelli, 1998; Hugman, 2003). The client (as expert) is placed at the centre of the intervention; language is used carefully, promoting client agency; and when social workers use SFP mindfully, there can be an awareness of structural inequality and the experience of discrimination baked into the ways strengths-based questions are asked.

As a result, even if you only have 10 minutes to speak with someone, an important opportunity is still available to ask questions imbued with the core assumptions of SFP, intended to invite thoughts about what life might look like tomorrow (if it was better in the way the client might want), or eliciting information about how someone has already lived elements of that imagined life, or simply showing admiration for how someone has managed to survive their current circumstances, determined to keep hold of the possibility of a better future.

Self-evidently, based on our social work values as well as our SFP core assumptions, it is the view of the authors that our clients in crisis deserve the opportunity for better futures no less than anyone else.

We accept that crisis situations are worrying and complex. But we have a strong belief that clients and families have a wealth of information to share about their own capabilities, and what life might look like beyond the crisis that they are experiencing.

The SFP approach – embedded in powerful, change-oriented and client-centred core assumptions (Goldie-McSorley, 2020) –asks questions to shift the attention of clients towards co-constructing new thoughts and 'memories' of what life might be like beyond the current crisis. These do not require any significant lead-time or preparation, they can begin to be asked in however long you have available. SFP is an approach that can help a client who is 'at breaking point'; and can lead to increased safety, alongside movement towards the client's 'best hopes'.

The SFP approach encourages the presence of safety and success through persistent, constructive listening (as espoused by Eve Lipchik in de Shazer et al., 1986). Listening with a constructive ear results in the asking of questions which promote the recognition of capability as well as the preferred outcomes of the client (and their professional network). It can reduce identified risk by collaboration. In crisis, it actively involves people in the co-creation of their own safety. It is our own best hope that the practice examples we have included will serve to provide robust evidence of this.

Methods of practice

These anonymised practice examples, which have been adapted to protect the identities of the clients and professionals concerned, have been provided using the language of workplace interventions. The pieces of writing are quite different from each other – one is in the first person, one in the third. The first scenario is a recording of a support visit to a suicidal young person in the community. The second records the s13 consideration work (Mental Health Act 1983) undertaken with a young person who has been admitted to a medical hospital. As the recordings have been given a workplace format, without much explanation as to intervention choices, a reflection has been added after each by the authors, to draw out the SFP thinking, and unpack the questions used.

An anonymised account of a visit to a family supported by Edge of Care Services, undertaken by Luke

'As planned, I arrived at the family home where I met with mum, she greeted me and updated me on some things before Jerry (15, personal pronouns: they/their) came downstairs. They said it would be helpful to go for a walk and talk, there had been something happening with their previous partner.

As we walked Jerry said things were 'shit'. When talking about how they have kept going and not given up, they alluded to "doing something" or "taking action", however it felt like [they were] talking in code/riddles.

They said they didn't want to tell me because of the hassle it would cause; I did not press the issue too much, but asked some questions, explained my worries, and asked if we could talk some more.

Then they let me know that earlier in the week they had taken some sleeping tablets with alcohol in the hope to fall asleep and not wake up.

Once at the local field I asked some scaling questions in relation to their mood and feelings of suicide, where 10 is where they are most at risk of killing themselves, and 0 is the furthest from that feeling. They explained that they were at 10; they wanted to be dead, and they talked about ways in which they would kill themselves by either overdose or hanging. They explained they have had thoughts about hanging themselves most days and they just want the pain to end.

They talked about what they go through in their head: Jerry was clear, stating regularly that they didn't want to be persuaded out of it; and still we were able to continue our conversations about them managing, and surviving (so far) the feelings around suicide; as well as to invite some thinking about hope, and faith in things being able to improve and change: towards a more pain-free life.

Jerry talked about a recent and important relationship being 'finished'. They talked about caring for [their ex-partner]; how often their ex-partner had wanted to end their life before they got together and how that had stopped, stating, 'I didn't do a bad job!'.

I asked about those efforts and energy, how they had [managed to be] that person for their ex: what it said about them they were able to be that caring person, and what they remember fondly from their relationship. I asked about the strength it took to cope with the pressure of supporting someone close to them.

Jerry said life without them isn't worth living and they couldn't see any point. And still I asked and had permission to ask a next question: towards any glimmer of hope or belief in a life worth living, a life with some less pain.

Jerry talked about fighting; fighting for so long and [always] fighting for other people that they did not feel like fighting anymore. I asked what had allowed them to fight for so long; how had they maintained that fight? I asked what they might notice if they could summon some strength to keep fighting for themselves at this time?

They made a comparison: if they were an animal, a vet would choose to put them down. They had planned to leave a note for a doctor to donate their organs to someone who needs them.

I asked them what it said about them that, even in thinking about death, they had geared themselves to helping someone else. Jerry talked about their ability to care and to want to care for others; they had always felt strongly about doing this. They said they have a skill for caring and being that [important] person for someone.

Jerry made it clear they didn't want me to take them anywhere - to a place of safety or hospital or anywhere - and again they couldn't be persuaded.

They mentioned attempts they had made to end their life, requests to be admitted to hospitals, calls made to helplines and agencies, all to get the help they needed. I asked what they thought it said that even as recently as yesterday they had called an agency to let them know how they were feeling?

I asked what they hoped for from calling; also, what did they hope from keeping my appointment today and talking with me in the field?

They said they want to be helped, but don't think they can be, and I asked again what it might tell them about themselves that they waited to let me know this. I asked them what the smallest sign of being helped might look like; and if these things started to happen, what they might notice in themselves that would alert them?

Whilst walking back towards the house they said there wasn't anything anyone could do... I asked what the smallest sign of hope returning might be for them, and they said they didn't know. I shared I was worried about them, and them being safe, and that I had a hope and belief in them living; so [I] asked what we might do that could show them some of the hope I had for them?

We spoke briefly with their mum, where I sensitively (around younger children) shared my worries and invited mum to share what she thought would work or has worked before for them, and what she thought might be useful or make a difference?

After this, Jerry let me know they would find it useful to keep talking and [for] me to take them to a hospital, and talk whilst I drove. They made the call, with their mum, and we made our way.

As we reached the hospital, I continued to ask for signs and descriptions of life shifting to feeling worth living, and of some hope returning. And then I asked: what tells them that there might be some hope? They said they had hope for the help they might get in hospital; the hope of getting out; some hope for a future for themselves.'

Reflexive discussion 1

The conversation with Jerry had been an exercise in persistent hope: gently asking for tiny signs of what hope might look like, and making sure to notice the actions that were evidence of Jerry's motivation to collaborate and to live.

Many readers of this transcript with experience in SFP may have thoughts and questions about what may seem an unexpected approach to the scale. Most commonly, zero will be the worst things could be, and 10 the desired outcome happening, or the *better* end of the scale. The reason for the ordering of the scale in this way was the requirements of Jerry. Right at the moment the practitioner was setting up the scale, Jerry decided they wanted 10 to represent their most risky/unsafe; the point at which they were likely to end their life. That was the way round that worked for them, and whilst in other conversations we would use more conventional Solution Focused scales, this one was a good fit for Jerry. In training colleagues in Solution Focused approaches, we have often had conversations which, in essence, acknowledge that scales of all sorts might be useful in crisis situations, particularly in contexts of suicide and self-harm (Jerome et al., 2024). These scales might not be Solution Focused scales, but they are none-the-less useful in the moment and need to be incorporated. This was an instance where practice moved from the 'rule book', but in another sense fitted with the essence of SFP and its fluid, client-driven roots.

The journey and the trajectory of recovery since that session has been nothing short of remarkable. Jerry has seized the opportunity; and begun to hold on to hope and to 'cope better'. They talk enthusiastically about future plans for education, being one day free of support services; of changes in mood; changes in socialising and a hope for themselves.

Luke has reflected subsequently on the conversation: having trusted Jerry; having trusted their wish for him to be there, and Jerry's wish to live. Luke's persistent hope is part of the DNA of his practice because of his SFP approach – his questions, and his determination to continue to ask his clients about hopes and strengths.

Luke has embodied core SFP assumptions as Jerry has talked: he has listened constructively (de Shazer et al., 1986), he has created a therapeutic space – a bubble – around himself and Jerry that has protected and strengthened the talking; and he has invited thoughts of life and a way of living that fitted for his client. Luke remembers not being fearful; not being disabled by worry. He remembers accepting and acknowledging the worry within the meeting, and deciding to respond with SFP questions: questions which enable a re-connection to a preferred version of living.

Many months later Jerry gave this feedback:

'Once he just came and met me on a random day, 'cos I was feeling really, really bad... and we just sat in a park and talked. And I felt like I had someone there I could trust... and I just blurted everything out... and that made me feel a bit better about it all... If they hadn't done that for me, I might have done something stupid, so it could even save lives.'

An anonymised account of a statutory mental health assessment (Mental Health Act 1983) undertaken by Nick

Some context-setting: In England and Wales the role of the Approved Mental Health Professional has ascribed to it a range of different duties. The key duty is to consider a person's situation on behalf of the local authority (s13(1) of the Act) and determine whether an application for compulsory admission needs to be made (s13(1)a). As per s13(2) 'all the circumstances of the case' need to be considered, and the AMHP is required to practice according to the Guiding Principles of the MHA Code of Practice (2015) which promotes least restrictive alternatives to compulsory admission. There has been research and reflective writing published over the course of 2024 which has re-visited these s13 Consideration responsibilities (Perry, 2024b, 2024a; Simpson et al., 2024), the importance of them, and the helpfulness of Solution Focused questions in the undertaking of them.

'The [Approved Mental Health Professional] has attended [the Medical Assessment Unit] ahead of Dr Nitin and spent some time with Yasmin and her aunt prior to other assessors arriving (including Lotty from Committed Coaches, an anonymised service that is providing intensive support for young people who are on the edge of care).

[The] AMHP has asked Yasmin what are her best hopes for the outcome of the assessment (having explained the reason for attending and the requirement of assessment following the imposition of the holding power): Yasmin says that she wants to go home and have a shower and go to bed.
Carrie [Yasmin's aunt] has been part of the 1:1 time offered and has updated the AMHP as to the difficulties at home over the past two weeks; and the injuries that Yasmin has inflicted on her nan. Carrie also referred to the trashing of the ward earlier in the day (which Yasmin said was because of her having been handled too roughly by the hospital security detail).

Carrie is concerned that Yasmin is not ready to return home and that she needs therapy and somewhere to go (when she is in crisis) - although Carrie thinks [the medical assessment unit] is not a good place for Yasmin to be, as the staff are not specialist regarding the needs of young people.

The AMHP has chaired an assessment in a side room of [the ward] as the Liaison Psychiatry interview room was not available - Yasmin stated that she would like this private space in which to have the meeting.

The meeting was attended by Yasmin, Carrie, Lotty (from Committed Coaches), Zayna (CAMHS) and Dr Nitin. The AMHP has attempted to frame the discussion via Solution Focused questions, alongside acknowledgement of the risks at home, and the seriousness of Yasmin's behaviours over the past two weeks.

The AMHP was able to ask some questions around what has helped Yasmin in the period of stability earlier in the year which has amounted to some months - over the course of the interview Yasmin said: having the right people around her (Carrie, Nan, Kris, Tina, Shireen); kickboxing; time with Kris [her boyfriend]; medication.

Yasmin has also identified that cannabis has had a negative effect on her physical and mental health - she agrees that she needs not to use it, and that this is difficult as her boyfriend uses cannabis a lot. Later in the interview Yasmin agreed to Lotty meeting with her and Kris tomorrow to explain to him the reasons why Yasmin must not use cannabis.

Yasmin is compliant with her meds and has re-started them today - Carrie has asked questions about PRN ('pre re nata' (Latin phrase used regarding medication, meaning 'when required') *meds for when Yasmin is agitated, and Dr Nitin has advised that Olanzapine 2.5mg should be used in this way - when agitated and when having difficulty sleeping.*

Yasmin realises that she needs to improve her behaviour in order to be able to stay with nan and Carrie, and a plan for this evening has been agreed (as well as a plan for the next few days): Yasmin will have a shower and have her meds; she will watch films with Carrie and have KFC; she will see Kris tomorrow (not today) and will meet with Committed Coaches tomorrow; Lotty will discuss cannabis use with Yasmin and Kris and explain the impact on her mental health; family therapy to start this month; Yasmin to get back into kickboxing (Friday) and also prepare for college; Yasmin to take meds and PRN meds conscientiously (with help from Carrie and nan).

Dr Nitin is not providing a medical recommendation [for compulsory admission] - Yasmin does not meet the legal grounds for any further detention - and the AMHP is content not to seek a further s12 opinion. (S12-approved doctors are those approved by the Secretary of State 'as having special experience in the diagnosis or treatment of mental disorder' (MHA 1983, as amended)).

The Ending of the s5(2) form has been completed and emailed to [the ward] and Yasmin has been discharged; Lotty will follow up tomorrow (and will confirm with CAMHS when the family are being offered family therapy - this is likely to be mid-late September).

Reflexive discussion 2

This is the anonymised record of an Approved Mental Health Professional (AMHP) intervention, undertaken on a medical assessment unit for a young person who had been kept on the ward under s5(2) of the Mental Health Act 1983 (as amended). This is an emergency holding power (of 72 hours duration) and requires the person to be detained for further specialist assessment of their mental health: to determine whether a s2 (compulsory inpatient) assessment, or a s3 (compulsory inpatient) period of treatment is required.

The Mental Health Act Code of Practice encourages AMHPs to give people awaiting assessment an opportunity for 1:1 time (14.54 – Department of Health, 2015). Nick chose to attend early to speak with the client and her aunt: to explain the purpose of the statutory work, and to ask some Solution Focused questions (Watson & Perry, 2022). Even the opening question – asking Yasmin her best hopes for the outcome of the assessment – has given the intervention a more person-centred direction.

Yasmin's aunt was keen for Nick to be aware of all the risks that her niece was presenting with. And in fact, when the multi-disciplinary interview starts proper, Carrie makes it clear that she does not feel that Yasmin can return home – she will need to be accommodated.

Whilst there was a need to acknowledge the risk concerns for all parties, there was also the possibility of asking about things that have gone well recently. Yasmin (with a heavy amount of sarcasm) is quick to tell her aunt that she has managed some things well over the past months, which her aunt concedes.

The AMHP has also noticed that there has been a period prior to this crisis when Yasmin has not been presenting to hospital. Nick asks for more detail about what helped things to go well in that period. Gradually Yasmin can speak about some of these. She is also insistent with the assessors about why she has kicked off on the ward earlier – this was due to her feeling that she was handled roughly by a security guard. This is acknowledged and followed up with the ward staff afterwards.

Other parties in the interview confirm the likelihood that there will not be a resource that can accommodate Yasmin locally, or any time soon.

In the interview itself, Nick asks Yasmin and Carrie to imagine that Yasmin has been able to return home, and that things have gone well; and they have been safe. He asks what they have found themselves doing during the course of the evening. As per the formal record of interview, Yasmin gives a very fluent description of an evening that will have helped. Yasmin and Carrie laugh with each other during this description. The actions described become the safety plan, which all the professionals endorse.

Other professionals that are present contribute their views about what is likely to be helpful when Yasmin has returned home, and support Carrie to stick to her boundary of Kris (Yasmin's boyfriend) coming round the *next* day; and for he and Yasmin to get some psychoeducation around the effects of cannabis on Yasmin's mental state.

After a break outside for a vape, Carrie changes her mind about Yasmin needing to be accommodated, and she does in fact go home.

Conclusions

It has been the experience of the authors that there is a disbelief amongst social workers that SFP can be used in crisis situations (and also that it can be a successful intervention). This seems a strange state of affairs given the relative brokenness of some of the statutory Health and Social Care systems in the UK – particularly for young people – and when there are strong attachments to other models of therapeutic intervention, even when these models are seen by practitioners to fail or be less than effective in crisis.

It is surprising to us that when there is so much need to plug the holes of systems and a society creaking under the pressure of chronic under-investment in public services, there is scepticism from social workers about Solution Focused practice. We don't believe that this scepticism is fair, helpful or warranted.

In this article we have shown two quite different case scenarios, in which social workers have used Solution Focused practice as the basis for their interventions in mental health crises involving young people and their networks. We hope that the content – provided in the language of workplace systems – will resonate with social workers and that the persistence and determination of the authors to frame questions from an SFP perspective can be seen and understood.

It takes training and practice to be persistent with SFP questions mid-crisis, where there is a strong pull to revert to the history of the problem and an organisational risk assessment which focuses on deficits.

As Guy Shennan's (2014) work has highlighted, it is not always possible to use SFP in a classical form. There is not always the time, or a conducive space, to have a conversation that flows from a best hopes question, through a detailed description of a preferred future, to a scaling question which gauges the client's proximity to the preferred future; as well as some description of incremental changes up the scale towards 'good enough'.

Scenarios like these are the lived reality of social work with young people in mental health crisis, where social workers try to get alongside young people and their families in whatever ways they can, perhaps only having fleeting moments to be part of a difference that will make a difference (Bateson, 1972).

It is the view of the authors that SFP questions can be a resource and a powerful force for change within mental health crisis situations: giving young people the opportunity to co-create a story in which some of the difficulties they are facing no longer block their path towards greater safety – and this newly created safety can enable further progress towards the future that they actually want.

Conflict of interest declaration

The authors report that there are no competing interests to declare.

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