Rhoda.

Interview With Cherlie.

1a) Over the years, practice changed, more due to exp r decid whether to do MHA Ax. Not set of things you can learn, exp More IMP than knowl. Does Ax which were appr, others fed back Was that way to proceed. Used learning in other ass. Confid in dec Making, thinking above them in a broader way. Complex b/c stack of exp similar scenario

1b) When you have supp from others, Coll's in team, SWIDs, consultants. When coll's prep r open to eng in a convers with you, option to looking 2 pros + cons doing an Ax, can focus on the person + not team dynamics.
Example - SWIDs MTG had convers with. Talked thr MH + risk factors. Unpicked risk, reduc risk. This opened up how much they had engaged. Started Mons day before, oh good you can visit over Wk & see how it goes. On Mon they're doing really well. Eng SWIDs in decision. In sharing decision supp each other with diff situation r joint dec + risk taking. Supp within team is more IMP to have good AMHP

Charlie

2a) - Starting point scepticism, critical of the request. Detaining is sometimes necessary & that is keeping person 2 centre. Start from point, surely there must be something else that can be done.

Hosp? Sharing the concern with + possibilities service user What can we do to help. Went to see with Bec someone who had stopped clozapine hosp might have to be an outcome. Tried avoid MHA Ax. Focus on others allern. Detention last resort on list.

2b) Being holistic Whats going on for person which might be affecting situation. Yes might have a diag & not taking Meds but is there anything else we can do to support Not just diag & treat plan. Being open minded to possibility May have an illness, consider if treatment worse than letting be eg M.C.

2c) Always start from point of don't want to be detained. Sometimes not as concerning as expected. Will change mind if reality = no need for detention. Knife example something said in jest, not a threat. Others views can be distorted.

Charlie.

creativity -

3a) Social stress factors we may be able to affect + avert need for ass. Making suff att's to engage, notes the door as no answer, let us know what's happening. Eng activities, try + have conver with people, why we are consid, what might be next step. They can decide treat or not, transparency. Contacting family they can offer solutions. Properly expl option of people coming into hospital & allow them to make a decision. More say over treatment if inf, neg eff of detention. Don't say if you don't mean.

3b) We use our experience. RIO identify docs past & what is happ currently. Finding right doc's. When seen doc & how that has gone. Prev AMHP report or MHT. What concerns the person or the family. If lacking capacity - What's their past attit to treatment etc. Can learn from fam re this. Ask person what's a problem for them. Adv visit beforehand should be de-fault position. Should be routine prac or V. limited cir's. Part of rel info is info provided by s/user.

Charlie.

4) VIEIM We are trying to unders the risk clearly enough. If we ~~Action~~ unpick risk & its not so bad we may be able to create time & this provides space to come up with alternatives. VIEIM trying to create more time, not over inflating risk.
If risk high can act rapidly.

b) As above - Positive use of time is trying to create more time. often we can reduce concerns by anal the info & if we can do this, = More space to try alternatives. Ass arr in a hurry, not very holistic & knee jerk reaction. It's about bal risk & time, & space to do something different. Converse of that, too many IMM concerns need to do it as a protective thing. Might be satisf after.