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Safeguarding MATTERS

Issue 34
November 2024

Mental Capacity Act SPECIAL EDITION

Welcome

to the latest issue of Safeguarding Matters.

This special issue focuses on the Mental Capacity Act (MCA). The MCA is a key priority for both Safeguarding Adults Boards and features in their current business plan. Whilst the key demographic covered by the Act are adults, it does apply to those who are 16+. We have featured a specific article on 16-18 year olds within this edition from a Children's Social Worker's perspective with accompanying case study.

The rationale for this particular topic is that local Safeguarding Adults Reviews and audits over the last few years have identified MCA learning including around:

- Best Interests
- Advocacy
- Recording of decisions and that assessments have been carried out
- Complexity of co-existing conditions
- Fluctuating capacity
- Role of parents and carers / listening to them / sharing information with them (with permission)
- Lack of understanding of the process by frontline workers and whose responsibility it is to carry out assessments

In addition, learning has identified the need for more suitable resources to support frontline practitioners in their daily practice in recognising the situations where a person's mental capacity is in question and demystifying the MCA process.

In support of this special edition on MCA, we have also published an accompanying "MCA What Good Looks Like series". These are 6 documents which focus on different elements of the MCA.

This Safeguarding Matters has been published in line with National Safeguarding Adults Week which runs 18th-22nd November.

The theme this year is Working in Partnership and is championed by the Ann Craft Trust. Safeguarding Adults Week is a time for organisations to come together to raise awareness of important safeguarding issues, such as locally in our case the Mental Capacity Act.

We encourage you to check out the Ann Craft Trust website to see what other topics they are covering during the week and events they are hosting. This includes professional curiosity, partnership working and professional boundaries.

We hope you find this edition and the additional resources useful.

Introduction to the Mental Capacity Act (MCA)

The Mental Capacity Act 2005 came into force in 2007. It is designed to protect and restore power to those vulnerable people who may lack capacity to make certain decisions, due to the way their mind is affected by illness or disability, or the effects of drugs or alcohol.

The MCA also supports those who have capacity and choose to plan for their future.

The MCA applies to everyone working in social care, health and other sectors who is involved in the support and treatment of people aged 16 and over who live in England and Wales, and who are unable to make all or some decisions for themselves.

SCIE, Introducing the MCA

The following five principles apply for the purposes of the MCA:

1. it must be assumed that a person has mental capacity unless they have been assessed as lacking mental capacity;
2. a person should not be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success;
3. a person should not be treated as unable to make a decision just because they make a decision that seems to others to be unwise or wrong;
4. an act or decision carried out for the person who lacks mental capacity must be done in their best interests;
5. before an act or decision is carried out, there must be consideration given to achieving the intended outcome in a way that is less restrictive of the person's rights and freedoms.

These five principles should inform all actions when working with a person who may lack or have reduced mental capacity and should be evidenced when making decisions or agreeing actions on their behalf.

For more information about the Mental Capacity Act in our local procedures, please follow this link.

MCA: What Good Looks Like series

We have just launched this suite of documents focusing on 6 key themes within the MCA:

- About capacity, the act and the court of protection
- Assessment Forms and expected standards
- Next of kin, living wills, attorneys, deputies, the Office of the Public Guardian
- Capacity Assessments
- Best interest decision making process
- Preferred communication and all practicable steps

These are quick reference guides for professionals and have a plethora of links and research should you wish to delve deeper into the topics.

Many thanks to Durham SAB for allowing us to adapt their documents for local use. These are supplementary to our existing "How To" guides in our procedures, which support staff in completing capacity assessments, relating to specific key decisions common to safeguarding.

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The new local LLR guidance:

Responding to self-neglect (including hoarding)

The Care Act 2014 included self-neglect for the first time as a category under adult safeguarding. Supporting people who self-neglect is associated with high risk to adults with care or support needs. People experiencing self-neglect are more at risk if professionals fail to assess mental capacity.

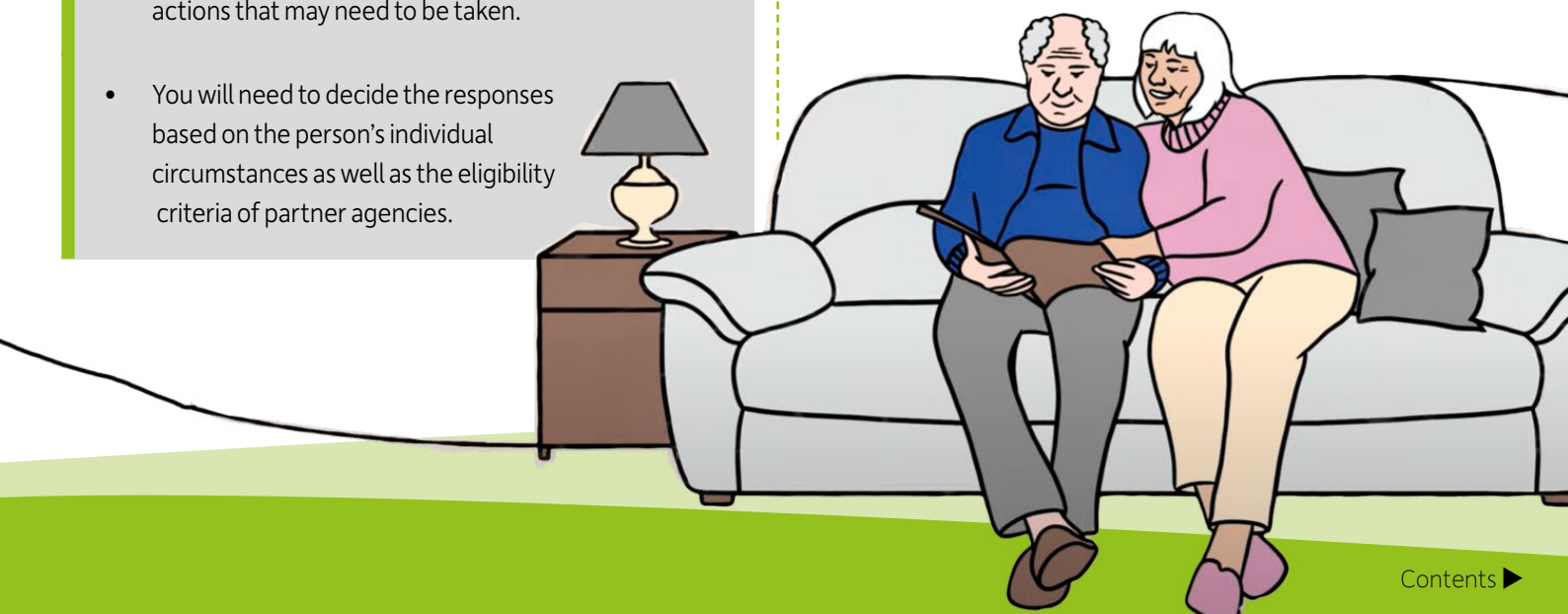
The Leicester, Leicestershire and Rutland Safeguarding Adults Boards have produced new self-neglect and hoarding guidance for practitioners which will form part of the Safeguarding Adults Multi-Agency Policies & Procedures from 1st December 2024. This guidance will:

- Support you as a frontline professional to work with people who are at risk of self-neglecting or hoarding. It replaces the LLR Vulnerable Adults Risk Management Guidance (VARM).
- Provide a risk assessment tool to support you to identify whether the person's self-neglect or hoarding is low, moderate, or high risk. Where a person is assessed as low or moderate risk, you should work flexibly with the person and colleagues in a multi-agency approach to achieve the best outcomes for them.
- The guidance does not specify which agencies need to be involved nor does it prescribe any specific actions that may need to be taken.
- You will need to decide the responses based on the person's individual circumstances as well as the eligibility criteria of partner agencies.

To accompany this new guidance, we have also created:

- a short introductory video to the procedures
- two 7-minute briefing documents (one on hoarding and one on self-neglect)
- a video for people who use our services explaining what self-neglect is.

During National Safeguarding Adults Week, we will be holding three 15 minute briefing sessions sharing the video introducing the guidance and offering practitioners the opportunity to post any questions they may have about the new guidance. These sessions will be held on 19th, 20th and 21st November at 9.15am-9.30am. Practitioners will only need to attend ONE of the following briefing dates. Please do not forward these links in any PDF format – they will not work. To attend please choose and click on one of the following to join on the day: Tuesday 19th November, Wednesday 20th November or Thursday 21st November. Questions asked during the session will be collated to form an FAQ to be published alongside the guidance and uploaded to our YouTube channel ready for the official launch on **1st December 2024**.



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Hoarding and MCA:

a recent court judgement "AC and GC"

The case of AC and GC [2022] EWCOP 39 heard in the Court of Protection provides helpful guidance to practitioners who are working with adults who are hoarding.

AC is a 92-year-old woman. She had been sharing her home (which she owned) with her son, GC, since her husband's death eleven years earlier. GC had given up his job and had become his mother's main carer. In February 2022 she was taken to hospital by emergency services. In March 2022, a best interest decision was made to discharge her from hospital to a care home. There had been concerns about the unsanitary environment of her home and the potential impact of this environment on her health and welfare.

In the summer of 2022, the question brought to the Court was whether AC could return home for a trial period, with a package of care. It was her wish to return home, while the local authority thought she should remain at the care home. Both AC and her son were diagnosed by a clinical psychologist, Professor Salkovskis, as having a hoarding disorder (among other conditions). AC was also diagnosed with Obsessive Compulsive Disorder.

The judge in the case provided guidance on the decision required in the case of hoarding and critical elements of that decision. The decision was defined as:

"Whether the person can manage their items and belongings?"

It was suggested that the relevant information would be:

I. **Volume of belongings and impact on use of rooms:** the relative volume of belongings in relation to the degree to which they impair the usual function of the important rooms in the property for you (and other residents in the property) (e.g. whether the bedroom is available for sleeping, the kitchen for the preparation of food etc). Rooms used for storage (box rooms) would not be relevant, although may be relevant to issues of (3) and (4).

II. **Safe access and use:** the extent to which you (and other residents in the property) are able or not to safely access and use the living areas.

III. **Creation of hazards:** the extent to which the accumulated belongings create actual or potential hazards in terms of the health and safety of those resident in the property. This would include the impact of the accumulated belongings on the functioning, maintenance and safety of utilities (heating, lighting, water, washing facilities for both residents and their clothing). In terms of direct hazards this would include key areas of hygiene (toilets, food storage and preparation), the potential for or actual vermin infestation and risk of fire to the extent that the accumulated possessions would provide fuel for an outbreak of fire, and that escape and rescue routes were inaccessible or hazardous through accumulated clutter.

IV. **Safety of building:** the extent to which accumulated clutter and inaccessibility could compromise the structural integrity and therefore safety of the building.

V. **Removal/disposal of hazardous levels of belongings:** that safe and effective removal and/or disposal of hazardous levels of accumulated possessions is possible and desirable on the basis of a "normal" evaluation of utility.

In this case a number of practicable steps had been taken to support the person to make the decision:

- the Fire Service had assessed the home and advised AC and GC
- AC and GC each had their own social workers
- there was collaborative multi-agency working over several years
- use of therapeutic relationships
- good analysis of identified risks.

According to the MCA (section 2(1) UK, 2005) a person lacks capacity to make a specific decision ***"because of an impairment of, or a disturbance in the functioning of mind or brain" and "it does not matter whether the impairment or disturbance is permanent or temporary."***

Professor Salkovskis explained at paragraph 21:

"when there is a combination of obsessive-compulsive disorder (OCD) and a hoarding disorder. They are disorders which impair life, can cause much distress and when the two interact it is much more serious, he said, 'like having Covid on top of asthma'."

Each person is unique and professionals need to respond to each individual's circumstances. This case does provide professionals working with people who hoard clear guidance how to complete a robust capacity assessment in relation to their hoarding behaviours. It was established that AC lacked capacity to manage her possessions and belongings and the Court made a best interest decision that AC was able to return home to live with GC with a list of conditions.

The judge stated at paragraph 40:

"I wish to draw attention to the very fine work which has been carried out in this case by all of the professionals. I have already spoken of the high quality of the work undertaken by the social worker. I mention now the skilled work undertaken by the solicitors for GC and AC, to progress the cases of their clients, to provide support and assistance to them and the very best information to the court. Their work has been acknowledged by counsel, who have been able to achieve a great deal prior to the start of this hearing as a result of that diligent preparation. I wish to thank them as well as counsel who have shown sensitivity and attention to detail."

Hoarding peer group information

A free hoarding peer support group, entitled "My Space at my Pace", meet on the last Wednesday of every month in Leicester. This is an opportunity for people who have a lot of clutter in their home to meet other people who are living a similar lifestyle to theirs.

This group is also open to family or friends who know of someone who is exhibiting hoarding behaviours and is directly affected. On some occasions, guest speakers attend to inform the group about the services that they can offer or are available to them. If you are a service and feel that the group would benefit from knowing about the services you or your organisation could offer, please get in touch with the Leicestershire Fire & Rescue Service Safeguarding Team via 0116 210 5555 or email: safeguarding@leics-fire.gov.uk if your service would like to present to their group. For more local information on hoarding see the LFRS website.

In addition, the peer group has made a video which we have published on our Safeguarding Adults Boards' YouTube Channel explaining how hoarding makes them feel. This video has been shared with the My Space at my Pace members' permission and has been made to raise awareness of how people with hoarding behaviours feel and can be made to feel by others because of their circumstances. We also have a fire safety and hoarding presentation on our YouTube Channel for practitioners which was shared at a Safeguarding Matters Live event from December 2022 with additional useful information.

What to do about self-neglect:

In October 2024, an animation on self-neglect was launched by the Safeguarding Adults Boards in Leicester, Leicestershire and Rutland.

Have a look at this animation with people who use your services to:

- identify the signs of self-neglect behaviours in themselves, friends and family members
- improve awareness within the community
- understand the support that is available
- understand the role of family, friends and neighbours in helping the person to access support.

Many thanks to North East SAR Champions for allowing us to customise the animation for local use with their permission. The animation can be found on our YouTube channel.

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Learning from local Safeguarding Adults Reviews and multi-agency audits

Safeguarding Adults Boards have a statutory duty under Section 44 of the Care Act 2014 to undertake Safeguarding Adults Reviews (SARs) into cases where individuals with care and support needs have been seriously harmed or died, abuse or neglect is suspected and there are concerns about how agencies worked together to safeguard the adult. When these reviews are undertaken they are focused on identifying how multi-agency safeguarding systems and practice can be improved in future.

The Second National Analysis of Safeguarding Adults Reviews in England, which was funded by Partners in Care and Health (PCH), supported by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), was published in June 2024. It looked at learning from Safeguarding Adults Reviews completed between April 2019 and March 2023. It reported that "Poor attention to mental capacity was noted in 58% of cases [considered]" (Stage 2 Report, June 2024, page 30).

Locally, mental capacity has been a prominent theme in both Leicester and Leicestershire & Rutland Safeguarding Adults Board Safeguarding Adults Reviews. Some of the issues raised include: Best Interests; advocacy; recording of decisions and that assessments have been carried out; complexity of co-existing conditions; fluctuating capacity; role of parents and carers (listening to them / sharing information with them with permission); lack of understanding of the process and whose responsibility it is to carry out assessments.

The Leicester, Leicestershire & Rutland Safeguarding Adults Boards also carry out multi-agency audits as part of their quality assurance processes. A Mental Capacity audit was completed in 2023-24. Where mental capacity assessments were completed, good practice was identified by all auditing agencies, with some examples of proportionate capacity assessments, practitioners being persistent and joint assessments being carried out by agencies.

Overall, when the Mental Capacity Act was followed, it led to better outcomes in respect of the safeguarding enquiries.

Learning was identified around understanding who can complete capacity assessments; the need for proportionate capacity assessments to be completed at the outset of any safeguarding enquiry, where doubts about capacity arise; assessments being decision specific; rationale around practicable steps taken needing to be detailed; and the importance of advocacy in safeguarding enquiries.

The learning from these local processes is fed into our learning and development resources, including our training. The themes identified have also informed some of the content in this special issue of Safeguarding Matters.

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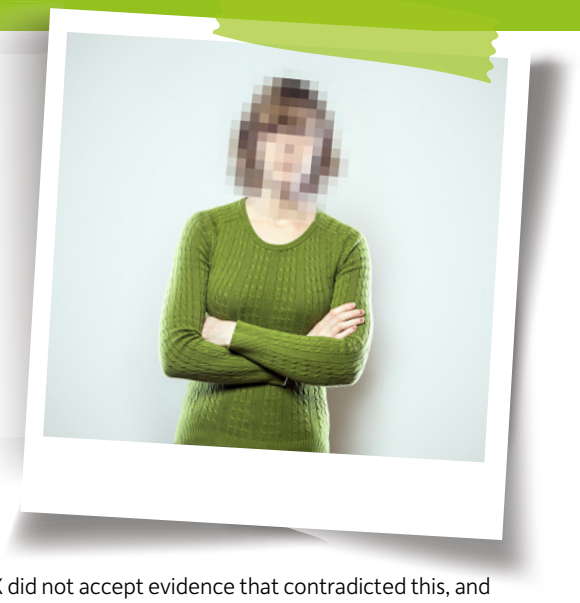
Health focus: MCA case study



As part of creating this edition, it was felt that practitioners might find it useful to read through an example of a practical use of the MCA in a health setting. Below is an anonymised case provided by Stacy Murrell, Adult Safeguarding Specialist Nurse from the University Hospitals of Leicester.

Patient X was highlighted to the UHL Adult Safeguarding Team when there had been difficulties in them accessing health services due to them having no GP, following a breakdown in their relationship with primary care services. There were concerns that Patient X had symptoms of malignancy, and eventually they were admitted to hospital and, during this admission, cancer was confirmed. Following discharge, Patient X was reviewed by a Consultant Oncologist and Specialist Nurse in the outpatient's clinic; treatment was offered to improve their symptoms which Patient X initially accepted. There were no concerns raised regarding Patient X's mental capacity during this initial consultation.

However, during a routine follow up call with the Specialist Nurse, Patient X stated that they no longer wanted to take the treatment, and the Specialist Nurse raised concerns regarding Patient X's presentation during this conversation. The nurse felt that Patient X appeared suspicious and paranoid, which was significantly different to their presentation in the clinic. Patient X believed that the medication would cause them harm; attempts to challenge this belief by providing education and reassurance were unsuccessful.

Multi-agency discussions took place, and various information was shared about Patient X's history. Patient X previously had contact with mental health services, and it was thought likely that they had a paranoid personality disorder. However, Patient X disengaged with services before a diagnosis could be made. Mental Health services had previously confirmed that they did not find evidence that Patient X had a serious mental illness. Previous mental capacity assessments that had been completed regarding Patient X's decision to disengage with services had established that they had capacity to make these decisions at the time. Paranoid ideas had been seen previously in Patient X's presentation. The information, combined with the concerns raised by the Specialist Nurse, prompted the Safeguarding Team to consider that there may be reason to doubt Patient X's capacity to decline treatment due to the influence of paranoid ideas and fixed beliefs, on their ability to use and weigh factual information, in the context of a possible undiagnosed and untreated mental health condition.

From reviewing available medical notes, it became apparent that there was a long history of paranoid ideas and beliefs in relation to Patient X's health and care that they had received, spanning over at least two decades. There appeared to be a pattern of Patient X presenting with symptoms which they believed to be related to a specific, usually uncommon condition. However, when faced with evidence that either suggested or confirmed that they did not have this condition, they did not accept this evidence and sometimes made allegations about the service who provided this evidence, stating that they had caused them harm. Patient X often did not believe alternative diagnoses that were made. Concerns had been raised previously that Patient X's presentation was psychosomatic in nature. This presentation continued through Patient X's contacts with UHL, as they spoke about alternative causes for their symptoms and made allegations that clinicians had caused them harm. Patient X did not accept evidence that contradicted this, and eventually disengaged with some UHL services.

All relevant information was presented to clinicians to ensure that they were fully aware of Patient X's history, so that they could consider this when establishing whether they had cause to doubt their capacity in relation to the decision to decline treatment. This case prompted discussions and considerations of a person's beliefs on their ability to use and weigh information and gave us the opportunity to consider relevant case law, for guidance in such a complex case.

Local Authority X v MM [2007] EWHC 2003 (Fam) at paragraph 81.

"If one does not 'believe' a particular piece of information then one does not, in truth, 'comprehend' or 'understand' it, nor can it be said that one is able to 'use' or 'weigh' it. In other words, the specific requirement of belief is subsumed in the more general requirements of understanding and of ability to use and weigh information".

Leicester City Council v MPZ [2019] EWCOP 64 at paragraph 34.

"The case law makes it clear that a failure to believe is a failure to understand and use or weigh in the context of the specific decision-making exercise engaged."

Royal Borough of Greenwich v CDM (Rev 1) [2019] EWCOP 32

"As a result of her personality disorder, CDM has problems regulating her emotions. She can, at times, experience emotional cascade when she engages in dysregulated behaviour. At such times, her emotions control her. She is unable to use or weigh information. She acts impulsively and without thought of the consequences for her actions."

Ultimately, the clinicians involved had to make a judgement whether they felt that Patient X's beliefs were impacting their ability to use and weigh information; this was based on the information available to them and Patient X's presentation at the time that the decision was made, using the balance of probability. Clinicians considered all of Patient X's interactions with the service to make this judgement, as it would not have been possible to obtain enough evidence regarding Patient X's beliefs from a singular interaction, due to the fluctuating nature of their presentation. This case highlighted the importance of multi-agency information sharing and obtaining a detailed history to be able to fully understand the challenges that a patient may face when they are presented with information. In this case, it was important for clinicians to understand the history behind the presentation that they were seeing so that adjustments could be made to the way that Patient X was approached, taking all necessary practicable steps to support Patient X to be able to make the decision.

Good practice section and useful information

National Resources	Who's it aimed at?	What's on offer?
Social Care Institute for Excellence (SCIE) MCA homepage	All staff, including managers, in adult social care services	Videos (free) Training courses (fees apply) E-learning (fees apply)
National Mental Capacity Forum	Stakeholders from health & social care, police, finance, housing, etc. to improve local implementation of the MCA	Free webinars on occasion
Social Care Institute for Excellence MCA Directory	Professionals across health and social care sector	Publications, videos and academic research (approx. 400 entries)
The Mental Capacity Act 2005 Resource and Practice Toolkit	Professionals who use the MCA	Guidance on how to implement the MCA
Understanding Mental Capacity – Open University	Anyone who needs to understand mental capacity and decision making in the UK	Free course – OU credits can be achieved
Mental Capacity Act Law and Policy – 39 Essex Chambers	Health and social care professionals	Case Law Webinars Podcasts Guidance
Using the Mental Capacity Act	A resource for families and friends of people with learning disabilities	Written information
Mental Capacity Act 2005 in Practice – Learning Materials for Adult Social Workers	DoH Guidance for social workers about putting the MCA into practice	Written information
Mental Capacity Act: making decisions	Government guidance for advice workers, health & care workers and IMCAs on how to make decisions under the MCA	Written information
Mental Capacity Act – Social Care and Support Guide	NHS website with information for all staff and members of the public	Written information

*__PLEASE NOTE__ – these resources are current to 5th September 2024. Case law and legislation may change and all practitioners are responsible for ensuring they are accessing the most up-to-date and relevant guidance when applying any legislation.

For additional local resources please refer to our "MCA: What Good Looks Like" series of leaflets which are packed full of hyperlinks for more information and our existing "How to" guides in our procedures, which support staff in completing capacity assessments, relating to specific key decisions common to safeguarding.

MCA myth busting

MYTH

If a person lacks capacity for a decision, their next of kin must make it.

FACT

The term 'next of kin' is often used, but it doesn't have any meaning in law – and therefore being defined as "next of Kin" does not give a person any powers to make decisions for any other adult. When a decision needs to be made, and someone lacks capacity to make that decision, for example to consent to or refuse treatment, medication or care, the decision must be made in the person's best interests.

If a person has made a Lasting Power of Attorney (LPA) the Attorney can make decisions on the person's behalf. There are two kinds of LPA – one is for financial and property decisions, and the other is for health and welfare decisions. Anyone over 18 can make a Lasting Power of Attorney.

Spotlight on 16-18 year olds:

interview and case study from children's services

Young people and the Mental Capacity Act (2005)

Young people are protected by the Mental Capacity Act (MCA) from the age of 16, though until they are 18 there is an overlap with the framework of the Children Act (1989). This means that their parents can in some circumstances consent to treatment on their behalf, but the MCA must always be considered where relevant.

For young people there are several things that need to be considered when making decisions in the **best interests** of young people (aged 16-17) who lack capacity for relevant decision-making.

Until they reach 18, young people cannot use the forward planning mechanisms in the MCA to make an Advanced Decision to Refuse Treatment (ADRT) or create Lasting Powers of Attorney (LPAs). They do have the right everyone else has to have their wishes and feelings put at the heart of how they are looked after and cared for. This means that, like anyone else, they should be encouraged to make a statement of wishes, which should be the basis of their care plan as far as possible. Today's craze for a certain pop group, or fashion, or make-up, might not last very long. Similarly, young people change faster and more dramatically than when they are older; this all needs to be considered in their care plan.

Consideration has to be given as to whether those areas of functioning where it is thought that they lack capacity can be supported in other ways. There may be training or work in building empowerment (such as self-esteem being promoted through socialisation with young people their own age) that may enhance the young person's decision-making.

The Care & Quality Commission (CQC) offer a useful guide on capacity and competence when assessing young people.

The following piece describes the approach taken by a Senior Social Work Practitioner in assessing a young person under the MCA to achieve the best outcome for him.

A Case Conversation with Katie Daglish, Senior Social Work Practitioner (SSWP), Disabled Children's Service (DCS), Leicestershire County Council

Biography

Katie started her Social Work career working in Adult Services with Leicestershire County Council around eight years ago. She worked in the Transitions Team, which has now become the Young Adults Disability Team. Within that Team, Katie carried out Mental Capacity Act (2005) assessments on young people and young adults between 17 and 18. This involved consideration not just about their care and support needs, but about other things as well, such as finances, their ability to manage their money (such as organising a Direct Payment, or a bank card). Sometimes the assessments were about contact with family, friends or relatives.

Katie went on to train as a Best Interest Assessor working primarily with adults who had a learning difficulty or disability. Then two and half years ago, Katie made the decision to move across to Children's Social Care to work in the Disabled Children's Service (DCS) and is now a Senior Social Work Practitioner in that team. She feels that she has found her niche in the DCS and her current role in supporting Social Work students, Newly Qualified Social Workers, and Social Workers who have come to work at Leicestershire Children's Social Care from countries outside the UK.

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The discussion about the young person and the MCA Assessment

Katie chose to have the reflective practice conversation about a young person who was over 16 and nearly 17, who we chose to call Toby (not his real name). Toby is neurodiverse, being on the autistic spectrum with Attention Deficit Hyperactivity Disorder (ADHD) and some learning difficulties, and can present well in his ability to communicate. At the time of the assessment, Toby was a young person in the care of the Local Authority under a Care Order (s31, Children Act 1989). He was living in a residential home that supported young people who have additional needs.

The prompt for undertaking the assessment was twofold. Firstly, due to his age, Toby would, like any other 16-year-old, be in a position of making some decisions (or what are usually referred to as "determinations") around his care and living. There was a need therefore to assess his capacity in relation to managing the practicalities of everyday living. Secondly, there was a more immediate issue around his compliance with medication to treat a severe infection on his back. This involved taking a prolonged course of antibiotics, which he was not prepared to do as he felt, based on previous experience, the treatment should only last a few days.

Katie was not Toby's allocated Social Worker at the time of the assessment. His Social Worker had been off work for some time. He did find it very difficult to deal with new people, and he had informed the care staff he did not want another worker bothering him.

It was for that reason that Katie, who needed to complete the MCA assessment, felt it was very important that she prepared well ahead of any meeting with Toby. Not having developed a working relationship with him, Katie read all the case notes and relevant reports so that it was clear as to how he communicates.

For Katie this was central to the undertaking of the assessment. It would be essential to set the right tone and phrasing of the questions.

Katie discovered that Toby did not like feeling that he was being patronised. Katie assessed that producing a script for the MCA that included lots of pictures and easy read most likely would have made Toby feel insulted. So, in discussion with the staff who best knew him at the residential home, Katie constructed a letter that was written in plain language and avoided technical terms and jargon.

She felt that an approach through a letter may prove more successful. The letter was kept as brief as possible, used language that he would appreciate and understand because he had a very good vocabulary and stressed that this was to protect his rights. Katie felt it was important that he was informed clearly that she didn't want to take any rights away from him just because he was finding it difficult. It also explained the assessment itself; what she was doing and why she was doing it.

To support Toby in the process, Katie had liaised with the staff at the residential home. From the discussions she found the best way to manage the session for the assessment. Toby had distanced himself from his family. It had also not been possible to find a way to help him engage with the Children's Rights Officers to offer him advocacy.

To provide the best opportunity possible for Toby to engage with the assessment and feel comfortable and confident in the process, Katie ensured things were in place that could help achieve this happening.

Katie, therefore, arranged with the staff at the residential home to create the best environment they could to enable Toby to contribute to the assessment. It was recommended that it took place within a Tutor session. Toby received his education on site at the residential home with a tutor with whom he had a very good relationship. He also had his key worker with him, with whom Toby also had a positive relationship. Katie felt it was essential to use the knowledge of the people she had spoken to about this young person

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and be clear about the things that needed to be considered to achieve the best environment for Toby. Katie felt that it was important to begin informally and set a relaxed tone for the meeting. Toby was offered the opportunity to raise any questions, and then the discussion progressed in a conversational way to explore the issues central to the assessment. An example of setting the tone was given by Katie. One thing she had been told was that Toby loves to bamboozle people with big words, and he did this with Katie during the initial chat before moving onto the assessment. Rather than looking confused, Katie responded by using equally big words. Toby thought that was hilarious so that helped build up a little bit of rapport. Katie put this well, ***"I suppose that's what it comes down to – responding to him as a young person with rights, but also a young person with autism and understanding how it impacts on him."***

The central issue for Katie in her approach to the assessment was ***"You presume capacity unless you prove it otherwise, and it's starting at that point. Whatever their disability is, you've got equality principles as well. You don't judge them by their disability, you judge them by the assessment."***

Katie explained that the session began with exploring Toby's understanding and ability to weigh outcomes of his decisions around his care and support. This was to provide some areas for conversation that he would be able to engage with before moving on to the more sensitive topic of the medication. So, for example, they looked at personal care and hygiene and using the kitchen to prepare meals (something Toby wasn't keen on, preferring others to cook for him, what teenager doesn't?). Katie probed the answers he gave and asked him to look at the situation when support wasn't there, asking him about what that would look like, and how it would affect him.

Katie found that Toby was able to show an understanding of the salient details of his care and support, and he demonstrated an ability to retain most of them, and to communicate his decision. He couldn't show the capacity to really weigh up the pros and cons and make decisions about his care. So, for that reason, Katie had to conclude that he didn't have capacity: ***"my judgement was that his inability to make that decision was due to his disability".***

Katie reflected on this process. We explored the question, ***"What were the things that you think you were able to do to keep that attention with him?"*** Katie felt that it was taking the approach that put ***"Engagement on his terms".*** For Katie this was the main thing and not talking down to Toby. ***"I spoke to him as I would an adult, so he didn't feel he was being demeaned".***

The other area explored was in relation to the medication regime, and Toby expressing that he was not going to continue with it. To do so would have serious consequences for Toby's health, and it was also impacting on his behaviour and tolerance due to the discomfort. Katie used the outcome of the MCA assessment to undertake a Deprivation of Liberty (DoL) assessment.

Toby was agreeable to taking his other medication which was mixed into his favourite yoghurt. So, the proposal was to use the same method for the antibiotics, although this would be covertly. Katie and the others involved in his care were, therefore, faced with an issue of DoL. Due to the issue, and to ensure Corporate Parenting responsibilities (as Toby was a young person in the care of the Local Authority) were included, Katie convened a Best Interests meeting at very short notice and got the professional network for Toby "around the table" (a virtual one). Katie explained that in this situation *"because of the length of time, this had to be agreed. And, because of the impact it was having on him, it was agreed by everyone there with conditions that this should be given covertly. It was only for this medication, which is all we were asking for anyway, because he had accepted the other one. He just wouldn't have this one".*

The outcome was that a DOL was applied for at the Court of Protection and granted in regards to administering the medication covertly.

Kate reflected on the process and the discussion and, in response to the question, ***"What are you most proud of in the work you did here with Toby?", she answered, "I think what I was most proud of is that I did manage to get him to engage with me for that length of time, and that was because of the preparation I'd done, the negotiations with the placement beforehand and all those other practical steps, and they were essential."***

MCA basic awareness and MCA in practice training

As part of the MCA business plan priority, the Safeguarding Adults Boards have commissioned Edge Training and Consultancy Ltd to provide 18 training courses across 2024-2025 covering 2 levels of MCA knowledge for staff working across LLR. These are entitled "basic awareness" (half day) and "in practice" (full day) and are a mixture of online and face to face sessions. They aim to enable participants working in our local area to have an awareness of the Mental Capacity Act 2005 and to be able to apply it to their everyday practice with people who use our services.

By the end of the course participants will be able to:

- Understand the key rules and procedures of the Mental Capacity Act
- Explain how their working practices will be affected by the legislation
- Illustrate the skills needed to assess capacity of a client they are working with
- Demonstrate practical application of the Act.

The courses have been proving popular and we have provided 5 in practice sessions and 9 basic awareness sessions and feedback has been positive.

"This was a very enjoyable session and Helen was and is clearly very passionate about the subject, which made it even more enjoyable to attend."

"It was great – slides were detailed and useful to have before the training started. The information was relevant and I really enjoyed the course. Thank you so much."

"The case law and associated case studies are an excellent way to understand the application."

"Thank you to Sarah for a very engaging session, it is one of the best training days I have ever been on (of any topic!)"

After the course everyone has the opportunity to attend a post course evaluation session with our local trainers, a few months after the training, to allow delegates to reflect on how they have embedded their learning and what other support they need and allows them the opportunity to bring some examples of their work to see how they can improve.

This enables the Safeguarding Adults Boards to gauge the impact the training has had and understand what additional MCA requirements we have across LLR.

Remaining dates for 2024/25: In practice:

Thursday December 5th 2024	9.30am-4.00pm	Virtual (Zoom)
Thursday January 16th 2025	9.30am-4.00pm	Virtual (Zoom)
Tuesday February 18th 2025	9.30am-4.00pm	Virtual (Zoom)
Wednesday March 26th 2025	9.30am-4.00pm	In-person City Hall, 115 Charles Street Leicester LE1 1FZ

Spaces are extremely limited for the remaining Edge sessions; to register your interest please visit our Event Brite page.

Spotlight on:

Approved Mental Health Professionals

Name: Sian Clark
Job title: Approved Mental Health Professional (and Social Worker)
Team: Approved Mental Health Professionals Team
Organisation: Leicester City Council
How long have you been in this role?: 18 months

Tell us about your role/team:

Approved Mental Health Professionals, or AMHPs as we are called for short, are qualified Social Workers, Occupational Therapists, Mental Health Nurses or Clinical Psychologists who have obtained a Post Graduate Certificate in Approved Mental Health. Our training ensures that we have an in-depth knowledge of the law relating to the Mental Health Act (1989) and other legislation including the Human Rights Act (1998) to ensure that the rights of the people we support are upheld.

There are just over 30 AMHPs who work for Leicester City Council. Some work solely in this role, others work in this role for part of their working week.

Out of hours, the Emergency Duty Team are AMHPs ensuring that there are AMHPs on duty 24/7. AMHPs work with both adults and young people aged under 18 years.

Tell us about your responsibilities or duties:

A significant part of our responsibilities is to consider requests made by other professionals or family members to complete an assessment to consider if a person requires an admission to hospital under a section of the Mental Health Act. An assessment should be the last resort, when community-based less restrictive options are not possible, and we often ask that community options are explored further before we complete an assessment. If an assessment is required then we will arrange for 2 doctors, ideally 1 will know the person, to assess them. If the doctors make a medical recommendation, it is ultimately the AMHP who considers the least restrictive option for the person experiencing mental ill health and makes the final decision and completes an application to admit someone to hospital. As well as making an application for admission, we complete an outline report detailing the situation for the person and why they need an admission to hospital.

The Approved Mental Health Professional's role is unique in Social Care, due to us working as autonomous professionals rather than agents of the Local Authority. This means that we cannot be told to make an application to admit someone to hospital by anyone.

We also are involved in Community Treatment Orders (CTOs) where we consider the doctor's plans to discharge someone into the community. Occasionally we also apply to the Magistrate's Court for a warrant which allows entry to someone's home if we have serious concerns about their mental health and they are not willing to engage with services.

Tell us about a typical day:

One of the things I enjoy about the role is every day is different! Initially it usually starts with me considering a request for an assessment, but I can end up seeing people in their home, in hospital or in a police station.

What is your safeguarding best practice top tip?

Don't just focus on the person being assessed but consider their wider support network and any safeguarding linked to this.

What one thing would you find most beneficial to help you in your safeguarding role?

Continued close working and communication with colleagues in other teams and organisations.

Contents ▶

The role of advocacy within the MCA

Advocacy is empowering people to have a voice and making a real difference to their lives by speaking for them when they can't and supporting them to speak for themselves when they can

POhWER

An advocate can help a person to:

- speak up for themselves or give their views
- understand the process they are going through, their rights and what choices are available to them
- be part of an important decision which is being made about them
- prepare for and take part in meetings and tribunals
- raise queries or concerns
- access information in the format which is most suitable
- access services that can support them
- Advocates can also provide information and signpost people to other helpful services.

Independent Mental Capacity Advocate (IMCA)

- IMCAs must be appointed and consulted to support someone who lacks capacity and has no one else to support them (other than paid staff) for all long-term changes to accommodation for example moving to a care home for more than 8 weeks or hospital for more than 28 days, for a deprivation of liberty, and for serious medical treatment.
- An IMCA may be arranged by a local authority or NHS organisation to support someone who lacks capacity to make decisions about safeguarding adults, even if there are family and friends who can be consulted.
- An IMCA may be instructed to support someone who lacks capacity to make decisions.

Care Act 2014 advocacy

- The Care Act states that advocacy must be arranged for an independent advocate to represent and support an adult during a safeguarding enquiry or Safeguarding Adults Review (SAR) if:
  - the person would have substantial difficulty in being involved
  - there is no one else who is suitable, and the person consents to the representative, or if they lack capacity the local authority is satisfied it is in their best interests
  - concerning care reviews, where no one else other than paid staff is available to be consulted.

The IMCA and Care Act advocate may be the same person.

Local provision

POhWER provides Independent Mental Capacity Advocacy and Care Act advocacy across Leicester, Leicestershire and Rutland. Their contact details are:

- Visit POhWER's website
- Call 0300 456 2370
- Email pohwer@pohwer.net
- POhWER's leaflet on IMCAs for people who use their services

SCIE also has a collection of tools to support use of advocacy: www.scie.org.uk/advocacy

Role of the Police Mental Health Triage Car service

Between 08.00hrs and 02.00hrs, 365 days a year, the Mental Health Triage Car service provides 'on-the-scene' assistance from mental health specialists at Leicestershire Partnership NHS Trust (LPT) to individuals potentially experiencing a mental health crisis in public places, whilst reducing demands on valuable police time.

Where individuals are deemed at significant risk to themselves and/or others, the Triage Car service works with other healthcare and support services to ensure individuals are helped to a therapeutic and health-based facility rather than being taken to police custody.

Leicestershire Police report the service has effectively halved the number of individuals detained on emergency police powers under the Mental Health Act.

The Mental Health Triage Car service were shortlisted finalists for the Seni Lewis Award 2024 at this year's HSJ Patient Safety Awards which recognises safety, culture and positive experience in patient care, celebrating its worthy finalists on a national scale.

Samantha Wood, Head of Service for Mental Health – Inpatients and Urgent Care at LPT, said: ***"We are very proud that the partnership we have with Leicestershire Police has been recognised for improving the safety of people struggling with mental ill health. Better communication and information sharing between us ensures that appropriate support and advice is available in the right place at the right time, often preventing individuals who are in distress from coming to harm or ending up going down a criminal justice route."***

Barney Thorne, Head of Mental Health for Leicestershire Police, said ***"It is valuable to all of us that the Mental Health Triage Car has been recognised in being nominated for this award. The service puts our communities at the heart of what we do in ensuring we can provide care for people in a crisis situation. The Mental Health Triage Car was originally piloted in Leicestershire over 10 years ago and has ensured there is a high standard of care shown by Leicestershire Police to individuals where there are concerns around their mental health. The service is a fantastic example of what partnership should and could be."***

This article has been adapted from the original publication by Brendan McGrath.

Relaunching the MCA Forum for providers in 2025

The Safeguarding Adults Boards are pleased to announce that we will be relaunching a free Mental Capacity Act Forum for providers in 2025.

This resource was previously available to Leicester providers to support understanding and awareness of the MCA and included presentations, requirements of decision makers, code of practice, signposting to resources, case studies and practical tasks to work through and build confidence in using MCA within the workplace. Unfortunately due to the pressures of COVID on providers, the forum discontinued during the pandemic due to the move from face to face to online with low numbers in attendance but we are delighted to relaunch this excellent resource to a wider audience across Leicester, Leicestershire and Rutland soon.

Feedback from previous sessions includes:

"I liked the activities and ability to ask questions"

"I liked having involvement of every person in the room and the way the session was delivered"

"I will apply in our duty"

Dates will be circulated to providers over the coming months inviting them to attend the forum.