Multi-agency involvement and differing perception of mental capacity: Ms. A

Ms A is a 35 year-old woman, who currently lives in a residential (mental health) placement. Ms A suffers from visual impairment, renal failure, diabetes, and emotionally unstable personality disorder. She was allocated to a Social Worker in April 2015 for the purpose of conducting a Needs Assessment to assess her eligibility for services under the Care Act 2014.

When the Social Worker met Ms A, she presented as stable, and demonstrated a good insight into her health needs. She was assessed as having the mental capacity to make her own decisions and demonstrated independent living skills that assured social work she could manage her own needs independently in the community.

At the time, Ms A expressed her wish to move from her family home and live in a council property to pursue independent living. For this reason, Ms A was encouraged to apply for housing through the housing department and in doing so, she became frustrated that her housing application would not be fast tracked or prioritised on the grounds that she has physical health care needs. This resulted in a rapid decline in her mental health.

Ms A's case was complex and challenging during the six-month period the social worker was allocated to her. As a consequence of her not receiving housing on an immediate basis, she began to present challenging behaviours that was in conjunction with the effects of her emotionally unstable personality disorder and social circumstances.

The presenting issues were as follows: a breakdown in the family dynamics; both intentional and unintentional homelessness; regular hospital admission due to her non- compliance with her medication regime i.e. insulin; harassing professionals from Multi-Disciplinary Teams involved in her care; withdrawing from support services set up in her best interests; threats to self-harm and suicidal ideation; regular police arrests for anti-social behaviour, including physical and verbal altercations with others; past and current trauma associated with the death of her brother; and developing inappropriate relationships with strange men via dating websites/members of the public that resulted in financial and sexual exploitation.

The main responsibility of the allocated Social Worker was to monitor her health and safety. This was extremely challenging due to a constant fluctuation in Ms A's mental state that impinged on her physical health and behaviours. The Social Worker was of the opinion that Ms A lacked the capacity to 'weigh up' the consequences of her decision making whilst in the midst of an episode, and therefore required specialist input from the Community Mental Health Team (CMHT) for the purpose of receiving long-term therapeutic intervention. The Social Worker's assessment of Ms A's capacity was often disputed by members of the mental health profession, whereby she was assessed as having the mental capacity to weigh up, retain, communicate and understand information over five separate occasions by either an Approved Mental Health Practitioner (AMHP), the Child and Adolescent Mental Health Service (CAMHS), doctors or an independent consultant practitioner. It was made clear to the social worker that in order for Ms A to receive support from the CMHT, she would need to willingly approach their service. Despite the social worker's efforts to encourage Ms A to accept support from the CMHT, she refused to do so, on the grounds that she feared being sectioned under the Mental Health Act 1983 and did not feel she warranted the need for mental health support.

Multi-Disciplinary approach

Social services remained involved for the purpose of ensuring Ms A was in a secure place of shelter and to manage her care needs. The Social Worker sought regular guidance from her manager, and chaired safeguarding meetings to explore a multi-disciplinary approach to managing Ms A's care and support needs, involving her family, members of the health profession, the Police, Mental Health Services, the Housing Department, and Occupational Therapy.

Conflict of interest

On one occasion a Vulnerable Adults and Risk Management Meeting (VARMM) was held, however there were no clear outcomes identified due to a conflict of interest between professionals who argued that Ms A had the mental capacity to make her own decisions, against a duty of care to monitor her safety which did not impinge on her human rights and ethical codes of practice.

Referral to Community Multi-Agency Risk Assessment Panel (CMARAP)

Eventually, Ms A's case was referred to CMARAP on two separate occasions. It was agreed at CMARAP that Ms A's primary diagnosis concerned her mental health condition, whereby a combined state of depression and anxiety was impinging on her behaviours and resulted in her physical, emotional and psychological health deterioration. As a result of this, a case transfer was agreed between adult social services and the CMHT on the grounds that the CMHT have more appropriate housing options and specialist services to meet her immediate and long-term needs. The CMHT remain involved and it has been reported that she is currently settled at her placement.

Lesson learnt

Ms A's case highlighted the dilemma faced by professionals between intervening in situations where there are safeguarding concerns, without imposing on that person's right to retain choice and control. In this instance, the Social Worker felt she could only do her best for Ms A by regularly encouraging her to co-operate and engage with services despite her resistance to do so.

This case also demonstrated the essentialism of record keeping and information-sharing with other professionals, in order to maintain shared accountability for Ms A's welfare and for evidence-based purposes.