Mental Capacity Assessments when People are Sleeping Rough

Identifying Challenges and Training Needs

Barney Wells,

Enabling Assessment Service London.

Goal of this session

- Provide background to attempts at delivering training and support in this area

- Examine some case studies

- Describe ongoing and recent challenges

- Ask for feedback on best ways forward. - Not offering conclusions

Background

Previously worked as AMHP including in statutory homeless MH team

Developed training for AMHPs in 2012

2012 SCR of Mr A who died in Lambeth in 2010 recommended development of better training and guidance around MCA for outreach workers

2012 Tools and Guidance published and training delivered to various groups over coming years

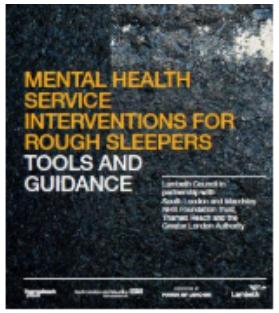
EASL remains involved in providing direct input in form of assessments and advice to outreach teams in London

MENTAL HEALTH

UCL MSC MODULE IN INCLUSION HEALTH

ONLINE INCLUSION HEALTH COURSE

HOMELESS HOSPITAL DISCHARGE NURSING



Pathway supported the opening of the UK's first homelessness service within an inpatient mental health unit; and our teams liaise with partners in mental health services, and include mental health professionals in the team.

However, many outreach workers face problems when supporting people who have mental health problems who are sleeping rough. This mental health and homelessness guidance is designed to address this.

Mental health guidance for outreach workers

Pathway worked with The Greater London Authority, Lambeth Council, South London and the Maudsley NHS Foundation Trust and Thames Reach to publish tools and guidance to help outreach workers supporting people sleeping rough.

The publication includes practical tools guiding workers through the use of the Mental Capacity Act and Mental Health Act. It has been regularly updated to include statutory changes, the most recent update was published in autumn 2017.

The tools and guidance are for everyone who works with clients or patients on the streets. The Faculty for Homeless and Inclusion Health endorsed this work to help us all respond to the needs of vulnerable people on the street.

Download the guidance documents and forms

Download the guidance – Mental Health Service Interventions for People Sleeping Rough
Mental Capacity Act Screening Tool
Mental Health Act Screening Tool
Hospital Homelessness Mental Health Admission Plan

Rough sleeping location:

Date of assessment:

1

What is the decision the person you are concerned about needs to make, and why do they need to make this decision now?

2

Is there reason to believe that the person may lack mental capacity to make the decision due to a known/suspected mental health problem, learning disability, brain injury, dementia or intoxication?

3

Has sufficient information been given to the person to help them understand the decision?

5

Is it felt that the person is free from external pressures to make their decision?

6

Can the person understand in simple language the information involved in making the decision?

7

Can they retain the information long enough to make the decision?

8

Can they use or weigh up the information to make the decision?

9

Can they communicate their decision (whether by talking, using sign language or any other means)?

10

The decision: does the person on the balance of probabilities have the capacity to make the specific decision at this particular time?

THE MENTAL CAPACITY ACT SCREENING TOOL

11

How did you decide what was in the person's best interests?

12

What action should be taken in the person's best interests?

Name of person completing form:

Date:

“Saving Lives project”

Initially hosted by SLAM and funded by Lambeth and GLA

Then hosted by Pathway and funded by GLA – project was managed and training delivered by EASL. Thames Reach and Mungos also involved and supportive

Training delivered to combination of specific groups especially outreach workers and AMHPs also Hospital discharge, psychiatric liaison staff some services such as Community Safety and Parks Police

Steering group chaired by Elizabeth Clowes oversaw programme including revisions to the guidance (3rd edition published in 2017)

No direct funding since 2018 but resources still available

“Saving Lives training”

Wasn’t just about MCA, also MHA, around risk assessment, the outreach role the wider context of decision making within mental health services

From 2016 included testimony from someone with lived experience

Training was generally well received in terms of feedback - more varied in terms of success reported by outreach workers in communicating concerns to other relevant agencies – MH, police, ambulance.

Challenge for outreach workers – when is it appropriate for them to be completing MCA assessments, when should they be providing the benefit of their knowledge of someone and their situation to others who might complete an assessment?

- More recently asked by St Mungo’s to develop some more explicitly MCA and SWEP focused training for their outreach workers

- What follows are some case studies and scenarios drawn from different trainings – aim is to give a sense of resources used and consider how well the reflect realities

Jane 1

Jane is a hostel resident, where Brian works nights.

Brian knows that Jane has a diagnosis of Borderline Personality Disorder, and that she sometimes binge drinks alcohol. He is also aware of her history of taking intentional overdoses.

At the start of his shift Brian is told by colleagues that Jane had difficult news earlier in the day and had then come to the office and left her medication with staff as she “felt unsafe”.

Several hours later Jane comes to the office, she appears heavily intoxicated with alcohol and is tearful – she demands the return of her medication, stating that she “can’t go on any longer” and that “life isn’t worth living”.

Jane 2

Brian is extremely concerned for her safety if she has access to her medication.

He feels that her ability to make decisions about staying safe is impaired by her intoxication and emotional state.

He refuses to give Jane her medication and asks her to meet with his manager to discuss this further the next morning.

He explains his decision to her and also justifies it by writing a progress note that explains his reasons referring to the relevant parts of the MCA: the four-step capacity assessment, and the Best Interests Check List.

SWEP Example 1

Its cold and forecast to get worse. SWEP has been declared

You visit the sleep site of a rough sleeper. Their clothes and bedding appear wet and the are shivering. They appear distracted when you attempt to speak to them.

You offer them a place in a shelter and they decline.

You ask what their reasons are for declining and they refer to fears that if they go indoors they will be gassed by the secret services.

- Are there grounds for you as an outreach worker to consider that this person might lack mental capacity to decide whether to accept shelter?

- Would you ask mental health services to attend and carry out a mental health assessment before you make a decision you would feel able to offer an opinion about whether they lack capacity?

SWEP Example 2

Its cold and forecast to get worse. SWEP has been declared

You visit the sleep site of a rough sleeper. Their bedding is organized and protected from the rain. They have plenty of insulation and are dry.

You offer them a place in a shelter and they decline.

You ask what their reasons are for declining and they refer to wanting to keep hold of the site they've got, they worry that if the go to the shelter it will be cleared. They explain that their immigration status means they won't eligible be for ongoing support with housing.

They know about and use a local day centre.

Would you complete a mental capacity assessment in this situation?

- No
- Yes
- Not necessarily but would reference that there weren't grounds to question their mental capacity to make a decision about accepting shelter

SWEP Example 3

It is May and the weather is mild.

You visit the sleep site of a rough sleeper. Their clothes and bedding are dirty and disorganized. They appear distracted when you attempt to speak to them.

You say that you may be able to help them access accommodation, but they say that they are not interested today.

You ask what their reasons are for this and they refer to fears that if they go indoors they will be gassed.

There are grounds to suspect that this person's capacity to make decisions about accommodation may be impaired. Would you:

- Complete a MCA assessment then call an ambulance?
- Stay talking to them, provide them information about day services they can access and suggest that you will visit them again in the coming days?
- Leave promptly and make a referral to mental health services?

George 1

George, a man in his 60s, slept rough in an area for many years. He declined offers of shelter or assistance even when temperatures were below freezing.

He happily spoke to outreach workers but they couldn't understand his decision making. Local mental health services agreed to meet with him and did so on the street several times. The mental health team, in discussion with the outreach worker, considered his mental capacity in relation the decision to remain street homeless.

As they did not establish evidence of significant mental impairment he could not be considered to lack capacity, nor to meet the criteria for an admission under the Mental Health Act 1983. He said that he would consider accepting accommodation if he felt that his physical declined. He was discharged by the mental health team, but with advice that street services could re-refer.

George 2

Some months later George referenced some unusual ideas about foreign powers influencing the unseasonable weather. Outreach re-referred to mental health services and a Psychiatric Nurse visited George on the street again. George repeated the idea but it was not felt to be a belief that was held with delusional intensity and it was not clear that it was linked to the particular decision to decline accommodation – given this he was again not felt to be lacking capacity.

The following winter George seemed less robust physically. Outreach increased their contact with him and were able to arrange a visit from primary care workers. George continued to decline shelter there and then but the following week he attended the local housing office and made a homelessness application. He told the housing officer that he was happy for them to get further details from the outreach team and the health professionals he had seen on the street. He was offered and accepted sheltered housing.

Darren 1

One November, Darren, a man in his late forties, began sleeping rough in a very public place, drinking alcohol chaotically seemingly from waking. He walked with a distinct limp and was occasionally seen to wince with pain.

He was offered a hostel place but declined, his reasons were unclear. Outreach services also have concerns about his physical health and noted that some statements he made seemed paranoid.

Following a referral to mental health services, a social worker agreed to attend with an outreach worker early in the morning. Darren was not visibly intoxicated, he had no sleeping bag and no socks (outreach worker advised that he had been both in previous days). He was willing to engage in chat and observes normal social niceties but was guarded when asked about his reasons for declining accommodation. He appeared distracted at times and some of his answers were non sequitors. He left the assessment and began drinking again.

One week later, a period of severe weather started and was forecast to continue. Darren continued to decline any shelter. When outreach contact the mental health team, the original social worker was on leave and there was no willingness to explore bringing the appointment forward.

Darren 2

The outreach team made a safeguarding referral to the local authority stressing the immediacy of the risks because of the weather, the lack of information about Darren's health and the possibility concern that his decision making was impaired.

A multiagency discussion including with primary care and the mental health team followed and Information was gathered from the local hospital about his physical health, it was also established that he was known to homeless services in a neighboring area.

Outreach team completed MCA screening tool

It was concluded that an assessment under the Mental Health Act 1983 was indicated. When this took place his presentation was similar to when seen by the social worker the previous week, the doctors and AMHP involved agree that the criteria for an admission under s2 are met. In hospital it transpired that Darren has significant symptoms of psychosis, including intrusive distressing auditory hallucinations and that his drinking was in part an attempt to block these out.

Challenges in practice

Inherent complexity related to:

- the person's needs

- different agencies – different knowledge bases and differing authority and priorities

- Interface between different laws and balancing of competing rights

- Impact of limited entitlements on options that are open to some rough sleepers

- The need to incorporate different frameworks and approaches – ie Trauma Informed

- Subjectivity!

Challenges in practice

- When does decision needs to be made? Risk assessment around this

- Is there time to bring in different services and professionals to support consideration of capacity? Court of Protection?

Who should carry out assessment of capacity?

- Sometimes the assessment may conclude that someone does lack capacity to make a decision about accommodation – but an intrusive intervention may not in someone's Best Interest and justified

- But need to keep the issue of capacity (and BI) under review

- Decisional and Executive capacity

Challenges in practice

Differences between areas

- Resources - OR, Accommodation, MH, Police

- Priorities, history and cultures. Place on the continuum between intervening and not intervening.

- KPIs (and beliefs about KPIs) etc can impact the discussion in an unhelpful way

Recent examples

Hackney - MS SAR

South London case

Recent positive developments

Safeguarding!

Resources including around MH (danger that funding will stop and OR will be de-skilled?)

Help to support better use of MCA

Situations that arise when the concerns are immediate

– Training, confidence and authority of street outreach workers to complete mental capacity assessments

- Support in communicating this to emergency services

- Training and involvement of police and ambulance Service and Police

Help to support better use of MCA

When the concerns are more chronic

– Training, confidence and authority of street outreach workers to at least contribute to mental capacity assessments and best Interest Assessments

- Resources and structures to support planned Multi-Agency working

-Safeguarding

- More routine reference to and consideration of capacity including when people are “compliant” but may lack capacity -