

i Reflect

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*Putting learning, development and good practice
into the heart of Camden Adult Social Care*



Learning and development opportunities

Safeguarding adults conference: 30 November 2017

The annual safeguarding adults conference will focus on learning from safeguarding adults reviews. The conference takes place at the Holiday Inn Bloomsbury. There are still a few places left: book on [TDSonline](#).

RiPfA pop up event: 11 December 2017

To raise awareness of Research in Practice for Adults (RiPfA), a learning resource that we are lucky to have in Camden, there will be a number of sessions throughout the day, with different themes, based at 5PS in the morning and the Peckwater Centre in the afternoon.

Pop in to sample a session and find out more about RiPfA.

Contact sally.nieman@camden.gov.uk for details.

Supervision workshops: 22 & 24 January, 1 February 2018

RiPfA are facilitating six half day workshops for Camden practitioners and managers on the theme of supervision and reflective practice.

There are 150 places available and the workshops are available on [TDSonline](#).

There are other formal training sessions available in the coming months. Look on [TDSonline](#) or contact L&D Adviser for Supporting People, Patricia Cox patricia.cox@camden.gov.uk.

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A week in the life of...

Huw Mathias is a social worker working full time as a Best Interests Assessor (BIA) in Camden's Deprivation of Liberty Safeguards (DoLS) team. The DoLS protect people who lack capacity to consent to their care and treatment arrangements in a care home or a hospital setting. BIAs carry out assessments to identify whether a deprivation of liberty is occurring, and if the care provided is proportionate to the risk of harm and is in the person's best interests..



"He that would make his own liberty secure, must guard even his enemy from oppression; for if he violates this duty, he establishes a precedent that will reach to himself."

Thomas Paine (1737 – 1809)

The essence of our being is not to be deprived of our liberty: this is the driving force in my role as a BIA to protect people's rights.

MONDAY

The DoLS team takes referrals from across adult social care including mental health, learning disability, physical disability and other neurological and acquired brain injury, older people and hospitals. First thing on a Monday I look over the 4 new referrals I am allocated at the start of each week. I book my visits for Monday afternoon and Tuesday of the same week. I look at Mosaic electronic records and any other supporting information to get a sense of the current circumstances. I also contact the next of kin or significant other to advise them of the DoLS referral. If there is no one suitable to consult with about the potential DoLS, I will arrange a referral for an Independent Mental Capacity Advocate (IMCA).

I have supervision with my manager booked in for this morning. This gives me the opportunity to discuss active cases and other practice issues, recent legal updates in relation to case law and DoLS and other important training requirements. I have CPD requirements for being a BIA as well as a social worker.

In the afternoon I go to a mental health hospital to complete an assessment of an elderly woman (A); as this woman does not speak English, I meet an interpreter at the hospital. In assessing A it becomes clear to me that she lacks mental capacity in relation to the DoLS so I request a mental health assessor is allocated to assess. The mental health assessor (a doctor experienced in mental health) must confirm a diagnosis of the impairment or disturbance in the functioning of the mind or brain. They also give a view of the impact of the potential DoLS on the person's mental health and well-being and whether they are likely to regain capacity for the purposes of any recommended DoLS authorisation I might make. I also speak with the appropriate professionals and others involved in the care of this individual on the ward and the allocated care co-ordinator, who in this case is a community psychiatric nurse. I read all relevant care plans and

computerised records about the patient in the hospital. There is no next of kin or other to consult so I have requested an IMCA to see the person too who will provide a report for me.

TUESDAY

I've arranged three assessments today. The first (B) is in a nursing home. This young person has an acquired brain injury as a result of a road traffic accident. I speak to the relevant people involved in the care of this individual and consult all relevant records in the care home. There is a sister who is very involved and is available to be at the assessment. I am also versed by the Speech and Language Therapist about specific communication techniques before meeting this young man to maximise his opportunity to tell me how he feels about the potential DoLS. His sister gives me much relevant background information that I have been unable to get from elsewhere, which is important in assessing proportionality and best interests of the individual concerned. As I assess B lacks capacity in relation to the potential DoLS, a mental health assessor is needed, the process in all cases.

I move on to assess a young woman with learning disabilities

(C) in a small residential learning disability care unit. C uses British Sign Language (BSL) so I have arranged for a BSL interpreter to be present. Again I speak to all relevant people involved in the person's care and the allocated social worker.

My third and last assessment of the day (D) is at a rehabilitation hospital to see an elderly man who has been transferred there from an acute hospital. This man has already been seen by a mental health assessor and was deemed to lack capacity regarding the DoLS. D told me very clearly and consistently that he did not wish to remain in hospital and wished to return to his home in the community. When I consulted with the next of kin, ward staff, social worker and therapists, it became apparent to me that there was nothing further to be done for this man in hospital and no reason to detain him against his wishes. Having followed through the best interests process, consulting with others and looking at risk and proportionality, I could not make a DoLS recommendation for this man to stay in hospital as I did not think this to be in his best interests. With reablement care and good additional support from others in the community, D returned home, shortly after me assessing him, which was his wish and in his best interests.

WEDNESDAY

I work at home to begin the task of writing up at least 3 DoLS reports that I need to have submitted by the end of the week. To complete a DoLS

authorisation a person must meet certain statutory criteria: six assessments (Mental Health, Age, No Refusals, Mental Capacity, Best Interests and Eligibility), undertaken by the mental health assessor and the BIA (both appointed by the local authority), confirm whether the person meets these criteria.

In writing reports it is vital to get a sense of the individual being assessed, their wishes, feelings and views about the potential DoLS and any relevant background information. Obviously obtaining other relevant people's views is very important as are the views of anyone who may be able to give insight about what the individual may have wanted if the individual cannot communicate this.

THURSDAY

I continue to write up reports in the office today at 5PS. Part of the office presence is being available for other staff who may seek advice regarding mental capacity and DoLS issues. I also provide shadowing and mentoring opportunities for practitioners who are training to become BIAs; I was shadowed on two of the assessments this week. Camden is currently training a number of new BIAs. I take time today to catch up on emails and go on the Law Society website to get case law updates. I make time to listen to a half hour webinar, which my manager and other BIA colleague then discuss and think about the implications of this case law change for our own practice. We also have a team meeting.

FRIDAY

I continue to write up reports. In the case of A, I recommend a DoLS authorisation for 6 weeks: the plan is for this woman to return home with the necessary support in place. In the meantime, I have made two conditions to be implemented while she remains on the ward. Both these conditions will help lessen the restrictions on A while she is in the mental health ward.

I have recommended an authorisation of 3 months for B. The care home is not appropriate long term and a more suitable less restrictive 24-hour facility is being looked for. I recommend to the allocated care co-ordinator that a place is found closer to family who will be able to visit more frequently and preferably with an enclosed garden space, which is important to this man.

I recommend a 12 months authorisation for C; her needs are being met and she is settled. However I attach a condition for a suitable educational outlet to be explored for C; she wants this and it will in turn help reduce the level of restriction within the care home currently as she will be getting out regularly when enrolled on an appropriate training course. Previously her health did not permit this but since being on different medication her health has improved and she will be able to attend a suitable educational outlet that can be identified for her.

Can animals have an impact on our wellbeing?

by Fiona Brown



It seems that in adult social care there is a lot of anecdotal evidence to support the theory that animals are 'good for our health and wellbeing'. But is this grounded in reality?

I have seen many examples of practice in this area – using animals to provide support and companionship for children with autism, older people with dementia, or people experiencing crisis. However, there is limited research to back up the many claims of the positive impacts that an animal can have on a person's wellbeing.

What research there is suggests that having a pet around can help to lower blood pressure (American Heart Association). Likewise, evidence suggests that dogs can not only make us calmer, but also happier (The Guardian). Studies, including Zasloff & Kidd (1994), show that people living alone have reported feeling significantly lonelier than those living with animals.

In the adult social care locality team in Camden, I have heard many examples from colleagues of the life-changing impact that a pet has had on the life of a person who often may be experiencing crises or who may be socially isolated or depressed.

I myself worked with an 80-year-old man who, after a long spell in hospital, was motivated to participate in rehabilitation therapy in hospital in order to expedite his return home so that he could be reunited with his two pet dogs. Indeed, research suggests that older adult dog owners may be more than twice as likely to maintain their mobility as people who do not own dogs (Thorpe et al 2006, cited in Hall et al).

Recently, a colleague at Camden told me of an elderly man with whom she worked in a strengths-based way, whose only goal that he identified on his support plan was to own a dog, and therefore her work with this man was based around this goal. As part of our strengths-based approach, practitioners are encouraged to look to the community for support. If animals do have a part to play in supporting adults, this might mean identifying ventures that can support people's relationship with animals, and also emphasising the importance of a pet in the assessment and support plan of those people for whom animals play or have played an important part in their lives.

Interestingly, in 1995 the International Association of Human-Animal Interaction Organisations called on governments to recognise the value of the human-animal bond and amend legislature to allow pets in care facilities. This position was also supported by the World Health Organisation (Community Care). However, research by the Society for Companion Animal Studies (SCAS) indicates that still only 29% of care homes allow animals. Those that do allow animals do not normally include dogs and cats within this. However, the Royal College of Nursing are now calling for hospitals to let more dogs and other animals onto wards and operating theatres after collecting many anecdotes about animals helping to support people who are anxious about having surgery, and helping with recovery (BBC, 2017).

There is also a work in progress at the moment looking into the [effects of animals on the health and wellbeing of residents in care homes](#) (led by the [National Institute for Health Research](#) (NIHR) Collaboration for Leadership in Applied Health Research and Care (CLAHRC) South West Peninsula). Their background

information states that: 'Animals are also believed to be therapeutic and pet therapy or animal assisted therapy is one of the treatments recommended by the National Institute for Health and Care Excellence (NICE) and Social Care Institute for Excellence (SCIE) guidance for people with all types and severities of dementia experiencing agitation.'



This systematic review will consider both quantitative and qualitative evidence to find out what interventions are being used, which of these are particularly appropriate for different groups of residents, and what the impacts are of animals on physical and mental health, social wellbeing and quality of life of older people living in residential or nursing care. It is hoped that it will contribute to the evidence base in this area.

If we think about it, this is an area for exploration that could have potentially huge economic benefits to social care and the NHS. The Companion Animal Economics (2016) has carried out research which suggests that potential savings of £126.45 billion could be made to healthcare in the UK through animal companionship. These savings are calculated by considering a range of factors and situations where animal companionship could be perceived to positively impact, including: aiding recovery from major illness; prevention of ill-health; physical wellbeing; social wellbeing; mental wellbeing; and fewer visits to the doctor.

There are also lessons for social workers working with people who may lack capacity around their care where a best interests decision is needed. In the case of Essex County Council v RF & Ors, where the court heard how a 91-year-old man had been deprived of his liberty illegally, the judge highlighted the importance of the man's relationship with his pet cat. Likewise, it was also highlighted in the [judgement in the case of Mrs P](#) (by her litigation friend, the Official Solicitor) v Rochdale BC, the importance of pets to people who lack mental capacity and the need to consider this when making best interests decisions.



The *Care Act 2014* encourages us all to focus on a person's wellbeing, encompassing all of the things that may fall within this category for a person. As some of the above examples demonstrate, an animal may have a huge positive impact on a person's life, and we should be exploring the potential for this across adult social care. But we also need to think about how we gather and record evidence to demonstrate whether animals can indeed play an important part in supporting people's wellbeing.

Related resources

[Pet Ownership and Cardiovascular Risk: A Scientific Statement From the American Heart Association](#)

<http://www.bbc.co.uk/news/health-40346539>

<http://www.communitycare.co.uk/2009/01/19/the-value-of-animals-in-care-homes/>

<https://www.theguardian.com/lifeandstyle/2015/dec/30/animal-assisted-therapy-nih-veterinary-science-mental-health-american-heart-association>



Fiona Brown was up until recently a team manager in one of the locality adult social care teams in Camden. She has left to move to Scotland.

This piece was originally written and published as a blog on the Research in Practice for Adults (RiPfA) [website](#).

What does working together mean?

by Rachel Duffield

Back in June a workshop was held between adult mental health workers and children's social workers with a focus on improving joint working. This was as a result of an audit undertaken by the Children's safeguarding quality and assurance sub group; it highlighted that the best outcomes for children came out of positive joint working between child social work professionals and mental health professionals, who were involved with the adult care givers.

The programme for the half day workshop included:

- * Myth busting: dispelling myths around children social workers and that of mental health with statements to consider.
- * Overview of both services
- * Series of workshops designed to get the tables talking and learning about each service, with case studies to discuss

FACT OR FICTION?

Children on child protection plans are visited weekly by children social workers?

All children whose parents have a mental illness must be referred to children's social care?

The discussions were lively and got practitioners talking about the resources and legislation with which they would be able to work with the child and family. Some of the feedback indicated that there used to be sessions held every 6 months between the services as a 'meet and greet' which people said was helpful.

There will be a follow up task and finish group to ensure that learning from the day and feedback is taken forward. There have been rumbles that this type of workshop would be beneficial between mental health and adult social care colleagues; if you think this is the case, please get in touch with me (rachel.duffield@candi.nhs.uk) or Sally Nieman (sally.nieman@camden.gov.uk) to discuss further.

Below are just some of the key points that came out of the day, but are pertinent to all joint working...

INFORMATION SHARING: Often seems to be a sticking point. As long as there is a clear rationale for why information is being shared, this is likely to have increased outcomes for the individuals and families.

NAMES TO FACES: Building relationships with people both inside and outside your teams can help improve joint working and aid being able to pick up the phone to ask those questions you're unsure about.

IT'S GOOD TO TALK! Children services and adult mental health services work with differing thresholds and legislation and this can at times be unclear: being able to talk through these and gain a better understanding of child proceedings or detention under the Mental Health Act can help to facilitate better risk management and give greater clarity for a whole family approach.

JOINT SUPERVISION: Following on from the workshop there will be a revision of the joint supervision protocol between the two services to guide practitioners and managers in cases where there is joint working.



WE ARE ALL HUMAN! Resources are squeezed, priorities are at times conflicting, demand for support and assessments are great, but no matter which team or profession we are part of, we are all people trying our best and sometimes its helpful to remind ourselves and each other of that.

Photoscope: Samsung Galaxy J5-6

by Martin Hampton

Photography yields numerous possibilities for social workers and practice educators. This is especially true when presenting information about a client and the home environment. The photographic resource is so ubiquitous on iPhones and tablets that old ideas about confidentiality are becoming redundant.

When given my Samsung Galaxy J5-6 by Shana Nessa, she informed me that the optical quality was so fine she preferred it to her Pentax SLR! I was intrigued and determined to try it out the Samsung myself. I suggest that you particularly experiment with the Mode Settings, particularly **PRO** where you can adjust the camera's sensitivity to light (ISO) and dispense with the flash. Using this setting, I also put a grid on the viewer, which has made me aware of perspective when shooting. When you have taken an image, you might want to try out the **cropping tool** and also try some of the effects such as **vintage, nostalgia, tint** etc.



*A walk to paradise garden
by W. Eugene Smith*

The Columbia School of Social Work in the USA regularly presents photographic exhibitions as an essential element of its Master's program; most recently

the exhibition: **'Photography for Advocacy, Story of a Juvenile Detention Prison System'**



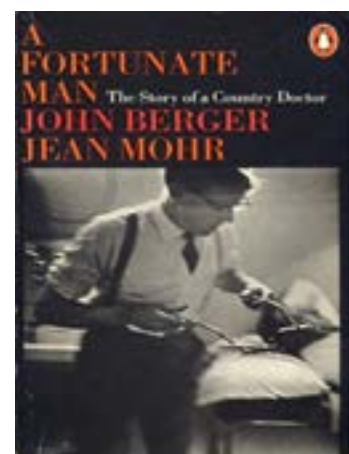
*Wake From Spanish Village
by W. Eugene Smith*

Photography provides visual evidence for social work. It is an innovative way of seeing and thinking about people and places. With clients and colleagues permission, I have started to photograph them with the Samsung, within the Camden environment.

Two practitioners who have used photography to affect social change are Lewis Hine and W.Eugene Smith, although there are many more. Lewis Hine believed that a picture could compel people to change social circumstances. Hine felt so strongly about the use of underage children as cheap labour he became an investigative photographer for the National Child Labour Committee. He travelled around the USA photographing the appalling conditions of children in all types of industries. The public

outcry that followed publication of his work give rise to the **1916 Keating Owens Act** which resulted in a minimum age of 16 and a maximum working day of 8 hours. Exercising photography as a social tool, Hine made a difference to the lives of American workers and children.

W. Eugene Smith is widely recognised as one of the most articulate of documentary photographers. His work on pollution in Japan resulted in compensation for impoverished and previously voiceless labourers. When he was recovering from a war wound, he made the now famous photograph **'Walk to Paradise Garden'**. Six years later, he made the **'Wake from Spanish Village'**. I have used both in supervision (see images above) to elicit responses from students to talk about **Erikson's Life stages** and **attachment, loss and bereavement**.



It is also worth looking at W. Eugene Smith's Country Doctor Series, which later inspired the photographer Jean Moher, and socialist theoretician John Berger to produce the classic study of the 'visiting professional' in other people's homes (a GP) entitled 'A Fortunate Man'. This is a great book to read when you are thinking about visiting clients.

From the 18th - 25th November,

'**Lost Rights, Found Justice, Refugee and Migrant Rights**' an exhibition with a photo competition and workshop, is at the Second Floor Lobby, Senate House, Malet Street, London, WC1E 7HU. This is a unique photography exhibition, which aims to increase public understanding of the rights and situation of refugees, migrants and those seeking asylum through creative visual and legal

tools. It includes photographs selected by a panel of photojournalists following a public call for submission. The launch will feature a guided commentary by human rights experts. Documentary photographer Kevin McElweney who has worked with refugees in Izmir, Lesbos, Athens and Idomeni will lead the workshop on 18th November.

Photographic Competition

I Reflect is delighted to announce a Photographic Competition with the title: '**Camden Community**'

Please send all photographs by e-mail attachment to sally.nieman@camden.gov.uk.

Shortlisted submission to be published in the next edition of I-Reflect magazine with bylines. Cath Millen, Principal Social Worker (and photographer, Australia Edition) will judge the submissions. Her decision is final. The prize will be a brand new copy of the beautifully printed book **W. Eugene Smith Masters of Photography** (ISBN 089381-836-4) purchased (at no expense spared) (£7.95).



Photographs taken by Martin Hampton with the Samsung Galaxy camera



Be My Eyes: Online community support

by Sally Nieman

The almost universal use of smart phones is allowing simple solutions to transform people's independence and access to support when they need it with the added benefit of extending the concept of community.

Be My Eyes is an app that connects blind and visually impaired people with sighted helpers from around the world via live video connection. So how does it work? The app allows visually impaired individuals to make a call out to other fully sighted users to "lend their eyes" via a video link. The volunteer helper receives a notification that someone needs help and a live video connection is established. From the live video the volunteer can help the blind person by answering the question they need answered. People ask for help with everyday activities where there is no-one around to help: for example, the best before date on food or navigating an unfamiliar situation.

Some months ago, a friend sent me an article about Be My Eyes and I signed up to be a helper. I admit to being somewhat excited, when, a good few months later working at my laptop in 5PS, I received my first notification that someone wanted help. I answered and was connected to a man in Canada; he was having problems with his television aerial and needed me to read the instructions on the television screen. Our video link showed the television screen only and I read out to him what it said. He was able to make the adjustments he needed. He thanked me and ended the call. It took less than 2 minutes of my time.



There are over half a million volunteers across 150 countries and nearly 50,000 blind or visually impaired users. Due to the size of the volunteer network and sophisticated matching technology, people can request assistance in their native language 24 hours a day. It is a great harnessing of the power of community capacity, technology and human connection.

Watch the video on www.bemyeyes.org. Sign up if you want to help or think about whether it might be a useful resource for any people with whom you work.

Strengths based practice update by Cath Millen

Most of you will know that over the next year we are aiming to transform our way of working in adult social care from care management to strengths based practice. To help us achieve this we are working with a small organisation called Partners for Change who have developed a specific strengths based model called the "three conversations". Quite a few other local authorities have started using the three conversations model and all report that it is working well. Have a look at their website if you get the chance at partners4change.co.uk.

Partners for Change are supporting us to set up innovation sites where practitioners can try out working in a different way, spending most of their time with people and in local communities and having greater autonomy over decision making. Practitioners will be trialling using streamlined ways of recording their work to free up time and focus on recording what is important.

We have been asking for volunteers to be "innovators" and are expecting to have two or three innovation sites that will run for three months and then be evaluated. Following the evaluation, more innovation sites will start, with the aim that by this time next year all of adult services will be working in this way. The innovation sites will now start on 4 December so we have a very short amount of time to get organised! It is a very exciting time and we will provide regular updates as to how the innovators are getting on. If you would like more information please contact me at cath.millen@camden.gov.uk.

OT Double handed care project

by Paul Faddy

It is almost two years to the day that the OT double handed care project started.

Initially the team reviewed all the existing Adult Social Care (ASC) double handed care packages - both commissioned care and direct payments. The team also reviewed all new double handed care packages. Most of the new cases were via the pathway reablement.

Once the existing cases were completed, the team went on to review unallocated Extra Care Sheltered (ECS) cases. The team identified an opportunity for easy savings, as we had seen the often vast difference between what ASC were paying the ECS providers compared with what they were actually doing.

The team has been able to reduce care in a number of ways. For example by: replacing mobile hoists with ceiling tract hoists, using the ReTurn patient turner and standing hoists – both of which only need one carer – instead of the old patient turner which needs two people; also through the use of in situ slide sheets and sitting slings. The team has also taught willing and able family members in moving and handling to act as a second carer. In some cases where the team was unable to reduce the care to single handed, we were still able to reduce the time of the second carer's calls.

The team have also improved the care clients receive by completing seating assessments and addressing pressure care concerns. We assessed a number

of clients who were previously bed bound but now have a seating regime in place. These interventions have improved the clients' quality of life and dignity.

The stats for the project so far – 317 cases have been reviewed. The sum total of the projected savings of each case reduced equates to approximately £1.2 million calculated over a year. This figure includes reablement care and clients that the team has identified as being eligible for Continuing Health Care funding. The project is clearly cost effective and an invest to save opportunity, as the savings far outweigh the wage bill for the project staff.

I want to take the opportunity to reassure that the team does not approach each case with a ruthless "slash and burn" mindset, prioritising saving money over all other considerations, as if we had morphed overnight into vampire squid Goldman Sachs wannabes.



Rather the team approach each review just as any OT would: by completing a functional assessment to determine the client's needs.

The team have had a mixed experience working with care agencies and their carers. There are many experienced, skilful carers, who do great work in a very difficult and underpaid profession. However there is a

high turnover of care agency staff, who often receive suboptimal training and ongoing support in moving and handling. We have come across a lot of poor practise. If there's a weird or dangerous way of using the equipment, carers will find it.



Carers, though, are usually receptive to advice in how to perform correct moving and handling – not only to do the best for the client, but also to protect their backs, one of the keys to their livelihood.

The biggest obstacle the team has faced has been care agency managers and their moving and handling risk assessors. We have been waging an Orwellian perpetual war to disabuse them of the notion that all hoisting requires two carers, even standing hoists and ceiling tract hoists. They have a blanket policy approach to hoisting. When confronted with that assumption, I reply with Ben Goldacre's maxim - "I think you'll find it's a bit more



complicated than that” - but I am met with responses ranging from sullen skepticism to willfully obtuse, which sets my ire index to incandescent. The team have attended the moving and handling training sessions put on by some of the Camden agencies, but will be working with Albert Simango in commissioning to rethink our strategy on addressing this assumption.

A real positive of the project is the joint working the team has done with our social work and access and support officer compadres

in the various hospital teams, Access & Response, locality teams, CLDS and, especially, Carol Hawthorne’s reviews team. We have all shared knowledge and skills, which I think has resulted in all of us becoming better, more rounded operators.

The future of the OT double handed care project is uncertain. There is only enough funding for two staff until the end of the current financial year. I am hoping we can have a constructive conversation with decision makers on the continuation

of the project, a project that is demonstrably not only cost effective, but one that provides positive outcomes to both clients and their carers. Until robots eventually replace homo sapien carers, there will be a need for occupational therapists to review clients who require moving and handling.



Looking back, looking ahead: Mental Capacity Act 10 years on

‘Decisions, decisions’ by Shabnam Ahmed

As we celebrate the 10th birthday of the Mental Capacity Act (MCA), it is important to reflect on how this life changing legislation is applied and understood in reality today. How we as social work practitioners can ensure and continue to be supported with our practice, ensuring that the principles are enshrined and reflected in our decision-making. It is also vital to consider some of the challenges and limitations thus far and any amendments required whilst the Act moves ahead into its tweenage years.



It is estimated that around two million people in England and Wales are deemed to lack capacity to make decisions for themselves. With an increase in life expectancy and the growing number of people with dementia, it is highly probable that this figure is likely to rise.

This Act has provided us, no doubt, with a legal framework, which promotes and safeguards decision making for those who are no longer able to do so, placing them at the heart of the process. The first three principles ensure an open minded, unbiased stance: assume capacity, take all practicable steps to enable the person to make the decision themselves and consider if their decision is unwise as opposed to one resulting from incapacity.

It frightens me to think what practice may look like today without this Act and I personally am very grateful for its existence today. However to say that it is complete, without its limitations and does not require a review, is something with which I would not agree. It is also clear that there are practice issues, which require our attention.

A recent report produced by the London branch of the Association of Directors of Adult Social Services on 27 Safeguarding Adult Reviews across London boroughs highlights the flawed use of the MCA as a central

theme. It states that the MCA was the area of practice where lessons most commonly needed to be learnt. Some key themes included:

- * Missing or poorly performed capacity assessments
- * An absence of best interest decisions.
- * Lack of scepticism and respectful challenge of decisions.



The report acknowledges any learning is rarely a result of poor practice on the part of an individual and is often an indication of systemic issues. Several landmark cases in law suggest we are setting the bar too high whereas the expectation should be no more than that of someone whose capacity we do not doubt. This perhaps suggest our continued paternalistic views and the protection imperative when working with vulnerable adults.

Self-neglect work often shows lack of consideration given to capacity assessments. Whilst assumption of capacity is the starting point, it is definitely worth considering someone's capacity when the level of self-neglect proves detrimental to their well being and there is a public interest.

Moving forward, it is worth bearing in mind the points raised by Alex Ruck Keene who says that "mental capacity is in the eye of the beholder". It is more about the assessor than it is about the person. He therefore advocates that amendments could lead us to an Act that looks quite different and would change and enhance practice.

In his view, the current model is a cognitive one and does not give enough weight to the executive functions of a person. He refers to principle 2, S.1(3) the support principle: 'take all practicable steps', as the 'orphan principle'. This needs to be developed further by putting flesh on the bones, as the Northern Ireland Capacity Act has done.

There is a need to reconsider the importance of the diagnostic element, as this has proved difficult in courts when relating to people who have both an impairment but there is also a question around coercion. It is very difficult in practice to distinguish between the two. Ruck Keene advocates strongly for the Act to make clear and reinforce the importance of the "causative nexus". Ensuring that all assessments demonstrate that the incapacitous decision is directly a consequence of the impairment.

So, whilst we wish the MCA a very happy 10th birthday, when lighting the 11th candle next year, we hope to see both more consistency and maturity in its application.

Carter, R. (2017) '*Flawed*' use of Mental Capacity Act key theme in safeguarding adults reviews. Community Care (online) Available : www.communitycare.co.uk/.../flawed-use-mental-capacity-act-key-theme-safeguarding

Ruck Keene, J. (2017) "*Is mental capacity in the eye of the beholder?*", Advances in Mental Health and Intellectual Disabilities, Vol. 11 Issue: 2 Available : <http://dx.doi.org/10.1108/AMHID-11-2016-0035>

Ruck Keene, J. (2017) "*The MCA – big issues for the next 10 years*"(online) Available:

<http://www.mentalcapacitylawandpolicy.org.uk/the-mca-big-issues-for-the-next-10-years/>

Mental Capacity Act 2005 – 5 principles

1. **A presumption of capacity**
 - * Start by thinking I can make a decision
2. **Individuals supported to make their own decisions**
 - * Do all you can to help me make a decision
3. **Unwise decisions**
 - * You must not say I lack capacity just because my decision seems unwise
4. **Best interests**
 - * Use a best interest checklist for me if I can't make a decision
5. **Less restrictive option**
 - * Check the decision made does not stop my freedom more than needed

