Multi-Agency At Risk Pathway

for working with those who do not engage with services

This pathway needs to be referred to where the level of risk in a situation previously being managed has now reached a level that is unacceptable.

The following pathway should be read as a complementary supporting document to the on-line Berkshire Multi-Agency Safeguarding Adults Policies and Procedures.
http://berksadultsg.proceduresonline.com/index.htm

Berkshire Healthcare Foundation Trust have issued guidelines to be followed by community mental health teams when service users go missing from home or do not respond to visits and where there are concerns that the person is at risk/vulnerable to harm. Policy no. ccr-bpd006 can be found on the website at http://www.berkshirehealthcare.nhs.uk/default.asp

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Introduction

Adults at risk who, for whatever reason, do not engage with services can have complex and diverse needs that often fall between different agencies; their needs are generally longstanding and recurring and put themselves and others at high risk.

This pathway needs to be followed where the level of risk previously being managed has now reached a level that is unacceptable, and all other reasonable attempts to minimise this risk have failed.

Aims of the pathway:

- To improve outcomes for adults at risk who do not engage with services.
- To deliver a coordinated, multi-agency response to provide solution based approaches.
- To establish consistent best practice across the West of Berkshire.
- For agencies to work in partnership and share information to ensure best outcomes for the person.

There is an expectation that all agencies - and individuals employed within these agencies - will work together to achieve the best outcome for the service user, whilst satisfying organisational responsibilities and duties.

Most agencies have policies or procedures for managing the situations outlined in this pathway.

Guiding principles:

- If staff are unsure whether to follow this pathway for a particular case, discussion with the safeguarding lead is strongly advised.
- Staff need to remember that the situation has got to this stage because nothing else has worked; agencies need to be flexible and try new ways of working. This includes commissioned services.
- Information sharing by all agencies is implicit in this protocol.

- Staff should seek legal advice at various stages throughout process.

- The person at risk should remain at the centre of the process. Consideration should be given as to how this person will be involved and notified of decisions.

- Throughout the process it is important that decisions and actions are accurately recorded, and a note made of those involved in the decision making process.

- To ensure an accurate view of the person's mental capacity, an assessment should be regularly considered throughout the process.

- This is a multi-agency process and each agency is required to nominate a lead worker to agree actions and make operational decisions.

At Risk Pathway

Follow the At Risk Pathway when:

- A risk assessment has been undertaken which indicates the situation has reached a level of risk that is unacceptable.

- All efforts to engage with the person and/or family have been exhausted.

- A referral to the safeguarding adults team has already been made in line with procedures if appropriate.

- In some cases, statutory powers are being considered.

Stages in the At Risk Pathway:

- 1 Referral
- 2 Multi-agency Panel Meeting
- 3 Review Meeting
- 4 Ongoing Support
- 5 Sharing Learning

At Risk Pathway

Stage 1 Referral

If mental capacity has not been considered by this stage it should be ascertained as soon as possible.

Ascertain whether any children or other vulnerable adults are at risk.

Obtain relevant legal advice.

Discuss with line manager whether to refer person to a multi-agency panel meeting.

Contact the appropriate senior practitioner (such as the Specialist Senior Professional or At-Risk Coordinator) for discussion about the case and agree way forward.

If a multi-agency meeting is required, an appropriate senior practitioner (such as the Specialist Senior Professional or At-Risk Coordinator) will be nominated to take the lead to coordinate services working with the person at risk.

Stage 2 Multi-Agency Panel Meeting

The purpose of the meeting will be to consider the situation and clarify whether any further action can be taken, making the necessary recommendations.

The appropriate senior practitioner will invite all agencies who have, or could have had, involvement with the individual.

Meeting will be chaired by someone who is able to take financial decisions.

Agree communication plan. Coordinating information in relation to actions completed and future actions to be carried out in between multi-agency meetings is a key part of the process. Careful thought should be given to who takes responsibility for coordinating the sharing of information and by what means.

Identify who is best placed to engage with the adult at risk i.e. who has the best relationship or the most appropriate skills.

Agree action plan, with timescales and named leads.

Set date for Review Meeting.

Stage 3 Review Meeting

An updated risk assessment is required for this meeting.

Agencies will share any new information.

Review actions and agree a revised action plan, with named leads and timescales.

If insufficient progress has been made, consider an alternative approach. Staff may need to explore other flexible, creative solutions.

Agreement needs to be reached on the way forward, with the nominated lead worker having the authority to make the ultimate decision.

This review process will be ongoing until the risks are managed.

Stage 4 Ongoing Support

Once risks are managed, consider what support is needed to meet the person's ongoing needs and ensure their well-being.

Any ongoing support to be clearly identified and agreed by relevant agencies. This should include any services that are commissioned.

Stage 5 Sharing Learning

Any learning and good practice to be shared with immediate colleagues and wider networks, including the Safeguarding Adults Partnership Board.

This is meant to be a dynamic process and this pathway will be amended as learning is developed.

West of Berkshire
Safeguarding Adults Partnership Board
April 2014

APPENDIX 1 – RELEVANT LEGISLATION

1. Community Care provisions

Mental Heath Act 1983

Section 2 - Admission for Assessment

Allows compulsory admission for assessment, or for assessment followed by medical treatment, for a duration of up to 28 days.

An application under Section 2 can be made by a relative or an Approved Mental Health Professional (AMHP) and must be supported by two medical recommendations, one of which must be from an approved doctor under Section 12 of the Act i.e. someone who has special experience in the diagnosis or treatment of mental disorder – this is generally a consultant or senior registrar psychiatrist.

The medical recommendations must agree that the patient:-

(a) is suffering from a mental disorder of a nature or degree which warrants his detention for at least a; *and*
(b) ought to so detained in the interests of his own health or safety or with a view to the protection of other persons

Section 3 – Admission for Treatment

Section 3 is similar to section 2; only the detention is for treatment and may be for a duration of up to 6 months, although this can be extended.

The grounds for detention are that the:-
(a) patient is suffering from one of the four specified categories of mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in hospital; *and*
(b) it is necessary for his own health or safety or for the protection of others that he receives such treatment and it cannot be provided unless he is detained under this section ; *and*
(c) appropriate medical treatment is available for him

Section 7 Guardianship

A guardianship application may be made in respect of a patient on the grounds that –
a) he is suffering from mental disorder which warrants his reception into guardianship ; *and*
b) it is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received.

The purpose of Guardianship is to enable 'the establishment of an authoritative framework for working with a patient with a minimum of constraint to achieve as independent a life as possible within the community and must be part of the patients overall care and treatment plan'.

Mental Capacity Act 2005 / Code of Practice and related guidance

The Mental Capacity Act sets out the statutory framework you must use to show whether or not someone might lack capacity to make a decision. The Act also sets out a 'Best Interests Checklist' which you must use when making a decision on behalf of a person who lacks capacity.

The five principles in the Act are:

- You must assume that the person has capacity unless it is established that they lack it
- A person is not to be treated as unable to make a decision unless you have tried all practical steps to help him or her make a decision without success
- A person is not to be treated as unable to make a decision just because he or she makes an unwise decision
- If someone lacks capacity to make a particular decision, any act done or decision you make under the Act must be done or made in the person's best interests
- Before you make a decision for someone who lacks capacity, you should choose the option that is the least restrictive of the person's rights.

The Mental Capacity Act also allows for people to name others they want to make decisions for them in the future when they might lack capacity. These arrangements are called 'Lasting Powers of Attorney'. LPAs can relate to decisions about a) one's property and affairs, or b) health and welfare, or both categories of decision.

Deprivation of Liberty Safeguards (DoLS) / Code of Practice and related guidance

Where a decision made under the Mental Capacity Act 2005 involves depriving vulnerable people of their liberty in either a hospital or a care home, extra safeguards have been introduced, in law, to protect their rights and ensure that the care or treatment they receive is in their best interests.

The deprivation of liberty safeguards provide legal protection by providing for deprivation of liberty to be made lawful through 'standard' or 'urgent' authorisation processes. This means that a 'managing authority' i.e. a relevant hospital or care home' must seek authorization from a 'supervisory body' in order to be able lawfully to deprive someone of their liberty. Before giving such an authorization, the supervisory body must be satisfied that a person has a mental disorder (as defined in s.1 of the Mental Health Act 1983) and lacks capacity to decide about their residence or treatment.

A decision as to whether or not deprivation of liberty arises will depend on all the circumstances of the case.

2. Environmental Health and Housing Legislation

Public Health Act 1936

This contains the principal powers to deal with filthy and verminous premises.

Section 83 states that where a local authority, upon consideration of a report from any of their officers, or other information in their possession, are satisfied that any premises –

a) Are in such a filthy or unwholesome condition as to be prejudicial to health, or
b) Are verminous

The local authority shall give notice to the owner or occupier of the premises requiring him to take such steps as may be specified in the notice to remedy the condition of the premises.

The steps which are required to be taken must be specified in the notice and may include:

- Cleansing and disinfecting
- Destruction or removal of vermin
- Removal of wallpaper and wall coverings
- Interior of any other premises to be painted, distempered or whitewashed.

There is no appeal against a Section 83 notice and the Local Authority has the power to carry out works in default and recover costs.

Section 84 covers the cleansing or destruction of Filthy or Verminous Articles: - in order to prevent injury, or danger of injury, to health.

Section 85 covers the cleansing of Verminous Persons and their Clothing

The Public Health Act 1936 S81 also gives Local Authorities power to make bylaws to prevent the occurrence of nuisances from filth, snow, dust, ashes and rubbish.

The Public Health Act 1961
Section 36 makes provision for the Local Authority to serve notice requiring the vacation of verminous premises and adjoining premises for the purposes of fumigation to destroy vermin. Temporary accommodation must be provided and there is the right of appeal.

Section 37 provides for household articles to be disinfested or destroyed at the expense of the owner.

Housing Act 2004
Gives the power to the Local Authority to inspect a property to identify any hazards that would be likely to cause harm and to take enforcement action where necessary to reduce the risk to harm. Where a property is deemed to be 'filthy or verminous' under the Public Health Act, it is more appropriate to use this legislation in dealing with the issues. Where there are structural concerns, then the Housing Act 2004 may be suitable.

Environment Protection Act 1990
Sections 79-80 allow a local authority to serve an abatement notice in relation to any premises in such a state as to be prejudicial to health or a nuisance

Building Act 1984
Section 76 enables urgent action to be taken to remedy defects to premises which are in such a state as to be prejudicial to health or a nuisance.

Prevention of Damage by Pests Act 1949

The Local Authority has a duty to take action against the owners/occupiers of land where there is evidence of pests. These are usually rats and mice but may include an infestation of any pest that has a public health significance.

Public Health (Control of Disease) Act 1984 Section 46
Imposes a duty on Local Authority to bury or cremate the body of any person found dead in their area in any case where it appears that no suitable arrangements for the disposal of the body have been made. Costs may be reclaimed from the estate or any person liable to maintain the deceased.

Part 7, Housing Act 1996 (as amended by the Homelessness Act 2002)
The homelessness legislation places a general duty on housing authorities to ensure that advice and information about homelessness, and preventing homelessness, is available to everyone in their district free of charge. The legislation also requires authorities to assist individuals and families who are homeless or threatened with homelessness and apply for help.

Under the legislation, certain categories of household, such as families with children and households that include someone who is vulnerable, for example because of pregnancy, old age, or physical or mental disability, have a priority need for accommodation. Housing authorities must ensure that suitable accommodation is available for people who have priority need, if they are eligible for assistance and unintentionally homeless (certain categories of persons from abroad are ineligible.) This is known as the main homelessness duty.

Regulatory Reform (Housing Assistance) (England & Wales) Order 2002 (RRO)
The RRO introduces a new general power enabling local housing authorities to provide assistance for housing renewal with a much greater degree of flexibility for local authorities in devising a policy to deal with poor condition housing, both in terms of the policy tools available to them, and in terms of their ability to work in partnership with others. If a local authority wishes to use the powers under the RRO it must adopt a policy setting out how it will use these powers.

3. Anti-Social Behaviour Legislation – Crime and Disorder Act 1998

The Crime and Disorder Act 1998 introduced new remedies and wide-reaching changes to the criminal law, including Acceptable Behaviour Contracts (ABCs) and Anti-Social Behaviour Orders (ASBOs)

An application for an ASBO may be made to the magistrates' court sitting in its civil jurisdiction, to a county court in appropriate cases and to a criminal court on conviction of a defendant.

An application may be made by a relevant authority if it appears to the authority that:-

(a) the person has acted in an anti-social manner i.e. in a manner that caused, or was likely to cause harassment, alarm or distress to one or more persons not of the same household as him *; and*
(b) such an order is necessary to protect relevant persons from further anti-social acts by him

A 'relevant authority' can be a Local Authority, the police or a Housing Association.

The terms of an Order are negative and prohibitory in nature and are specific to the nature of the complaint. Breach of the terms of an ASBO without reasonable excuse is a criminal offence and renders the offender liable to arrest and prosecution.

Under the Crime and Disorder Act 1998, there are procedures which must be followed in order to obtain an ASBO. Questions about whether an application for an Anti Social Behaviour Order would be appropriate should be made to the Inspector Hate Crime and Anti Social Behaviour or the Anti Social Behaviour Officer.

Consideration as to inviting the relevant Neighbourhood Policing Team to participate in multi agency work for individual cases should be given in all cases.

4. Other - Human Rights Act 1998

The Human Rights Act 1998 came into full force on 2 October 2000. The aim of the Act is to ensure that a set of basic human rights, which are listed in the Act, are fully respected and enforced in the UK. The Act is designed to make public authorities more accountable for their decisions and public authorities must therefore act in accordance with the Convention on Human Rights. The national courts will be able to enforce such rights against these authorities. The most relevant Articles are likely to be:-

Article 3 – Right not to be subjected to torture or to inhuman or degrading treatment

Article 5 – Right to Liberty and Security

Article 8 – Right to respect for Private and Family Life

There is a also a right under the Convention for the Protection of Property (Article 1, Part II)

The Convention sets out that there shall be no interference by a public authority with the exercise of these rights except such as in accordance with the law and as prescribed.

Appendix 2

Situational incapacity

The focus of the Mental Capacity Act 2005 ("MCA") is on whether a person is cognitively able to make an informed decision. Mental incapacity in the context of the MCA means that

> *" … at the material time, [s]he is unable to make a decision for [her- or] himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain" (section 2(1) MCA).*

However, practitioners also need to bear in mind the possibility that although cognitively capacitated to make a particular decision, a person may be incapacitated by their situation. This is particularly important in safeguarding adults situations.

The leading case on situational incapacity is regarding SA, decided by Mr Justice Munby in 2005. In brief, SA was a young woman who required protection from an unsuitable arranged marriage. SA was deaf and had no speech or oral communication. She functioned at the intellectual level of a 13- or 14-year-old. She could communicate in British Sign Language but not in Punjabi, the main language within her family.

SA wished to marry a Muslim man of her parents' choosing, but someone who spoke English and was prepared to live in the UK. She was able to give an informed consent to marry, but only if provided with a full understanding of what was proposed.

The Local Authority applied to court because of information suggesting that SA was about to be taken to Pakistan to be married against her wishes. The LA were concerned that SA would not be able to communicate with people around her, and would feel isolated. This would affect her well-being and mental health, and make her possibly unable to recognise the risk she was exposed to.

Mr Justice Munby held that the High Court did have power to make declarations to protect SA, even though her incapacity arose from her situation rather than her cognition:-

"The inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either

(i) *under constraint or*

(ii) *subject to coercion or undue influence or*

(iii) *for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent."*

The judge went on to explain that there were three broad ways in which situational capacity might arise. These were:-

1 - "Constraint" - which could fall short of incarceration, and would apply whenever there is "some significant curtailment of the freedom to do those things which in this country free men and women are entitled to do".

A person could perhaps be "constrained" in this way if they were prevented from going out, or otherwise prevented from contacting others to whom they might express their views or who might give them advice.

2 - "Coercion or undue influence" – which would apply where "a vulnerable adult's capacity or will to decide has been sapped or overborne by the improper influence of another … [particularly] where the influence is that of a parent or other close and dominating relative, and where the arguments and persuasion are based upon personal affection or duty, religious beliefs, powerful social or cultural conventions, or asserted social, familial or domestic obligations, the influence may … be subtle, insidious, pervasive and powerful. In such cases, moreover, very little pressure may suffice to bring about the desired result."

This can perhaps be summarised as being situationally incapacitated by being subjected to undue pressure. This could include being pressurised by arguments referring to religious, cultural or familial expectations.

3 - "Other disabling circumstances" – which would apply where "circumstances … may so reduce a vulnerable adult's understanding and reasoning powers as to prevent him forming or expressing a real and genuine consent, for example, the effects of deception, misinformation, physical disability, illness, weakness (physical, mental or moral), tiredness, shock, fatigue, depression, pain or drugs. No doubt there are others."

This is a general category of situation might which prevent the person "forming or expressing a real and genuine consent", for example because they have been given misleading information, or are in shock or pain.

This is perhaps the hallmark of situational capacity: is the person, though cognitively capacitated in general, preventing by their situation from giving (or withholding) a "real and genuine consent"?

An earlier case, Re G decided by Mr Justice Bennett in 2004 concerned a 29-year-old woman with a history of mental illness. The court application was made to protect Ms G from the effects of contact with her father. The judge found that Ms G was cognitively capacitated to decide whether to see him. However, the judge accepted medical evidence which showed that contact with him was likely to lead to a significant deterioration in Ms G's mental health and the loss of such capacity. The judge concluded that

> *"… if the declarations sought are in G's best interests, the court, by intervening, far from depriving G of her right to make decisions … will be ensuring that G's now stable mental health is sustained, that G has the best possible chance of continuing to be mentally capable, and of ensuring a quality of life that [previously] she was unable to enjoy".*

In 2012, the Court of Appeal confirmed that the inherent jurisdiction of the High Court remains available to protect people who, although cognitively capacitated, may be incapacitated by their situation. In the case of DL v A Local Authority, DL was a man in his 50s who was accused of making physical and verbal threats towards his parents, controlling their activities and movements and restricting their access to professionals.

The Local Authority obtained injunctions preventing him from assaulting, coercing or degrading his parents, and trying to persuade his father to transfer the house they shared to his (DL's) ownership and from trying to persuade his mother to go into care.

DL challenged the injunctions, claiming that the Mental Capacity Act had replaced the inherent jurisdiction of the Court and only applied to people who were cognitively incapacitated.

The Court of Appeal clarified that the Court's inherent jurisdiction has not been replaced. While it did not enable the Court to override the decision of a competent adult, the inherent jurisdiction was "in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity because they are

a) Under constraint

b) Subject to coercion or undue influence, or

c) For some other reason deprived of the capacity to make the relevant decision"

It is important to consider situational capacity, particularly in cases where people appear only marginally cognitively capacitated and at potential risk.

Applications to the High Court for declarations to protect someone who is situationally incapacitated need to be made under the Court's inherent jurisdiction rather than under the Mental Capacity Act.

Joint Legal Team
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