Please note the content of this training scenario is correct as of July 2024. It is up to individuals using the scenario to confirm if there have been any subsequent changes in case law or guidance requiring inclusion prior to use.

Scenario 8 (Mental Health based)

Overview:

P is a 20 year old young adult who lives with her parents. She has a familial trauma history and was previously open to Children and Young People mental health services. P has a history of reactive emotional dysregulation and intermittent serious self-harm in response to various life stressors.

More recently, P has been in increasing conflict with her parents, which has been associated with an escalation in self-harm activity. P has attended A&E multiple times over recent months, following incidents of overdose and cutting and burning her skin.

On all occasions, P was assessed by the nursing team as having mental capacity to accept treatment for her self-harm, which was provided. On the last occasion, P was seen by the Mental Health Liaison Team who confirmed that she could be discharged, but referred for 'follow up contact' the next day by the locality mental health Initial Response Team. P was subsequently contacted by the locality Initial Response Team but stated that 'all was fine' and that she didn't wish to engage.

What happened?

Yesterday, P's parents brought her to A&E following her taking a significant overdose. P's parents explained that there has been an ongoing deterioration in her mental state over the previous week, and that she had been repeatedly expressing suicidal ideation, stating that 'she didn't want to be here'. P had also been researching painless ways to end her life. In this context, P also refused consent to having her baseline physical health checked, stating that she didn't care if she lived or died. The medical team assessed that P lacked capacity to consent to having her baseline physical health observations checked at the time, and agreed that undertaking some minimal observations would be in her best interests. After taking some time to engage with P and provide some person-centred reassurance and support, P then reluctantly allowed some light-touch baseline physical health observations to take place.

P was then urgently referred to the hospital Mental Health Liaison Team, who assessed it was necessary to arrange a full 'Mental Health Act (1983) Assessment', to consider P's admission to psychiatric hospital. The assessment concluded that P should be admitted to a mental health unit for further assessment, care and treatment, and an inpatient bed was identified. When asked for her views regarding an inpatient admission to a mental health unit, P was ambivalent and reluctant to engage in conversation about it. The Responsible Clinician (psychiatrist) explained the details of an informal admission to P, but the Approved Mental Health Professional (AMHP) expressed concerned that P may be unable to consent to being an informal patient. An assessment of capacity took place for informal patient status. After which, P was assessed to *have* mental capacity to consent to be an informal patient in psychiatric hospital, but she refused. After further discussion, it was agreed that P would be admitted for assessment and treatment according to S.2 of Mental Health Act 1983.

The above case example demonstrates the key points below:

- Whilst the starting assumption (MCA Principle 1) is that an individual should be assumed to have capacity to make the decision in question - where there is reasonable doubt as to a person's capacity to make the decision, the relevant staff must undertake and document a full assessment of capacity. This will confirm whether the person is making a capacitated decision or lacks capacity and requires implementation of the MCA best interests process.

- That all assessments of capacity must be time and decision-specific. For example, that previous assessments should be reviewed as people's circumstances change, and separate assessments are required for each specific decision. In this case, one for baseline physical health observations in the context of overdose, and one for the decision to be an informal patient under S.131 of the MHA 1983;

- Whilst person-centred reassurance and support might not always result in a person having or regaining mental capacity to make their own decision, it can facilitate the delivery of care and treatment in a person's best interests, and reduce the likelihood of non-compliance and the use of restrictive practice;

- The above case example is a reminder that even where a person is assessed as HAVING capacity for some or all decisions, this does NOT dilute our professional safeguarding responsibilities. If ongoing concerns or risks are evident, consideration must be given to instigating additional safeguarding processes and frameworks, including consideration of the Mental Health Act 1983 where appropriate.