Case study 'Joanne', evidence 2: Reflective account 1

The Case study I am going to discuss is a 64-year-old lady with Downs Syndrome and Vascular Dementia, who I will call Mary. I have chosen to discuss this case because it is a very complex one so it shows that I can work in very complicated situations. I did this piece of work with a senior social worker on the team because it was so complex she needed some help with the case. One of the difficulties was that this lady had no insight into her situation. I had two main roles in this work - working with Mary’s niece who provided a large amount of support and supporting Mary alongside the senior worker.

Under the Carers Recognition and Services Act 1995 the niece was entitled to a carers assessment in her own right. I carried out the carers assessment which acknowledged that the support I was providing was meeting her needs. My role with Mary was about empowering her to sustain a Community presence. This situation was a prime example of how people in power can target the vulnerable, the niece was trying to keep Mary in the Community, but the OT was liaising with the warden and they were voicing their concerns that they felt Mary was not managing in the community. Mary moved to the sheltered accommodation when her mother died after Mary had been caring for her mother for a long time. There were also concerns about how accurate the information that the warden and the OT were providing. In terms of Anti- Oppressive practice I was disgusted at how oppressive people could be to an individual who had no insight into her condition. At times individuals were not interested in what Mary had to say and decided to make their own choices.

Part of my involvement with Mary was to try and maintain her Community Presence; According to the Warden other residents were advising her that Mary was going out wandering. Mary did not understand the concerns and was not able to accept responsibility in relation to her situation. I therefore did discuss my concerns with my manager in supervision. This was a time where we were able to reflect. We identified that I could use a Task Centred Model in this case.

The niece was at an extremely vulnerable time due to the stress of the situation, there was also information that Mary was incontinent of both Urine/Faeces, again on observation there was no indication on how true this was.

Major meetings were planned in relation to the Mary's capacity. Part of my role with Mary involved including her in what she thought of her situation. It was decided that Mary did not have capacity to make a decision, part of my process involved supporting the social worker in the Best decision practice which is part of the Mental Capacity Act (2007) law. In terms of this Act I have found it extremely difficult and frustrating. I feel professionally as workers it does support us as practitioners, but
more legal intervention is required. I feel that it protects individuals with any Mental Health Problems.

After a number of meetings with the family, the Psychiatrist, the learning disability nurse and the warden, due to the stress the niece was under she felt that the best decision would be for Mary to go to a residential home. Mary was then placed there and apparently agreed to stay there, again, there were concerns about this. A short while later I visited and there were concerns that Mary was trying to leave the building. After a day Mary had lost her ability to perform Daily living skills in the community even with a maximum support package in place this process could not be implemented. Due to the strange environment Mary’s memory had deteriorated. To observe Mary become distressed, angry, disorientated and try to leave the property whilst in a situation that was quite clear that she did not wish to be in was very distressing. My anxiety levels at times were also extremely high due to the fact that regardless what was going on I still had to try to work with Mary and she was an extremely volatile lady and at times could become abusive to me.

The next step was to arrange for an advocate about mental capacity “There remains the users who, because of their disability, are unable to express their own views and/or who wish to have independent representatives to act on their behalf. This will include suffering from dementia or severe learning disability. These users will be disadvantaged if the authority/agency confines itself to the promotion of Self-advocacy” (HMSO 1991). The advocate was then able to work closely alongside Mary and try to ensure that her interests were protected. The role of the advocate was to listen to Mary’s views and try to establish what she thought of the situation.

By this time if Mary had left the residential care home, she would have no familiarity of the area (as the home was approximately 10 minutes away) and she seemed to have no road sense so there was significant risk. Mary was allegedly trying the door on a number of occasions, and the home owner would not have any legislation to bring her back. He would have to rely on Common Law. After discussions with the consultant it was felt that a Guardianship order would be the best option. The guardianship involved 2 medical recommendations (Doctor, Psychiatrist) a pre planning meeting would then have to be held, a Social Report is completed on why guardianship is the safest option. I ensured that Mary’s niece was keep fully informed and involved. She said that she felt reassured that if her aunt did go missing then the home owner could be able to contact the police and request that Mary is returned to the home.

The advocate and myself have stayed involved with Mary she has become more familiar with the home, and has regular involvement with washing up, laying the tables. She enjoys becoming involved in these tasks.

The Act produces many difficulties in it as you could argue that this may be a good thing, as two professionals need to complete a consent form. All decisions have to be recorded, and a number of steps taken to identify your decision, usually referring to the Best Decision practice.

My role as a Social Worker is to respect service users and work within their best interests. Lots of people with Downs Syndrome get dementia. If an individual has
dementia then they would probably still insist that they wish to remain at Home. Due to their memory impairment they are not able to understand the risks, they may also have no insight into their condition and this can be quite challenging as you are there as a Social Worker to ensure their safety and wellbeing is protected. In terms of my values this has been quite challenging as I decided to enter into the profession to help people. One of the issues is that in this role you also have to protect the service user, this is not always agreeing with they want. As an individual I have always worked on the basis of treating people how you would like to be treated. If an individual has no capacity and is not safe then you have a duty to take them to a place of safety.

A main concern is how the Mental Capacity Act coincides with the Human Rights Act, the right to be respected, the right to privacy, if a service user is then being placed against her will then this will not be seen as abiding by the Human Rights Act. The frustration here is this situation could be misinterpreted as being similar to the Bournewood Judgement. This ruling was made by the high court and it was identified that an individual was taken to a day centre, and because he seemed to be acting out of character he was taken to the hospital. It was then found that he was stopped from seeing his carers they then started legal proceedings and it was found that he was being detained against his will. This case has become known as the Bournewood Judgement.