Edie

1a) More confident, assertive & self assured - helps ensure things happen the way they should eg docs have seen person - knowledge helps good range of K about MD + tmt & know clients & what they need to get better K of knowing docs + staff & their knowledge of risk. K of resources is vital & feeling floundering I don't ax. More tolerance of risk with experience. When asked to ax more experience to say no don't use ax to decide if mtg ax don't put ppl through if not needed

b) Some ppl see support as weakness I don't. Consulting others helpful, sounding boards enriches ax & decision making - advice offered if don't take - specialist - child's dementia ASD. or person who knows person well +ve risk - united front.
Client M: support went well colleagues AMHPs + RC agreed in ax. Another client → several in office clarifying involvement of SW & psychologist. RC wanted as planned + agreed

2 a) Guiding principles empowerment involving wider family etc. look at purpose & effectiveness of interven. Does not ask for individual. looking @ persons wishes & views of admission → their values come in to that. Their way of life T. & happy with life style when unwell HRA Art 3 Degrading tmt v dignity anti depot - pinned down don't fight injection is poison bear in mind. If someone anti. SL client advanced strat about if unwell- choices of meds & dose to try to divert MHA PS - ? Heading to MHA - had recovery plan which he stuck to & recovered. Back to SC - tramp identity indoor tramp - self neg only risk. Psychotic flat chaotic in her world this isn't bad Offered to extract rubbish But 6th Many months listening to them & giving time. MC do they like to live dangerously - extreme sports etc - unwise decisions. Ensuring that have right ppl to advocate if wanted. Trusting ppl & giving them opps. - let them try. MC age &

frailty, vulnerability - Art 3 rights 'controlled' - would say depot. degrading tmt. The vibe of the person.

b) Everything we may look at in a CTAp start with own views & wishes, MCA past & present wishes. Whole current life; family situation; social supports employmt, age & phys dis.; cultural differences. → being different doesn't → MD - importance of leaving situation & what that could mean & effects on close ppl & what they would say - can they handle it? Indv - effect of admission - what would that do to them? Distress to the pers Distress to carers. Previous exp. of MD nature & course of & Ψ - look at substances.

c) Being able to be receptive to all info which means there'll be more possibly & options. Being open to & changing minds / surprised - open to being wrong. NO preconceptions assumptions PD: ~~Hospital~~ Detention not likely to be helpful. Ideal not what's assumptions / suspicions.

a) Things you want - doc to see person
Scords to check out for comm. tnt. S(2)
doc to review. Jax with conr. if doubts
to see if S(2) can be d. ~~doubt~~ would
want joint ax ~~co~~ or alone / SW colleague
Being transp. with person explaining
concerns of service - recom. giving
due warning of possible outcomes
Help of social networks to see if support
is alternative to ax. be trusting →
give opps & time. Could be sleeping
of subs / hasn't ~~sleep~~ slept / time
out through meds. Need CA &
landing on caseload - sorting
issues - housing / s/care/alpack - sty
can family stay - can someone
secure it as risk. Client own
experience → relapse plan (PS).
Identifying source of safe cannabis
instead of skunk. ? Multiple
visits to try & engage person.
- Ppl don't want SWIDi giving info.

) Reading records - consult profs with
K of situation consu. family &
friends consult person
want to know person's capacity
go to law & criteria - spring board
Nature & degree - ? hosp a/decent
[illegible]

info from ppl who know about speaiions. person's own wishes needs & values.

4 a) Risk Art 3, 5, & HRA Risks need to be proportionate risks of adm & det & trt in hospital & art 3 - inhuman & degrading trt. (uc). Got to be risks severity / degree. likelihood. PD risk(s) can be high can be accidental tragedy tve risk taking not enough I'm getting better at it — experience & knowledge instinct for genuine risk. ⇒ impact of not q & t leaving situation - get views. What's left if it's left. Previous response to trt in past does it help that much or for long? What happens to quality of life after MCA unwise decisions & history — person extreme. Maybe MH q not MCA leave as are-are ppl signed up to risk taking inc family. To other ppl or property more likely to be MHA than MCA. Distress of person overlooked & not seen as a risk. Distress of close ppl & family.

b) Time to explore + gather assimilate & process info — more thoroughly with more time. Checking reliability

o. Risk exasserated by Health
for response. Exploring less
tricave options. Ensuring consult.
s assessed. Collateral to from fam
uers. Checking on same page with
n- sleeping off subst. - 136 000
t getting sleep.. Hold on
reas for 14 days - 2 refs
t - giving chance for alternative
work. Risks not that great
yway - want to do job self
~~med~~ rather than suds (trust)
ver nap.

~~Recommendation~~