**SOCIAL CIRCUMSTANCES REPORT FOR**

**GUARDIANSHIP RENEWALS**

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| **AMHP Details:** |  |
| **Name:** |  |
| **Office Address:** |  |
| **Contact Number:** |  |

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| **Service User Details:** |  |
| **Name:** |  | **Mosaic No:** |  |
| **Address:** |  | **D.O.B.:** |  |
| **Sex:** |  | **Ethnicity:** |  |

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| **Current Legal Status:** |
| **Guardianship expiry date:** |  |
| **Deprivation of Liberty Safeguards:** | Start date: |  | End date: |  |

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| **Responsible Clinician:** |  |
| **Name:** |  | **Contact No:** |  |
| **Previous Acquaintance?** | Choose an item. |
| **Specialism?** | Choose an item. |  |
| **If Yes** – please state:*i.e. LD/CAMHS/ED* |  |
| **Joint Assessment with AMHP?** | Choose an item. |
| **Assessment Date:** |  |
| **Consultation Details:** |  |

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| **Brief Summary of History** *(including risks):*  |
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| **Care and Support Plan Guidance** |
| **Please ensure a copy is provided** |
| * Ensure the care and support plan is completed using a strength-based approach
* Identify **all the** **needs** of the service user and how these are to be met
* Identify which needs are eligible for **s117 aftercare** and which are not
* Identify the Service User’s outcomes
* Identify any parts of the care and support plan which include **continual supervision and control**
* Identify **conditions of** **restrictions**
* If there is a placement to specified accommodation has funding been approved
* Identify which parts of the care and support plan require the power(s) of Guardianship to be used
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| **Statutory Visits Completed** |
| **3 months:** | **Date:** | **If no visit, reason why?** |
| **6 months:** | **Date:** | **If no visit, reason why?**(not applicable) |
| **9 months:** | **Date:** | **If no visit, reason why?**(not applicable) |
| **Admission to hospital (general or psychiatric):** | **Date:** | **If no visit, reason why?** |

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| **Consultation with Others:***(Amend as necessary - not all will be relevant/practicable)* |
| **Role:** | **Name:** | **Details of discussion/views:***(including whether consent to contact was sought; justification for contacting if no consent)* |
| **GP:** |  |  |
| **Professional responsible for the care of the individual:** |  |  |
| **Other Professional:** |  |  |
| **Children’s Services:** |  |  |
| **Family/ Friend:** |  |  |
| (Other) |  |  |

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| **Nearest Relative:** |  |
| **Name:** |  |  |
| **Relationship to Service User:** |  |
| **Address:** |  |
| **Contact Number(s):** |  |
| **Able to Consult?** | Choose an item. |
| **If ‘No’-why?** |  |
| **Date of Contact:** |  | **Method of Contact:** |  |
| **How NR identified:***(in accordance with s.26 MHA; including whether this is via delegation/displacement)* |  |
| **Views of the NR:** |  |
| **Please state if certain information should not be shared with the service user** |  |
| **NR informed of Rights?** | Choose an item. | **Details:** *(method/who has been requested to complete?)* |  |
| **NR Delegation:** *(Does the NR wish to delegate?)* |
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| **NR Displacement:** *(Is displacement indicated? What action taken?)* |
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| **Are they the service user’s carer?**  | Choose an item. | **If yes, have they been offered a carer’s assessment?** | Choose an item. |

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| **Sources of Other Information** |
| Have you read RiO *(if applicable)* | Choose an item. |
| Have you read Mosaic/Liberi? | Choose an item. |

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| **Details of interview with Service User:** |
| **Was an IMHA involved?** | Choose an item. | *If not, why* |  |
| **Who was present:***(Was the service user supported by anyone during interview?)* |  |
| **Location:***(specifics to be given to demonstrate how upheld confidentiality, dignity etc.)* |  |
| **Offered to see alone?** | Choose an item. | *(If not, why – i.e. risks)* |  |
| **Content of interview:***(include introductions, how informed of process CoP 14.51. How interviewed in a suitable manner (s.13(2), CoP 14.49). Service User’s views and wishes. Engagement in interview process.)*  |
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| **Duration:** |  |

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| **MCA:** |  |
| **Does the person have capacity to make decisions relating to their care and treatment?** | Choose an item.  |
| **If not has an IMCA been involved?** | Choose an item. | (If no, reason why not) |  |
| **Does the person have capacity to decide where to live?** | Choose an item. |
| **Does the person have the capacity to understand Guardianship and its powers** | Choose an item. |
| **MCA 2 stage Capacity Test:** | Stage 1 – *does the person have an impairment of/ or a disturbance in the functioning of their mind or brain?* | EVIDENCE: |  |
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| Stage 2 – *to establish if the person can understand information relevant to that decision, retain* *that information, weigh up that information as part of the decision-making process, communicate their decision.* | EVIDENCE: |  |
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| **Do they have any Advanced Decisions?** | Choose an item. |
| **Is there an LPA?** | Choose an item. |

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| **Rationale for recommendation for Guardianship:** |
| **Refer to Guiding Principles - Least Restrictive Option & Maximising Independence; Empowerment & Involvement; Respect & Dignity; Purpose & Effectiveness; Efficiency & Equity)** |
| * *Why is the use of MCA as the least restrictive option not applicable?*
* *What aspects of the care plan require the powers of Guardianship and why?*
* *What are the predicted outcomes if Guardianship is not implemented?*
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| **Service User informed of recommendation?***(Please note: It is only at the point of acceptance, or the date that transfer is agreed that Guardianship comes into effect)* | Choose an item. | **If ‘No’ – why?** |  |
| **Has Service User been provided with a copy of this report** | Choose an item. | **If ‘No’ – why?** |  |
| **Details of immediate issues:***(i.e. Protection of Property / Pets etc.)* |   |

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| **Delays to MHA Assessment:***(Were there any delays to completing MHA assessment? Tick all that apply)* |
| **Reason:** |  | **Length of Delay:** |  |
| **Responsible Clinician:** |[ ]   |
| **Advocacy availability:** |[ ]   |

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| **Please indicate what onward referrals have been completed (if any):** |
| **Children’s services/child safeguarding** [ ]  | **Adult Safeguarding** [ ]  | **Carer’s Assessment** [ ]  |

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| **Time Spent** |  |
| **Time of MHA Assessment:** |  |
| **Time spent preparing for assessment:***(include admin tasks after assessment i.e. onward referrals)* |  |
| **Time spent completing assessment:***(on site with Service User)* |  |
| **Time spent completing Social Circumstances Report:** |  |

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| **Signed by AMHP** |  |
| **Date** |  |