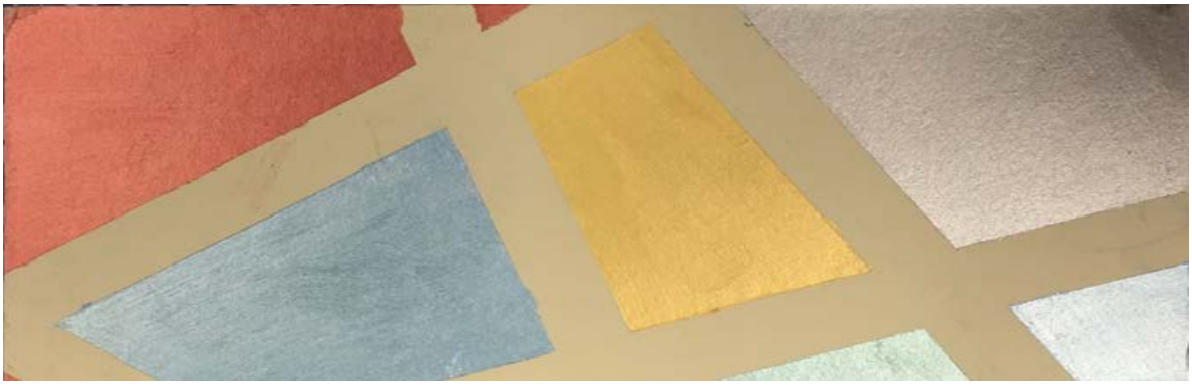
MENTAL CAPACITY REPORT:
THE WIDER CONTEXT
December 2023 | Issue 137



Welcome to the December 2023 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: the least worst option as regards compulsory feeding, putting values properly into the mix and the need for a decision actually to be in contemplation before capacity is considered;

(2) In the Property and Affairs Report: relief from forfeiture in a very sad case;

(3) In the Practice and Procedure Report: counting the costs of delay, guidance on termination cases, and a consultation on increasing Court of Protection feeds;

(4) In the Wider Context Report: forgetting to think and paying the price, the cost of getting it wrong as litigation friend, Wales potentially striking out alone on mental health reform, and a review of Arianna's book on social care charging;

(5) In the Scotland Report: reduction of a Will: incapacity and various vitiating factors, and an update on law reform progress.

You can find our past issues, our case summaries, and more on our dedicated sub-site here, where you can also sign up to the Mental Capacity Report.

We will be taking a break in January, so our next Report will be out in February 2024. For those who are able to take a break in December, we hope that you get the chance to rest and recuperate. For those of you who are keeping the systems going in different ways over that period, we are very grateful.

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The picture at the top, "*Colourful*," is by Geoffrey Files, a young autistic man. We are very grateful to him and his family for permission to use his artwork.

Contents

Care homes, hospitals and hospice visiting consultation response

As we went to press, DHSC published the responses to the consultation on visiting in these places, the summary being as follows:

> *The majority of responses supported the government's proposal to introduce a fundamental standard on visiting.*
>
> *The government will now work with CQC to develop and introduce a new fundamental standard. This will focus on visiting, against which CQC will assess certain registered settings as part of its existing inspection framework. We intend to lay the necessary regulations in Parliament to introduce this additional standard as soon as possible. We will also work with CQC to publish the necessary guidance to the health and social care sector to ensure this new standard is clear and upheld.*
>
> *Through this new standard, CQC will be able to specifically include visiting considerations as part of its wider regulatory assessment of providers. This could include using civil enforcement powers in line with its published enforcement policy when it is necessary and proportionate to do so.*
>
> *Of the themes we observed within our consultation, respondents cited that they found government guidance unclear, and that strict visiting times and complicated complaints processes were some of the barriers to visiting in health and care settings. Legislation will therefore help to create a consistent understanding of what is acceptable across all relevant providers. We will also seek to make guidance on the complaints process clearer for when issues do arise.*
>
> *Some respondents expressed concern that through the provision of a standard and accompanying guidance, 'exceptional circumstances' or*

'reasonable explanations' (where a provider may restrict visiting) may actually provide the conditions for more restrictive practices, which is contrary to our intention. We recognise that there will always be some, very limited, circumstances in which visiting cannot be facilitated by the provider to maintain the safety and wellbeing of service users and staff. However, we do not plan to include a list of these circumstances in the statutory instrument itself. We are clear that visiting is critical to the health and wellbeing of everyone.

While the majority expressed clear support for a consistent approach across CQC-registered settings, we recognise concerns raised by sector representatives about the requirements for some health and care settings potentially putting individuals at increased risk. For this reason, we intend to exclude services for substance misuse and inpatient detoxification or rehabilitation services from the requirement. This reflects the complex circumstances and risk of relapse for a vulnerable person, and visiting is already carefully considered within care plans in these settings. Supported living settings and 'extra care' housing schemes will also not be in scope of the regulation. These settings generally exercise 'exclusive possession', in which the individual has a tenancy agreement and they can decide who visits. All guidance will clearly set out the scope of this new regulation.

We intend to address concerns about residents of care homes being discouraged to take visits out of the home by overly burdensome restrictions upon their return. A care home is a person's home, and we will be including a provision in regulations that residents should be encouraged to take visits out of the care home to support their wellbeing.

We have received clear support and heard the positive impact that this policy would have, particularly for service users and their loved ones, with powerful personal testimony. The range of support provided by many visitors, which often extends beyond companionship to a 'care supporter' role and advocate, is fundamental.

Some have called for this right to be protected within new, primary legislation. Given the overwhelming support in this consultation, and the role of CQC as the regulator in England, the government believes the most proportionate and appropriate way in which to protect and enable visiting is to now move to introduce a new CQC fundamental standard on visiting. This puts visiting on the same level as other fundamental standards, such as that which requires providers to meet the nutritional and hydration needs of service users.

A new fundamental standard on visiting provides a standard to be enforced by CQC as part of its existing civil enforcement powers. This will highlight the importance of visiting to providers and all stakeholders, and ensure that providers account for the vital role that visiting plays.

One part did rather leap out as us – the assertion that those in supported living settings and extra care housing schemes generally exercise 'exclusive possession,' and in which the individual has a tenancy agreement and they can decide who visits. As a bald proposition this is distinctly questionable, and we might suggest not obviously a very sound foundation upon which to exclude those in such placements from the regulation – many of whom may very well be in places which could well change (in effect) overnight from a care home to a supported living

placement without any actual change for the individuals concerned.

Forgetting to think and paying the cost

In the Local Government and Social Care Ombudsman complaint determination 22 017 529, the Ombudsman identified that North Yorkshire Council repeatedly missed opportunities to assess the mental capacity of a woman, Mrs Z, regarding her ability to manage her finances when this was in doubt. As a result, its decision to charge her for the full cost of her care fees for several years before she died, based on incomplete information regarding her finances, was fault. This fault caused significant uncertainty and distress to her relative, Mr X, who is the executor of her will. The Ombudmsan also found that he Council's communication and complaint handling with Mr X had also been poor. In recognition of the uncertainty caused by the Council's inadequate assessments of Mrs Z's finances, the Council agreed to write off the £21,987.06 debt it said she owed. The Council also agreed to apologise to Mr X, pay him £350 to recognise his own frustration and time and trouble and carry out several service improvements to prevent this fault occurring in future.

The decision stands as a helpful reminder that (as the Ombudsman says at paragraph 21) of the report "The [relevant person or body] must assess someone's ability to make a decision when that person's capacity is in doubt."

Short note: the cost of getting it wrong as a litigation friend

In the financial remedies proceedings in *Y v Z* [2023] EWFC 205, the litigation friend for the wife apparently became unwell, and essentially failed to do anything very much at all in his role as litigation friend. This led to a hearing where HHJ Edward Hess found himself in significant difficulties as regards the way forward given the litigation friend's non-appearance and non-engagement. Whilst the judge managed to find a way through, the hearing could not be the final hearing that was envisaged, at a cost to the husband of some £42,128.79. The question was whether the costs should be borne by the wife herself, or by the litigation friend, Dr X. HHJ Hess concluded that it should be Dr X:

> *34. In deciding what costs orders to make I remind myself that the starting point (under FPR 2010 Rule 28.3(5)) is for there to be no order as to costs, but Rule 28.3(7) allows me to depart from this in certain circumstances, including where there has been relevant non-compliance with orders or litigation conduct (as there has been here, as described above). The Court of Appeal decision in Barker v Confiance Limited [2021] 1 WLR 231 suggests that, whether pursuant to the undertaking or by reference to Senior Courts Act 1981, section 51, the court can make a costs order against a litigation friend if, in all the circumstances, it is just to make a costs order.*
>
> *35. I have reached a clear view that the fair and just outcome here is for me to make an order for Dr X to pay the whole of the costs wasted by the hearing this week not being able to be dealt with as a full final hearing and I assess this at £42,128.79, to be paid within 14 days. While Ms Phipps invited me to consider apportioning this 50:50 between the wife and Dr X, I have decided that the appropriate order is to hold Dr X 100% responsible for these costs. He willingly took on the role of litigation friend and his performance has been wholly inadequate. I accept that he has not been well, but this fact does not adequately excuse or explain his conduct and he should not escape the consequences of what has happened.*

Tier 4 CAMHS, detainability under the MHA 1983 and (righteous) judicial frustration

Lancashire County Council v X [2023] EWHC 2667 (Fam) (High Court (Family Division) (HHJ Burrows)

Article 5 ECHR – deprivation of liberty – children and young persons

Summary

This case was rightly described by the judge as extremely disturbing, involving the most intense level of restrictions imposed on a child (of 15) seen by any of the professionals involved, but no obviously lesser state of restrictions that could be envisaged to keep her safe. The case had involved an escalating series of crises and stays in acute hospitals whilst a search for appropriate accommodation in the community continued. To give a flavour of the seriousness of the situation, we set out the narrative given by the judge in the lead-up to the most recent hearing.

> *26. At* [the earlier] *hearing, in agreement with Ms Bowcock, K.C., I said that this was clearly a case for a secure accommodation order. In fact, a secure accommodation placement might well be better for Claire because the relational security might be less intense. It must be difficult for somebody who is in good mental health to have four people with them all the time, but for somebody with the terrible difficulties that Claire has it must be awful. However, what else can be done when a person is trying to harm themselves as determinedly and seriously as Claire is? The most recent example I was given at that hearing was that she smashed a door down at the placement in the West Midlands, not so she could escape but so she could get access to the screws which she could then ingest.*

27. Before the hearing on 26 September there was another event where over the weekend Claire climbed on to a conservatory roof, smashed some glass and ingested it. As a result, she was taken to the A & E department at a Midlands Hospital, and as a result of that Carolann House gave immediate notice and they have refused to allow her to return, although they have continued to provide support for her in the Hospital. She remained in hospital in a cubicle off the ward, medically fit for discharge, where "medically" once again refers to physically fit, but there must be severe doubts as to whether she is mentally fit for discharge from a hospital.

28. However, once again she was assessed for MHA admission and the assessment proved negative. She is not in need of in-patient psychiatric care at Tier 4, it is said. So, LCC once again was left holding Claire in circumstances where, and this is not a criticism of the Council, they have no idea what to do with her. The only thing they can do is to look for a placement that may be able to provide her with support and care and then, once she is there surround her with what is assessed as being a necessary level of support in the circumstances.

29. If it is the wrong sort of place, a place that is not secure enough, then that level of security is going to have to be intense. It is probably going to be 4-to-1. That is likely to make things worse because Claire will see herself as being heavily restricted, and not having a normal life. Her ability to regulate the emotions that will follow from that are well-documented and non-existent. So, we can anticipate further self-harm, further destruction, further attempts to escape and further admissions to hospital if she is lucky enough not to kill herself in the process.

30. On 26 September 2023, the application before me was a modest one. Keep the restrictions in place but just change the address from the placement in the West Midlands to the cubicle off the Accident & Emergency Department at the Midlands Hospital where there will be four people constantly with her, constantly restricting her, occasionally restraining her, and always making sure that she does not harm herself.

As HHJ Burrows noted:

31. I found myself in a position where I had to authorise that level of detention because the alternative was too horrible to contemplate. However, I wanted to know why it is that CAMHS and Tier 4 psychiatric services consistently and persistently regard Claire as not being detainable under the MHA. She has a mental disorder. It appears it is of a nature and a degree that needs treatment of some sort and in a place of security. It means that she is an enormous risk to her own health and safety but also, potentially anyway, to others. In the absence of any other suitable placement, it seems necessary for her to receive at very least assessment and probably further treatment in a psychiatric facility to address that disorder. I am only a judge, I am not a psychiatrist or an AMHP, but Claire seemed to me to be detainable.

32. I wanted the person who most recently assessed her to provide the assessment and an explanation as to why, in their view, she is not detainable. The alternative to her being in a psychiatric facility is that she is in a non-psychiatric secure facility, potentially, or worse, in a wholly inadequate facility in which people are doing their best but are doomed to fail because of her behaviour. That is an explanation I wanted by the time of the next hearing.

At that hearing, HHJ Burrows:

33. [..] *heard from a very senior and specialist nurse, HZ, who provided me with a statement and attended remotely to assist the Court. I am grateful to HZ for her expertise and candour. HZ explained to me why Claire was not detainable within a Tier 4 CAMHS facility under the MHA. That conclusion was reached after a lengthy period of assessment during which Claire engaged with those assessing her. The assessors were aware of the detailed history I have summarised above. They were also aware of the CAMHS assessment carried out whilst Claire was placed in Salford. Claire's presentation in Salford was summarised in a letter from Greater Manchester NHS Foundation Trust dated 18 August 2023. During the assessment at Salford "there was no evidence of an acute mental disorder that would likely respond to treatment in an acute mental health inpatient setting. There was no objective evidence of mood disorder, acute anxiety or psychotic features". The self-harm Claire had inflicted "was in the context of emotional dysregulation linked to social stressors, namely……attachment difficulties and feelings of destabilisation due to multiple placement moves, and removal from family and usual social support networks".*

34. That assessment appears to focus heavily on the degree of disorder at the time of assessment and not on its nature over time. In relation to her family and usual support networks, it will also be noted that Claire's removal from her family and those networks came about because of the crisis I have described in which her family and those networks were incapable of keeping her safe. In short, I did not find the Salford assessment very compelling. HZ and

> *her colleagues concluded that there were no obvious signs of a diagnosable mental health condition that would warrant Tier 4 admission. Her behaviour appeared to be "due to her traumatic and adverse childhood experiences" and (emphasis added) "she would warrant **longer term therapeutic work** in collaboration **with a contained and varying environment**".*

HHJ Burrows found himself:

> *36.* […] *extremely concerned about HZ's evidence and the position of her Trust. The apparent consensus amongst the mental health professionals who have treated Claire is that she needs treatment for her underlying disorder, but that is best achieved in a social setting which is stable, safe and secure. Until that is available the treatment will not be offered. This position appears to ignore what is almost universally recognised elsewhere, namely that there is a chronic lack of secure accommodation for our young people with serious mental health and behavioural problems. I need only refer to the recent judgment of the President, Sir Andrew McFarlane in Re X (Secure Accommodation: Lack of Provision) [2022] EWHC 129, along with his predecessor six years ago, in Re X (A Child) (No. 3) [2017] EWHC 2036 (per Sir James Munby, P) to provide support for this Court's concerns. Furthermore, in the Court of Protection recently, Theis, J, VP, made the same point in an appeal from one of my decisions concerning the lack of appropriate accommodation for challenged young people: see Manchester University Hospitals NHS Foundation Trust v JS (Schedule 1A Mental Capacity Act 2005) [2023] EWCOP 33.*

HHJ Burrows heard from the consultant within the Sandwell CAMHS crisis team, who was able to offer that DBT treatment could start immediately, which "*recognises two aspects of this case that seem clear. First, that Claire needs therapeutic input to address the underlying mental health condition, whatever that may be. Although she ideally needs that in a place where she is secure and stable, the fact is that level of security and stability simply is not available at the moment. Finding an alternative placement is likely to prove difficult and may involve a protracted search period, and that is the second aspect. Certainly, if the experience of previous searches is an indicator, finding a satisfactory placement rather than one that is barely adequate will take a while. In the meantime, Claire needs the treatment and other input*."

However, pending the identification of appropriate secure accommodation, and

> *45. So far as the Tier 4 issue is concerned, I remain troubled that this young woman who has been dysregulated for so long and has been so determined to cause herself serious harm, is not detainable under the MHA. However, there is nothing this Court can do to require the use of the MHA. The guardian is pondering whether judicial review of the sectioning decision is a feasible option. I consider in the meantime that it is necessary for an expert to be instructed to consider Claire's overall mental health care and the direction of that care. This appears not to be taking place in a coordinated way as it is. What I cannot do is compel anyone to detain Claire under the MHA. This was made clear, albeit under slightly different circumstances by Mr Justice McDonald in Blackpool BC v HT (etc) [2022] EWHC 1480. What His Lordship said at [51] is also highly relevant to this case:*
>
> > *This matter represents another example, amongst many examples, of a case in which the acute lack of*

> *appropriate resources, for children assessed as not meeting the relevant criteria for detention under ss 2 or 3 of the Mental Health Act 1983 (the 1983 Act) but requiring therapeutic care within a restrictive environment for acute behavioural and emotional issues arising from past trauma, creates tension between a local authorities and the NHS. As a result, the matter comes before the court with the local authority asserting that the NHS should be making provision for the child and the NHS arguing that the child does not meet the criteria for such provision.*
>
> *46. I am troubled however, that those involved in CAMHS provision and Tier 4 decision making have to recognise this resource crisis and have to take the lack of adequate social provision into account when making decisions under the MHA. Of course, a 14- or 15-year-old child should not be detained in a secure psychiatric facility if there is a less restrictive option that can achieve appropriate care for her. Or, put another way, treatment in Hospital is not necessary if (but only if) there is suitable care available outside Hospital. If that placement is not available within a reasonable timescale, then treatment in Hospital is surely necessary. I have dealt with this elsewhere, in a similar context, in Manchester University Hospitals v JS [2023] EWCOP 12.*

HHJ Burrows found himself able to authorise the continued deprivation of Claire's liberty where she was given that she was slightly better settled, and declaring that it was in her best interests to receive such treatment.

Comment

Grimly, Claire's situation is, as HHJ Burrows identified, not unusual, as systems essentially continue to be pushed to and beyond their limits in the face of increasing demand (especially amongst adolescents) and diminishing supply. HHJ Burrows' concern about the approach of those charged with Tier 4 assessment has been shared by other judges, and indeed, more broadly by those who are troubled about the fact that what is in effect a commissioning process appears to drive consideration of whether a person is or not detainable under the MHA 1983, a question which is not on its face anything to do with resources.

It is striking in this case that a judicial review was being contemplated to tease out the question of why Claire was not considered detainable for purposes of the MHA 1983. However, it is also necessary to highlight that HHJ Burrows' approach to detainability might need something of a recast in light of the decision of the Upper Tribunal in *SF v Avon and Wiltshire Mental Health Partnership* [2023] UKUT 205 (AAC), a decision which may suggest that a rebalancing towards greater recourse to judicial authorisation (for those under 18) and /or recourse to DoLS (for those over 18 lacking the relevant decision-making capacity) for those cases where, in effect, all that is being done is keeping the person as physically safe as possible.

Wales striking out alone on mental health reform?

In a fascinating development, James Evans MS, who won the relevant ballot, is to seek to put before the Senedd in Wales the equivalent of a Private Members Bill to amend the provisions of the Mental Health Act 1983 so as to introduce significant parts of the reforms proposed by the Independent Review of the Mental Health Act. The proposals have the support of Mind Cymru; Adferiad; the Royal College of Psychiatrists; and the Royal College Mental Health Expert Advisory Group.

The Explanatory Memorandum to the proposal for a Mental Health Standards of Care (Wales) Bill explains how the Bill would:

1. Enshrine statutory principles on the face of the MHA 1983 in Wales;
2. Replace the Nearest Relative (NR) provisions in the Act with a new role of Nominated Person; and
3. Enshrine a change in the criteria for detention to ensure that people can only be detained if they pose a risk of serious harm either to themselves or to others, and that there must be a reasonable prospect of therapeutic benefit to the patient.

A further change – not proposed by the independent Review – would be to introduce the provision for remote (virtual) assessment under 'specific provisions' relating to Second Opinion Appointed Doctors (SOADs), and Independent Mental Health Advocates (IMHAs). And further changes would be introduced to the existing Mental Health (Wales) Measure 2010 to ensure that there is no age limit upon those who can request a re-assessment of their mental health and to extend the ability to request a reassessment to people specified by the patient.

The Explanatory Memorandum sets out a number of areas that were considered, but not advanced, as follows:

a. *Placing a duty on clinicians to have regard to advance choices – the clinical checklist provisions. This is largely a codification of what should already be happening, and as a matter of good clinical practice could be progressed without legislation.*

b. *Shortening the period that a patient may be kept in detention for treatment so that a patient's initial detention period will expire sooner and if the patient's detention is to continue it must be reviewed and renewed more frequently. There are some resource implications to this in terms of clinician and others time to carry out the reviews more frequently.*

c. *Amending the frequency that a person may seek reviews through Mental Health Review Tribunals (MHRTW). This would result in a different regime compared to England and would have significant resource implications as the MHRTW would need greater capacity to deliver this.*

d. *Amending section 132 of the Act to place a statutory duty on hospital managers in respect of detained patients to supply complaints information to both the patient and the NP. Supply of information could be achieved without legislation. From April 2023 there is a legal duty of candour requiring NHS organisations in Wales to be open and transparent with service users, which includes talking to service users about incidents that have caused harm and apologising and supporting them through the process of investigating the incident.*

e. *Amending s.117 aftercare provisions to ensure the deeming provisions are consistent with other legislation. This relates to who is responsible for providing aftercare when a patient moves between different local authority areas. This has been a more significant issue in England than in Wales. Since we cannot legislate to change the system in England, Wales-only legislation would only serve to complicate matters around*

crossborder issues, and risks potentially creating cracks in the system.

f. *Autism and learning disabilities. Changing in how the Act applies to patients with a learning disability and/or autistic people under Part 2 of the Act to end the practice of patients in this group being detained under the Act in unsuitable long-stay wards, in line with the principle of least restriction. Welsh Government are currently reviewing the Code of Practice for Autism Services. How neurodivergent people including autistic people receive support / treatment when diagnosed with co-occurring mental health concerns will be integral to this review*

It is perhaps of note that the proposed measure draws directly on the work of the Independent Review, rather than on the draft Bill put before the Westminster Parliament and, as such, for instance, proceeds on the basis that it is possible to put principles on the face of the MHA 1983. It is also of note that the measure does not seek to remove autism and learning disability – a proposal that had been put forward in the draft Bill, but which the Independent Review had not called for as it did not consider that such would solve the problem of unnecessary and unnecessarily extended detentions of autistic people and those with learning disability.

Assuming that this progresses, this is a striking development by contrast to the legislative silence that has descended in England. It also raises the prospect of some interesting devolution issues to navigate as regards (for instance) the application of the statutory principles to Part 3 patients.

For those wondering whether an enterprising MS might take the opportunity of introducing an equivalent provision to bring into force the LPS or an equivalent thereof in Wales, the answer is such lies outside the legislative competence of the Senedd (otherwise, given the furious response of Welsh Government to the delay, it is entirely likely that it would have sought to do itself).

The Health and Social Care Committee sounds concerns about Right Care, Right Person

The Health and Social Care Committee sent a letter in September (the precise date does not appear on the letter) to (then) Secretary for Health and Social Care Steve Barclay setting out a number of concerns about the Right Care, Right Person National Partnership Agreement ('RCRP'). This followed an evidence session held in September 2023. The RCRP approach was first developed in Humberside, and has now been made the subject of an agreement between DHSC, the Home Office, NHS England, the National Police Chiefs' Council, the Association of Police and Crime Commissioners and the College of Policing on what steps should be taken around individuals experiencing mental health crises.

The Health and Social Care Committee heard from police and health representatives from Humberside and the West Midlands, where the approach is being rolled out, as well as from the charity Mind. The committee expressed its concerns that RCRP cannot work without health partners responding in a timely manner. However, it appeared that police forces were proceeding with withdrawing support regardless of whether health systems were ready to take on a more prominent role. Evidence from the West Midlands was that the mental health trust was looking to implement RCRP within a 12-18-month timeline. It was not apparent what financial support was being provided by NHS England to support trusts and ICBs, whether this would represent additional funding, or whether

ICBs and Trusts would be required to take up new duties out of existing budgets. A recommendation was made that clarity be provided in the Autumn Statement.

The Committee highlighted that while representations had been made about how much police time and resources would be saved, there appeared 'to be a total lack of evaluation in terms of health outcomes or services.' There had been no real evaluation on the effects on health services in Humberside, and the Committee was keen that this not recur in the national rollout. The Committee recommend that health evaluations are set up in all areas that implement RCRP, designed and implemented with national support.

The Committee also noted that while it supported reducing waiting times in A&E, a 'move towards a one-hour handover as "a very difficult ask for the NHS" giving the example of 11-hour waits in the West Midlands.' In Humberside, a real challenge was that there were not sufficient psychiatric inpatient bed to facilitate patients moving on from A&E. This challenge was not unique to Humberside, and the Committee felt it "*is important therefore that NHS England works to provide a solution to the challenges in A&E*." It recommended that:

> *the Government and NHS England explore, through consultation, options to speed up the assessment process and ensure a timely handover of care from police officers to the healthcare service. These options might include steps to ensure that sufficient staff are available 24/7 to complete mental health assessments for patients in A&E, designating A&E as a place of safety, strengthening the Mental Health Act Code of Practice or funding to build dedicated areas in emergency departments to support those with mental health needs who also have a physical injury. The rollout of mental health liaison services in acute hospital emergency departments provides a good opportunity to address the challenges we have heard in terms of staffing. The reform of the Mental Health Act and the New Hospitals Programme also present opportunities to address this* […] *.but there are issues that must be addressed to ensure a consistent, safe and well-monitored rollout.'*

My heart breaks – solitary confinement in hospital has no therapeutic benefit for people with a learning disability and autistic people

Baroness Sheila Hollins has published her final report as Chairperson of the Independent Care (Education) and Treatment Review (IC(E)TR) programme for people with a learning disability and autistic people in inpatient settings. In fact the final report was completed in July 2023, but was not published until 8 November 2023, alongside the Government's responses. The summary of the report, entitled *My heart breaks – solitary confinement in hospital has no therapeutic benefit for people with a learning disability and autistic people*, is as follows:

> *This report focuses on people with a learning disability and/or autistic people who are detained in mental health and specialist learning disability hospitals.*
>
> *The Independent Care (Education) and Treatment Review (IC(E)TR) programme reviewed the care and treatment of 191 people who were detained in long-term segregation between November 2019 and March 2023. The programme was established because of serious concerns about the use of long-term segregation, and in particular about lengthy stays and difficulties in discharging people from long-term segregation. The aim was to identify the blocks to discharge and to*

assess whether independently chaired Care (Education) and Treatment Reviews (C(E)TRs) would be more effective than commissioner chaired C(E)TRs in developing the right support for each person detained in long-term segregation.

Safe and wellbeing reviews set up after the Cawston Park Hospital Inquiry assisted in identifying people in long-term segregation. At the start of the second phase of the programme there were 115 people in long-term segregation and a similar number were in long-term segregation at the end. At the time of writing, of the 114 people who received an IC(E)TR in the second phase, 48 had moved out of long-term segregation, including 7 people who had been discharged from hospital.

The data collected by NHS England does not measure the numbers of people who have had an IC(E)TR, remain in hospital and have been moved to conditions of higher security. Robust information is also not available about whether any of the 191 people who received an IC(E)TR review have since died, due to inconsistencies in reporting by providers. This information is critically important and should be considered by NHS England and the Care Quality Commission (CQC) for future work in this area. I am pleased to hear that CQC are beginning to address this through improvements to their notifications system.

During this period some additional interventions were established in an attempt to improve individual outcomes. A Senior Intervenors pilot which supported 17 people (but ended in March 2023 pending evaluation of its effectiveness), and the HOPE(S) practice leadership and culture change programme (funded until 2024) were both commissioned by NHS England. These interventions, working alongside IC(E)TRs, have helped to achieve the outcomes obtained so far.

The Oversight Panel found a lack of urgency in addressing the many systemic issues that were identified through the IC(E)TR reviews.

International consensus across various sectors and disciplines on the harms caused by enforced isolation are scientifically evidenced and compelling, and the consensus is that enforced isolation has no therapeutic benefit. Members are unanimous in recommending that all instances of enforced social isolation, including seclusion and long-term segregation, should be renamed 'solitary confinement'. The panel recommends that its use with children and young people under the age of 18 should be ended with immediate effect, and that the use of solitary confinement for people with a learning disability and/or autistic people should be severely curtailed and time limited. Minimum standards for the use of solitary confinement should be introduced urgently through amendments to the Mental Health Act 1983: Code of Practice.

The DHSC's responses to the unanimous recommendations can be found here.

WHO / OHCHR guidance on mental health, human rights and legislation

The World Health Organisation and the Office of the High Commission on Human Rights have jointly launched new guidance entitled "Mental health, human rights and legislation: guidance and practice.' The guidance proposes new objectives for law, including setting a clear mandate for mental health systems to adopt a rights-based approach. It outlines legal

provisions required to promote deinstitutionalisation and access to good quality, person-centred community mental health services. It highlights how laws can address stigma and discrimination and provides concrete measures on how to eliminate coercion in mental health services in favour of practices that respect people's rights and dignity.

There is much very useful material in the guidance about practical steps that can be taken to reduce coercion. However, as the guidance notes (at page 12):

> *The adoption of the CRPD has prompted new commitment in reforming legislation on mental health. While it is too early to understand the true impact of the CRPD on national mental health legislative frameworks, as discussed in Chapter 2, several countries have begun to integrate CRPD-inspired measures into their laws, such as reasonable accommodation, advance directives, and supported decision-making. Nevertheless, most countries have fallen short of challenging biomedical approaches and the legitimacy of the denial of legal capacity and compulsory treatment powers, thus failing to embrace rights in the field.*

An alternative framing of this might be that most countries have adopted what the CRPD requires, rather than what it is said to require by the CRPD Committee. And, again, it would be immensely helpful if the WHO / OHCHR could clarify whether they consider that the same approaches apply outside the response to mental ill-health, for instance to dementia, acquired brain injury or intellectual disability.

Book Review

Arianna Kelly, *Social Care Charging* (Law Society, 2023, 368 pages, £75)

In the pithily titled "Social Care Charging" Arianna Kelly has provided a practical guide for practitioners picking their way through the minefield of charging for care under the Care 2014, and navigating questions of capital, disregards, direct payments and top ups.

Over eleven clearly set out and well-signposted chapters, Kelly's book takes the reader through the legislative context and the practical implications of each aspect of the social charging framework. This includes analysis of the inevitable interplay between the Mental Capacity Act and the various charging regimes, and the obligations on local authorities – and other relevant parties – to consider P's capacity to consent to arrangements or the steps that must be taken to provide assistance to those lacking capacity with regard to property and affairs who are in need of statutory funding or otherwise fall to be financially assessed and evaluated.

Kelly ventures beyond the usual statute-case law confines of such textbooks. This book includes extracts of contemporary legal reporting that informs practitioner debates in order to answer the sorts of questions with which lawyers commonly and currently struggle. The book also contains the relevant extracts of a wide range of underpinning statutes and statutory instruments, extending as far – helpfully – as to include specific extracts of the Mental Health Act 1983.

As she tells us, Kelly herself worked on the draft Care and Support Bill and the depth of her knowledge of some issues – and her frank acceptance that some questions and issues (such as the complexity of paragraph 15 of Schedule 1 of the Care and Support (Charging and Assessment of Resources) Regulations 2014) are as yet without an answer and in need of further judicial consideration – is clear and

refreshing. The book professes its aim as providing *"an accessible, practical guide to answering common issues about adult social care charging and financial issues"*. In my view, it succeeds wholeheartedly in this endeavour, not least in its provision of what I consider to be the key to any effective practitioner textbook: a thorough and workable index. Highly recommended.

Nicola Kohn

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Introduction

Following on from our analysis of the Codes of Practice in the October 2023 newsletter, we will discuss the Code of Practice for Financial Advisors and the impact of the ADCMA 2015 on the regulatory frame-work for the financial services industry in Ireland.

It is interesting to note, that a documentary by the national Broadcaster RTE in 2021 on the Wardship regime[1], raised many questions as to how the new Assisted Decision-Making regime would adapt and develop, regarding the assistance and support of the relevant persons with their financial affairs.

DSS Code of Practice for Financial advisors

The DSS Code of Practice gives a plain English approach to the considerations a financial advisor will need to reflect upon when providing these supports to the relevant person.

Some of these considerations include:

- the type of decision to be made;
- the complexity of the decision to be made;
- the person's individual circumstances;
- when the decision has to be made.[2]

The Code also underlines the responsibilities of financial advisors and reminds them that their previsions of the code do not alter their existing obligations to advise.[3]

> *It is important to remember that the provisions of this code do not alter any existing obligations that apply to financial service providers under consumer protection codes. For example, in providing advice or a financial service, or selling a financial product, a financial service provider may already need to consider whether a specific financial product or service is suitable for their customer.*[4]

The Code also underlines that the varying complexity of financial decisions different financial products or services require varying levels of capacity.

> *Different financial products or services require different levels of capacity. For example, a relevant person may require no support in making decisions around their day-today banking but may need support to take out a loan in order to understand the repercussions of failing to make a repayment.*[5]

Some of the considerations, for financial and banking service providers around the ADCMA 2015 act in the coming months and years will

[1] RTE, "Wardship -The Decision Makers."
[2] DSS, "Code of Practice for Financial Service Providers" at pg. 6, available at link here.
[3] Central Bank of Ireland (Central Bank) regulates financial services providers in Ireland. See website here
[4] DSS, "Code of Practice for Financial Service Providers" at pg. 10
[5] *Ibid.*

include the design of additional features and services, some of these may include:

- *Designing ADCMA 2015 compliant features and services applied at client on-boarding (e.g. taking out insurance or creating a new bank or savings account).*
- *Drafting and reviewing ADCMA 2015 compliant suites of support documents for staff who will be interacting with relevant persons, decision-making assistants or co-decision-makers on a regular basis.*
- *Have appropriate systems (online or in person) in place to support ease of use, case management etc. for relevant persons or their support tier, in respect of financial services.*
- *Financial Service providers will need to continue to create awareness around customer-facing staff in relation to identifying and dealing with capacity issues by supporting the decision-making process.*

Future Developments

It is also worthwhile noting that the implementation of the Assisted Decision-Making act 2015 has acted as an impetus for the review of the Consumer Protection Code[6], specifically in respect of 'vulnerable customers.

> *The Central Bank confirmed the importance that the new requirements are considered in the ongoing review of the Consumer Protection Code. Vulnerability is a specific topic in the Code Review as well as consumers' best interests.*[7]

The Irish Banking Culture Board (an initiative funded by the 5 main retail banks within the Irish Market) made submissions to the Central Bank on this topic noting:

> *The Group may also support the Central Bank to enhance consumer protection, as the Consumer Protection Code is updated and other legislation, such as the Assisted Decision-Making Act (2015) comes into force, which will result in additional codes of practice for finance professionals.*[8]

Conclusion

The review of the Consumer Protection code is timely considering the changing financial services landscape, the implementation of the ADCMA 2015 and the challenging circumstances facing many consumers, especially those who may be experiencing difficulties during the current cost of living crisis.

It will be interesting to see how the regulatory framework will be reviewed and amended to provide supports to vulnerable persons and to relevant persons under the ADCMA 2015.

Henry Minogue BL

[6] Central Bank, "The Consumer Protection Code."
[7] Central Bank, "Consumer Advisory Group (CAG) Minutes of Meeting."
[8] Central Bank, "Irish Banking Culture Board Submission to Central Bank of Ireland in response to Consultation Paper 136: Enhancing our Engagement with Stakeholders."

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Simon has wide experience of private client work raising capacity issues, including *Day v Harris & Ors* [2013] 3 WLR 1560, centred on the question whether Sir Malcolm Arnold had given manuscripts of his compositions to his children when in a desperate state or later when he was a patient of the Court of Protection. He has also acted in many cases where deputies or attorneys have misused P's assets. To view full CV click here.

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Adrian is a recognised national and international expert in adult incapacity law. He has been continuously involved in law reform processes. His books include the current standard Scottish texts on the subject. His awards include an MBE for services to the mentally handicapped in Scotland; honorary membership of the Law Society of Scotland; national awards for legal journalism, legal charitable work and legal scholarship; and the lifetime achievement award at the 2014 Scottish Legal Awards.

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Conferences

Members of the Court of Protection team regularly present at seminars and webinars arranged both by Chambers and by others.

Alex is also doing a regular series of 'shedinars,' including capacity fundamentals and 'in conversation with' those who can bring light to bear upon capacity in practice. They can be found on his website.

Adrian will be speaking at the World Congress of Adult Support and Care. This event will be held at the Faculty of Law of the University of Buenos Aires from August 27-30, 2024. For more details, see here.

Advertising conferences and training events

If you would like your conference or training event to be included in this section in a subsequent issue, please contact one of the editors. Save for those conferences or training events that are run by non-profit bodies, we would invite a donation of £200 to be made to the dementia charity My Life Films in return for postings for English and Welsh events. For Scottish events, we are inviting donations to Alzheimer Scotland Action on Dementia.

Our next edition will be out in February. Please email us with any judgments or other news items which you think should be included. If you do not wish to receive this Report in the future please contact: marketing@39essex.com.

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