MENTAL CAPACITY REPORT:
MENTAL HEALTH MATTERS
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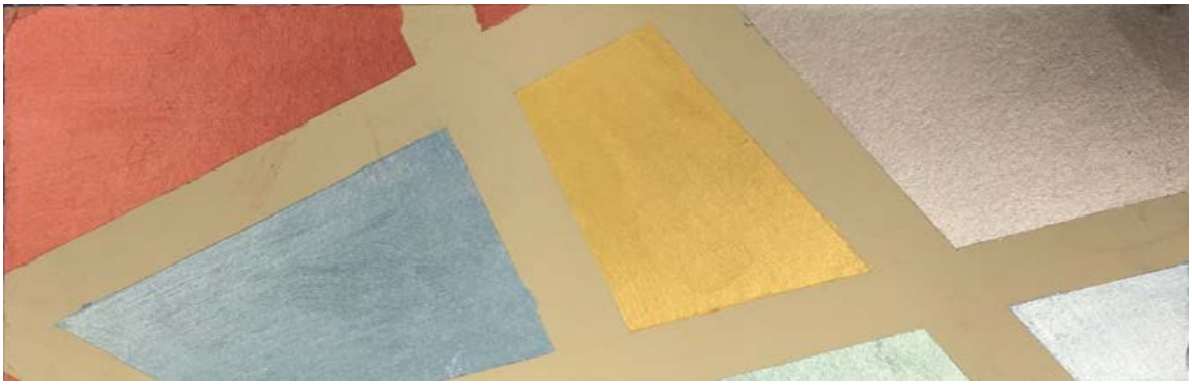

Welcome to the April 2024 Mental Capacity Report. Highlights this month include:

(1) In the Health, Welfare and Deprivation of Liberty Report: a very difficult dilemma arising out of covert medication, and key deprivation of liberty developments;

(2) In the Property and Affairs Report: fixed costs for deputies, deputies and conflicts of interest, and the Child Trust Fund saga continues;

(3) In the Practice and Procedure Report: three amended Practice Directions, when (and why) should the judge visit P and fact-finding in the Court of Protection;

(4) In the Mental Health Matters Report: the Government (rather surprisingly) responds to the Joint Committee on the draft Mental Health Bill, and important reports from the PHSO and CQC;

(5) In the Wider Context Report: a snapshot into litigation capacity and Jersey sheds light on the concrete realities of assisted dying / suicide;

(6) In the Scotland Report: the Assisted Dying for Terminally Ill Adults (Scotland) Bill.

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.

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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

Government response to the Joint Committee on the draft Mental Health Bill published

To the surprise of some, given the silence for over a year, the Government published on 21 March 2024 its response to the report of the Joint Committee on the draft Mental Health Bill, published in January 2023. Whilst no Bill appeared in the most recent King's Speech, so no legislation will be forthcoming this Parliament, the Government does say in its response that "[w]*e will seek to introduce a revised bill when Parliamentary time allows*." The responses to the key recommendations are as follows.

Detention criteria: wording

The government agrees that it will be important to clarify the new detention criteria in the code of practice. It will set out in guidance its view on how the terms 'serious harm' and 'likelihood' should be interpreted in practice by decision makers.

The committee recommended that consideration of 'how soon' harm might occur should not be included in the draft bill itself. Their view was that it would be difficult for professionals to assess objectively. They were concerned that it might dissuade potentially beneficial and shorter interventions at an earlier stage that would be in keeping with the principles. The government has agreed to review the wording on 'how soon' harm may occur.

Detention criteria: Part 3 patients

The committee recommended that the changes in detention criteria should be consistent for individuals under either Part 2 or part 3 of the MHA.

The government has not agreed to this change. Their view is that leaving the detention criteria for Part 3 patients as currently drafted will ensure that, for example, vulnerable neurodivergent offenders in the criminal justice system, who would otherwise go to prison, can continue to be diverted to hospital (where appropriate), where they are more likely to receive more therapeutic and specialist support.

Statutory test for competency for children under 16

The committee recommended that the government should consult on the introduction of a statutory test for competency, or 'child capacity', for children under 16.

The government has not accepted this recommendation. They are concerned that setting out a statutory test for competence in the MHA could potentially put under 16s in a more complicated position, particularly those assessed as having competence to consent to

decisions under the MHA definition but who would be considered not to have competence using the existing test of *Gillick* of competence, or vice versa. Their view is that the best place to set out how practitioners should assess children and young people's competence and capacity under the Act is in the code of practice.

Advance Choice Documents (ACDs)

The committee recommended that there should be a statutory right for patients who have been detained under the MHA to request an advance choice document be drawn up. Their view was that this should be offered to everyone who has previously been detained, as recommended by the independent review.

The government has not accepted this recommendation. It supports placing a duty on services to carry out activity in relation to ACDs (the precise meaning of this phrase is somewhat obscure) as opposed to introducing new rights for individuals to request an ACD. They think that this approach is likely to be more effective as, rather than the onus being on individuals to 'request' to create an ACD, it will be on services to take action. They agree that a mechanism to store ACD information digitally is the best means of ensuring that they can be shared easily and readily accessed by the relevant professionals at the point of need.

Mental Health Tribunal: role in challenging treatment decisions

The committee agreed with the Independent Review that a mental health tribunal (in a slimmed down a form) should be able to consider whether a patient is entitled to challenge their treatment plans, if requested, following a Second Opinion Appointed Doctor (SOAD) review of their care and treatment plan or a major change in treatment. They recommended that the government amend the draft bill to allow for pilots in the first instance.

The government has not accepted this recommendation. They do not think the tribunal should be able to make determinations about whether an individual clinical judgement about treatment, made in good faith, is right or wrong in a particular case.

Interface of the MHA and the MCA

The committee recommended that the government review the interaction between the two pieces of legislation. In particular, it said the government should review the use of the MCA to authorise admission to, and treatment in, mental health units.

The government said it will continue to consider the interface between the MHA and the MCA as it implements mental health reforms. It will also continue to engage with stakeholders to understand what support and guidance could help improve application of the interface. It will not be considering concerns the committee expressed in relation to LPS as the government has decided to delay LPS beyond the lifetime of this Parliament.

Principles

The committee recommended that section 118 be replaced with a new section, requiring the Secretary of State to draw up the code of practice having regard to and including the principles set out in the independent review: choice and autonomy, least restriction, therapeutic benefit and the person as an individual.

The government has said that the new principles will be clearly set out up front in the next revision of the code of practice. Their view is that this will make it clear to practitioners that the

recommended principles should inform all decisions made under the Act.

Appointing a Nominated Person: role of Approved Mental Health Professionals (AMHPs)

The government accepted the recommendation to work with AMHPs to improve the practicalities around appointing a nominated person in the legislation. They intend to amend the Bill in order to improve the final provisions.

Short-term emergency detention power

The committee recommended that the government should consult further on a short-term emergency detention power, and whether this would provide greater legal clarity to clinicians and accountability for what is happening in A&E services.

The government accepts that there may be a need to provide greater legal clarity to clinicians in A&E. It will continue to engage with stakeholders to understand how the current legal framework is being applied and what, if any, legislative changes may be required.

Use of the MCA to deprive people with learning disabilities or autistic people of their liberty in inpatient mental health units

The committee recommended that the government should urgently review the operation of the MCA, with a view to amending the deprivation of liberty safeguards so they cannot be used as an alternative route to the MHA to deprive people with learning disabilities or autistic people of their liberty in inpatient mental health units for lengthy periods of time.

The government said it does not believe that it is always inappropriate for the MCA to be used to authorise a deprivation of liberty for the treatment of mental health conditions. In certain circumstances, where a person lacks the relevant capacity but is not objecting to admission to hospital or treatment, they think it may be the most appropriate option.

The government notes the concern of the committee that Deprivation of Liberty Safeguards will continue to be available to apply to some people with a learning disability and autistic people when the Bill is implemented. They are aiming to reduce the scope of the MHA to detain people with a learning disability and autistic people without a co-existing psychiatric illness.

The government will review the impact of changes to the detention criteria with regard to people with a learning disability and autistic people, with the aim to ensure detention in hospital is only used where there is a direct therapeutic benefit to the person, and not simply a displacement from the MHA to the DoLS.

Discharge from mental health care: making it safe and patient-centred

The Parliamentary and Health Service Ombudsman (PHSO) has published a new report, 'Discharge from mental health care: making it safe and patient-centred.' The PHSO analysed more than 100 complaints investigated from 2020 to 2023 involving failings in mental health care, finding that "[c]*omplaints related to discharge and transitions in care emerged as common themes across these cases*." The report identifies common failings in care:

> ***Failings in patient, family and carer involvement in discharge planning****: 'The most common failing we see in our casework involving discharge planning in mental health services (and in our health casework more broadly) is the involvement of patients, their families and carers in decision-making. Patients' own views are sometimes not fully considered when services are making*

decisions about the risk of discharge from inpatient care… We cannot underestimate the importance of communicating effectively with families and carers about the day discharge happens. If families are not expecting discharge, or are unable to prepare for it, then patients are not given the best chance of being able to stay at home with the right support. The cases we have investigated show where the duty to take a person-centred view of discharge has not been met. The planning for where an individual is being discharged to and their support system beyond the hospital, including signposting to voluntary and community sector organisations, has not been good enough. To break the readmission cycle, a joined-up view of the social factors involved in this transition is just as important as looking at the physical or mental health aspects.'

***Poor record-keeping**: 'One of the central parts of the previous NHS Care Programme Approach (the standard for coordinating care around the needs of mental health service users), which was in place until September 2019, was having a written care plan that is jointly agreed with members of the multidisciplinary team, GP, individual patient, carers and any other relevant agencies…Care plans that are missing or not managed well can have significant negative consequences for care, at that time and in the future. Poor management of care plans also affects family, carer and patient involvement in planning for discharge. When complaints about care are made, poor records can worsen the distress for complainants and their families. They can be left not knowing how decisions were made and whether a different outcome could have been possible. Without adequate records, we can also be prevented from getting answers to our questions and making sure accountability and learning can take place.'*

***Poor communication between clinical professionals and teams in planning transfers of care**: 'Discharge from mental health services or transfers of care usually involves multiple teams and professionals. This means decision-making can be incredibly complex and challenging. Effective communication between professionals who understand the aims and potential risks of discharge is vital to make assessments and planning as comprehensive as possible. Poor joint-working across clinical professionals, and between physical and mental health expert teams, results in quick readmission. This shortfall is especially severe in the case of eating disorders where cross-team, and sometimes cross-trust, management is vital.'*

The report also makes recommendations 'about how good discharge should be carried out and the wider values that guide discharge care':

1. We note the Department of Health and Social Care's (DHSC) national statutory guidance on discharge from mental health settings. As it is implemented, DHSC and NHS England must engage with people and services to assess the impact the guidance has on them. In particular, they must make sure that Integrated Care Systems account for the different professionals that should be involved in the discharge multi-disciplinary team (MDT). To make sure transitions of care consider a patient's full condition and situation, an MDT must be involved in discharge planning and delivery. This team should include representatives of the different points in a patient care pathway. This will create a 'safety net' of care around a person when they leave an inpatient setting. The MDT members should be

seen and referred to as equal partners in someone's care.

2. NHS England should extend the requirement for a follow-up check within 72 hours of discharge for people from inpatient mental health settings to include people discharged from emergency departments.

3. NHS England and integrated care boards (ICBs) should make sure that people who are being discharged from mental health settings can choose a nominated person to be involved in discussions and decision-making around transitions of care.

4. NHS England should make sure that patients and their support network are active and valued partners in planning transitions of care and are empowered to give feedback, including through complaints.

5. The Government must show its commitment to transforming and improving mental health care by introducing the Mental Health Bill to Parliament as a priority.

The Report also expressed disappointment that reforms to the Mental Health Act have been indefinitely delayed, and called on the Government to take action:

One of the major failings identified in our casework around discharge is the lack of involvement of families and carers around important decisions. Enshrining this in law would go some way to building the foundations for discharge care and planning that puts people, their carers, loved ones and safety at its heart. We are disappointed by the lack of government progress to bring the desperately needed proposed reforms into law. The long overdue Mental Health Bill is an opportunity to overhaul the way the system works when people are in a mental health crisis and make it fit for the twenty-first century. Mental health campaigners have worked tirelessly for the reform of this law. Their voices must not go unheard, and we will continue to support calls for reform.

The report is worth a closer read, not just for the other resources it points to - the Department of Health and Social Care's 'Suicide prevention in England: 5-year cross-sector strategy' in published September 2023, and Rethink Mental Illness' Getting Started: lessons from the first year of implementing the Community Mental Health Framework' - but also for its cut-out-and-keep table of which bodies are responsible for which mental health complaints – a tangled web which in and of itself seems to suggest reform is well overdue. (see paper p.12).

CQC Monitoring the Mental Health Act in 2022/20223

CQC published on 21 March the 2024 its latest report on the monitoring of the MHA 1983 in England. Key findings included that:

Workforce retention and staffing shortages remain one of the greatest challenges for the mental health sector, affecting the quality of care and the safety of both patients and staff.

Longstanding inequalities in mental health care persist. More work is needed to address the over-representation of Black people detained under the MHA and to prevent prolonged detention in hospital for people who need specialist support.

Despite additional investment, rising demand and a lack of community support means that children and young people face long waits for mental health support, and a lack of specialist beds

means they continue to be cared for in inappropriate environments.

It is promising that people, including staff, are aware of the drivers that can lead to a closed culture developing. But we are still concerned that too many abusive and closed cultures persist in mental health services.

Research corner: an RCT into open doors on psychiatric wards

A interesting article appeared recently in the Lancet Psychiatry describing the results of a randomised control trial that must have been a challenge to get ethical clearance for: *Indregard, A. M. R., Nussle, H. M., Hagen, M., Vandvik, P. O., Tesli, M., Gather, J., & Kunøe, N. (2024). Open-door policy versus treatment-as-usual in urban psychiatric inpatient wards: a pragmatic, randomised controlled, non-inferiority trial in Norway*.

A Norwegian team conduct a controlled trial to compare the use of coercive practices in open-door psychiatric wards and 'treatment-as-usual' (locked) wards in an urban hospital setting. 556 patients were randomly allocated between the different types of settings, and the primary outcome measured was 'the proportion of patient stays with one or more coercive measures, including involuntary medication, isolation or seclusion, and physical and mechanical restraints.' The trial found that 'the proportion of patient stays with exposure to coercion was 65 (26·5%) in open-door policy wards and 104 (33·4%) in treatment-as-usual wards…with a similar trend for specific measures of coercion. Reported incidents of violence against staff were 0.15 per patient stay in open-door policy wards and 0.18 in treatment-as-usual wards. There were no suicides during the randomised controlled trial period.' The authors consider that '[t]he open-door policy could be safely implemented without increased use of coercive measures. Our findings underscore the need for more reliable and relevant randomised trials to investigate how a complex intervention, such as open-door policy, can be efficiently implemented across health-care systems and contexts.'

Government response to the rapid review into data on mental health inpatient settings

On 23 January 2023, the government launched an independent 'rapid review' into mental health patient safety, chaired by Dr Geraldine Strathdee. The purpose of the rapid review was to produce recommendations to improve the way data and information are used in relation to patient safety in mental health inpatient care settings and pathways, including for people with a learning disability and autistic people. The report was published on 28 June 2023. The Government's response was published on 21 March 2024, including a set of steps to gather better quality data, overseen by a ministerial-led bespoke steering group to oversee a work programme.

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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 following open events: the World Congress on Adult Support and Care in Buenos Aires (August 27-30, 2024, details here) and the European Law Institute Annual Conference in Dublin (10 October, details here).

Peter Edwards Law has announced its spring training schedule, here, including an introduction – MCA and Deprivation of Liberty, and introduction to using Court of Protection including s. 21A Appeals, and a Court of Protection / MCA Masterclass - Legal Update.

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 May. 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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