

## **Severe Brain Injury – The Non –Compliant Client**

28<sup>th</sup> May 2007

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12KBW Seminar: Severe Brain Injury - Improving the case management  
of the non compliant client in severe brain injury cases.  
Thursday 24<sup>th</sup> May 2007

## **The non- compliant client Gerard Martin QC**

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**12**  
King's Bench Walk

## The Non Compliant Client

A BETTER WAY TO LITIGATE

Gerard Martin QC  
24<sup>th</sup> May 2007

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## Caroline's case

- ❑ Female of 21 years, severely brain damaged, sexually disinhibited, living in her own house with four carers per 24 hours, long history of non-compliance over 10 + years, during which time by non compliance she got what she wanted, now sleeping with a man twice her age, father feared she would end up being murdered.

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## Caroline's case settled at the court door – success - no

- The compensation arrived too late
- The rehab opportunity had long gone
- Claimant had learned that non compliance worked for her
- Case management could not contain her non compliance
- Wrong experts used in case

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## Can we improve the way we litigate?

- My answer is “yes”.
- MCA 2005 (in force 1 10 07 ) and Code of Practice help achieve it.
- This presentation sets out what can be done to improve the prospects for a better outcome for those clients with a non compliant issue.
- The first thing to do may be to give the family the Headway literature on what to expect following a severe brain injury.

## Preparation for First Case Con

- ❑ Is client a patient? See MCA s1-4 and code.No longer need medically qualified certicator, neuropsychologist can provide.
- ❑ Ask yourself should C be present at meeting even if patient with non compliance? Section 4 of Act has to be applied to decision.
- ❑ Which experts to be present? Clinical neuropsychologist and deputies ?

## Patient? The MCA test

- ❑ Issue specific.
- ❑ Two-stage test,first the diagnostic test-unable to make a decision because of an impairment of or disturbance in the functioning of the mind or brain.
- ❑ Second stage – the functional test- unable to understand, retain or use the information,relevant to decision,or not able to communicate his decision.

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## If a patient, should he be at meeting?

- Apply “best interests principle” see s4(4) and code para 5.21-24
- Timing of meeting
- Place of meeting
- Frequent breaks
- Persons whose presence might assist-spouse/family member
- After meeting, written note of meeting provided

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## From case perspective – which experts attend first meeting?

- Counsel and solicitor
- Neuro-rehab. consultant
- Case manager
- Treating neuropsychologist?
- The person or persons proposed to act as property and affairs/ personal welfare deputies

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## Counsel and solicitor- teamwork

- ❑ They must have identified the non compliance issue.
- ❑ They must have received advice from their experts in advance on best management.
- ❑ They must formulate how non compliance is to be managed and explain it to all appropriate parties.
- ❑ They must focus on how to expedite getting funds for rehab.

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## Neuro-rehab consultant- role at meeting.

- ❑ To begin to formulate the rehab plan/plan for life.
- ❑ To inform, at the appropriate time and place the client/spouse/family what can be expected in terms of medical recovery for the client.
- ❑ To advise re non compliance, best management- whether a role for medication.

## Case manager- role at meeting

- ❑ To inform the family re the various support packages available.
- ❑ To advise from experience which package is likely to achieve the best therapeutic outcome.
- ❑ To be informed how best to communicate/manage the client, by the other treating experts.
- ❑ To contribute to the case plan and plan for life assuming non compliance an issue.

## The Court of Protection and Deputies

- ❑ The court may appoint deputies to make decisions about personal welfare and finances but in deciding whether in best interests of patient to make the order to appoint the court must have regard to
- ❑ A decision by the court is to be preferred to appointment of a deputy and
- ❑ The deputy's powers should be as limited in scope and duration as is reasonably practicable

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## The Person to Be Appointed Financial Deputy- Role at Meeting

1. To inform the client and family of the services he can provide.
2. To inform them of the decisions that may need to be made.
3. To consider the potential the client may have to be regarded as not a patient for some issues.

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## How a financial deputy can help minimise non compliance?

- The financial deputy may advocate a money management system that gives incentives for compliance.
- Provides a simple system which may empower the client- debit card etc.
- Deflects problems from the family to the deputy.

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## The personal welfare deputy's role?

- He or she may refer to the C of P or make decisions themselves, see s17, including
- Where Claimant is to live.
- What contact Claimant has with a specified person, but a court only can order as follows
- Prohibiting a named person having contact.
- Substitution of a person responsible for P's healthcare, s 20 (2).

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## Treating neuropsychologist- role at meeting

- To inform the case management, short and long-term plan.
- To advise the lawyers how best to communicate with the client and get the most beneficial responses from him.
- To agree and provide a programme of training for support team and/or client on an ongoing basis during lifetime of case.
- To advise on the patient issue as it arises.

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## The legal case strategy in managing non compliance

- ❑ Non compliance should be easy to spot for the legal team at the outset, but is as much their issue to manage as it is for the care team.
- ❑ The lawyers must give the same message to the client as that given by the care team and must consistently apply it and reinforce it.

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## Legal case strategy continued

- ❑ Focus on simplest way to achieve liability award.
- ❑ Obtain interim payment but then involve deputy in how it is to be managed with the client.
- ❑ Insist on good record keeping from case manager with monthly reports to solicitor
- ❑ At least, yearly case con with counsel to audit whether case plan and care plan are achieving their goals. Client to attend, unless not in his best interest.

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## Legal case strategy continued

- ❑ If a problem arises, as it is bound to do, the legal team can't ignore it as someone else's job.
- ❑ We have to address/solve/manage the problem, if we don't the problem will get worse. Teamwork helps.

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## How does MCA improve case management

- ❑ Best interest principle empowers client
- ❑ Code emphasises communication has to be client centred
- ❑ Early case con helps each discipline inform the case plan.
- ❑ The new role of deputies can help to solve many of the problems in this type of case.

- ❑ There are good reasons to be optimistic for the future of this type of case!





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**Brain injury problems and non compliance  
Dr Camilla Herbert, Consultant Clinical  
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## **Brian injury and non compliance – the clinician's view**

Dr Camilla Herbert  
Consultant in Neuropsychology and Rehabilitation,  
Kerwin Court, Horsham  
Brain Injury Rehabilitation Trust

24<sup>th</sup> May 2007

## **Autonomy, Capacity and Risk Assessment**

- ◆ Individuals are presumed to have capacity until proven otherwise
- ◆ Individuals with capacity can (and do) make unwise decisions, and the making of an unwise decision does not mean that the individual lacks capacity.
- ◆ Risk taking is part of rehabilitation as well as part of everyday life

## What do we mean by noncompliance?

- ◆ Not doing what the professionals/carers want the person to do?
- ◆ Not doing what the family want the person to do?
- ◆ Not doing what is in their best interests?

## Non cooperation with treatment or care regimes

- ◆ 'active'
  - Aggression
  - Overt refusal
- ◆ 'passive'
  - Failure to attend sessions/appointments
  - Not participating fully
  - Not following through with actions/decisions

## Core areas of difficulty

- ◆ Physical
- ◆ Cognitive
- ◆ Behavioural
- ◆ Emotional

## Possible reasons for noncompliance

- ◆ Memory and organisational skills
- ◆ Reduced initiation
- ◆ Reduced insight/awareness
- ◆ Low mood/high anxiety
- ◆ Raised levels of fatigue
- ◆ Reduced levels of arousal
- ◆ Acting impulsively

## Memory

- ◆ If you don't remember appointments well, then you will miss them
- ◆ You may turn up without relevant documents
- ◆ You won't remember what was said or what you agreed to
- ◆ You won't remember who you have rung or what was said, so will ring again and again
- ◆ You probably won't have a system for keeping track of these things without help

## Poor organisation

- ◆ You may have all the relevant letters/reports but not be able to find them
- ◆ You may know you have a meeting but not where or when
- ◆ You may know where but not how to get there
- ◆ You may think it is next week or have booked a hair appointment for the same day

## Poor initiation

- ◆ Knowing what to do but not being able to do it – “my get up and go has got up and gone”
- ◆ Being able to respond when prompted but not initiating unless prompted

## Lack of insight or awareness

- ◆ Specific conditions where individual is not aware of a problem – anosognosia
- ◆ Awareness of some areas of difficulty but not others
- ◆ NB awareness changes over time, as part of recovery and therapeutic interventions

## Emotional responses

- ◆ Emotionally driven denial – can be protective at some stages and should only be challenged in context of a therapeutic process
- ◆ Low mood – appropriate response to stressful situation at times; other times it becomes a clinical problem in its own right
- ◆ High Anxiety – again, can be appropriate, but can also affect progress in rehabilitation – fear of failure
- ◆ Learned helplessness – a learnt response on the basis of previous experience.

## Fatigue

- ◆ As part of the brain injury per se
- ◆ Mental and physical fatigue
- ◆ Sleep disturbance or altered sleep pattern
- ◆ Secondary to medication
- ◆ Secondary to pain

## Arousal levels

- ◆ brain based changes in level of arousal
- ◆ More common in early stages but may persist
- ◆ May be amenable to medication in some cases

## Acting on impulse

- ◆ Clients who can tell you what they ought to do, promise that they will, and then do something else entirely...
- ◆ Not being able to control their behaviour – aggression, socially unacceptable comments and gestures, sexual disinhibition
- ◆ Financial impulsivity

## Non compliance and capacity

1. Maximise compliance through understanding the clinical picture
2. If non compliant but capable of making own decisions....
3. If non compliant but not capable of making decisions...

## ABI and “impairment of or disturbance in the mind or brain”

- ◆ Clients in post traumatic amnesia
- ◆ Clients who lack insight
- ◆ Clients with significant cognitive difficulties
- ◆ Clients with severe challenging behaviour
- ◆ Clients with impulsive and disinhibited behaviours

## How do you assess capacity?

**Must use the 2 stage test**

**Factors to be considered include:**

- General Intellectual ability
- Memory
- Attention and concentration
- Reasoning
- Verbal comprehension and expression
- Cultural influences
- Social context

There is no universal test for capacity; It is decision and time specific; The more complex the decision the greater level of capacity required.

## Assessing Capacity

- ◆ Does the person have general understanding of what the decision is and why they are being asked to make it?
- ◆ Do they understand the consequences of making, or not making, the decision?
- ◆ Are they able to understand the information relevant to the decision?
- ◆ Can they assess the relative importance of the information?
- ◆ Can they use the information as part of the decision making process?
- ◆ Can they communicate their decision

## Some general points to consider?

- ◆ How well do standardised tests relate to everyday function?
- ◆ What is the role of insight/awareness in acquired brain injury
- ◆ The 'hidden' nature of many cognitive deficits
- ◆ How does one measure or describe behaviour such as impulsivity, and report on changes pre/post injury that differentiate it from personality and individual differences?

## Vignette 1 – Joan Non compliance with placement

- ◆ 58 year old lady with severe memory problems
- ◆ Not managing in the community after death of husband
- ◆ Refusing additional help or residential placement

## Assessment

- ◆ Neuropsychology assessment
- ◆ Review of notes
- ◆ Interview with relative
  
- ◆ Case conference(s)

## Clinical challenges

- ◆ At risk both directly (smoking, self neglect etc) and indirectly (actions of neighbours, road safety etc)
- ◆ High levels of anxiety and social isolation likely to be contributing to the presenting problems re neighbours
- ◆ She consistently refuses to consider any suggestions that involve leaving her home and becomes distressed at the mention of any alternatives to the current situation
- ◆ However, her distress is short-lived as she does not recall the suggestions during the course of the conversation.

## Capacity to consent to residential placement

- ◆ **Communication** - ? Valid representation of a considered view – possibly not but was communicating a high level of distress
- ◆ **Understanding in broad terms** – no, but can this be enhanced
- ◆ **Awareness of her own situation** – no, but can this be enhanced
- ◆ **Free from pressure** - yes
- ◆ So.. Unable to consent to or refuse placement but still need to consider her expressed preference and her distress as well as the duty of care/ protection

## Vignette 2 – Brian Noncompliance with rehabilitation

- ◆ 27 year old motorcyclist 9 weeks post injury
- ◆ Out of PTA but lacks insight into deficits
- ◆ Determined to self discharge from rehab unit
- ◆ Lives alone; friends and family all work

## Assessment on rehab unit

- ◆ Range of neuropsychology tests and feed back of results
- ◆ OT assessment in kitchen
- ◆ Road safety assessment
- ◆ Staff observations and discussions with Brian

## Capacity to Self Discharge

- ◆ Communication – yes
- ◆ Awareness of risks and benefits – no
- ◆ Appreciation that the risks/benefits apply to his case – no
- ◆ So.. if he is not capable of making that decision. What happens next?

## Non compliant but then...

- ◆ If , after all persuasion, Brian refuses to engage in any aspect of the programme, staying on the unit is unlikely to be helpful anyway – rehabilitation works best when the client is actively engaged
- ◆ The risks at home, whilst real, could be managed by an extensive (and costly) package of support, and his rehabilitation needs could be reviewed at a subsequent date
- ◆ Balance of autonomy and prevention of harm is sometimes a pragmatic not an ethical or legal issue



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Practical Aspects of  
Case Management with  
the  
Non- Compliant Client

Jo Clark-Wilson



‘Predicting the Unpredictable!’

## Brain Injured Clients

- Clients before the brain injury
- Consequences of the brain injury
- Clients' responses to the brain injury

## Possible Impairments

- Fatigue and sleep problems, pain, sensory and motor deficits
- Reduced independence and increased reliance on others
- Slowness of thinking, impulsivity and inability to forward think.
- Reduced attention and memory skills
- Poor planning and organization and problem solving and reasoning skills
- Irritability, frustration, verbal and physical aggression
- Fluctuations and lability of mood
- Lack of insight or denial of deficits
- Social Skills deficits

## Underlying Presenting Issues

- These types of problems after brain injury are often 'invisible' to others.
- They affect all aspects of the clients' life

## What is Case Management?

Case Management is:

“a collaborative process which assesses, plans, implements, co-ordinates, monitors and evaluates the options and services required to meet an individual's health and social needs, using communications and available resources to promote quality, cost-effective outcomes”.

## Case Managers Creed

To be a case manager, one must be courteous, diplomatic, caring, shrewd, persuasive, assertive, creative, supportive, understanding, responsible, slow to anger, adaptable, a Sherlock Holmes, a motivator, up-to-date, good looking, have a good memory, acute business judgement, emotional stability, and the embodiment of virtue, but with a good working knowledge of sin and evil in all its forms. ✂ A case manager must understand insurance, electricity, chemistry, physiology, mechanics, architecture, physics, bookkeeping, banking, merchandising, selling, shipping, contracting, claims adjusting, law, medicine, real estate, horse trading, and human nature. ✂ A case manager must be a co-ordinator, clinician, coach, therapist, educator, and administrator. ✂ A case manager must be a mind reader, a hypnotist, and an athlete, must be acquainted with machinery of all types and materials of all kinds, and must know the current price of everything from a shoestring to a skyscraper, an aspirin to an amputation. ✂ They must know all, see all, and tell nothing, and be everywhere at the same time. They must satisfy the payroll administrator, the accounts department, the Inland Revenue, the insurance company, the supervisors, the solicitor, the insured, the claimant, the Law Society, and the British Medical Association. ✂ Apart from that it's a piece of cake...

THE CASE MANAGER'S CREED

## Case Manager Referrals

- CV to establish whether the case manager has the qualifications, registration, knowledge, understanding and experience to do the job
- Confirm the Case Manager has the relevant backup support

## **Assessments: Reports, Interview and Observation**

- Gather all relevant background information about the client and their family and relevant others
- Establish their previous and current functioning and lifestyle.
- Determine who is involved in supporting or working with the client
- Find out about the clients' accommodation and local environment
- Determine potential risks

## **Goal Planning: ROMP**

- Establish realistic, achievable and structured goal plans with clients and their family and/or relevant others
- Agree the Rehabilitation and / or Maintenance Goals and Case Management plan with the clients, their family and relevant others.
- Determine how rehabilitation programme could be established, coordinated and monitored and who would need to be involved.
- Preparation of report, as required, detailing the goals, means of achieving these and costs.

## Team Approach

- Establish team, including client, family, Receiver, Psychologist and relevant others
- Determine the principles of working together and decision making within the team
- Establish and agree the communication and feedback systems with all concerned

## Case Management Process

- Liaise with relevant others to design and put the rehabilitation / maintenance programme into practice, with systems for monitoring progress and time scales for review etc.
- Deal with the practical issues, for instance, accommodation, transport, which impact on client's independence etc.
- Organise the recruitment, training and monitoring of support workers, if required
- Do whatever is required!

# Case Management

Guidelines for Case Management /Professional Code of Practice

Human Rights Act

Care Standards Act

Mental Health Act

Employment Law

Working Time Directives

Health and Safety Law

And, of course, Commission of Social Care Inspection

# Records

- Rehabilitation and Maintenance Plan
- Risk Assessment and Management System
- Support Workers Guide
- Support worker notes
- Recording charts  
e.g. ABC charts, frequency of behaviours,  
functional charts etc.
- Outcome measures
- Analysis of case management input

## Principles of Working with the Non-Compliant Client

- Rapport with Client and Family
  - Active listening with understanding
  - Non-judgemental, clear and positive approaches
  - Supportive approach, with positive guidance and incentives to facilitate the clients' participation in the programme, without direct confrontation
  - Structured, but flexible, approach to increase the links between planning, structure, use of cognitive-behavioural strategies, working within social boundaries and the law.
  - Work closely, as a member of the team

That Seems Easy Enough!

But.....

## Client Frustrations

- Clients' 'invisible' deficits are often not recognized.
- Clients often become 'overwhelmed' and unable to cope.
- Clients want to be 'normal'.
- Clients often do not want to be with others, who are not 'normal'.
- Clients want to retain independence and control, even when they do not have the capacity to do this.
- Clients want to do what they want to do and stopping them can be difficult, if not impossible at times.

## Family Issues

- Clients and families initially have limited understanding of the underlying problems arising from the injury
- Families initially want to protect, as their loved-ones have often nearly died, and will get better
- Families sometimes find it easier not to confront issues and keep the peace to prevent outbursts
- Families sometimes want support but resent the intrusion of people visiting their home or believe that they will be able to manage better on their own
- Families can become overwhelmed and have their own difficulties, including anxiety and depression, and there are changes in relationships, and for spouses, marital breakdowns

## Society

- Clients are often deemed to be lazy, rude, awkward, stubborn and aggressive
- Clients considered to be 'odd' - and become isolated as they do not fit into societal norms
- Clients seek friends and will often participate in antisocial activities, to be a 'member of a group'.
- Clients often easily influenced and taken advantage of, especially if they are thought to have money, or considered a good match (relationships, children, access visits etc).....

## Rehabilitation Process

- Clients learning to cope with impairments and deficits, and improving, adapting and adjusting to their altered situation.
- Therapeutic relationships and interventions affect the way that clients can view and deal with their challenges.
- External influences can positively and negatively affect the rehabilitation process.
- Dynamic interplay of all the above during the rehabilitation process can be particularly difficult, leading to improvements, but also on occasions, to behavioural responses of withdrawal, avoidance, denial, confrontation and emotional crises.

## Situations that can occur with the Complex Non-Compliant Client

- Behaviour consequent of excessive drinking or taking of illicit drugs
- Purchasing illegal weapons via the internet to protect self
- Suicide attempts
- Threatening and physically aggressive behaviour towards partners, relatives and support workers
- Impulsive behaviours
- Antisocial activity
- Sacking of support workers
- Sex with support workers
- Impulsive spending, financial exploitation and aggression towards others to obtain money or goods
- Being vulnerable to the influences of others, for instance, stealing cars, delivering drugs to the dealers
- Impulsively stealing cars and driving when not legally allowed to drive

## Principles of Case Management

- Establish and maintain the working relationship
- Know and accept clients' condition and limitations
- Help the clients and families understand and cope with disabilities and adjust to changes in their lifestyle
- Enable the clients to gradually progress and develop more independence and structure in their lives, use of strategies, stability of mood and to create a positive future lifestyle.

## Principles of Case Management

- Ensure their safety and protection, as far as possible.
- Balance needs with risks
- Enable the client and their families to learn alternative ways to perceive situations and emotionally deal with them
- Monitor the situation and know when to intervene or to actively do nothing
- Work around problems, rather than directly confront them

## Principles of Case Management

- Set boundaries and establish rules, so that systems can be developed to maintain client
- Change the rules, systems or external environment, to enable the client to achieve greater control of their actions. Find out what works for each individual
- Establish what can be achieved in rehabilitation without undermining working relationships.
- Facilitate a consistency of trained care within a care regime, should this be required

## Principles of Case Management

- Maintain close communication and liaise with all others involved in rehabilitation and care to ensure consistency of approach and prevent manipulation of team members
- Record what is being done in detail
- Monitor and review situation and pre-empt patterns of behaviour to prevent problems from arising
- Discuss issues and seek back-up support from others, as required
- Provide crisis intervention, when required

## But what about the Case Manager?

Needs to have support from the team to create new ideas of how to get around problems, to discuss difficult situations and to debrief after traumatic experiences.

# Mental Capacity

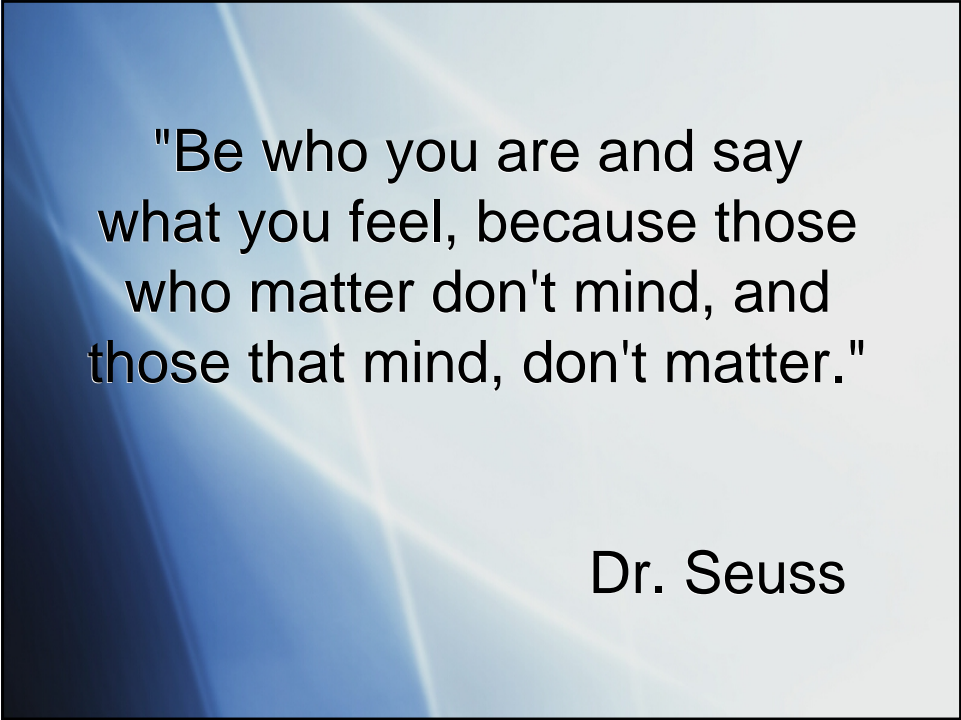
- What capacity does the client have to make decisions about their psychological and physical safety and their financial management?
- What needs to happen if the client does not have the capacity to give valid consent and who else can make decisions on their behalf?
- What are the roles and responsibilities, authorities and accountabilities of those involved with the client?
- What actions do each agency and professional have to do to ensure protection, if the client is deemed to be a vulnerable adult?



What Happens If Problems Arise

Who Takes Responsibility?

Who Makes The Decisions?



"Be who you are and say  
what you feel, because those  
who matter don't mind, and  
those that mind, don't matter."

Dr. Seuss