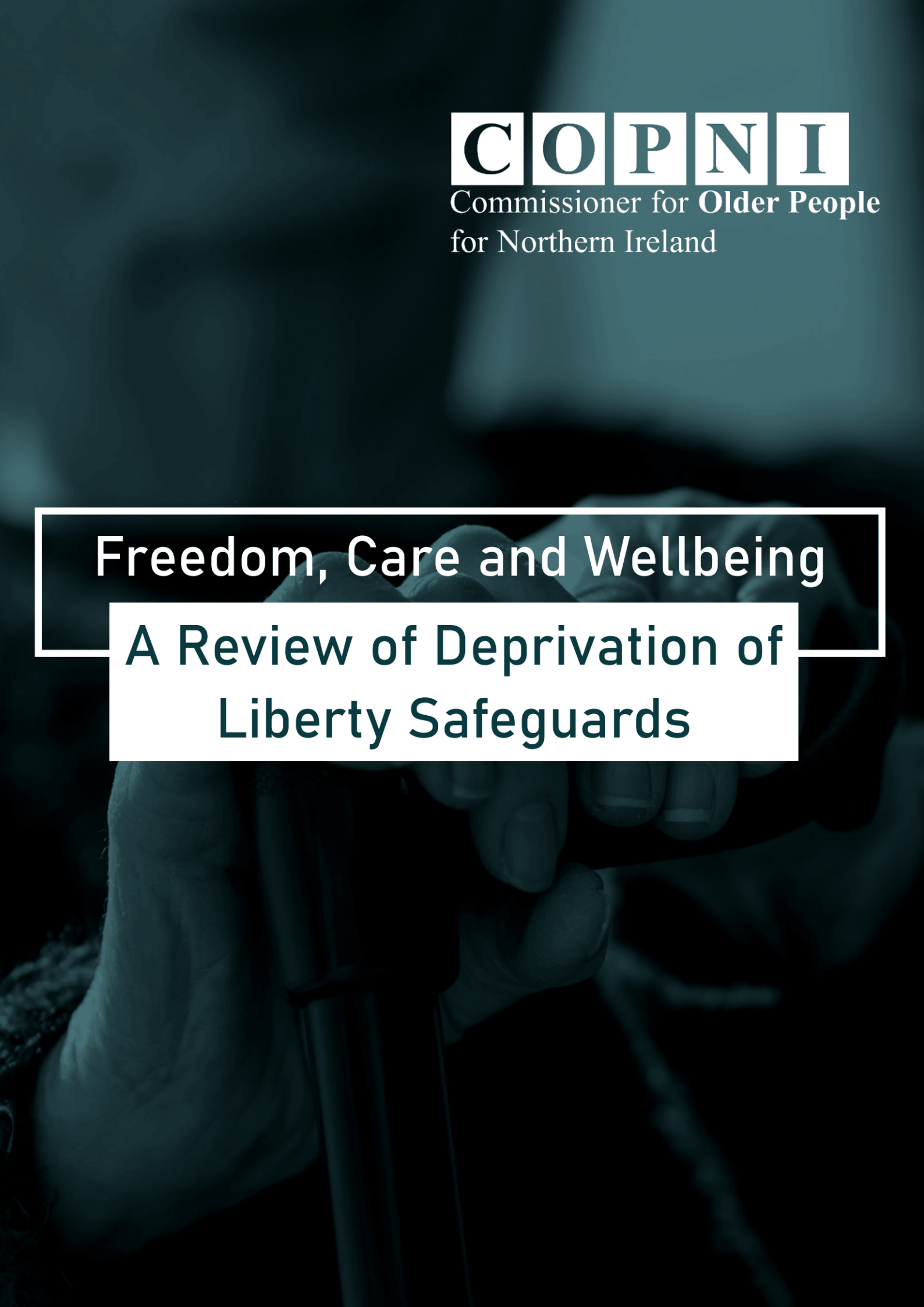

COPNI
Commissioner for Older People for Northern Ireland

Freedom, Care and Wellbeing

A Review of Deprivation of Liberty Safeguards

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COPNI
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LIST OF ABBREVIATIONS AND ACRONYMS

AGNI	Attorney General for Northern Ireland
ASW	Approved Social Worker
BHSCT	Belfast Health and Social Care Trust
COPNI	Commissioner for Older People for Northern Ireland
D	The person depriving someone else of liberty
DHSC	Department of Health and Social Care (UK)
DHSSPS	Department of Health, Social Services and Public Safety
DoH	Department of Health
DoJ	Department of Justice
DoL	Deprivation of Liberty
DoLs	Deprivations of Liberty
DoLS	Deprivation of Liberty Safeguards
ECHR	European Convention on Human Rights
ECtHR	European Court of Human Rights
HRA	Human Rights Act 1998
HSC	Health and Social Care
IMCA	Independent Mental Capacity Advocate

MCA 2005	Mental Capacity Act 2005
MCA	The Mental Capacity Act (Northern Ireland) 2016
MHO	The Mental Health (Northern Ireland) Order 1986
NHSCT	Northern Health and Social Care Trust
OAGNI	Office of the Attorney General for Northern Ireland
P	The person deprived of liberty
PCC	Patient Client Council
POSH	Prevention of Serious Harm
QUB	Queen's University Belfast
RCN	Royal College of Nursing Northern Ireland
RQIA	Regulation and Quality Improvement Authority
SEHSCT	South Eastern Health and Social Care Trust
SES	Socioeconomic Status
SHSCT	Southern Health and Social Care Trust
STDA	Short-term Detention Authorisations
The Act	The Mental Capacity Act (Northern Ireland) 2016
The Order	The Mental Health (Northern Ireland) Order 1986
The Regulations	The Mental Capacity (Deprivation of Liberty) (No. 2) Regulations (Northern Ireland) 2019
WHSCT	Western Health and Social Care Trust

INTRODUCTION

According to Article 5 of the European Convention on Human Rights (ECHR), every person has the fundamental right to liberty. However, this right is not absolute, and a person can be lawfully deprived of their liberty on specific grounds and "in accordance with a procedure prescribed by law."[1] Therefore, although the right to liberty is a basic human right, there are limited circumstances in which it is lawful to deprive someone of their liberty.

Article 5 of the ECHR accepts that "persons of unsound mind" can be deprived of liberty after a procedure prescribed by law.[2] Consequently, people with brain or mental impairments and disorders are regularly deprived of liberty to be provided with care. This happens mostly to older people.[3] Depriving people of their liberty to provide them with care is often seen as normal, rational, and sensible. It is usually understood that these detentions are carried out to help the person, and that it is in their best interests to be deprived of liberty, as they will receive the care and attention that they require in order to enjoy a good life. In addition, they could have accidents or harm themselves in many ways if no intervention was done, hence detentions are justified to prevent these occurrences. The possible consequences of not depriving them of liberty for their health and safety would be too high to accept.

Nevertheless, while this may sound simple, depriving someone of a basic human right like the right to liberty always presents great complexity. Who should decide that a person needs to be deprived of liberty? How to assess the "best interests" of that person? How will people be protected against arbitrary detentions? In essence, what is a "legitimate" deprivation of liberty (DoL)?

First, making unwise decisions cannot legitimise depriving someone of his or her liberty. Every person makes decisions that are damaging to themselves in one way or another, whether it is smoking, crossing the road with the red light or cycling without a helmet. We are all entitled to make decisions that are damaging to ourselves without

[1] Council of Europe, European Convention on Human Rights, as amended by Protocols Nos. 11, 14 and 15, ETS No. 005, 4 November 1950.

[2] Council of Europe, European Convention on Human Rights, as amended by Protocols Nos. 11, 14 and 15, ETS No. 005, 4 November 1950.

[3] Responses to FOI submitted by the BHSCT, the NHSCT and the SHSCT showed that the percentage of people deprived of liberty in Northern Ireland older than 65 ranged between 75% (BHSCT) and 87% (NHSCT).

the risk of being detained for being unwise. Second, depriving someone of their liberty based solely on the presence of an impairment or disorder cannot be justified either, as the situation of people with brain or mind impairments or disorders can vary enormously. For instance, the decision-making capacity of two individuals with dementia can be very different, and a single criterion cannot reasonably be applied to individuals in early stages of dementia, and individuals with advanced dementia.

The Mental Capacity Act (Northern Ireland) 2016 (MCA or 'the Act') was enacted in May 2016 to regulate these types of situations. The Act pertains to individuals with **a disorder or impairment of the brain or mind**, who as a consequence **lack decision-making capacity** (and are at **risk of harm**). It provides a framework by which such individuals can be deprived of liberty in accordance with a legal procedure that provides the necessary safeguards for the person. The legislation is meant to protect individuals against arbitrary detention and baseless assumptions and aims to ensure that deprivations of liberty are always done in the person's best interests. It also aims to ensure that help and support is provided to the person, and that the person's views and values are placed at the centre of the process.

Although the original intent of the MCA was that it would be fully implemented by April 2020, a phased approach has been adopted due to the difficulties of full implementation by that date. At present, it is in its first phase of implementation, which includes research provisions, provisions for money and valuables in hospitals and residential care and nursing homes, and crucially, provisions in relation to deprivations of liberty (DoLs).

Prior to the MCA, the legislation that regulated care and treatment of individuals with mental health conditions was the Mental Health (Northern Ireland) Order 1986 (MHO or 'the Order'). The fundamental difference between the MCA and the MHO lies in the fact that the conditions of entry to their protections are different. For the MHO, the presence of a mental disorder is the factor that activates the legal protections for forced assessment and admission into hospital, or detention for treatment. If the patient presents one of the mental disorders specified in its Article 3, the MHO makes provisions for forced admission to hospital or detention for treatment, provided that a medical assessment confirms that these actions would be in the person's best interests.

In contrast, the presence of a mental disorder is not sufficient to deprive someone of their liberty under the MCA. Apart from this condition, the MCA also requires that the person lacks capacity to make decisions about their care. Therefore, prior to depriving

someone of their liberty to provide them with care and treatment, a series of assessments must be conducted to ensure that the person lacks capacity. Assumptions cannot be made on the basis of any mental health condition or disorder, and anybody is by default assumed to have capacity until an evaluation has been conducted confirming otherwise.

The MCA also expands its protections to other settings as compared to the MHO. The MHO regulates assessment, admission and detention for treatment in hospital, but does not make provision for residential care or nursing homes. However, it was obvious that in these settings there were instances in which individuals were effectively being deprived of liberty—including through restraint (physical or chemical). Many voices warned that this lack of legislative framework within these settings had to be addressed.

Moreover, legislation in this area needed to be aligned with Article 5 of the ECHR (right to liberty and security) and the Human Rights Act 1998 (HRA), as well as with rulings regarding the right to liberty of mental health patients from the European Court of Human Rights (ECtHR) (the "Bournewood" case) and the Supreme Court (the "Cheshire West" case). The Bamford Review of Mental Health and Learning Disability was initiated in 2002 to examine the legislative framework in Northern Ireland around these issues and published a report in 2007 with recommendations to update mental health legislation to include capacity.

The Bamford Review identified several significant gaps. First, every person had to be protected against unreasonable, unlawful and arbitrary DoL. Second, these protections had to be expanded from hospitals to any setting in which a person was deprived of liberty. And third, it was held that nobody could be deprived of liberty if they had capacity to make decisions for themselves (even if those decisions were unwise in the opinion of carers, friends, relatives or medical professionals). The MCA was enacted to address these gaps.

Since its initial drafting, the MCA has been praised for being a progressive and groundbreaking piece of legislation, as compared to other similar pieces of mental health and mental capacity legislation. Unlike in other jurisdictions, when fully commenced, it will merge mental health and mental capacity legislation. Until it is fully implemented, both the MHO and MCA will apply in Northern Ireland. When fully implemented, the MCA will replace the MHO for those aged 16 and over—while in England and Wales, mental capacity and mental health law persist as separate pieces of legislation. The MCA provides clear and tangible protections and safeguards for people deprived of liberty in

Northern Ireland, and also for healthcare professionals that now have specific guidelines for good practice and protections from liability.

However, a piece of legislation like the MCA is neither simple to interpret, nor easy to execute. The costs associated with its implementation are high and hard to predict. The challenges it poses to those who have the responsibility to carry out the work can sometimes be overwhelming. Research conducted in England and Wales on the Mental Capacity Act 2005 (MCA 2005), which is based on similar principles as the MCA of Northern Ireland, has shown that public authorities are struggling to cope with the demands of the Act, leading to enormous backlogs and delays in implementing safeguards. The current context in Northern Ireland is not favourable either, with limited funding and workforce availability for Trusts, the Department of Health (DoH), and social care providers. All things considered, while the MCA is a progressive and advanced piece of legislation, it is necessary to evaluate its current functioning in terms of efficiency and effectiveness.

Currently, the Northern Ireland Trusts commission 12,559 care home placements, of which 3,186 are under a DoL. This means that approximately 25% of care home placements are under a DoL, but the number of people that are deprived of liberty in these settings is even higher, as these figures do not include the number of people deprived of liberty under emergency provisions.[4]

TABLE 1. Live care home DoLs by Trust

	Live care home DoLs
Belfast	847
Northern	672
South Eastern	630
Southern	268
Western	769
Total	3,186

[4] According to the figures provided by the NHSCT, a total number of 20.23% of their commissioned care home placements are under a live DoL, while an additional 9.9% are under emergency provisions. The figures from the SHSCT show that 11.92% of them are under a live DoL and an additional 3.7% are under emergency provisions.

There are approximately 2,200[5] individuals in the age group between 76 and 90 years of age who are lawfully deprived of their liberty. And while an MCA DoL is not equivalent to other forms of deprivation of liberty, such as being in prison, it still constitutes a violation of Article 5 of the ECHR if the necessary safeguards are not in place or properly implemented. This underscores the significance of the Act for residents of care homes, as the wellbeing of these individuals is dependent on an adequate application of the legislation and its principles.

The fundamental objective of this report is to provide an overview of the application of the DoLS. The report commences by exploring the background to the Act, including a brief introduction to the MHO and an overall description of the legal framework that arose from Bournewood and Cheshire West. The report then outlines the Deprivation of Liberty Safeguards (DoLS) process, as it is currently being implemented in Northern Ireland. Finally, there is an evaluation of the current DoLS process, identifying its strengths and weaknesses, the challenges faced by all the actors involved, and consideration of how the process can be strengthened.

[5] This figure is an estimate. The total number of people deprived of liberty (including live authorisations, extensions and emergencies) across all Trusts has been calculated using the total number of live Trust Panel Authorisations/Extensions from the DoLS Newsletter (MCA DoLS Newsletter - April 2024) and the NHSCT data on emergency provisions (obtained through a FOI response). The number of people deprived of liberty by age was estimated using the small age groups breakdown obtained in a FOI response by the SHSCT and the NHSCT (66+, 76-90 and 91+).

BACKGROUND

The Mental Health (Northern Ireland) Order 1986[6]

The Mental Capacity Act (Northern Ireland) 2016 was enacted to safeguard the rights of individuals who lack capacity to make decisions and to protect them from arbitrary detention. Prior to its enactment, Northern Ireland did not have standalone mental capacity legislation. Instead, the legal framework was governed primarily by the Mental Health (Northern Ireland) Order 1986, which made provision for compulsory admission, detention, and non-consensual treatment of individuals with mental disorders. The 1986 Order focused on mental illness rather than decision-making capacity.

Admission for assessment (short-term) and detention for treatment (long-term) under the MHO can occur when the person is:

a) suffering from a mental disorder of a nature or degree that warrants his or her detention in hospital for assessment (or for assessment followed by medical treatment);

   and

b) failing to detain the person would create a substantial likelihood of serious physical harm to him or herself or to other persons.[7]

The MHO bases the criteria for admission for assessment and detention for treatment on clear and set definitions of what a mental disorder is. A mental disorder is defined in Article 3 of the MHO as “mental illness, mental handicap and any other disorder or disability of mind”. Article 3 provides definitions of these related expressions (‘mental illness’, ‘mental handicap’, ‘severe mental handicap’ and ‘severe mental impairment’). [8]

[6] This section is based on Potter, M. (2020) ‘Chapter 11 Mental Health Law’ (pp. 405-435). In White, C., Northern Ireland Social Work Law, London: LexisNexis. This resource provides a comprehensive review of the MHO.

[7] Potter, M. (2020) ‘Chapter 11 Mental Health Law’ (pp. 405-435). In White, C., Northern Ireland Social Work Law, London: LexisNexis; page 414.

[8] The Mental Health (Northern Ireland) Order 1986; Article 3 (“Definition of ‘mental disorder’ and related expressions”).

Following this set definition of mental disorder, the MHO makes provision for admission and detention for patients. The admission can be based on applications made by an Approved Social Worker (ASW) or the person's 'nearest relative'.

> ***Person who may make application for assessment***
>
> *5.— (1) Subject to the following provisions of this Article, an application for assessment may be made by—*
>
> *(a) the nearest relative of the patient; or*
>
> *(b) an approved social worker.*[9]

The application is to be founded on a medical recommendation. Once the application for assessment or treatment has been made, it must be supported in writing by two registered medical practitioners.

As mentioned, not only can an ASW make an application for admission or detention, the person's nearest relative can also make an application. The nearest relative is defined in the MHO.[10] In addition, the nearest relative has other powers that include the power of discharge from detention, although this power can be overruled by the doctor responsible for the patient's treatment.

The MHO also makes provision for police powers in relation to transfer and compulsory holding or detention of a voluntary inpatient when the patient tries to leave the hospital. Companion legislation includes the establishment of the Mental Health Review Tribunal, which continues to be a relevant body under the MCA and is referred to as the Review Tribunal.[11]

Overall, Harper and others (2016) define the MHO as "traditional mental health legislation … Entry to its powers is through 'mental disorder' and risk of harm criteria".[12] The

[9] The Mental Health (Northern Ireland) Order 1986; Article 5 ("Person who may make application for assessment").

[10] "Usually, the nearest relative is the older of the two people who are highest in the following list, regardless of gender: husband, wife or civil partner; partner (of either sex) who has lived with the patient for at least six months; daughter or son; father or mother; brother or sister; grandfather or grandmother; aunt or uncle; nephew or niece. Out of the list above, a person who lives with, or cares for, the patient is likely to be seen as the nearest relative. A person who is not a relative, but who has lived with the patient for at least five years, can also be seen as the nearest relative". See NI Direct (n.d) Your rights in health.

[11] Potter, M. (2020) 'Chapter 11 Mental Health Law' (pp. 405-435). In White, C., Northern Ireland Social Work Law, London: LexisNexis; page 406; and The Mental Health Review Tribunal (Northern Ireland) Rules (Northern Ireland) 1986. The 1986 Rules have been amended after the enactment of the 2016 Act (The Mental Health Review Tribunal (Amendment) Rules (Northern Ireland) 2016) and the DoLS Regulations of 2019 (The Review Tribunal (Amendment) Rules (Northern Ireland) 2019).

[12] Harper, C., Davidson, G., and McClelland, R. (2016) 'No Longer 'Anomalous, Confusing and Unjust': The Mental Capacity Act (Northern Ireland) 2016', International Journal of Mental Health and Capacity Law, 22: 57-70; page 58.

MHO makes provision for assessment and treatment based on a set definition of mental disorder specified in Article 3 of the Order. It is based on external medical assessments that are independent of the patient's judgement, and on his or her best interests. Importantly, if the patient presents a mental disorder, the Order sets out powers for a series of external individuals, but none of these powers are limited by the determination of whether the patient has capacity.

Bournewood and Cheshire West[13]

In 1997, an individual known as HL was confined by the staff at Bournewood Hospital for care and treatment, and his foster carers were prevented from visiting him. The hospital argued that HL was being treated in his best interests, noting that he never objected to the treatment or attempted to leave. They also expressed concern that his foster carers might try to remove him from the hospital, which they believed would prevent him from receiving necessary treatment, something that would be—in the opinion of the hospital staff—contrary to his best interests. Although HL's foster carers were not his biological relatives, they felt his absence was akin to losing a family member and sought to have him released from the hospital. This led to a legal battle, with the carers arguing that HL was being 'detained'.

Initially, HL was not formally detained by the hospital, leading his foster carers to argue that his confinement lacked any clear legal basis and amounted to false imprisonment.[14] As a result of their legal challenge, the High Court ruled that HL was not, in fact, detained. However, the Court of Appeal later concluded that HL had been detained. This ruling implied that many others like HL could also be considered to be 'detained' in hospitals and nursing homes at the time. After Bournewood Hospital appealed, the House of Lords held that HL was not being detained under common law and unanimously held that even if HL had been detained it would have been justified, accepting the argument that the hospital staff acted in his best interests and that HL never objected or attempted to leave.

[13] This section is based on the review conducted by Series, L. (2024) 'Liberty Tactics: On the rise of 'Deprivation of Liberty Safeguards', Journal of Elder Law and Capacity, 2024(Spring): 1-33.

[14] Series, L. (2024) 'Liberty Tactics: On the rise of 'Deprivation of Liberty Safeguards'', Journal of Elder Law and Capacity, 2024(Spring): 1-33; page 8.

His foster carers eventually took their challenge to the ECtHR,[15] which ruled that "HL had been deprived of his liberty, in the meaning of Article 5 of the European Convention on Human Rights (ECHR), since he was subject to 'continuous supervision and control' and 'not free to leave'",[16] both of which constitute a DoL. These two criteria—continuous supervision and control, and the inability to leave—became the cornerstone of the legal definition of 'deprivation of liberty.' This definition was later affirmed by the UK Supreme Court in the 2014 'Cheshire West' case[17] which is commonly referred to as the 'acid test'.

A significant milestone in the development of mental capacity legislation in the UK was the coming into force of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) in 2008, which the UK ratified in 2009. "A major implication of the UNCRPD, as set out in Article 14, is that disability, including mental disability, should no longer be a criterion for detention as it is in most mental health laws including the current Mental Health (Northern Ireland) Order 1986."[18] [19] [20]

In the 2014 Supreme Court ruling in the Cheshire West case[21] Lady Hale maintained that there should be no difference between people with and without disability regarding the conditions of what constitutes a DoL. A definition of 'deprivation of liberty' should be universally applied to anybody, regardless of capacity, care arrangements, the intention of carers, or location. Therefore, according to the 'acid test', any person that is under constant supervision and control and not free to leave is subject to a DoL. Prior to these developments, there was a general absence of protections and safeguards for people in Northern Ireland with disabilities who were assumed to lack capacity. This situation is commonly referred to as the 'Bournewood gap'. It particu-

[15] R v Bournewood Community and Mental Health NHS Trust Ex p. L [1997] EWCA Civ 2879; R v Bournewood Community and Mental Health NHS Trust Ex p. L [1998] UKHL 24; HL v UK [2004] ECHR 720.

[16] Series, L. (2024) 'Liberty Tactics: On the rise of 'Deprivation of Liberty Safeguards'', Journal of Elder Law and Capacity, 2024(Spring): 1-33; page 10.

[17] P v Cheshire West and Chester Council and another; P and Q v Surrey County Council [2014] UKSC 19.

[18] Harper, C., Davidson, G., and McClelland, R. (2016) 'No Longer 'Anomalous, Confusing and Unjust': The Mental Capacity Act (Northern Ireland) 2016', International Journal of Mental Health and Capacity Law, 22: 57-70; page 65; citing Bartlett, P. (2009) 'The United Nations Convention on the Rights of Persons with Disabilities and the future of mental health law', Psychiatry, 8(12): 496-498. 'In 2009 the UK signed up to a United Nations agreement that states deprivation of liber-ty cannot be justified by the existence of long-term physical, mental, intellectual or sensory impairments' (Harper et al, 2016)

[19] The UK's signing in 2009 of the UN agreement meant that 'a deprivation of liberty cannot be justified by the existence of long-term physical, mental, intellectual or sensory impairments.' See Caughey, C. (2018, March 15) Ending 'substituted decision making' in crisis care: lessons from Northern Ireland, Mental Health Today.

[20] See United Nations Convention on the Rights of Persons with Disabilities.

[21] P v Cheshire West and Chester Council and another; P and Q v Surrey County Council [2014] UKSC 19.

larly affected individuals in care homes and community settings who were subsequently considered to have been unlawfully deprived of their liberty. It also raised broader concerns about whether existing mental health legislation adequately protected their human rights.[22] At that time, people in these circumstances required a series of legislative safeguards to ensure that any deprivation of liberty was lawful and aligned with both domestic and international human rights obligations.

Bamford review

The Bournewood gap meant that Northern Ireland needed mental capacity legislation. As mentioned in previous sections, a major concern arising from the Bournewood case was that existing mental health legislation in the UK and Northern Ireland had become incompatible with Article 5 of the ECHR.

> *As a general rule, domestic law must conform with European Convention law, and there are three key Convention rights that concern people with mental health issues, namely articles 3, 5 and 8 (11.8 page 407).*[23]

In consequence, the Bamford Review of Mental Health and Learning Disability was established in 2002 to examine the law and policy that affected people living with a learning disability and mental health issues in Northern Ireland.[24] The origins of the MCA are found in the recommendations set out as part of the Bamford Review.[25] The Bamford Review found that human rights principles were not being properly upheld for individuals with mental illnesses and learning disabilities. The mere presence of a mental disorder was enough to trigger the powers of the Order, and to justify forced admission for assessment in hospital and involuntary detention for treatment. In set-

[22] Concerns have been raised that current mental health legislation fails to uphold the human rights of individuals with disabilities. The relationship between mental health and mental capacity legislation remains complex. The Mental Health Act 1983 and the Mental Capacity Act 2005 coexist in England and Wales. Unlike in these jurisdictions, the Mental Capacity Act (Northern Ireland) 2016 is intended to replace The Mental Health (Northern Ireland) Order 1986. The King's Speech 2024 included a commitment to modernise the Mental Health Act in England and Wales, and discussions regarding an updated Mental Health Bill have begun in the House of Commons. See House of Commons Library (2024) Reforming the Mental Health Act.

[23] Potter, M. (2020) 'Chapter 11 Mental Health Law' (pp. 405-435). In White, C., Northern Ireland Social Work Law, London: LexisNexis; page 407.

[24] Harper, C., Davidson, G., and McClelland, R. (2016) 'No Longer 'Anomalous, Confusing and Unjust': The Mental Capacity Act (Northern Ireland) 2016', International Journal of Mental Health and Capacity Law, 22: 57-70; page 58.

[25] Department of Health (2007) Bamford review - A comprehensive legislative framework.

tings such as care homes, there were no legal protections in place. In contrast, the review emphasised the importance of respecting an individual's decision-making capacity, regardless of whether they have a physical or mental illness.[26]

Before the Mental Capacity Act (2016) in Northern Ireland

Despite the absence of legislation that dealt with deprivations of liberty of individuals who lacked capacity, in the period between Bournewood, Cheshire West, and the implementation of the DoLS through The Mental Capacity (Deprivation of Liberty) (No. 2) Regulations (Northern Ireland) 2019 (the Regulations), the health and social care sector of Northern Ireland retained responsibility for ensuring that the practices within the sector were compatible with the ECHR and common law principles.

It is evident that during the period between the key court cases and the enactment of the MCA in 2016 (and the Regulations in 2019), there were individuals in Northern Ireland who lacked capacity and were deprived of their liberty. Despite the absence of a formal legislative framework to address these cases, care providers and Trusts could not act at their own discretion when dealing with such individuals due to the principles established by the ECHR and common law. To address this gap, the Department of Health, Social Services and Public Safety (DHSSPS) issued interim guidance in October 2010.[27] This guidance provided instructions to relevant stakeholders, outlining how health and social care providers and Trusts should operate. The circular emphasised that

> *it is accepted that to avoid further violations of Article 5(1), new procedural safeguards are required for patients who are not formally detained, but who are, in effect, deprived of their liberty in the best interest under common law doctrine.*[28]

The circular placed clear responsibility on care providers to avoid liability and outlined key safeguards. These involved taking all reasonable steps to assess capacity, main-

[26] Harper, C., Davidson, G., and McClelland, R. (2016) 'No Longer 'Anomalous, Confusing and Unjust': The Mental Capacity Act (Northern Ireland) 2016', International Journal of Mental Health and Capacity Law, 22: 57-70; page 59.

[27] The guidance was issued to the attention of: Chief Executive of HSC Trusts, Chief Executive of HSC Board (for cascade to GPs and other relevant practitioners), Chief Executive of PHA, Chief Executive of RQIA (for cascade to private, hospitals, clinics and other relevant establishments and agencies), Chief Executive of PCC, British Medical Association (NI), Royal College of Nursing (NI), Royal College of Psychiatry (NI), British Association of Social Workers (NI), College of Occupational Therapists (NI). See Department of Health (2010) Deprivation of Liberty Safeguards (DOLS) – Interim Guidance.

[28] Department of Health (2010) Deprivation of Liberty Safeguards (DOLS) – Interim Guidance' section 16.

taining effective communication with friends and family, providing information to patients and their relatives about care arrangements, and regularly reviewing those arrangements.

Despite the efforts of the DHSSPS and other parties, it was evident that legislative provisions would be necessary to safeguard patients and staff. An indicator of this gap is the fact that 3.7% of all Trust Panel applications between 2019 and 2024 were refused, with 3.2% of them requiring further investigation.[29] This suggests that before the Act came into effect, some individuals were being deprived of their liberty in situations that would not meet the criteria under the new framework introduced by the Act. In sum, the previous system allowed for deprivations of liberty that may not have been justified under the more rigorous standards now in place.

TABLE 2. Trust Panel applications (% by outcome and year)[30]

	2020	2021	2022	2023	2024	Total
Authorised	79.74	90.91	95.49	97.74	98.87	91.55
Interim	7.17	3.94	0.42	1.53	0.53	3.16
Refused	7.66	4.48	2.94	0.61	0.45	3.70

While the DHSSPS took reasonable steps to offer interim guidance for care providers to align with the requirements of the ECHR and common law principles, this effort was not sufficient. Specifically, the MCA and the DoLS Code of Practice provide comprehensive and practical guidance on the full implications of the Act and its requirements for care providers—guidance that was lacking prior to the implementation of the Regulations. This detailed framework has been essential for ensuring that individuals' rights are protected and that care providers can operate effectively.

[29] This is based on the information received by COPNI in the Trusts' response to a FOI.

[30] Calculations based on information obtained in a FOI response issued by the NHSCT, WHSCT, SHSCT and BHSCT. Numbers are not exact, as the BHSCT did not provide an exact number of refused applications in a year when the number was lower than 5. "Use of <5 (less than five): We are unable to provide an exact figure - exempt from release under section 40(2) of the FOI Act - as this could make patients personally identifiable. Disclosure would constitute a breach of the principles of the General Data Protection Regulations 2018". In these cases (years 2023 and 2024), the number assigned was 0. Other Trusts did provide numbers lower than 5.

MENTAL CAPACITY ACT (NORTHERN IRELAND) 2016

The Mental Capacity (Northern Ireland) Act 2016 (MCA) establishes a statutory framework for substitute decision making on behalf of individuals who lack the capacity to make decisions for themselves. Whilst the Act enables substitute decision making where necessary, it places a strong emphasis on supported decision making. Anyone assessing whether a person lacks capacity must first provide all practicable help and support to enable the person to make the decision, before determining that they are unable to do so.

When it is sufficiently proven that a person lacks capacity, and because of this the person is at an unacceptable risk of harm, the Act ensures the protection of the person by allowing others to make decisions for them, insofar as these decisions are made in their best interests.

The MCA was enacted in 2016 to fill a legislative gap in Northern Ireland. Prior to this, the MHO provided the legal framework for regulating involuntary detention for treatment in hospitals. However, there was no framework governing situations in which individuals were deprived of their liberty in settings such as care homes. This gap raised significant human rights concerns, which the MCA was intended to address.

Currently, the MCA has only been partially implemented. Although the Act covers a wide range of areas, DoLs is just one aspect of its broader scope. Other provisions, including those relating to short term hospital detention, lasting powers of attorney, police powers, independent mental capacity advocates (IMCAs), acts of restraint, and criminal justice matters, have not yet been commenced. At present, only the provisions relating to deprivation of liberty, research, and the management of money and valuables are operational.

In 2019, the Northern Ireland Executive agreed to implement the MCA in phases, starting with the DoL provisions introduced through the Mental Capacity (Deprivation of Liberty) (No. 2) Regulations (Northern Ireland) 2019. These Regulations primarily established safeguards for DoLs in care homes, and in some circumstances, hospitals.[31]

[31] The MHO remains as the legal framework that regulates short term detentions for treatment in hospitals. However, stakeholders have described situations in which deprivations of liberty are completed in hospitals. This occurs generally in situations in which a patient requires to be transferred to a care home after receiving treatment in hospital.

Since the implementation of the Act, many individuals who lived in care homes have been issued DoLs through Trust Panel authorisations. Currently, according to data from Northern Ireland Trusts, 25% of all care home placements commissioned by Trusts are under a DoL.

This report addresses the provisions of the Act that have been implemented, specifically, the DoLS. However, significant parts of the Act remain unimplemented. This phased implementation has presented challenges for Trusts, care providers, health professionals, and other stakeholders. While the primary focus of this research is the DoLS, there is consideration of concerns raised by stakeholders regarding the impact of the phased implementation of the MCA.

One of the things that makes the MCA a unique piece of legislation is that it merges mental health and mental capacity legislation. As a result, when the Act is fully implemented, the same principles and norms will apply across all medical and social care settings. However, it is important to note that the MHO remains in force, primarily regulating short-term assessments and detentions for treatment in hospitals until it is superseded by the full implementation of the MCA. Although the MCA is intended to fully replace the MHO for those aged 16 and over,[32] until the Act is fully implemented, the MHO continues to serve as the primary legislation governing short-term detentions for patients with mental health disorders in hospitals. Currently, 'if a person can be detained under the 1986 Order, then the 1986 Order framework must be applied.'[33]

As mentioned, the principal differences between the MCA and the MHO relate to the issue of capacity and the range of situations provided for by the respective pieces of legislation. Under the MCA, assumptions cannot be made on the basis of a disease or a condition, and evaluations must be made on the basis of capacity. The MHO is solely centred around mental disorder and hospital treatment. It is based on very clear definitions of what a mental disorder is,[34] and involuntary detention and treatment is dependent on medical advice if a mental disorder is present. The MCA is more wide ranging, as it covers several types of treatments and interventions and regulates a wider range of situations (including those regulated by the Order). Moreover, the MCA focuses on the capacity of an individual to make informed decisions at a certain point in time. Therefore, there will be instances where individuals who would have qualified

[32] This is distinctive of the MCA in Northern Ireland, as in other jurisdictions, two pieces of legislation coexist. This occurs in England and Wales with the coexistence between the Mental Health Act 1983 and the Mental Capacity Act 2005.

[33] Department of Health (N.D.) Mental Capacity Act Background.

[34] The Mental Health (Northern Ireland) Order 1986; Article 3 ("Definition of 'mental disorder' and related expressions").

for involuntary detention under the MHO will not meet the threshold under the MCA as they would have capacity in relation to the care and treatment they receive in hospital.

Overall, the MCA places the person's capacity at the heart of decisions about care and treatment. A person who is, or may be, subject to a DoL remains at the centre of the process. Even where substitute decision-making is required because the person lacks capacity, any decision made on their behalf must be in their best interests and must give particular weight ("special regard") to the person's past and present wishes, feelings, beliefs, and values. When others, such as family members or carers, are consulted during the DoLS process, it is to help ensure that the person's rights, preferences, and values are fully considered.

Principles

The MCA provides a statutory framework for substitute decision making[35] for people aged 16 or over who lack capacity. That is to say, if a person (P) is proven to lack capacity, another person (D) can make decisions for them, provided that these decisions are in P's best interests. Thus, the two general criteria used to make substitute decisions across health and social care are 'impairment of decision-making capacity' and 'best interests'.[36]

The MCA presents five statutory principles, four of which relate to capacity, while the fifth relates to best interests. The departure point, and most important principle of the act is the presumption of capacity.[37]

PRINCIPLE 1 – No-one should be treated as lacking capacity unless proven they do.

The starting point when assessing capacity should be the assumption that the individual has capacity. If there is a suspicion that a person lacks capacity, this must be proven through an appropriate assessment; otherwise, the individual should be presumed to have capacity and must not be deprived of his or her liberty.

PRINCIPLE 2 – No assumptions can be made.

[35] There has been discussion on whether the MCA should promote substitute or supported decision making. Overall, in any circumstance in which a person who lacks capacity does not make decisions for themselves; this is substituted decision making. See Dignity in Care (2015) Does the MCA promote Substituted Decision-Making or does it promote Supported Decision-Making?.

[36] Lynch, G., Taggart, C., and Campbell, P. (2017) 'Mental Capacity Act (Northern Ireland) 2016', BJPsych Bulletin, 41: 353-357; page 353.

[37] See Department of Health (N.D.) MCA Principles.

Unlike the MHO, the Act prioritises individual autonomy in decision-making, regardless of whether a mental or physical disorder is present. As a result, the existence of a disorder alone does not justify non-consensual intervention; additional safeguards and assessments are required to determine whether the person has capacity or not.

PRINCIPLE 3 – Help and support must be provided.

All practicable help and support must be provided to enable the individual to make their own decisions. A determination of lack of capacity can only be made after all possible assistance has been given. The individual should retain as much autonomy as possible throughout the process and after the process.

PRINCIPLE 4 – No assumptions can be made because of unwise decisions.

Everyone makes unwise decisions at times, including choices that may be harmful to themselves. When these unwise decisions are made by older people, or by individuals with disabilities, their family members, friends, or caregivers may feel tempted to step in and make decisions on their behalf. However, making an unwise decision should not be mistaken for a lack of decision-making capacity. Proper assessments must be conducted, and safeguards must be applied before concluding that someone is incapable of making their own decisions.

PRINCIPLE 5 – All acts and decisions must be made in the person's **best interests**.

As part of this principle, it is important that anything that is done "for or on behalf of a person lacking capacity must be done in their best interests and—innovatively—with special regard to their past and present wishes and feelings." This has been defined in the Act and the DoLS Code of Practice as **special regard**.[38] The special regard is determined through consultation with P and with other people (P's 'nominated person', relatives, carers, etc.) and aims to put P's wishes and values (past and present) at the centre of the process.

Deprivation of Liberty Safeguards

The principles described above are designed to guide the entire process of safeguarding people against arbitrary detention. They are meant to be followed from the mo-

[38] Caughey, C. (2018, March 15) 'Ending 'substituted decision making' in crisis care: lessons from Northern Ireland', Mental Health Today.

ment in which a person is suspected of lacking capacity, to the end of the safeguarding process when a DoL is authorised or rejected by a Trust Panel. In this section, the safeguards introduced by the MCA will be described by delineating the **Deprivation of Liberty Safeguards** (DoLS) process.

A deprivation of liberty is determined in light of the **'acid test'**, as provided in the Cheshire West ruling.[39] A person is deprived of liberty when they are under 'constant supervision and control' and 'not free to leave.' The DoLS Code of Practice states that in order to determine if a person is deprived of liberty, the following assessment of the situation must be conducted:

> *2.6. To test if a person who lacks capacity is deprived of his or her liberty the following questions must be asked:*
>
> *a. is P under continuous supervision and control?*
>
> *b. is P free to leave?*
>
> *2.7. If P is under continuous supervision and control and is not free to leave P is subject to a DoL.*[40]

A DoL may be authorised if the person lacks capacity to make decisions about the arrangements, is at risk of serious harm if not deprived of liberty, and it is determined to be in their best interests—taking into account all relevant circumstances, with particular regard to their past and present wishes.

A different process applies for streamlined authorisations for Short-Term Detention Authorisations (STDA) in hospitals than is the case for applications to a Trust Panel for a DoL in settings like care homes. This report only addresses the latter. If health and social care staff who provide care to a person have reasonable belief that the person lacks capacity and is at risk of serious harm because of their lack of capacity, a DoL might be necessary, as it would be in the person's best interests. However, depriving someone of their liberty represents one of the most serious interferences with a person's fundamental rights under Article 5 of the ECHR, and can only be justified with robust safeguards and due process. To guarantee compliance with human rights legislation, the MCA makes provision for a series of safeguards. These safeguards are meant to guarantee that nobody is deprived of their liberty unlawfully and arbitrarily,

[39] Mental Capacity Ltd (N.D) Mental Capacity Act (Northern Ireland) 2016: overview part 3.

[40] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; sections 2.6 and 2.7.

and that all DoLs align with Article 5 of the ECHR,[41] Cheshire West[42] and the UNCRPD.[43] Therefore, a series of safeguards must be observed before depriving someone of their liberty.

If the health and social care staff providing care for a person believe that the person should be deprived of liberty due to an unacceptable risk of serious harm for that person, they can make a referral to the relevant Trust. Whenever they do so, the Trust in their area will assess if a DoL is necessary. If it is determined by the Trust that a DoL is needed, the DoLS process is commenced, in conjunction with the necessary safeguards.

However, this process can be lengthy and care homes often find themselves in situations in which there is an immediate risk of harm to the person, and safeguards cannot be completed quickly enough. If the care staff believe the person must be deprived of his or her liberty as a matter of urgency (before all the safeguarding procedures can be conducted), due to the risk of harm to the person, they can implement **emergency provisions**. This occurs when the person is deprived of liberty, but a full authorisation (with all necessary safeguards) cannot be obtained in time to protect the person. To implement emergency provisions, the staff are protected from liability by applying **two general safeguards in addition to the Prevention of Serious Harm (POSH) condition**.

1) Have a reasonable belief that the person lacks capacity.
2) Have a reasonable belief that the deprivation is in the person's best interests.[44]
3) The Prevention of Serious Harm (POSH) condition is met.

Once this has occurred, the Trust must ensure the remaining **additional safeguards** are completed as soon as possible. These additional safeguards are:

1) Formal assessment of capacity.
2) Consultation with the nominated person.

[41] Council of Europe, European Convention on Human Rights, as amended by Protocols Nos. 11, 14 and 15, ETS No. 005, 4 November 1950.

[42] P v Cheshire West and Chester Council and another; P and Q v Surrey County Council [2014] UKSC 19.

[43] See Office of the United Nations High Commissioner for Human Rights (2017) CRPD/C/GBR/CO/1: Committee on the Rights of Persons with Disabilities: Concluding observations on the initial report of the United Kingdom of Great Britain and Northern Ireland.

[44] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 7.3.

3) Trust Panel authorisation.[45]

Once the additional safeguards have been completed and the Trust Panel application has been authorised, the person will be subject to care that amounts to a deprivation of liberty. An authorisation approved by the Trust Panel lasts for 6 months but can be extended. The reason for extension can be (but not limited to) that it would be appropriate to continue the DoL. It can be extended for a further 6 months initially and 12 months thereafter.[46]

It is important to stress that the circumstances of two individuals under a DoL can be very different, as one of them may be at higher risk of harm, such as presenting more frequent exit-seeking or self-harm behaviour than the other. These differences illustrate that two DoLs can be dissimilar, thereby indicating the necessity for scrutiny of the unique circumstances of each individual. In consideration, one DoL may require restraint, but not all cases would necessarily require such a measure.[47] The DoLS Code of Practice stresses that

> *A DoL must be considered on individual merit and on the particular circumstances of each case; blanket assumptions must not be made. Account must be taken of a whole range of criteria such as type, duration, effect and manner of implementation of the measure.*[48]

All of these considerations must be captured in P's **care plan**, which is designed to detail the care arrangements provided for P and ensure that they are proportionate to P's circumstances. The care plan must be completed using the MCA **Form 4**[49] and should be submitted with all the other documents needed for a Trust Panel authorisation.

Capacity

The central safeguard introduced by the MCA is the requirement to **assess capacity** before implementing a DoL. Under the MCA, nobody can be deprived of liberty based

[45] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 7.3.

[46] Western Health and Social Care Trust (N.D.) Mental Capacity Act.

[47] A DoL is not the same as restraint, although restraint that is ongoing, planned and regular can be considered to be a DoL. See Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 7.32. The DoH has conducted a recent consultation to begin provisions on Acts of Restraint under the MCA [sections 9(4)(a) and 12]. See Department of Health (2024) Consultation on commencement of provisions under the Mental Capacity Act (NI) 2016 relating to Acts of Restraint.

[48] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 2.8.

[49] All the MCA forms can be found in the DoH website.

solely on the presence of a disease, condition or mental disorder. While the MHO details a series of conditions or disorders that justifies involuntary detention for treatment, the MCA puts capacity at the centre of deliberations.

The definition of lacking capacity always refers to the matter or act in question. With the deprivation of liberty provisions commenced, capacity would be assessed in relation to said deprivation of liberty. A person lacks capacity whenever they are unable to make a decision 'on that matter', that is, a person 'lacks capacity' about the deprivation of liberty.[50]

> *A person ("P") lacks capacity in relation to a DoL if P is unable to make a decision for himself or herself about the matter, because of an impairment of, or a disturbance in the functioning of, the mind or brain.*[51]

When a person is suspected of lacking capacity to make decisions for themselves in relation to their care arrangements, and because of this the person is at risk of harm, and it is in their best interests, the person may need a DoL in which case, the DoLS process will begin. The first step of the process will consist of assessing capacity. A practitioner will test if a person lacks capacity through the **Formal Capacity Assessment** (Form 1),[52] which consists of three elements. All of them must be met:

a) The **Functional Test** assesses whether the person is unable to make a decision.

b) An **Impairment or Disturbance Test** assesses whether P has an impairment of, or a disturbance in the functioning of, the mind or brain. The cause and length of the disturbance is not relevant.[53]

c) The **Causal Link** assesses if a connection exists between the two tests above. This connection is necessary in determining that a person requires a DoL.[54]

A capacity assessment requires a suitably qualified professional who has sufficient experience and training.[55] If the assessor concludes that the person lacks capacity,

[50] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 5.4.

[51] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 5.2.

[52] Department of Health (2019) MCA(NI) 2016 - Form 1 – Statement of incapacity (Statutory Form).

[53] For some examples on causes of impairment or disturbance see section 5.18 of Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice.

[54] Mental Capacity Ltd (N.D) Mental Capacity Act (Northern Ireland) 2016: overview part 2.

[55] According to the Code of Practice, the professions that can conduct capacity assessments are the following: social worker; medical practitioner; nurse or midwife; occupational therapist; speech and language therapist; dentist; and practitioner psychologist. See Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 8.9.

they will fill in Form 1 and the process will move on towards completion of the rest of the safeguards.

Best Interests

If it has been established that a person lacks capacity and substitute decision-making is needed, "any act done or decision made for or on behalf of P must be done in P's best interests."[56] The principle of **best interests** is an important safeguard for P. It aims to gather a holistic understanding of P's views, beliefs, values, will and preferences prior to lacking capacity, so that any decision or act made for or on behalf of P would be in line with P's wishes if P had capacity. This is done through the **Best Interests Determination Statement** (Form 2).[57]

If a DoL is to be implemented, P's wishes would have to be taken into consideration. While there is a concise definition of what constitutes a DoL, which is determined by the 'acid test', every deprivation of liberty is different depending on the person's circumstances, personality, the risks involved, and past and present wishes. To determine what a DoL would look like in practice, the best interests determination is a crucial step. The practitioner completing the 'Best Interests Determination Statement' must follow a series of steps to ensure that P's best interests are adequately captured, including:[58]

- Consider if there are reasons why the deprivation of liberty is not in P's best interests.
- Consider whether it is likely that the person will have capacity at some time in the near future to make the decision themselves.
- As far as practicable, encourage and help P to participate as fully as possible in the determination of their best interests.
- Have special regard to past and present wishes, feelings, beliefs, values and any other factors.

[56] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 6.1.

[57] Department of Health (2019) MCA(NI) 2016 - Form 2 – Best interests determination statement (Statutory Form).

[58] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 6.15 to 6.36.

- Consult and take into account the views of relevant people.
- Consider less restrictive actions.
- Have regard to whether failure to deprive P of liberty is likely to result in harm to others with resulting harm to P. This condition, also known as the **Prevention of Serious Harm (POSH) condition**, is a safeguard and it is also assessed in the **Medical Report** (Form 6[59]).

As stressed above, special regard is a crucial step in the Best Interests Determination Statement. Through the participation of P and relevant people in P's life, the practitioner completing P's application must try to capture as accurately as possible P's past and present wishes. Special attention must be paid to the opinion of the **'nominated person'**, who must be consulted about any decisions made regarding P. The nominated person is meant to empower P and to safeguard and promote P's wishes and values. As such, the nominated person is not a decision-maker, but somebody who is meant to represent P's voice throughout the process. The nominated person is appointed by P (if P has capacity to do so), or by the Review Tribunal.[60]

The practitioner conducting the assessment must make sure that the DoL is in P's best interests. This means that the special regard to the "wishes, feelings, beliefs, values and any other factors that P would have considered relevant" must be given "top priority."[61] Despite being given priority, special regard must not determine by itself whether or not a DoL is necessary. However, if a decision is made against P's past and present wishes, such a decision must be justified.

> *Special regard is not absolute; it does not mean that P's past or present wishes and feelings, beliefs, values must be adhered to, particularly if there are practical reasons why they cannot. Persons making best interests determinations should be aware of the increased need to justify a best interests decision that is made contrary to P's past and present wishes and feelings, beliefs and values.*[62]

The legislation and the Code of Practice are not specific as to the depth of the special regard requirements. For example, the Code of Practice states that the practitioner conducting the Best Interests Determination Statement should "consult and take into

[59] Department of Health (2019) MCA(NI) 2016 - Form 6 – Medical report (Statutory Form).

[60] Department of Health (N.D.) MCA - Nominated Person.

[61] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 6.24.

[62] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 6.25.

account the views of relevant people",[63] as far as it is "practicable and appropriate",[64] with consideration of the difficulties in contacting and gathering the views of these individuals. The Code of Practice also states that "less restrictive actions" should be given consideration. These would include the use of technology ("such as sensors or GPS trackers") or using staff ("by providing personalised care")[65] to avoid a deprivation of liberty. However, the Code of Practice also states that the Best Interests Determination Statement "does not require arrangements that are impossible or that would not be normally put in place".[66] This suggests that less restrictive options may be impacted by the availability of technology and staff, and that the practitioner conducting the assessment may take these limitations into account. In sum, the Code or Practice is non-specific as to the extent the practitioner should go in consideration of the "special regard" factor. Indeed, stakeholders interviewed for this study have reported that some practitioners go to significant lengths trying to capture special regard as compared to other practitioners.[67]

Trust Panel authorisation

One of the four basic additional safeguards listed above is the **authorisation of the DoL by a Trust Panel**. After the assessments have been completed by the relevant practitioner, the information compiled must be evaluated by a Trust Panel. A Trust Panel is a group of specially trained staff that meets regularly to assess applications for deprivations of liberty in their Health and Social Care (HSC) area. It consists of three professionals[68] who make a decision on whether the application completed by practitioners justifies the authorisation of the DoL. To approve the DoL, the Trust Panel must confirm that all authorisation criteria are satisfied:

1) The person lacks capacity.

[63] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; sections 6.27 to 6.29.

[64] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 6.29.

[65]Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 6.31.

[66] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 6.31.

[67] Dr Danielle McIlroy is a QUB lecturer that has researched on Best Interest decision-making in Northern Ireland.

[68] According to the Code of Practice, the panel will consist of one medical practitioner; one approved social worker; and one other healthcare professional. See Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 14.4.

2) The DoL would be in the person's best interests.
3) Appropriate care or treatment will be provided to the person where the DoL will happen.
4) The POSH condition is met.[69]

After reviewing the information provided in the **'Application for Trust Panel Authorisation'** (Form 5) and the other documents,[70] the panel makes a decision based on the agreement of at least two of the three members of the panel. This decision will be one of the following possibilities:[71]

1) Grant **full authorisation**, in which case, the DoL will be authorised, and the person will be deprived of liberty.
2) **Refuse the authorisation**, in which case the person will not be deprived of liberty.
3) Grant **interim authorisation**, in which case, the person will be deprived of liberty for 28 days. In these 28 days, the panel will gather further evidence to make a final decision. The interim authorisation cannot be extended further, and the panel will make a final decision after 28 days have passed.[72]

TABLE 3. Trust Panel Applications by outcome (2020-2024)[73]

	Total	%
Authorised	9001	91.55
Interim	311	3.16
Refused	364	3.70
Not heard/carried forward	156	1.59
Total	9832	100

[69] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 11.6.

[70] The annexes that should be submitted with Form 5 are: 'Statement of incapacity' on Form 1; 'Best Interests Determination Statement' on Form 2; 'Care plan' on Form 4; 'Medical report' on Form 6; and 'Statement whether P has capacity to decide to apply to the Review Tribunal' on Form 7. See Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 11.9.

[71] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; Flowchart 4, page 66.

[72] See Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 14.10.

[73] Data obtained in an FOI response issued by four HSC Trusts (NHSCT, SHSCT, WHSCT, BHSCT). The data is not exact for the period. It covers the period between December 2019 and August/September 2024 (depending on the date in which the Trusts issued the response).

Review process

If a full authorisation has been granted, the MCA guarantees the right of P to review the decision. This right consists of a review of the case by the Review Tribunal, which is an independent judicial body that is not linked to any Trust. The Tribunal assesses the authorisation to make sure the decision to authorise the DoL was made in accordance with the MCA, the criteria have been met, and all the legal obligations have been adequately applied.[74] After reviewing, the Tribunal adjudicates on whether the DoL should continue or cease. There are a number of people who can apply to the Tribunal to review an authorisation:[75]

1) The person to whom the authorisation relates (P) if he or she has capacity to do so.[76]
2) The nominated person. If P has capacity to apply to the Tribunal, the nominated person can only apply if P gives consent.
3) The Attorney General for Northern Ireland (AGNI). If the practitioner completing the forms concludes that P has no capacity to apply to the Review Tribunal, the case will be automatically referred to the AGNI by completing Form 7. The AGNI will the decide if the case should be referred to the Tribunal.
4) The Department of Health.
5) The Master (Care and Protection).
6) The HSC Trust must refer the case to the Tribunal if a DoL authorisation has been in force for two years and has not been considered by the Tribunal in that time.[77]

[74] Lynch, G., Taggart, C., and Campbell, P. (2017) 'Mental Capacity Act (Northern Ireland) 2016', BJPsych Bulletin, 41: 353-357; page 355.

[75] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; sections 15.6 to 15.8.

[76] Having capacity to apply or not is determined during the DoLS process. If P is deemed not to have capacity to apply to the Tribunal, the assessor completing the forms will include a Form 7 in the Trust Panel application.

[77] Or one year if P is under 18. Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; sections 15.8.

TABLE 4. Case intake of the Review Tribunal by type of referral[78]

	Dec 19 Mar 20	Apr 20 Mar 21	Apr 21 Mar 22	Apr 22 Mar 23	Apr 23 Mar 24
AGNI referral	183	1086	1779	1782	1080
Application by P	0	<5	<5	7	6
Application by P's nominated person	0	0	6	<5	<5
Section 48 from Trust	0	0	23	237	293
Other[79]	35	202	156	98	117

The application to the Tribunal can be done at any point during the time in which the DoL authorisation is in place. Where P has capacity to do so, P can apply to the Tribunal, but this is not the most common scenario. In most Trust Panel applications, P is considered to lack capacity to apply to the Tribunal (76.7%).[80]

TABLE 5. % of authorised Trust Panel applications that contained a Form 7 (incapacity to apply to Review Tribunal)[81]

	NHSCT	WHSCT	BHSCT	SHSCT	SEHSCT	Total
2020	71.05	92.64	81.96	37.82	ND	68.51
2021	65.50	81.15	100.00	89.83	ND	84.94
2022	72.61	82.03	77.84	81.66	ND	77.91
2023	72.02	83.80	41.45	71.49	ND	65.89
2024	82.35	90.00	33.90	95.73	61.72	80.72
Total	71.72	84.28	64.85	76.96	61.72	76.70

P can also authorise the nominated person to apply to the Tribunal if P has capacity to do so. If P has capacity and refuses to authorise the nominated person to apply, then the nominated person cannot refer the case to the Tribunal. If, in turn, P is deemed to lack capacity, the nominated person can refer the case to the Tribunal. None of these situations are common. Between April 2020 and March 2024, the Review Tribunal has received on average 1718 cases per year, of which only approximately 10 every year are applications made by P or P's nominated person.[82]

[78] Data obtained through a FOI response issued by the Review Tribunal.

[79] Short Term Detention Authorisations/Extensions; Applications to Appoint/Revoke Nominated Person (NP).

[80] Data obtained through FOI responses sent by HSC Trusts.

[81] Data obtained through FOI responses sent by HSC Trusts.

[82] This data has been obtained through a FOI request to the Review Tribunal. The exact number of annual applications made by P between 2020 and 2022 is unknown, as it is lower than 5 and the Tribunal cannot provide an exact number lower than 5 due to data protection regulations. Similarly, the exact number of annual applications made by the nominated person between 2022 and 2024 is unknown (for the same reasons) but it is also lower than 5.

If P is deemed to lack capacity to apply to the Tribunal, the case will be automatically referred to the Office of the Attorney General for Northern Ireland (OAGNI). The practitioner completing the assessment will submit a **Statement of Incapacity to Apply to the Review Tribunal** (Form 7)[83] to the Trust Panel, and if the DoL is authorised, it will be automatically reviewed by the OAGNI, which will consider if a further referral to the Tribunal is needed.[84]

TABLE 6. OAGNI's DoLS activity[85]

	Cases received	Referred to RT	% referred to RT
Dec 19 - Mar 21	3358	1440	42.88
Apr 21 - Mar 22	5409	1591	29.41
Apr 22 - Mar 23	5607	1649	29.41
Apr 23 - Mar 24	6091	1183	19.42
Yearly average	5116	1466	28.65

Currently, as the Act has not been fully implemented, the OAGNI's function in regard to the MCA is to refer the question of whether a deprivation of liberty authorisation is appropriate to the Review Tribunal.

Maura McCallion, who is Division Head at the OAGNI, explains that the role of the OAGNI under the MHO and the MCA is very similar. The Attorney had the same power to refer a case to the Tribunal under Article 72 of the MHO. However, there are substantial differences in the routine notification of cases, which has had an impact on the volume of work that the OAGNI has been doing under the MCA.

> *That's the big difference as to why there's so many more referrals now, it's because the Attorney's been put on notice of these cases in a way that wasn't as routine under the MHO. Under the Order, a case might be drawn to the Attorney's attention by a family member or an advocate, or a doctor themselves might say "this person clearly can't apply to the Tribunal, would you have a look at it?" But that would be rare enough compared to now where we have an obligation on the Trust to tell the Attorney. (**Maura McCallion**, Division Head at the OAGNI)*

The OAGNI considers the case and establishes if there are grounds for referring it to the Review Tribunal. The primary reason for referring the case to the Tribunal would be that the information contained in the forms included in the Trust Panel application

[83] Department of Health (2019) MCA(NI) 2016 - Form 7 – Statement that the person lacks capacity whether an application should be made to the Review Tribunal (Statutory Form).

[84] Department of Health (2024) 1.1 Deprivation of Liberty Safeguards (DoLS) overview.

[85] Data obtained through a response to a FOI request sent to COPNI by the OAGNI.

suggests that the person appears to object in some way to the supervision and care provided to him or her. Through the review of the information contained in the forms, the OAGNI aims to elicit the individual's views, to determine what they may be trying to express, and what they would be likely to do if they had decision-making capacity to apply to the Tribunal.[86]

If there are reasons to believe the DoL has been improperly authorised, the Review Tribunal may request additional information. The Tribunal also receives queries regarding the appropriateness of care and treatment, and when necessary, seeks information from the Trust to clarify areas of concern.

However, it is very rare that the Tribunal revokes a DoL. To date, the number of cases in which the Review Tribunal has revoked an application is very small (only 4 authorisations have been revoked from December 2019 to August 2024).[87]

TABLE 7. Case outcome of the Review Tribunal[88]

	Dec 19 Mar 20	Apr 20 Mar 21	Apr 21 Mar 22	Apr 22 Mar 23	Apr 23 Mar 24
Take no action	35	465	1391	1430	1365
Authorisation revoked by RT	<5	<5	<5	<5	<5
Other outcome[89]	48	360	651	393	74

If the authorisation is revoked by the Tribunal, this triggers a Trust review of the situation. The Trust may then request an appeal, which will commence a subsequent appeal process.[90] In terms of living arrangements for the patient, there would be a full review of the person's circumstances. The person will not be automatically discharged from the care home in which they received care and treatment prior to the authorisa-

[86] This information was provided in a personal interview conducted with Maura McCallion, Division Head at the OAGNI.

[87] The exact number of authorisations revoked by the Tribunal was not provided in the FOI response submitted to COPNI by the Tribunal. The Tribunal confirmed that less than 5 authorisations were revoked every year. In an interview with the MCA Implementation Team of the DoH, Phil Hughes, Professional Advisor to the DoH confirmed that this number to be 4 since December 2019.

[88] Data obtained through a FOI response by the Review Tribunal.

[89] NP appointed/revoked; person discharged by Trust; person deceased; case invalid; case withdrawn by Trust/ OAGNI

[90] "A decision by the Tribunal can be appealed on a point of law to the Court of Appeal. Also, as with all decisions by public bodies leave for judicial review can be sought in the High Court". See Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 15.10

tion being revoked. However, the care home may believe that the person cannot receive the care and treatment it requires without the protection of the DoL and, if that is the case, the case will be reviewed to find the best possible arrangement.[91]

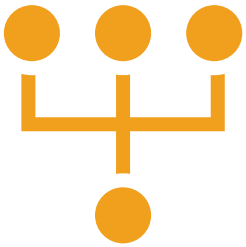
[91] This process was described by Phil Hughes, Professional Advisor to the DoH MCA Implementation Team in an interview with COPNI in August 2024.

KEY FINDINGS

OLDER PEOPLE

In Northern Ireland, it is estimated that one out of 92 individuals older than 66 are deprived of liberty under the MCA. For people aged 76-90, this number grows to one out of 57, and for those older than 90, approximately **one out of every 25 persons are deprived of their liberty in Northern Ireland**. There are an estimated 2,200 individuals between 76 and 90 years of age who are deprived of their liberty under the MCA, which highlights the relevance of this legislation for older people. Stakeholders across the health and social care sectors have reported significant resource issues in older people's MCA teams.

WORKLOAD AND WORKFORCE



The implementation of the DoLS under the MCA has significantly increased workload pressures for all parties involved, including Trusts, the DoH, the OAGNI, and care homes. **The resource demands have exceeded initial expectations**. Trusts have experienced recruitment challenges, while care homes, particularly dementia units, face staffing issues. The OAGNI noted higher than anticipated activity levels, and the DoH has acknowledged that the resources required for implementing the DoLS were underestimated.

EXTENSIONS

DoLS extension reviews continue throughout a person's lifetime. Since 2021, **the number of monthly extensions completed by Trusts has increased by 27%, with an average annual growth of 8.5%**. Extensions now serve as the primary driver of activity for Trusts and the OAGNI. Extensions are less likely to require review by the Review Tribunal, as more cases report no changes in the person's condition. Research participants have reported that the number and frequency of extensions are often frustrating for practitioners, nominated persons, family members and carers, who often perceive little value in completing recurrent extension reviews when P's circumstances remain unchanged.

TRUSTS

In Northern Ireland, Trusts manage the DoLS process by conducting assessments, completing forms, and authorising the DoL. This represents a significant implementation difference with England and Wales. While this approach has advantages—such as reducing the risk of DoLS activity being influenced by bed pressures and standardising procedures—it also presents challenges. Research participants stressed that the workload associated with the DoLS were higher than expected for Trusts. Despite a 20% increase in the number of social workers between 2018 and 2024, and a 27% rise in medical staff, challenges around recruitment and retention remain significant. As a consequence of such pressures, research participants stressed that the **professionals completing assessments are often unfamiliar with P** and P's circumstances.

PUBLIC AWARENESS

Stakeholders have observed that the public tends to ignore the principles and implications of the MCA. For example, there is a common misconception that relatives and friends have decision-making authority over P. Stakeholders have emphasised the need to address these outdated perceptions **and increase public awareness of mental capacity issues**. They also highlighted the importance of encouraging individuals to make advance preparations for the possibility of losing capacity, underscoring the benefits that planning for such a situation can have for each of us.

CARE HOMES

In Northern Ireland, care homes do not have responsibilities for completing assessments or Trust Panel applications, unlike in England and Wales. Nevertheless, representatives of the care home sector have reported **immense workforce and workload pressures, particularly in dementia units.** The sector has called for the urgent introduction of an acuity tool to determine residents' care needs and determining safe and effective staffing levels. Amid these challenges, some care home representatives have openly refused to take on the task of completing DoLS forms. Others, however, have expressed willingness to do so, provided that practitioners are given protected time.

EMERGENCY PROVISIONS

Waiting times for full authorisations of individuals under emergency provisions have been reported as an issue by research participants. According to the data provided by some Trusts, approximately one **out of four emergency provisions are likely to be in place for more than six months**. Approximately, one out of four people that were deprived of liberty across all Trusts was under emergency provisions, and about 6% of all care home residents were under emergency provisions.

IMPLEMENTATION

Statistical variations were noted in the activity levels of Trusts regarding the MCA. **Drastic reductions and increases in activity of more than 300% difference** from one year to the next have been in some areas. The proportion of live DoLs in operation in care homes is up to four times higher in some Trusts than in others. Research participants noted that the thoroughness of the assessments may vary depending on the practitioner completing them, or on the programme of care.

PHASED IMPLEMENTATION

Phased implementation is causing significant issues. In some situations, practitioners are having to work with two different pieces of legislation that cover almost identical circumstances. Stakeholders have pointed out that **the same hospital patient can be processed under both the MCA and the MHO in a very short space of time**. The two frameworks also allow different actions on the part of carers and health professionals, which may lead to legal risks if the wrong legislation is relied upon. The lack of IMCAs and confusion around police powers have also been reported as issues linked to the phased implementation of the MCA.

TRAINING

Stakeholders have praised the Regional Training Group and Trusts for designing and providing high-quality training that meets very high standards. However, nurses and care home managers have called for **additional training that focuses specifically on practical, real-world situations**. This is particularly important for nurses working within a dual legislation context. Also, it is particularly significant due to the high turnover of staff in social care. The DoH states that it remains committed to delivering, reforming, and improving its training programs, continually adapting to new challenges and situations that arise in real life practice.

EVALUATION

What does this evaluation aim to achieve?

There is little doubt that the MCA is a progressive piece of legislation, aligning Northern Ireland with the ECHR and HRA 1998. However, the MCA goes further than simply mirroring rights based standards. It advances the legal framework on mental capacity in ways not seen, for example, in the MCA 2005 of England and Wales. From its inception, and continuing post-enactment, policymakers and legal scholars have praised the MCA for its innovative and person centred approach, placing capacity and an individual's best interests firmly at the centre of the process.

However, the principles of a piece of legislation do not determine in full its practical implementation. Many bodies, institutions, instances of decision making, and professionals are involved in guaranteeing that the law is implemented correctly and to a high standard. The implementation of the law also depends on the available resources and service demand, and the capacity of the system to respond to unexpected issues.

The implementation of the MCA in Northern Ireland has occurred simultaneously with well-publicised struggles in the sector, with the DoH and HSC Trusts attempting to maintain services and stabilise the system in a context of rising costs and limited funding.[92] It may be reasonable to assume that resourcing levels and funding gaps can also impact the delivery of the MCA.

Although the protections introduced by the MCA are undoubtedly essential, there is a clear risk of the workload straining the system's capacity. The current demands on resources risk undermining the efforts of professionals dedicated to ensuring that DoLs are properly implemented to safeguard individuals from arbitrary detention. The great

[92] One of the pillars of the three-year plan for the health services launched by Minister Mike Nesbitt in December 2024 is 'Stabilisation' ("Stabilisation of services, including mitigating the deterioration of some services as a result of budgetary pressures"). The latest budgets from the DoH have highlighted important funding gaps, which has obliged the DoH to cut services to meet raising costs. See Department of Health (2024) Budget 2024-25 - Equality Impact Assessment and (2025) Draft Budget 2025-26 - Equality Impact Assessment. Important savings measures are also being implemented across all HSC Trusts. See Department of Health (2024) Budget update 21 November 2024.

demands for assessments, the large amounts of applications completed and submitted to Trust Panels, and the necessity of completing the process promptly may force practitioners to prioritise speed over thoroughness.

A key ambition of this report is to provide decision makers with an opportunity to reflect on the positive and negative aspects of the first years of implementation of the MCA. The intention is to provide decision-making bodies with an opportunity to consider how the MCA has impacted their work and to what extent they feel capable of meeting its requirements in the future. Additionally, the study seeks to pinpoint areas for enhancing the efficiency of service delivery and strengthening protections within the framework of the legislation.

Existing research, evaluations and shortfalls

A motivation for conducting this review stems from previous research carried out in other jurisdictions with mental capacity legislation. The MCA enacted in Northern Ireland in 2016 shares basic aims and principles with the MCA 2005 that extends to England and Wales. It also shares with this piece of legislation basic definitions of what constitutes a deprivation of liberty derived from Cheshire West. Issues identified with the MCA 2005 may be reproduced in the MCA in Northern Ireland, due to their similar structures—although the system of delivery varies in important aspects described throughout this report.

A recent study by Age UK highlighted a series of shortfalls in the MCA 2005. In particular, the report highlights that the demands derived from the ruling of Cheshire West and the change in the definition of the meaning of DoL that resulted from it, has had an enormous impact on the delivery of the MCA 2005. Some of these issues may, in fact, be transposed to the context of Northern Ireland. The issues identified by Age UK include:

- An enormous backlog of uncompleted applications (126,000 in 2022/23).[93] [94]

[93] Age UK (2024) A hidden crisis: older people and deprivation of liberty in care homes; page 3.

[94] Northern Ireland may benefit from a more advantageous health workforce ratio (3.4) in relation to the general population than England (2.3) and Wales (3.1). However, comparisons between jurisdictions are complex due to the integration of health and social care services in Northern Ireland into the HSC. Calculations based on data from ONS (2024) The healthcare workforce across the UK: 2024, and Office for National Statistics (2024) Population estimates for the UK, England, Wales, Scotland and Northern Ireland.

- Completed applications took an average of 156 days to be authorised (although the statutory timeframe is 21 days).[95]
- Care homes often do not have sufficient staffing levels to deliver care in a way that reflects the human rights principles of the Act.[96]
- Difficulties in recruiting staff for DoLS teams.[97]
- The Best Interest Assessment is in many cases a 'box-ticking' exercise.[98]

These issues may present themselves in a different way in Northern Ireland, as the delivery system of the DoLS process is different. While managing authorities like care homes are responsible for applications in England and Wales and the applications for a DoL are authorised by local authorities, in Northern Ireland the applications are at present completed by practitioners assigned by the Trust and approved by a Trust Panel. The managing authority does not have any responsibility in the DoLS process besides the initial referral to the Trust stating that a patient may lack capacity and, if necessary, implementing emergency provisions.

Other research on the MCA 2005, particularly regarding its impact on frail older adults, revealed inconsistencies in how the Act was applied across various care settings and regions, highlighting challenges for care providers in its interpretation and implementation.[99] Hinsliff-Smith et al (2017) emphasised the need for additional training to equip staff with the knowledge and skills to implement the Act effectively. The authors also criticised the training provided by the Department of Health and Social Care (DHSC) in England as being overly theoretical and insufficiently tailored to practical contexts, such as those encountered in care homes.[100]

Another review of the MCA was conducted by the House of Lords in 2014 and concluded that the ethos of the MCA 2005 had not been properly respected in practice. Frequently, when an individual was assumed to lack capacity, capacity assessments

[95] In consequence, older people are deprived of their liberty for long periods of time before an assessment is completed. See Age UK (2024) A hidden crisis: older people and deprivation of liberty in care homes; pages 3-4.

[96] Age UK (2024) A hidden crisis: older people and deprivation of liberty in care homes; page 4.

[97] Age UK (2024) A hidden crisis: older people and deprivation of liberty in care homes; page 10.

[98] Age UK (2024) A hidden crisis: older people and deprivation of liberty in care homes; page 11.

[99] Hinsliff-Smith, K., Feakes, R., Whitworth, G., Seymour, J., Moghaddam, N., Dening, T., and Cox, K. (2017) 'What do we know about the application of the Mental Capacity Act (2005) in healthcare practice regarding decision-making for frail and older people? A systematic literature review', Health & Social Care in the Community, 25(2): 295-308; page 295.

[100] Hinsliff-Smith, K., Feakes, R., Whitworth, G., Seymour, J., Moghaddam, N., Dening, T., and Cox, K. (2017) 'What do we know about the application of the Mental Capacity Act (2005) in healthcare practice regarding decision-making for frail and older people? A systematic literature review', Health & Social Care in the Community, 25(2): 295-308; page 303

were not carried out adequately and supported decision making was not well embedded.[101] This was all due to a lack of understanding of the principles of the Act by those who had to implement it. Other reviews have asserted that the knowledge of nurses to conduct capacity assessments must improve vastly,[102] and that the absence of central ownership and responsibility on the part of the DHSC in England (as the Act is implemented largely by managing authorities and local authorities) was among the causes of the inadequate implementation of the Act.[103]

A review of the literature conducted by Marshall and Sprung (2018)[104] also found that decisions to apply the MCA 2005 were often made by one person,[105] were influenced by prejudice and personal views,[106] and were largely based on the prevailing clinical agenda and bed pressures.[107]

Early research conducted on the implementation of the Mental Capacity Act (Northern Ireland) 2016 indicates that similar issues related to underfunding, lack of personnel, lack of resources and increased workload for health professionals may already be occurring in Northern Ireland. Boyle et al (2023) conducted an early evaluation of the Act that focused on the experience of social workers. According to their review, social workers were generally satisfied with the training received and the level of support offered by the DoH, although many of them highlighted the need for further guidance on completing capacity assessments.[108] The greatest issue reported by social workers was that of increasing workload and insufficient time.

According to the review by Boyle et al (2023), a Trust Panel application takes on average 11 hours and 23 minutes of work for a social worker, from 4 hours to 30 hours—

[101] House of Lords (2014) Mental Capacity Act 2005: Post-Legislative Scrutiny. London: House of Lords; page 50.

[102] Marshall, H., Sprung, S. (2016) 'Community nurse's knowledge, confidence and experience of the Mental Capacity Act in practice', British Journal of Community Nursing, 21(12): 615-622.

[103] Marshall, H., Sprung, S. (2018) 'The Mental Capacity Act: 10 years on – the key learning areas for healthcare professionals', Nursing: Research and Reviews, 8: 29-38.

[104] Marshall, H., Sprung, S. (2018) 'The Mental Capacity Act: 10 years on – the key learning areas for healthcare professionals', Nursing: Research and Reviews, 8: 29-38.

[105] Brown, H., Marchant, L. (2013) 'Using the Mental Capacity Act in complex cases', Tizard Learning Disability Review, 18(2): 60-69.

[106] Taylor, H. J. (2016) 'What are "best interests"? a critical evaluation of 'best interests' decision-making in clinical practice', Medical Law Review, 24(2): 176-205.

[107] Heslop, P., Blair, P., Fleming, P., Hoghton, M., Marriott, A., Russ, L. (2014) 'Poor adherence to the mental capacity act and premature death', The Journal of Adult Protection, 16(6): 367-376.

[108] Boyle, S., Montgomery, L., and Davidson, G. (2023) 'Implementation of the Mental Capacity Act (Northern Ireland) 2016: social workers' experiences', International Journal of Mental Health and Capacity Law, 29: 24-47; page 30.

although in more complex cases, an application could take up to five days.[109] These obligations are in addition to other priorities for social workers, which raises questions about the capacity of this overworked workforce to deal with the extensive demands of the MCA.[110]

Age

Since the outset of the implementation of the MCA 2005 in England and Wales, and the MCA 2016 in Northern Ireland, the total number of people lawfully and 'officially' deprived of liberty has grown significantly.

A DoL is one of the most serious interferences with a person's human rights. A DoL must always be implemented with the aim of guaranteeing the safety and wellbeing of the person, and always in that person's best interests. If safeguards are not properly applied, the consequences may be serious, with clear implications for legal and human rights. This is particularly significant given the high number of DoLs authorised each year, and the broader social impact that may result from systemic failures.

TABLE 8. Percentage of Trust Panel applications by age[111]

Total	NHSCT[112]	BHSCT	SHSCT
16-17	8.0%	2.1%	1.5%
18-64(65)	4.8%	23.2%	20.2%
65(66)+	87.2%	74.7%	78.4%

[109] Boyle, S., Montgomery, L., and Davidson, G. (2023) 'Implementation of the Mental Capacity Act (Northern Ireland) 2016: social workers' experiences', International Journal of Mental Health and Capacity Law, 29: 24-47; page 34.

[110] While this section has been completed based on the evidence provided by stakeholders—many of which have direct experience with completing applications—and the literature above mentioned, it must be noted that prior to the publication of this report, a Belfast Trust representative approached COPNI to state that "The reference to competing demands on social workers does not reflect the operational model in Belfast Trust. Here, dedicated staff are employed specifically for DoLS work and do not have other competing duties. Moreover, the work is not solely undertaken by social workers. The timescales referenced also do not align with regional audit data."

[111] This data was obtained through responses from the NHSCT, the BHSCT and the SHSCT to a FOI sent by COPNI. The age distribution varies slightly across Trusts. The BHSCT provided an age distribution of Trust Panel applications divided in three categories: 16-17, 18-64 and 65+. The NHSCT provided a distribution of 16-17, 18-65 and 66+. The SHSCT provided an age distribution of 16-17, 18-65 and 66+. The WHSCT responded "It is not currently possible to provide this information as it is currently not recorded". The SEHSCT only provided a breakdown by age for under 18 and 18 and over.

[112] Based on a randomised sample of 125 Trust Panel applications (25 per year since 2020). The NHSCT provided this information alongside its FOI response: "This information is not currently collated by the current NHSCT systems. However, from a randomised sample of the Trust Panel applications from each year, please see breakdown of the age of service users below".

While the MCA does not only impact older people, previous examinations of mental capacity legislation in England and Wales[113] have shown that most deprivations of liberty affect older people. The data obtained by COPNI shows that the same occurs in Northern Ireland.

Up to one out of 92 individuals older than 66 are estimated to be deprived of liberty under the MCA in Northern Ireland. For people aged 76-90, this number grows to one out of 57, and for those older than 90, it is estimated that one out of every 25 persons are deprived of their liberty.[114]

The proportion of people deprived of liberty in Northern Ireland also increases with age. More than half of the total number of deprivations of liberty affect individuals in the age group 76 to 90. This represents 57% of all Trust Panel applications, while this age group is just 7% of the population. The age group of people older than 90, which represents less than 1% of the population of Northern Ireland, comprises 13% of the total number of deprivations of liberty.[115]

TABLE 9. % of Trust Panel applications by age of Person (smaller age groups)

	16-17	18-35	36-50	51-65	66-75	76-90	91+
NHSCT	8%	0%	1%	4%	16%	57%	14%
SHSCT	1%	5%	3%	12%	11%	56%	12%

Apart from the sheer number of older people that are deprived of liberty under the MCA, stakeholders have raised concerns over other issues related to older people that require attention. These concerns included insufficient resources and difficulties recruiting professionals to deliver services.

[113] Age UK (2024) A hidden crisis: older people and deprivation of liberty in care homes.

[114] These numbers have been calculated using the data on the number of total deprivations of liberty in care homes (live DoLs and emergency provisions) obtained through FOI responses from the NHSCT, SHSCT, SEHSCT and WHSCT. These figures were used to estimate the total number of people deprived of liberty across all Trusts, broken down by age groups and compared with population data. According to the data from these Trusts, the average percentage of residents of care homes in emergency provisions is 6.2% (in addition to the people with DoLs in place). Based on this data, the number of people deprived of liberty across all Trusts has been estimated on 3,965 individuals (3,186 care home DoLs reported by all Trusts and an additional 779 that would represent 6.2% of the total commissioned care home placements, which were reported to be 12,559). The estimated number of people deprived of liberty by age group was estimated using the small age groups breakdown obtained in a FOI response by the SHSCT and the NHSCT (3,457 individuals of 66+, 2,252 between 76-90; and 571 older than 91+). These numbers were then compared with the total number of people in these age bands from NISRA's 2023 mid-year population estimates to obtain the final figures.

[115] Data on Trust Panel applications by age was obtained through responses to a FOI request submitted to COPNI by the NHSCT and the SHSCT. Data on structure of the population of Northern Ireland was obtained from NISRA's 2023 mid-year population estimates.

*Across the region, there are significant workload pressures which are impacting front line services. The MCA has added pressure to what was already a strategic challenge in terms of meeting the demand for services with reduced staffing levels … In terms of the quality of the assessments completed for MCA, what can be included in the forms and the quality of assessment can vary. It can vary between Trusts but also between individual programmes of care. A practitioner within one programme of care may complete a very detailed, lengthy assessment whereas staff from another programme of care may complete a very brief, succinct form without the same level of detail. (**Anonymous,** HSC Trust)*

*There is a significant backlog right across the entire network of mental health services in Northern Ireland at the moment for even urgent assessments. Even urgent assessments for child and adolescent, but older people are always worse. They do not appear to have the same level of priority … Growing old is a privilege. You know, many people don't get a chance to grow old. Yet our government doesn't respond effectively with safe staffing. We're continuously on the back foot. Particularly when it comes to older people, the challenge is underpinning the effective provision for dementia. (**Dr Kevin Moore,** Director of Nursing at Dunluce Healthcare)*

Ongoing monitoring of the DoLS process is of the utmost importance, as DoLS represent a cornerstone of rights protections for older people in Northern Ireland. Any issue with the application of the DoLS and any concerns with resources or loopholes in the legislation will, inevitably, affect older people disproportionately.

DoLS process

To evaluate the DoLS process in Northern Ireland, it is essential to first outline how the process operates, as it differs from that in other jurisdictions. This is particularly relevant because the way the DoLS are executed is not strictly defined by legislation, allowing public authorities a certain degree of flexibility in determining how the process is implemented in practice. This review will focus solely on care home DoLS, with some attention also paid at the DoLS currently conducted in hospitals—in particular, the interaction between the MHO and the MCA.

If a care home in England and Wales believes that a person in their care may require a deprivation of liberty, the responsibility to complete an application to obtain a DoL authorisation falls on the care home (referred to as the "managing authority"). The application is submitted to the local authority, which is then required to make a decision within 21 days of receiving the application. If there is an imminent risk of harm, care

homes can issue an "urgent authorisation" to implement a DoL.[116] A recent Age UK report highlighted a significant delay in processing these applications, showing that completed applications took an average of 156 days to be authorised by local authorities in England and Wales—well beyond the statutory 21-day timeframe.[117]

In Northern Ireland, the DoLS process is centrally managed by individual Trusts. If a care home believes that a patient requires a deprivation of liberty, they must make a referral to the Trust informing it of this reasonable belief. The Trust will then assign a practitioner to assess if a Trust Panel application is needed, and if that is the case, the DoLS process will start. The process will involve professionals assigned by the Trust who will complete the necessary forms for the Trust Panel application. Similar to England and Wales, if there is an immediate risk of harm to the person, the care home may implement "emergency provisions".

Phil Hughes, Professional MCA Advisor at the DoH, noted that the legislation enabled care home staff to complete forms, and it was initially planned in 2019 that care home staff would also be trained to play a role in the Trust Panel application. However, she noted that with the onset of COVID-19—placing substantial strain on care home staff—the MCA Implementation Group led by the DoH decided to shift the responsibility for completing assessments of care homes patients onto the Trusts, thereby alleviating some of this pressure on care homes.

Rosaline Kelly (Senior Nurse Professional Practice, Royal College of Nursing Northern Ireland, RCN) believes that the integrated structure of Northern Ireland's health and social care sectors, along with the Trusts' responsibility for the DoLS process, "makes things easier" and adds a level of simplicity to the process in Northern Ireland as compared to England and Wales.

Responsible authorities like care homes in Northern Ireland must make an initial identification of residents who might lack capacity and pass on this information to the Trust's dedicated MCA teams, which will then determine if a DoL is needed. In such a case, the MCA team will then complete the application. As Kelly and Hughes note, the approach adopted in Northern Ireland is not explicitly stipulated in the legislation. The legislation allows for granting authority to the staff members of the "managing authority" to participate in the completion of capacity assessments or best interests assess-

[116] Age UK (2024) A hidden crisis: older people and deprivation of liberty in care homes; page 8.

[117] In consequence, older people are deprived of their liberty for long periods of time before an assessment is completed. See Age UK (2024) A hidden crisis: older people and deprivation of liberty in care homes; pages 3-4.

ments. Similarly, the DoLS Code of Practice allows for managing authorities to complete forms. Moreover, in the case of the Best Interests Determination Statement, the Code of Practice recommends that it should be the care staff carrying out the DoL (D) who should complete it.[118] Despite this, Kelly and Hugues both agree that considerations around care homes' capacity and resources at the time of implementation were significant factors in the decision to relieve care homes of this responsibility.

Home Manager Connie Mitchell further explains that care homes were hesitant to take on this responsibility, noting that they already had "enough work to keep residents safe", a sentiment that was intensified by the challenges posed by COVID-19. Other stakeholders within the care homes sector stressed this reluctance, arguing that such additional demands could be overwhelming. In addition, Aisling Byrne (Responsible Person at Blair Lodge Residential Home) cites difficulties regarding the qualification of professionals, pointing out that many carers in these settings are not members of the qualified professions authorised to complete the necessary forms.[119] [120]

The DoLS process in Northern Ireland presents several advantages that have been highlighted by stakeholders from the DoH, Trusts, care homes, and healthcare staff. One key benefit is the standardisation of procedures, ensuring a consistent approach across the region that does not depend on the internal culture of the care home. In principle, this should reduce the risks of care homes requesting DoLs due to bed pressures. Additionally, this framework alleviates the burden on already strained care homes by removing the pressure to complete forms, which can be extremely time consuming.

However, the system of Northern Ireland is not challenge-free. Assigning the responsibility for DoLS applications to Trusts seems to have led to significant resourcing pressures. Local authorities in England and Wales are issuing DoL authorisations within an

[118] As D is carrying out the DoL, D must be primarily satisfied that the DoL is in P's best interests. "No matter who this person actually is or how many people were involved in the best interests determination, the ultimate responsibility for reasonable belief of best interests lies with the person who is carrying out the deprivation of liberty, D. D can be a care worker, health and social care professional or someone else. D must satisfy himself or herself that the act is in P's best interests to be protected from liability." See Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; sections 6.6 to 6.9.

[119] See the list of professions in Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 11.7. In contrast, in England and Wales, "a mental capacity assessment can technically be conducted by anyone." See Mental Capacity Ltd (N.D) Mental Capacity Act (Northern Ireland) 2016: overview part 2.

[120] This issue would primarily affect residential homes and supported living services, particularly those supporting individuals with learning difficulties. However, it would be less problematic for older people's services. As Rosaline Kelly points out, the manager of a registered nursing home must be a registered nurse, and at least 35% of its staff are also registered nurses.

average of 156 days (way beyond the 21 statutory days), even without the added responsibility of completing the applications. In Northern Ireland, Trusts take on this additional duty, which likely intensifies the existing pressures they face.

The aim of this section is to explore some of the issues raised by stakeholders regarding the functioning of the DoLS process in Northern Ireland.

Emergency provisions

The MCA and DoLS Code of Practice stipulate that six essential safeguards must be completed to lawfully deprive a person of their liberty. However, the MCA acknowledges that completing these safeguards can take time. Prior to completing all safeguards, individuals may be at an "unacceptable risk of harm" if a DoL is not authorised promptly by a Trust Panel.[121] In such situations, the use of emergency provisions is permitted to ensure the immediate safety of the individual believed to lack capacity. These emergency provisions are designed to provide a temporary solution while the formal DoLS process is completed, ensuring the safety of vulnerable individuals during those critical times.

TABLE 10. % of residents on emergency provisions in care homes[122]

Trust	Total care home placements commissioned	People on emergency provision in care homes	%
NHSCT	3321	330	9.94%
SEHSCT	2223	124	5.58%
SHSCT	2248	84	3.74%
WHSCT	1920	64	3.33%

Care providers face liability if they fail to adequately implement emergency provisions. If a DoL is not in place and an individual is at risk of harm, the care provider would be liable should anything occur due to their omission in safeguarding P by not utilising

[121] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; sections 4.4 to 4.6.

[122] Data obtained through an FOI to the HSC Trusts. The BHSCT reported no emergency provisions. Asked about the difference perceived in the data between the BHSCT and others, the Belfast Trust submitted a description of their MCA model: "Since 2021, when a referral is made to the Mental Capacity Act Service in Belfast Trust, the patient is placed under emergency provisions until the DoLS process has commenced. Emergency provisions remain in place for Short Term Detention patients for 2-3 working days, at which time a Short-Term Detention Authorisation is completed. For Trust Panel Authorisation patients, Emergency Provisions remain in place for a maximum of 6 weeks and for an average of 4 weeks. This is because all referrals are allocated within 1-2 working weeks, and it takes on average 4 weeks to process a referral including Trust Panel hearing." If the definition of emergency provision of the BHSCT covers "until the DoLS process has commenced", this would mark a significant difference with other Trusts that could explain the difference observed in the data.

these emergency measures. Consequently, emergency provisions are an essential tool for ensuring the protection of individuals who lack capacity.

> *If you don't implement those and the person left the care home, for example, and came to harm, then of course you could be liable. So, I think that the most important thing would be to understand that you can use the emergency provisions, what they are and then what to do next. (**Rosaline Kelly**, Senior Nurse Professional Practice, RCN)*

Implementing emergency provisions results in the deprivation of someone's liberty, an action that if not carried out adequately presents serious human rights risks. Therefore, when applying an emergency provision, D must adhere to the following two key safeguards to avoid liability as well as ensuring that the POSH condition is met for a deprivation of liberty to take place in an emergency situation:

1) Have reasonable belief that P lacks capacity; and
2) Have reasonable belief that the DoL is in P's best interests.

As the DoLS Code of Practice states, D cannot rely on emergency provisions indefinitely, and the **additional safeguards must be completed as soon as possible**. These additional safeguards are the 'Formal Capacity Assessment', the 'Consultation with Nominated Person' and the 'Authorisation by a Trust Panel'.

> *If the emergency provisions are relied upon the safeguards must be put in place as soon as possible; an application to the Trust Panel must be made without undue delay.*[123]

Despite this, the Act or the Code of Practise do not stipulate a set or maximum length for emergency provisions, aside from the general recommendation of completing additional safeguards promptly.

Some concerns were raised by stakeholder about the length of emergency provisions. The data obtained by COPNI from HSC Trusts shows that approximately one out of four emergency provisions last for longer than six months. This figure is, however, based solely on the information provided by the NHSCT and the SHSCT. In the Northern Trust, 25.8% of emergency provisions had been in place for over six months (85 out of 330 cases), with 19 cases (5.8%) extending beyond a year. In the case of the SHSCT, 22.9% of the total number of emergency provisions extend for more than six months. Stakeholders have expressed concerns about these durations. As Professor

[123] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 7.18.

Gavin Davidson (Queen's University Belfast) argues, six months seems to go beyond the scope of emergency intervention.

TABLE 11. Duration of live emergency provisions[124] [125]

NUMBER OF MONTHS	NHSCT		SHSCT	
	TOTAL	%	TOTAL	%
Under 2 months	136	41.2%	31	37.4%
Over 2 months but less than 6 months	109	33.0%	33	39.8%
Over 6 months but less than 12 months	66	20.0%	19	22.9%
Over 12 months but less than 18 months	9	2.7%	0	0%
Over 18 months but less than 24 months	3	0.9%	0	0%
Over 24 months but less than 36 months	4	1.2%	0	0%
Over 36 months	3	0.9%	0	0%
Grand total	330		83	

COPNI engaged with Trusts and the DoH to discuss the duration of emergency provisions. During these discussions, Trusts highlighted their financial and workforce challenges while cautioning against generalising data from certain Trusts as representative of the overall situation in Northern Ireland. They emphasised that all Trusts had autonomy to implement DoLS from the outset and they operate different models (see

[124] A Freedom of Information request was sent to all NI Trusts asking for a breakdown of live emergency provisions and their duration. Other Trusts responses: *SEHSCT*: "Emergency DOLS duration can be from 1 day to 6 months maximum. Active Emergency Provisions (Jan-Mar25) is 124". *WHSCT*: "The MCA team does not maintain information on the use of emergency provisions. Where these have been applied, they are maintained by the relevant service. The MCA team have reviewed the information it maintains. Where an application has commenced, but is yet to complete, we have identified 64 applications as off the 25th of February 2024, all of these are in the process of being progressed. There are governance arrangements around these processes. When staff identify that emergency provisions are required, they commence the assessments that are required to make application to the panel in a timely way. Emergency Provisions are typically pro-cessed within a 3-month period."

[125] The Belfast Trust reported that the number of emergency provisions was 28 in total, all of them shorter than 2 months. Asked about the difference perceived in the data between the BHSCT and others, the Belfast Trust submitted a description of their MCA model: "Since 2021, when a referral is made to the Mental Capacity Act Service in Belfast Trust, the patient is placed under emergency provisions until the DoLS process has commenced. Emergency provisions remain in place for Short Term Detention patients for 2-3 working days, at which time a Short-Term Detention Authorisation is completed. For Trust Panel Authorisation patients, Emergency Provisions remain in place for a maximum of 6 weeks and for an average of 4 weeks. This is because all referrals are allocated within 1-2 working weeks, and it takes on average 4 weeks to process a referral including Trust Panel hearing." This would mark a significant difference with other Trusts in terms of counting data.

Appendix 1), which may have led to an overrepresentation of emergency provisions in some Trusts.[126] [127]

When asked about the duration of emergency provisions in the NHSCT, a representative from the Trust explained that a review had been initiated "over the past 6 to 9 months" after it had been highlighted that "the distribution of people in emergency provisions was quite wide and there have been service users who had been on emergency provisions for a protracted period of time."

A representative from the SHSCT highlighted that the majority of emergency provisions for those cases between 2 and 6 months and 6 and 12 months (see Table 11) are within the seven Integrated Care Teams services. These Teams face staffing deficits, alongside staffing shortages in Memory and Learning Disability services.

Other stakeholders, particularly care home workers and managers, have reported instances where residents in their care have had emergency provisions in place for over a year. In most cases, they attributed this issue to staff turnover within the Trusts' MCA teams. In any case, the data obtained by COPNI suggests that these situations (emergency provisions in place for more than a year), while concerning, may be more occasional than systemic.

Most stakeholders have suggested that the length of emergency provisions may be a result of **resource pressures**. Connie Mitchell (Home Manager at Aughnacloy House) and Linda Graham (Regional Manager at Spa Nursing) pointed to a possible capacity issue within Trusts, and Lynn Elliott (Director at Home Instead) also highlighted staff turnover within Trusts as a possible reason. Professor Davidson also remarked that there is a risk that resource constraints could lead to an over-reliance on emergency measures.

[126] In Table 11, differences can be observed in the data provided by the Trusts, which may be a consequence of the different models operated by each of them (see Appendix 1 for a description of these models). The proportion of shorter-term emergency provisions (less than 2 months) is higher in the SHSCT than the NHSCT. However, these differences may also be due to the demographics of each Trust and the interpretation that each Trust makes of the need or not to proceed with the DoLS process after a referral (the proportion of DoLs in care home placements commissioned by the NHSCT is about 20.2%, while in the SHSCT is 11.9%).

[127] Some Trusts have provided data on the duration of emergency provisions until the start of the DoLS process. This would represent the time between a referral to the Trust and the moment in which the DoLS process is commenced (for instance, when assessment is made by the Trust, and it is judged that a Trust Panel Application is needed). The duration of emergency provisions under this definition is naturally shorter (in the case of the BHSCT, approximately 5 days). However, the data presented in Table 11 and provided by the NHSCT and the SHSCT expresses the time between the point in which it is deemed that a Trust Panel authorisation is needed, and the moment in which the Trust Panel authorises the DoL.

Karen Harvey (Professional Advisor for Social Work at Regulation and Quality Improvement Authority, RQIA) stressed that emergency provisions were among the most concerning issues identified through RQIA inspections. Harvey stresses that she believes the efficiency of Trusts has increased in reducing the length of the provisions and that the RQIA has found that communication between care homes and Trusts is generally satisfactory. However, she expressed concerns that the duration of these measures is at times higher than what would be desirable.

In conclusion, an emergency DoL should not be prolonged unnecessarily, as there is a clear risk that D may incorrectly assume that P lacks capacity. The MCA mandates that the DoLS process must begin with the assumption that P has capacity until formal safeguards are applied. Even if there is reasonable belief that P lacks capacity and is temporarily deprived of liberty to prevent serious harm, the default position is that P has capacity unless assessed otherwise. Consequently, extending emergency DoLs excessively could undermine their intended purpose. Indeed, such extensions could invite legal challenges, given that P is presumed to have capacity until the end of the DoLS process. Ultimately, prolonging these measures excessively is antithetical to the foundational principles of the MCA.

While stakeholders raised a general concern over the length of certain emergency measures in place, this concern was not considered to be, at present, overly worrisome. However, it was clear that for purposes of effective management the number and duration of emergency provisions should be monitored closely. In this regard, **Trusts and the DoH should expand the data collection available (internally and externally) relating to emergency measures**. The importance of effective monitoring of emergency provisions is demonstrated by the fact that, around one out of four individuals deprived of liberty across Northern Ireland are under emergency provisions.[128]

The data and examples shown here indicate that emergency provisions may be extending beyond what is desirable for all parties involved. In most instances, this situation appears to stem from financial constraints and, most acutely, workforce pressures. In addition, the fact that managing authorities (i.e. care homes) do not participate in the assessment process—unlike in England and Wales—may increase the resource pressures on Trusts and the difficulties in reducing the use of emergency provisions. These issues will be discussed in the following section.

[128] 330 (NHSCT) and 84 (SHSCT) individuals were deprived of liberty under emergency provisions (FOI). As of April 2024, the total number of live TP/Extension Authorisations in the NHSCT was 1034 and it was 414 in the SHSCT. See Department of Health (2024) MCA DoLS Update – April 2024.

Resourcing issues

The implementation of a piece of legislation like the MCA relies heavily on the resources available. Resources influence what individuals responsible for implementation can do and play a critical role in shaping how the legislation is applied in practice at every stage of the process. During COPNI's engagement with HSC Trusts for this research Trust representatives indicated that they often operate over budget, while others, though not exceeding their budget, reported facing significant cost pressures.[129]

Resource availability directly impacts the capacity of Trusts to assign practitioners to conduct assessments, complete necessary documentation, and allocate professionals to sit on Trust Panels. This, in turn, may impact the number of individuals subject to emergency provisions at any given time. If Trusts are unable to allocate personnel to complete assessments and sit on Trust Panels, additional safeguards cannot be completed rapidly.

In addition, once a DoL has been authorised, how it is implemented can vary considerably depending on resources. The specifics of how a DoL is enforced and shaped in P's care plan depend on various resource-related factors, such as staff-to-patient ratios and the availability of supportive tools like wearable technology or falls alarms. The availability of resources at every stage ultimately shapes the application of the legislation.

Apart from the DoH and Trusts, other stakeholders that participated in this review have emphasised that the implementation of the MCA has led to a significant increase in workload for everyone involved. Stakeholders across the board agree that while the MCA has introduced additional responsibilities, it has not been accompanied by a comparable increase in resources to manage the growth in workload. This has resulted in a substantial burden on staff and institutions. This view has been shared by nurses in hospitals, the OAGNI, the social work profession, Trusts, and the DoH.

> *It's obviously extra added workload, but you know you just deal with it. You just … It's getting your head around that. … It's just another thing you have to do. (**Melissa Rutledge**, Registered Nurse at the Southern Health and Social Care Trust, SHSCT)*

> *It's about 500 a month, probably over … It was a new work stream, so that was quite large. Larger than anticipated. We didn't expect the numbers to be quite as high as they are. So,*

[129] Trusts informed COPNI that since 2020/21, they have received £3.5 million in recurrent funding. In addition, the Trusts have allocated £161,604.50 in programme funding for various projects.

> *we've had to recruit new staff for that … I mean, obviously it has challenges, we're in a pretty tight budget situation, so we're doing our best. (**Maura McCallion**, Division Head at the OAGNI)*

> *Some of the challenges are the sheer volume of cases that are being processed through the Trust Panels into the Attorney General's office and then to the Review Tribunal. (**Phil Hughes,** Professional MCA Advisor at the DoH)*

> *I think that the resource implication is significant because I personally don't believe that the MCA can be delivered within the contemporary picture of adult social services. (**Anonymous**, HSC Trust)*

> *They decided to roll this out in nursing homes first. I'm not aware that there was any consultative process within the nursing home sector as to whether the nursing home sector was ready. But certainly, within the formal Trusts where deprivations were taking place continuously, the Trusts definitely weren't ready for a fundamental shift from the Order to the Act. (**Dr Kevin Moore,** Director of Nursing at Dunluce Healthcare)*

The challenges faced by stakeholders are considerable, often making it difficult for hospitals, Trusts and care providers to fulfil in due time the duties mandated by the Act. Such challenges will be examined in this section.

While most stakeholders acknowledged the need for additional resources, they also acknowledged that the current financial climate in the health and social care sector makes it unlikely that a substantial increase in funding will occur in the near future. Being aware of this reality, stakeholders attempted to identify ways to enhance the efficiency of the system without a significant increase in resources and without compromising the rights and protections of residents and staff.

- *Staffing issues*

Some stakeholders connected with HSC Trusts interviewed by COPNI have argued that the dedicated **MCA teams are "under-resourced" and "understaffed."**[130] They highlight challenges in recruitment of staff and argue that more professionals are needed to carry out adequately the DoLS processes across the region. According to sources within Trusts, the MCA has added significant pressure to what was already a "strategic issue of workforce retention and recruitment." A **shortage of social workers** to meet the demands of the DoLS process and the consequent delays in completing authorisations were repeatedly highlighted.

[130] See Appendix 1 for a description of the service delivery model of the HSC Trusts.

TABLE 12. Proportion of MCA forms completed by type of professional[131]

	Form 1	Form 2	Form 4	Form 5	Form 6	Form 7
Social work	86.31%	96.39%	93.73%	94.30%	0.00%	93.47%
Nurse	10.46%	3.42%	5.89%	5.32%	0.00%	5.05%
Medical	1.90%	0.00%	0.00%	0.00%	100.00%	0.84%
AHP	1.33%	0.19%	0.38%	0.38%	0.00%	0.63%
Other	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

The structure of the DoLS process in some Trusts places a lot of responsibility for leading the process on the social work profession.[132] [133] Considering this, it would be expected that Trusts would require additional financial and workforce resources to allocate social workers to complete assessments. However, Trust representatives have informed COPNI of the challenges they face in recruiting professionals to conduct these assessments.

> *Within our Trust, we have practicing social workers who are doing additional hours as well as staff who have retired who complete bank hours each month. That is problematic, in that bank provision by its nature can be inconsistent.[134] We would see the availability of staff would vary throughout the year. (**Anonymous**, HSC Trust)*

Even though the rate of social work professionals being hired by HSC Trusts has increased by 19.9% since 2018 (see Table 13), it seems that Trusts are still experiencing issues in to meeting their obligations around the DoLS. The need for a consistent inflow of social work professionals within the sector is evident in HSC workforce statistics. The vacancies rate for the social work profession within the HSC sector remains

[131] Based on responses to FOI requests submitted by the NHSCT, SHSCT and SEHSCT. The BHSCT submitted data, but it only included percentages and not overall numbers, and therefore, the numbers could not be added to the table above. However, the data from the BHSCT seemed to be different from the rest. Forms 1-7 (excluding Form 6, completed always by a medical professional): Social work (42%), Nurse (48%), Medical (0%), AHP (10%), Other (0%).

[132] According to stakeholders, social workers lead the process when care home residents require a deprivation of liberty, while nurses lead the process for hospital patients who require a DoL prior to their transfer into a care home.

[133] "Under the Mental Capacity Act (Northern Ireland), a capacity assessment requires a 'suitably qualified' professional to complete. This can include a wide range of health professionals who must have at least 2 years' experience as well as specific training. This is different to England and Wales, where a mental capacity assessment can technically be conducted by anyone." See Mental Capacity Ltd (N.D) Mental Capacity Act (Northern Ireland) 2016: overview part 2.

[134] Asked about the issue of bank staff, Phil Hughes confirmed that the use of bank staff was due to an informed decision by the Trusts: "An informed decision was made in February 2020 to actively recruit experienced staff who had retired within the previous 2 years and were not in a position to do face to face work to support the covid response. This meant we brought back very experienced doctors, nurses and Approved Social Workers who could continue to support the implementation of the MCA and inform the development of innovative ways of working."

high and has increased every year up to March 2024 (see Figure 1). In other words, more social workers have been hired, more social worker roles have been advertised, and more social workers are being registered with the NISCC (see Figure 2).

FIGURE 1. HSC social workers active vacancies (2017-2024)[135]

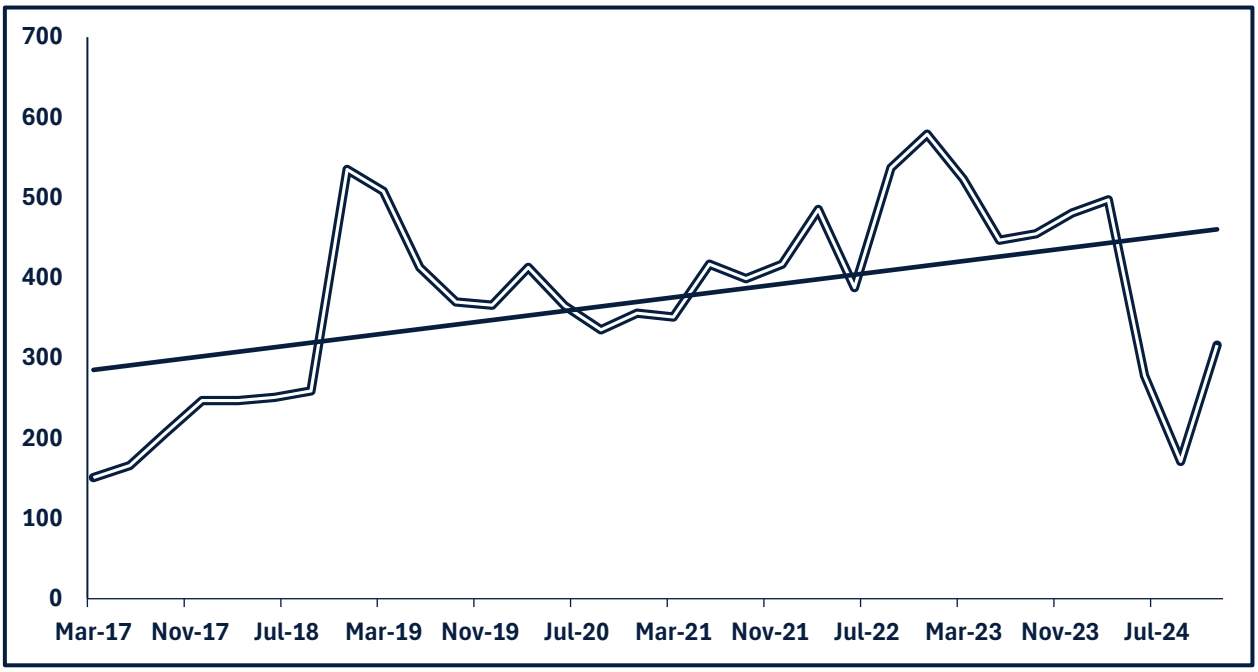


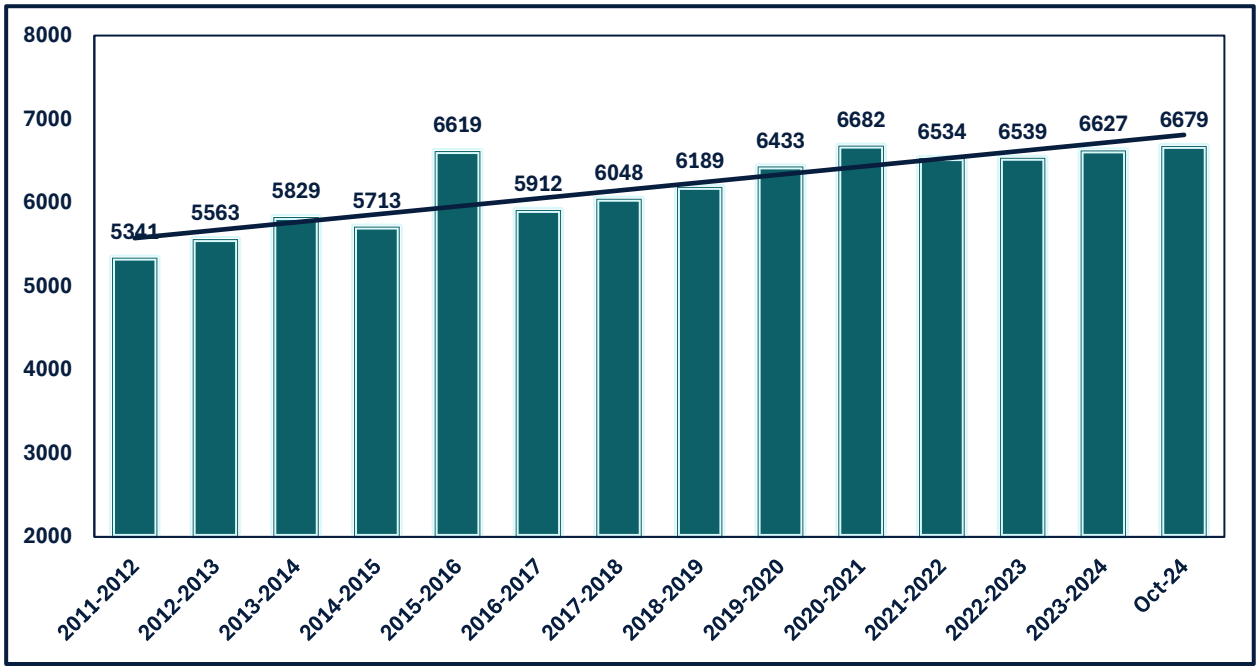
TABLE 13. Total number Social Workers by HSC Trust (2018-2024)[136]

	2018	2024	% increase (2018-2024)
Belfast Trust	955	1,109	16.13%
Northern Trust	939	1,028	9.48%
South Eastern Trust	643	833	29.55%
Southern Trust	704	846	20.17%
Western Trust	732	915	25.00%
HSC Board & Regional Services	50	91	82.00%
Total	4,023	4,824	19.91%

[135] Department of Health (2024) Northern Ireland health and social care (HSC) active recruitment statistics December 2024; "Table 6: HSC Vacancies Actively Being Recruited by Profession, 31 March 2017 to 31 December 2024".

[136] Department of Health (2024) Northern Ireland health and social care (HSC) workforce census March 2005 to March 2024; Northern Ireland Health and Social Care Workforce Census March 2024, Northern Ireland Health and Social Care Workforce Census Tables March 2018; "Table 5a: Social Services Staff (excluding domiciliary care) by Trust. Calculation based on all social work professionals (excluding Social Care Staff and Other Social Services Staff)".

FIGURE 2. NISCC Social Work Registrants by Year[137]



These pressures are not just limited to the social work profession. Sources in the DoH have also identified **issues with medical staff resources**. All Trust Panel Applications and Extension Authorisations require a medical report (Form 6 and Form 14), indicating that the medical profession must be involved in crucial stages of the assessment process. The medical assessment components can only be undertaken by medical staff who have sufficient experience and training. The DoH has indicated that medical staff availability to undertake MCA work was challenging for all Trusts, especially during the first year of the implementation.[138]

Similar to the workforce increases and vacancies outlined above for the social work profession, the HSC sector has ramped up its recruitment efforts (Figure 3) and workforce (Table 14) of medical professionals. The headcount of medical professionals across the region is today 27% higher than it was in 2015. Despite this, Trusts experience continuous pressure due to the demand for medical assessments that are needed for all Trust Panel applications and extension authorisations.

[137] Data obtained through a FOI to NISCC. Includes registrants in all HSC Trusts, Probation Board for Northern Ireland, Barnardo's, Self-employed/Independent, and Youth Justice Agency.

[138] "This was partially due to the impact of Covid but also due to ongoing competing pressures in the acute settings. Four of the five Trusts resolved this issue within 2 years of implementation through improved training, focused medical leadership, and strong governance arrangements. WHSCT has improved its acute medical involvement over the last year and continues to work through their engagement plan."

FIGURE 3. HSC medical active vacancies (2017-2024)[139]

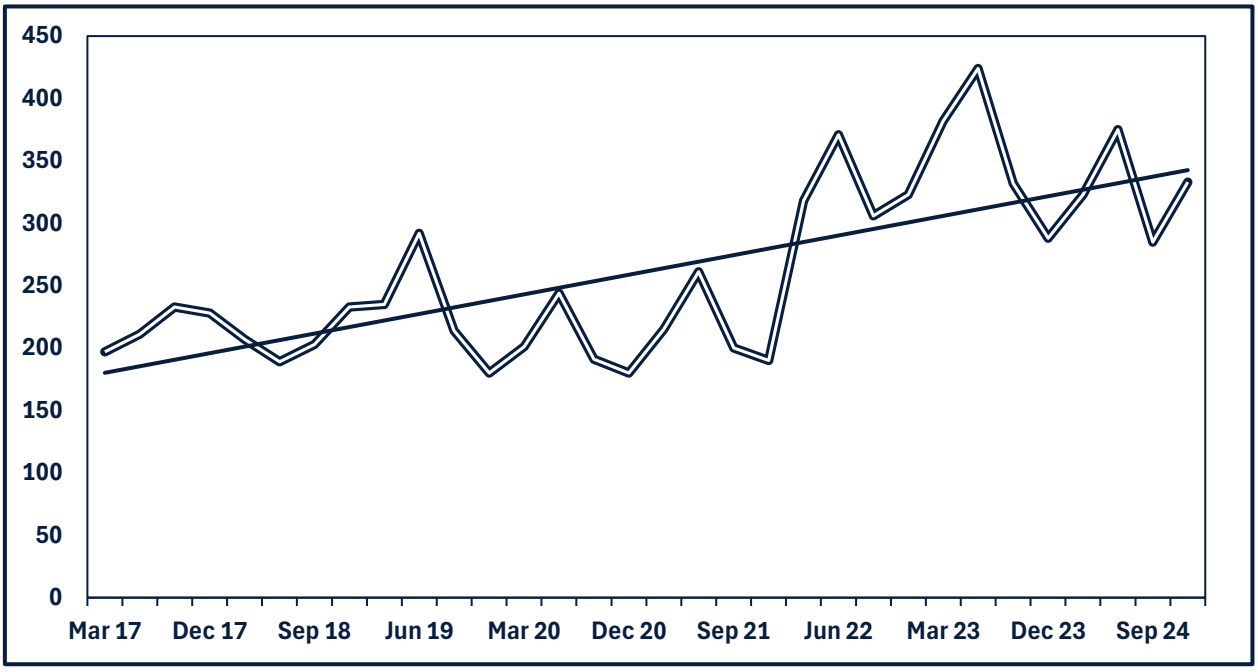


TABLE 14. HSC medical workforce (2015-2024)[140]

Year	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Headcount	4,276	4,308	4,402	4,519	4,654	4,851	5,179	5,196	5,254	5,442
	Difference		% increase							
2015-2024	1,166		27.27%							

For this reason, stakeholders suggested that changes in the DoLS process would be beneficial. It was argued that changes should factor in the current levels of supply and demand, taking into account the likelihood of reduced funding and workforce constraint in the coming years. Stakeholders suggested that in the likely scenario that the DoH spending remains restricted, changes in the operational aspects of the MCA should be considered. Even the modification of primary or secondary legislation, which would be much more difficult to implement, was suggested.

These financial and strategic difficulties were also acknowledged by the department's MCA Team. Debbie Sharpe (Head of the MCA unit at the DoH) stated that the department is aware that the DoLS process possibly requires more resources than initially

[139] Department of Health (2024) Northern Ireland health and social care (HSC) active recruitment statistics December 2024; "Table 6: HSC Vacancies Actively Being Recruited by Profession, 31 March 2017 to 31 December 2024". Total Medical (excluding dental).

[140] Department of Health (2024) Northern Ireland health and social care (HSC) workforce census March 2005 to March 2024; Northern Ireland Health and Social Care Workforce Census March 2024, Northern Ireland Health and Social Care Workforce Census Tables March 2018; "Table 2a: Medical & Dental Staff by Trust".

envisaged. According to Sharpe, the department expects to conduct a programme of work to develop an updated implementation plan that will determine the level of resources needed to implement the rest of the Act.

It is likely that additional resources and strategic adjustments will be necessary to improve the functionality of the DoLS process and align it with the current resource landscape. The following section outlines stakeholder suggestions to achieve this goal.[141]

- *The role of other professionals and the managing authority*

One of the most common themes that stakeholders involved in the DoLS process have raised is the possibility of engaging other professionals and institutions in the DoLS process. This would include managing authorities (i.e. care homes).

As shown in the previous section, participants pointed out that an entire tranche of work has been placed almost entirely on social work and medical practitioners in terms of managing the process. In consequence, the pressures placed on these professions and on Trusts remain consistently high. Engaging other professions in the DoLS process could reduce this pressure.[142] Although it is difficult for COPNI to assess how realistic this suggestion is, the MCA was envisaged to be multidisciplinary, and the DoLS Code of Practice lists seven professions that can assess capacity and complete Trust Panel applications:

a) Social worker
b) Medical practitioner
c) Nurse or midwife
d) Occupational therapist
e) Speech and language therapist
f) Dentist
g) Practitioner psychologist[143]

[141] The issues with workforce level in this section are well-documented and researched, and other Trusts and the Department were keen to highlight such issue in the report. Nevertheless, it must be noted that a member of the Belfast Trust approached COPNI prior to the publication of the report to state that "The staffing constraints described do not reflect the arrangements in Belfast Trust. We have not experienced challenges in recruitment or retention, nor are DoLS assessments placing strain on any core team. A central MCA Service is in place, ensuring timely assessments and meeting demand."

[142] This would be limited in the case of medical practitioners, which must conduct medical assessments that cannot be done by any other professionals.

[143] This list is included in the Code of Practice to enumerate the professions that can conduct Formal Capacity Assessments and can make applications to a Trust Panel. See Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; sections 8.9 and 11.7.

Another issue that arose during COPNI's engagement with stakeholders is the possibility of managing authorities participating in the DoLS process through the completion of forms for Trust Panel applications. As mentioned previously, in Northern Ireland, the DoLS process in entirely conducted by Trusts without the participation of managing authorities, a situation that differs from that of England and Wales. This reliance on Trust resources is putting additional pressure on the already stretched services provided by Trusts. The participation of care homes in the DoLS process could relieve Trusts from some of their most acute resource challenges.

In addition, within the current DoLS process in Northern Ireland, D is not conducting the capacity or best interests assessments. Stakeholders within Trusts noted that when the Act was introduced, the initial expectation was that care homes would participate in the process. This is referred to in the DoLS Code of Practice. The initial expectation was that the worker who has the best understanding of P should be the person completing the forms—especially the Best Interests Determination Statement. This was to ensure that the person applying for a Trust Panel authorisation would have ample knowledge and understanding of P. This would increase P's protections, safeguards and participation in the process. The guidelines within the Code of Practice state that D—the person caring for P and carrying out the DoL—would be the most suitable person to conduct the best interests assessment.

> ***Who must make a best interests determination?***
>
> *6.6. The person ("D") who carries out the act in relation to P has responsibility for making sure that the act is in P's best interests …* [144]
>
> *6.8 … No matter who this person actually is or how many people were involved in the best interest determination, the ultimate responsibility for reasonable belief of best interests lies with the person who is carrying out the deprivation of liberty, D. D can be a care worker, health and social care professional or someone else. D must satisfy himself or herself that the act is in P's best interests to be protected from liability, regardless of whether D has made the best interests determination independently or on the basis of evidence provided by others.*[145]

Although the Code of Practice does not determine that D *must* be the person conducting the best interests assessment, it emphasises the need that the person conducting

[144] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 6.6.

[145] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; section 6.8.

the assessment should have deep understanding of P, which makes D the most suitable person.

This does not mean that the practitioner assigned by the Trust is unaware of P's circumstances, as there is a statutory duty in place to gather information from people who know P. However, a representative of a Trust has argued that within the current system and due to workload pressures, the Trusts are not capable of ensuring that the social worker sent by the Trust has sufficient knowledge of P.

> *The ideal of the social worker who knows P conducting the assessments is often not happening in practice. The social workers have such significant workload issues that they are not able to assume additional MCA tasks, as such the work is then completed by bank staff. (**Anonymous,** HSC Trust)*

For this reason, involving managing authorities (i.e. care homes) in the DoLS process could relieve the workload currently assumed by Trusts. However, this issue is controversial. As highlighted above, during the COVID-19 pandemic, the DoH decided to release managing authorities from their responsibilities in filling in forms and completing Trust Panel applications with the intention of not straining further the resources and the pressures that care homes were experiencing. Yet, it is evident that circumstances today are different, and perhaps managing authorities would now be in a better position to participate in the process.

However, many representatives from the care home sector that engaged with COPNI did not seem willing to assume this responsibility. Some care home managers and care home workers stated that they had openly voiced their refusal to undertake this work in the past to the DoH.

Connie Mitchell, a nurse and Home Manager at Aughnacloy House, claims that care homes generally were opposed to completing Trust Panel applications, stating that staff have "enough work to keep residents safe." For Mitchell, assuming the responsibility to complete the forms in circumstances in which resources are already stretched would be irresponsible towards residents and staff.

While not all care home managers expressed themselves openly against the possibility of completing the forms, they all acknowledged that it would have an impact on workload pressures. Linda Graham, a Nurse and Regional Manager at Spa Nursing Group, observed that she was trained to complete forms because of the initial expectation that the person working with P would do it. She acknowledged the importance of knowing P in a personal capacity, and the benefit of having established good relationships with P to be in a good position to complete the assessment. She also

stressed that Trust workers frequently require the assistance of nurses who know the person well, as they often lack the knowledge of P due to lack of contact.

Others, however, stressed that **given the current workload of care home workers, adding Trust Panel applications to it would be too much of a burden** at present:

> *I do think some of the nurses might say they wouldn't want that responsibility or to hold that responsibility. That would just be an opinion that I think some of them would hold. (**Aisling Byrne**, Responsible Person at Blair Lodge)*

> *It would be an issue of capacity for the nurses. Most nurses that are working within the nursing home sector are literally, you know, paperwork, paperwork, inspections, RQIA inspections, Trust inspections, care plan reviews... You know, I could imagine if I walked into a nursing home now and said like "we want to send you on the training so that you can form part of the Trust Panel or do capacity assessments" they probably would run 100 miles in the opposite direction. Not because they don't necessarily want to do it. The problem is, what will we take off them to enable and facilitate them to do it? (**Dr Kevin Moore,** Director of Nursing at Dunluce Healthcare)*

Trusts and social work professionals seem to be overwhelmed by having the sole responsibility for the DoLS process. It also seems that staffing and resource issues are not going to improve in the foreseeable future. The situation appears to require a strategic reform of the process, which could **involve the participation of other professionals and other institutions**, since the Act and the Code of Practice make provision for that, and doing so would not require legislative changes. However, if this is to be done, consideration should be given to the concerns of care home professionals over the workload they experience—both in terms of caring for patients and adhering to other administrative procedures. If care homes are to assume some responsibility for completing forms—which they do not seem to fully oppose—it would probably require the protection of their time in other areas. Moreover, some flexibility could be considered in involving care homes. While some care home managers expressed open opposition to conducting this work, others thought that this work could actually have benefits to the therapeutic relationships within the care home, and indicated they weren't entirely opposed to undertaking this responsibility. Therefore, the participation of some care homes in the DoLS process on a voluntary basis could be considered.

- *Additional resources*

Not all deprivations of liberty are the same. The care arrangements outlined in a person's care plan when deprived of liberty depend on various factors. Many of these factors are associated with the individual's behaviour, such as whether they exhibit exit-

seeking tendencies, aggression, or self-harming actions. Other factors relate to the capacity of the care facility to provide a safe level of care, proportionate to the person's needs, which would in turn depend on the resources available to adequately provide such care. In practical terms, a person who is under a DoL can enjoy a higher or lower level of freedom, depending on the care provider's access to workforce, technologies, etc.

Generally, care home representatives agreed that **more staff would be beneficial for good therapeutic relationships that would enhance patients' safety and well-being**. The majority of representatives referred to the need for the DoH to develop acuity tools or safe staffing legislation to achieve this goal.[146]

> *There are two things that probably have impact, money and workforce … Maybe a person with dementia needs to be on a one to one for their own safety, but because that provision is not there, you haven't allocated staff to it, you might may not have the funding to do that based on a regional rate that the care homes get. (**Aisling Byrne**, Responsible Person at Blair Lodge).*

> *Our government doesn't respond effectively with **safe staffing**. We're continuously on the back foot. Particularly when it comes to older people, the challenge is undermining the effective provision for dementia. (**Dr Kevin Moore,** Director of Nursing at Dunluce Healthcare)*

> *I would say what we need is training … and again, more resource in terms of staffing (**Yvonne Diamond**, Responsible Person at Wood Green Healthcare)*

> *I think one of the best things that would help support residents living in a care home would be an **acuity tool** that would assess residents' dependency needs and that would impact on the staffing ratios to support residents. I'm thinking more of residents living in dementia care homes. I think the ratio of staff to residents with dementia should be higher. (**Connie Mitchell**, Home Manager at Aughnacloy House)*

Professor Gavin Davidson also noted that "there's a difference between the least restrictive option if resources were unlimited and the least restrictive option that's currently available".

Although the term "deprivation of liberty" tends to be seen as a blanket term, the way in which a deprivation of liberty is enforced and the level of restriction that it involves in a person's freedom varies enormously. Dr Danielle McIlroy (Lecturer at QUB) notes

[146] A consultation to bring forward safe and effective staffing legislation was recently conducted by the DoH. The consultation period closed on the 14th of October 2024. See Department of Health (2024) Safe and Effective Staffing Legislation in Northern Ireland Consultation.

that a deprivation of liberty can include a “keypad exit and one-to-one support staff” for one person, and “having a watch or tracker and supervision” for another. Although the implementation of the safeguards is different, both individuals are deprived of their liberty.

In this regard, stakeholders mentioned examples of additional resources that could increase freedom for P, besides staffing. Technology was referred to several times as key to improving the freedom for P even when P is under a DoL.

> *Some of the restrictions in the home can be as high as having direct supervision 1 to 1. That is quite invasive and distressing at times for a resident. Our least restrictive options would be general supervision in a communal room. We could also use some technology such as alarm mats, pressure mats, things like that. I know the Trust are supporting us at the moment in obtaining a light laser that triggers when someone breaks the beam because of very high risk of falls, as it's less restrictive than having someone sitting watching the person in case they get up and fall. (**Connie Mitchell**, Home Manager at Aughnacloy House)*

> *Sometimes a person could come to harm because they don't know how to use the equipment in their house, or they could get lost coming back from the shop or something like that. So, there's so much like assistive technology. For example, if I did have a little tracking device that I could put into your watch and I knew that you'd gone up to the shop, but you took the wrong turn on the way home, then I could go and get you. And I don't need to keep you locked up or walk you up and down to the shop all the time. (**Rosaline Kelly**, Senior Nurse Professional Practice, RCN)*

In conclusion, resourcing issues have arisen at all stages of the DoLS process, and even after a DoL is in place. This may be, in part, a consequence of the novelty of the legislation, because a new legislation like the MCA may involve higher costs than initially envisaged.

Trusts and social workers have been assigned a level of workload that was likely not envisaged initially. This has clearly caused difficulties for Trusts attempting to fulfil their responsibilities, while subject to a shortage of the necessary professionals needed to conduct the DoLS process. Despite an increase in the number of social workers being hired across the HSC sector, and an increase in the number of social workers registered with the NISCC, the number of vacancies for social workers across all Trusts has not only remained high since implementation but has increased over the years. Trusts and other stakeholders have unambiguously stated that HSC Trusts were not ready to undertake the workload arising from the MCA and are still unable to operate its procedures smoothly.

In order to alleviate the pressures on Trusts, additional funding would be welcomed. However, the participation of other professionals, practitioners and institutions in the DoLS process might also be needed for greater efficiency. Under the present circumstances—with limited funding and workforce availability—and with no operational changes, it seems unlikely that Trusts will ever be able to adapt to the demands they face and deliver the DoLS process as smoothly as they would desire.

Extension activity

Among the Trusts' current obligations arising from the MCA, one of the most time and resource consuming is the extension activity. Extensions, with the requirement to review periodically P's circumstances (every six months during the first year, and every twelve months thereafter), constitute an essential safeguard of the MCA, and comprise a substantial amount of work for Trusts, social workers and the OAGNI. For Trusts, extensions require a constant use of resources that make it difficult to fulfil other core duties of the act.

> *A Trust Panel application could take somewhere between 8 and 9 hours of dedicated time to complete… An extension takes approximately 4-5 hours on average to complete. For example, if we complete 100 extensions within a month, that's approximately 400 hours, factored out over the course of a year, that is a significant bulk of time. Regionally there could be as many as 3500 extensions completed within a year, so again the resource implication of the volume of work is significant. (**Anonymous**, HSC Trust)*

The level of activity in terms of Trust Panel authorisations across all Trusts seems to have stabilised during the past two and a half years, following an initial rush of activity in the months and years that followed December 2019. After the initial influx of new cases that required a Trust Panel authorisation (around 3700 Trust Panel applications were submitted in 2021[147]), the number of new applications has stabilised to approximately 2000[148] per year in 2022 and 2023.

In contrast, the number of extension authorisations has increased steadily since the implementation of the Act, and the proportion of work that Trusts dedicate to extensions in the period 2023-2024 was much higher than it was in the period 2020-2022.

[147] This number has been estimated from a response obtained by COPNI to a FOI request from the NHSCT (694 applications in 2021), the WHSCT (641), the SHSCT (885) and the BHSCT (885). A total number (3726) has been estimated based on the data from the other Trusts to include the SEHSCT.

[148] This number has been estimated from a response obtained by COPNI to a FOI request from the NHSCT (612 applications in 2022 and 419 in 2023), the WHSCT (495 in 2022 and 480 in 2023), the SHSCT (338 in 2022 and 221 in 2023) and the BHSCT (218 in 2022 and 519 in 2023). A total number (1,995 in 2022 and 1,966 in 2023) has been estimated based on the data from the other Trusts to include the SEHSCT.

Therefore, the number of hours dedicated to extensions has increased significantly, and given the nature of this work—namely, that it must be conducted regularly throughout a person's entire life while deprived of liberty—it seems unlikely that a substantial reduction in the workload requirements around extensions will occur.

TABLE 15. Trust Panel Applications and Extensions[149]

	Trust Panel (TP) DoL Applications	Extension Authorisations	Total	% of extensions
2 Dec 2019 to 30 Nov 2022	9132	6875	16007	42.9%
1 April 2023 to 26 April 2024	2350	3900	6250	62.4%

Not only does the work relating to extensions constitute a significant workload for Trusts, but it does also for the OAGNI.

> *Extensions, we could be looking at them every six months for the duration of their adult life for example. The anticipated situation is that someone with a learning disability who has an authorisation in place maybe at age 19, their condition, the situation might change. And the Attorney is notified and on a six-monthly basis so she can have a look at the paperwork and check whether there's any need to refer to the Tribunal at that point. (**Maura McCallion,** Division Head at the OAGNI)*

Extensions are meant to provide a higher level of protection for P. If a proper revision of P's case is conducted regularly through extension reviews, it will take no longer than 12 months for Trusts, OAGNI or the Review Tribunal to identify any relevant changes in P's condition, and release P from the DoL if appropriate. If such revisions are not conducted, this could impact on P's rights and well-being should changes occur and the Trust is not notified through periodical reviews.

However, there are other mechanisms in place to protect P if their capacity status changes. The care home, as Phil Hughes (Professional MCA Advisor at the DoH) observes, has the obligation to report to the Trust immediately when they suspect that these circumstances have changed. Therefore, care homes have the duty to report changes in capacity status at any stage without waiting for the Trust to conduct an extension review and the OAGNI to consider it.

The number of extensions is growing annually (see Figure 4), but based on the data of the OAGNI, it seems that fewer of them are further referred to the Review Tribunal.

[149] Department of Health (2024) MCA DoLS Newsletter, April 2024; Department of Health (2024) MCA DoLS newsletter, December 2022.

The OAGNI is less likely to refer extensions to the Review Tribunal, as compared to new applications.

FIGURE 4. Trust Panel Applications and Extensions[150]

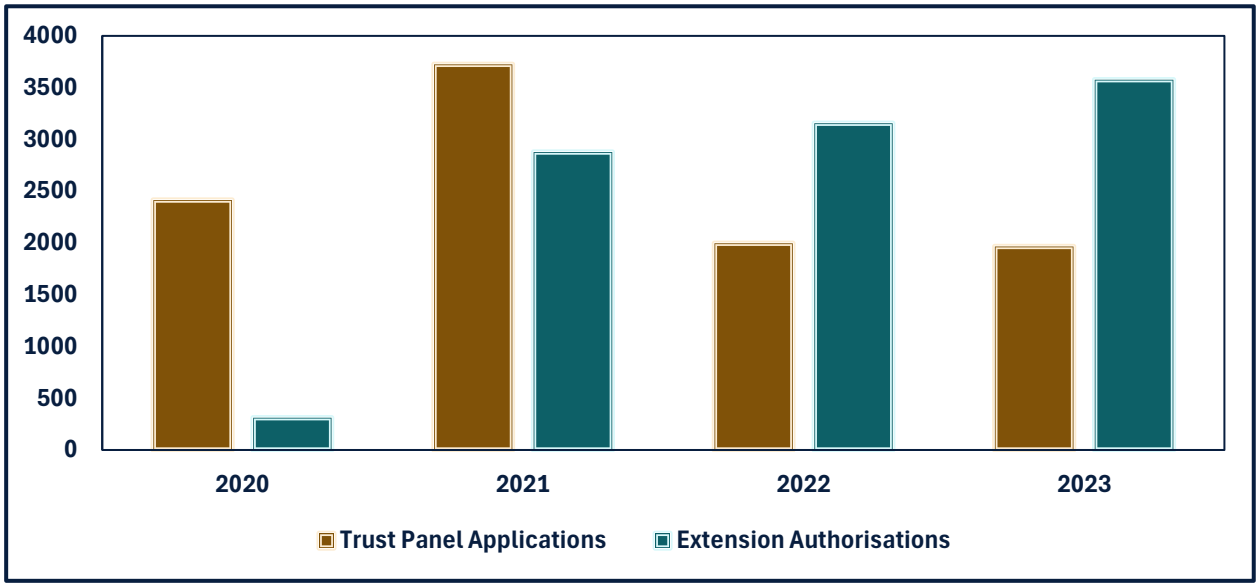
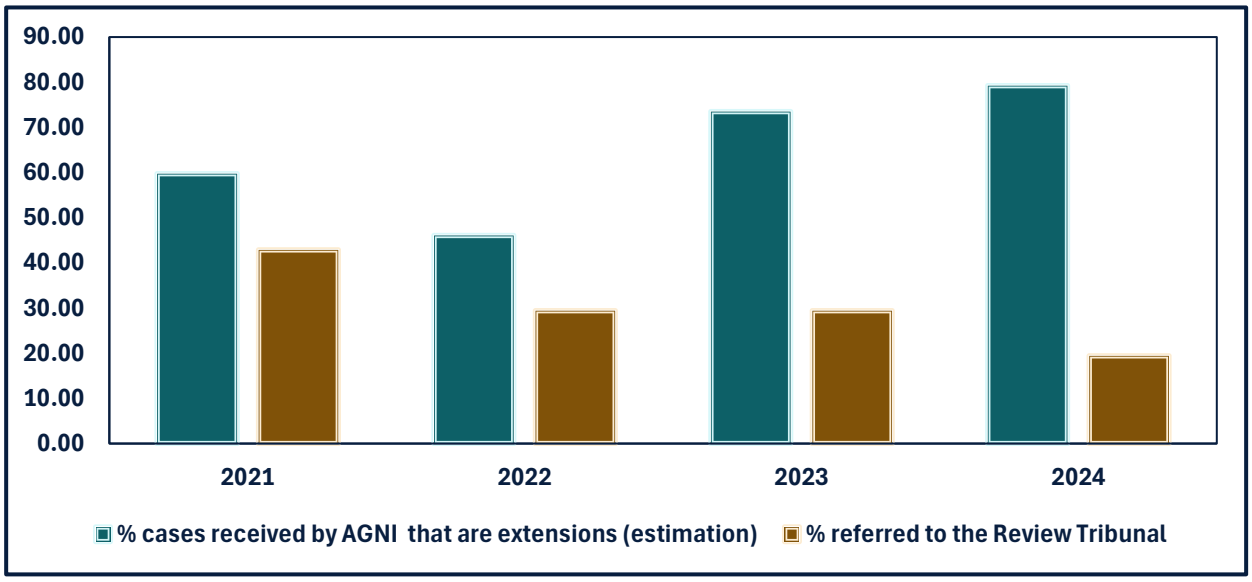


FIGURE 5. % of cases received by the OAGNI and referred to the RT (by type)[151]



[150] Data obtained through responses sent to a FOI by the BHSCT, NHSCT, SHSCT and WHSCT.

[151] This graphic shows an estimation of the proportion of cases received by the OAGNI per year that are extensions (the rest of them are new Trust Panel applications that contain a Form 7). It also shows the proportion of cases that the OAGNI refers to the Review Tribunal in the same period. It shows that the more extensions the OAGNI receives, the lower number of cases it refers to the Tribunal. The estimated proportion of extensions has been calculated using the total number of cases received by the OAGNI (information provided in response to a FOI to the OAGNI) and the total number of new applications that contain a Form 7 (information provided in response to a FOI to all HSC Trusts, although the final figures are estimated as the SEHSCT did not respond). The dates may not fully coincide. The information provided by the OAGNI corresponds to periods between April and March. The year "2021" includes the three extra months between December 2019 and March 2020.

As shown in Figure 5, as the proportion of cases reviewed by the OAGNI that are extensions grew, the proportion of cases referred to the Review Tribunal decreased. This may relate, partly, to the fact that a person's deprivation of liberty has been reviewed at an earlier stage.[152]

This is a significant indicator that extensions are less likely to require revision, as the situation of P in most cases does not change. The extensions conducted by Trusts and reviewed by the OAGNI are an additional safeguard for P. Yet, stakeholders expressed concern that in most cases the circumstances remain unchanged, and that resources are being used in extension reviews in which the possibility of P regaining capacity is often non-existent. Stakeholders also reported that in these situations—for instance, if P's condition is irreversible—extensions can also be frustrating for family members.

> *Nominated persons are saying "why are we doing this?" You know, "my mother, my father, my brother is settled". We're getting to the position where families are saying "this is not useful, why are you wasting my time and your time?" (**Anonymous,** HSC Trust)*

Stakeholders explained that each extension requires substantial coordination and paperwork, involving a team to track deadlines, allocate responsibilities, and complete documentation. Many patients have already undergone their fourth or fifth extension with no change in their condition. Considering the resourcing pressures on the Trust, the extension activity is likely having an impact on other key safeguards.

From this viewpoint, the initial Trust Panel application and its related safeguards appear to be more essential than extensions. This is due to the fact that the initial application and authorisation process guarantees the completion of an initial set of safeguards that were absent until the completion of the DoLS process. In contrast, for a person deprived of liberty with an authorised application, all safeguards have been implemented (and in most cases have been reviewed on a number of occasions). The purpose of extensions is to confirm that the DoL is still needed. This does not mean that extensions have no value, or that they do not provide a much-needed layer of protection. However, as extensions operate in perpetuity, they can become an unproductive or unthinking rote process, especially those that cover younger individuals with

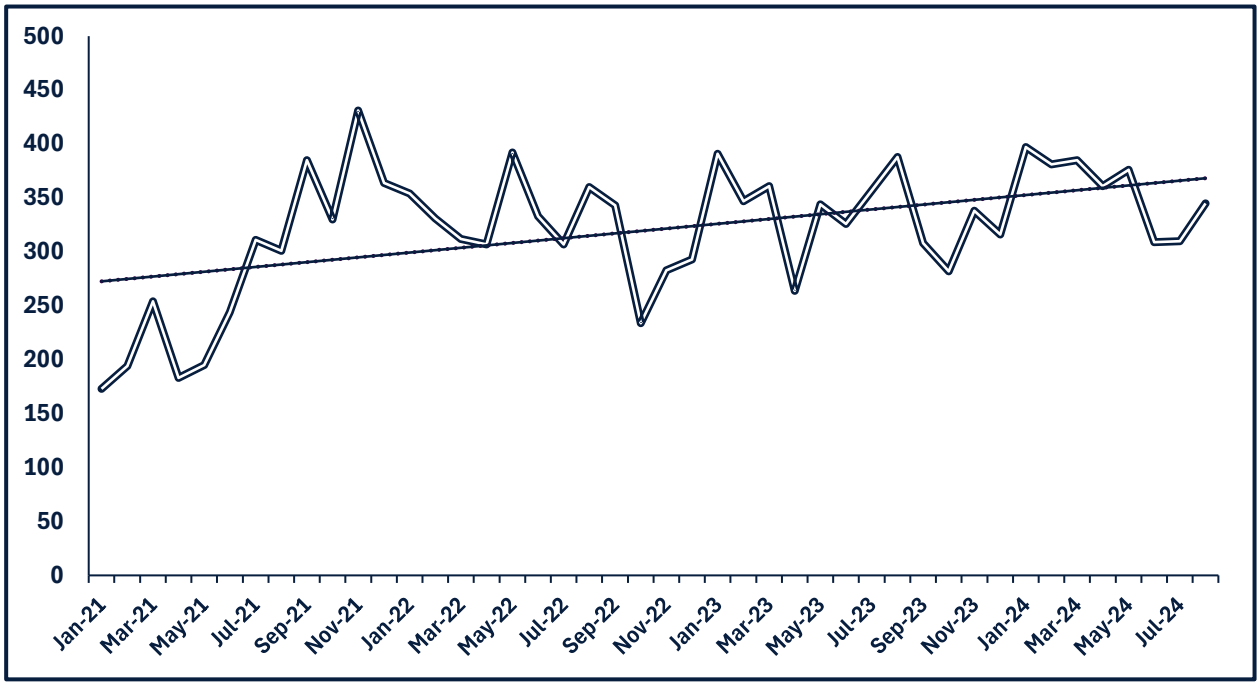
[152] It must be further noted that the criteria for including a Form 7 (incapacity to apply to the Review Tribunal) in an application has been thoroughly discussed between the OAGNI and Trusts. Stakeholders have stressed that the criteria now are far better understood by Trusts, which has lowered the proportion of new applications that are being sent to the OAGNI since 2021. The proportion of authorised applications that contained a Form 7 was 84.9% in 2021, 77.9% in 2022, 65.9% in 2023 and 66.8% in 2024, indicating that the new applications today received by the OAGNI would be more likely to contain information that would prompt further referral to the Review Tribunal.

learning disabilities. Likewise, as the number of people living with dementia in Northern Ireland is expected to treble by 2040[153], this scenario is likely to increase the number of older people in need of extensions.

> *The extension mechanism within the legislation is appropriate in that it supports a review of the case and ensures P's rights are upheld. However, it is the fact that this process runs in perpetuity that I find challenging … We currently have service users who are on their 5th and 6th extension, and nothing will have changed in their circumstances in that time, as the legislation gets older, we could have those same individuals on their 20th or 30th extension and nothing may have changed. What value is that? (**Anonymous,** HSC Trust)*

Since 2020, the number of Trust Panel extension authorisations has increased across all HSC Trusts every year (see Figure 6 and Table 16). Since the year 2021, the total number of extensions completed across all HSC Trusts has increased by an average of 8.5% annually.[154] It is likely that this rate of increase in the extension activity of Trusts will continue, and therefore, the volume of extensions will keep growing in the future.

FIGURE 6. Extension activity across all HSC Trusts[155]



[153] The Bamford Centre, Ulster University (n.d.) DFC – Dementia Friendly Communities.

[154] Data obtained through a FOI sent and responded by all HSC Trusts.

[155] Data obtained through a FOI sent and responded by all HSC Trusts.

TABLE 16. DoL extension authorisations (across all HSC Trusts)[156]

	Monthly average	% increase
2021	280.42	
2022	320.75	14.38%
2023	335.17	4.49%
2024	358.00	6.81%

Karen Harvey (Professional Advisor for Social Work at RQIA) suggested that the frequency of extensions create a significant administrative burden, and in many of these cases, patients' conditions remain unchanged. She stresses that from the point of view of RQIA, this is a legal requirement that must be respected but stated that she believes there is space for implementing changes that can increase the efficiency of the system without reducing rights and protections.

> *I do think that there are a number of people who, you know, their situation isn't changing where there's not a lot of change in terms of the reporting. From an RQIA perspective, if there's a requirement on the legislation that this needs to be done, then it must be complied with … I would be happy to work with the Trust and others if we can, you know, trim that down and still be compliant with our responsibilities (**Karen Harvey**, Professional Advisor for Social Work at RQIA)*

Staff from within one of the HSC Trusts further suggested that a "small legislative change" would be welcomed. However, when the MCA Implementation Team was questioned about this possibility, they indicated that the challenges of amending primary legislation are significant and careful consideration needs to be given to any proposals for piecemeal changes when the full Act has not yet been implemented. Legislative changes at this point could create further challenges, but the DoH continues to work with key partners in supporting phase one implementation with consideration given to exploring MCA changes as part of ongoing discussions.

TABLE 17. Number of extensions per year (BHSCT)[157]

Year	Extensions	% increase
2020	17	
2021	381	
2022	438	14.96%
2023	564	28.77%
2024	1052	86.52%

[156] Data obtained through a FOI sent and responded by all HSC Trusts.

[157] Based on the data obtained in a FOI response submitted by the BHSCT. The other Trusts also submitted data on extensions, but the data from the BHSCT is the only one that covered the year 2024 in full to be compared with previous years.

In conclusion, extension reviews are unquestionably essential, especially for individuals with fluctuating capacity and whose condition may improve. On many occasions, however, extensions are time and resource consuming, adding nothing of value for P, care providers or family, as P's circumstances remain unchanged. Extensions have become the main area of activity for Trusts and the OAGNI. As extensions operate in perpetuity, they have increased steadily every year, and should they continue to increase at the same rate, they will consume increasing resources. Therefore, while acknowledging the complex balance between rights and efficiency, stakeholders suggested that there is a qualitative distinction between cases of individuals with fluctuating capacity (including those who may improve) and those whose condition in terms of capacity will not improve. Stakeholders recommended that while the protections should be there for all, priority in terms of resource and focus, should be given to those whose condition may improve.

Interpretation and application

Trusts have implemented the MCA independently, although they all have done it within the boundaries and requirements of the legislation. From that baseline, Trusts were given freedom to implement a service delivery model, and as a result, they have developed slightly different MCA models (see Appendix 1). This may be beneficial in some areas as the Trusts can exploit their strengths.

However, the implementation of the MCA by individual Trusts may also present challenges. The statistics regarding Trust Panel applications and Trust Panel extension authorisations completed annually by the various HSC Trusts in Northern Ireland indicate that the implementation of the MCA may vary across Trusts, despite sharing the same legal framework. While it is not possible to indicate the exact nature of these variations, the data revealed significant differences.

For instance, the number of live care home DoLS in the Western Health and Social Care Trust (WHSCT) in relation to the total number of care home placements commissioned is approximately four times higher than in the SHSCT. The percentage of live care homes DoLS in the WHSCT is approximately 40% of total care home placements, while the percentages in other Trusts are significantly lower (see Table 18). Although these differences are striking, they depend on many factors, such as the population distribution by age in each Trust. Nevertheless, other variations have been observed in this area, as the proportion of DoLS in the Western Trust in relation to the population aged over 65 is 17% higher than that of the Belfast Health and Social Care Trust (BHSCT) and 40% higher than that of the NHSCT.

TABLE 18. DoL Trust Panel applications by year (as a % of care packages)

	Care home placements commissioned	Live care home DoLs	%
Belfast	2,847	847	29.75%
Northern	3,321	672	20.23%
South Eastern	2,223	630	28.34%
Southern	2,248	268	11.92%
Western	1,920	769	40.05%
Total	12,559	3,186	25.37%

These differences must be approached with caution, and such variations, while notable, cannot be fully examined through broad statistical analyses. However, when this issue was raised in COPNI's engagement with stakeholders, a representative from a Trust confirmed that the implementation of the MCA is not always consistent across Trusts.

> *Each Trust was allowed to integrate MCA within their organisation in a way which worked best for them. As such, there are five different models of MCA service provision. Each model varies slightly with some opting for a 'centralised' model of an MCA service, with other's implementing more integrated models within their existing service structures. Within the five different models then, there can be five different approaches, attitudes and cultures in relation to the MCA within each organisation. (**Anonymous,** HSC Trust)*

Trusts have provided a brief description of their model of service delivery (Appendix 1), which may contribute to explaining the difference in numbers observed. However, as the quote above notes, within the independent models there may also be independent cultures and interpretations of the core concepts of the Act. As another Trust staff member assessed, the fluctuation in interpretation across Trusts—and within Trusts over the years—also reflects variations in interpretation. The participant continued:

> *This is driven by each Trust's interpretation of the legislation at that point. For instance, one Trust may adopt the position that a DoL should only be implemented if P is actively attempting to leave or being stopped from leaving. This then impacts on the activity and level of DoLs within that Trust. However, when that interpretation of the legislation is then revised there are significant spikes in activity as a different interpretation of the legislation leads to a much wider cohort of service users who meet the criteria for being deprived of their liberty, and so require provision of new Trust Panel applications. This is also evident within Short Term Detention activity across the region, some Trusts activity, (despite having comparable sized acute hospitals) will be significantly lower than the other Trusts. (**Anonymous**, HSC Trust).*

The available data on the number of Trust Panel applications by year may support this hypothesis (see the example of the BHSCT).

TABLE 19. DoL Trust Panel applications by year (BHSCT)[158]

	Total	Difference from average	Annual variation
2020	324	-56.11%	
2021	885	41.08%	164.97%
2022	218	139.17%	-305.96%
2023	519	0.46%	138.07%
2024	651	-19.91%	25.43%
Average 20-24	521		

Similarly, comparisons can be made with the data on short term detention authorisations (STDA) reported by each Trust. Between 2019 and 2022, the cumulative number of detentions in the WHSCT was more than seven times lower than the figures reported by the NHSCT and SHSCT.

TABLE 20. Short Term Detention Authorisations[159]

	Cumulative 2 Dec 2019 to 30 Nov 2022	Difference from average
BHSCT	260	-43.69%
NHSCT	571	34.57%
SEHSCT	393	4.94%
SHSCT	566	33.9%
WHSCT	78	-378.97%
Average	373.6	

Professor Gavin Davidson emphasises that there appear to be no identifiable patterns in individuals' capacity across regions or over time that would explain these differences. Instead, these variations likely arise from differences in how services operate and how the Act is interpreted across various locations and periods.

[158] Data obtained from a response from the BHSCT to a FOI by COPNI.

[159] Department of Health (2022) MCA DoLS Update – December 2022.

Some stakeholders have expressed concerns that differences in the application of the Act sometimes may affect the interpretation of the 'acid test', or at least, lead to disagreements on its interpretation between care homes and Trusts.[160] An example is provided by Connie Mitchell, Home Manager at Aughnacloy House, who discussed a case in which she perceived that a person would require a DoL, due to the fact that the person in her opinion fitted the criteria of the acid test, but the Trust disagreed, arguing that the person did not exhibit exit-seeking behaviour.[161] Rosaline Kelly further contends that a person's capacity to exhibit exit-seeking behaviour should not be relevant in determining whether they are subject to a deprivation of liberty. She asserts that some practitioners believe that if a person, for example, cannot get out of bed, they are not experiencing a deprivation of liberty. However, she argues that, in her opinion, this view is inconsistent with the requirements in Cheshire West.

According to QUB Researcher and Lecturer Dr Danielle McIlroy, her research has highlighted variations in how best interests decisions are made.

> *Some practitioners reported further exploration of the individual's special regard and really tried to capture the person's wishes, feelings, beliefs and values about the decision, about what their special regard would have been prior to lacking capacity and what their views are now, and if the person is unable to communicate that verbally, trying to capture special regard through different means. So, there is evidence within my research of practitioners really, trying to capture that, however there was also evidence within the research that others may not have gone to the same extent. (**Dr Danielle McIlroy**, Lecturer at QUB)*

According to Dr McIlroy, her doctoral research shows that the efforts made by practitioners to involve P in the best interests decision varies. She particularly discussed 'best interests meetings', which may involve professionals, family members, care providers and P to determine P's best interests. However, there is a limited guidance about them in the current Code of Practice.[162] Consequently, their occurrence is inconsistent with some individuals reported to have had meetings and others who have not.

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[160] The definition of deprivation of liberty in the Code of Practice indicates that "if P is under continuous supervision and control and is not free to leave, P is subject to a DoL" (section 2.7) The following is an extract from section 2.15 of the Code of Practice that exemplifies this standard: "For example, a person is receiving palliative care which involves strong pain killers. The effect of the pain killers is that the person is physically unable to leave as the medication has a strong sedative effect. The person is then under continuous control and supervision and un-able to leave (due to the medication). However, this does not automatically mean the person is not free to leave. The question that must be asked is if the person was able to leave would the person be prevented from leaving". See Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice.

[161] Ms Mitchell did not specify Trust.

[162] Only one mention to such meetings can be found in the Code of Practice as part of the "scenarios" included in Annex B. Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice.

However, stakeholders have emphasised that implementing a piece of legislation like the MCA is not simple, and that these types of issues, especially in early stages of implementation are to be expected. Karen Harvey (Professional Advisor for Social Work at RQIA) noted that these differences in implementation might be normal with new legislation. She added that the five different Trusts ultimately operate independently, and that requires a process of adaptation that is currently underway. In fact, work is ongoing to standardise the process through a review.

In relation to the difficulties of implementing such complex and novel legislation, Professor Gavin Davidson stresses the difficulty of separating what the practitioner 'thinks' is the best interests for the person and identifying it with 'special regard' for their perspective. It is hard to argue that any written guidance or set of principles in the Code of Practice will eliminate the inherent subjectivity of this principle and the difficulty in applying it in an adequate manner.

In addition, COPNI has learned that discussions regarding the interpretation of Article 5 of the ECHR are ongoing. The OAGNI and the DoH have submitted a request to the Supreme Court seeking clarification on the meaning of the expression 'lack of valid consent' that the ECtHR has referred to as a condition to attract the protection of Article 5.[163] Specifically, it raises the question of whether a person deprived of liberty, if openly demonstrating 'valid consent' to their care arrangements—such as appearing content and in agreement with these arrangements—might not be deemed deprived of liberty. This interpretation hinges not only on the concept of 'valid consent' itself but also on the broader value attributed to a deprivation of liberty. Stakeholders have argued that this value lies in its tangible impact on P and their friends and family. Such perspectives highlight the inherent challenges in interpreting complex principles, as outlined in the Act. Moreover, they underscore the importance of regional consistency to ensure that interventions by different authorities across Northern Ireland remain stable and equitable.

Despite the understandable difficulties of implementing a complex piece of legislation such as the MCA, the disparity in its implementation across Trusts should not be as wide. This is particularly important for the care staff, due to the obvious risks involved

[163] "In *Guzzardi v. Italy*, the European Court of Human Rights ('European Court') considered what circumstances would amount to a deprivation of liberty attracting the protection of Article 5. The Court held that the distinction between deprivation of and restriction upon liberty is merely one of degree or intensity, and not one of nature or substance–one must start with the concrete or actual situation of the individual concerned and take account of a range of criteria, such as the type, duration, effects and manner of implementation of the measure in question.26 The European Court has provided that a person is deprived of liberty for the purpose of Article 5 where the following three elements are present: … b) Lack of valid consent (the subjective element)." See

in being the person implementing the DoL. Care home staff and managers interviewed have openly highlighted this concern.

> *These grey areas shouldn't really be happening with the MCA whereby you could be found guilty technically of an assault, common assault or otherwise, if you stand in the person's way, or you lock the door and you're restricting their civil liberty to exit. (**Dr Kevin Moore,** Director of Nursing at Dunluce Healthcare)*

In conclusion, the inconsistencies and varied interpretations highlighted here may be partially attributable to the normal process of adaptation to a highly complex and innovative piece of legislation. However, it would be concerning if identical situations are treated differently across HSC Trusts. In this regard, Debbie Sharpe acknowledges the constant work that the team in the DoH is continuing to do to improve standard practice.

> *We do continually try and support key partners in learning over the last five years since phase one implementation and work collaboratively to ensure that the approaches to implementation are efficient and consistent, appreciating the workload and the burdens that some of our key partners are under. We want to ensure that we're supporting key partners in working the best way possible. And so, there are a lot of ongoing workshops and engagement behind the scenes looking at what's happening operationally, so we can explore if the DoLS processes and systems can be improved. And in terms of any sort of legal changes at this stage, I think it would be difficult to confirm anything at present when we haven't, as yet, rolled out the legislation in full. However, the department continues to engage with the multi agencies to explore options that will improve the current systems delivering the DoLS across HSC Trusts. (**Debbie Sharpe,** Head of the MCA unit at the DoH)*

Data collection

Throughout the conduct of this research, COPNI has noticed that the Trusts have experienced difficulties in providing the data requested. Despite showing transparency and willingness to support this research to the best of their capacity, there are important gaps in the data that was received from Trusts by COPNI.

For instance, Trusts struggled to provide a breakdown of emergency provisions by duration. Only the NHSCT and the SHSCT managed to provide these figures. This may be due to the different models in operation, as other Trusts may have lacked a system for a centralised collection of emergency data, which is gathered by the local MCA teams. However, this highlights the necessity of gathering further centralised data to have greater control over the implementation of the DoLS. Moreover, better data collection

would provide stakeholders with the capacity to monitor the implementation of the Act and raise concerns if any issues are identified.

A thorough process of data collection would be essential to adequately monitor the use of emergency provisions and would contribute to effective interventions to reduce the prevalence of those of excessive duration. If data is not routinely collected, issues like these may remain hidden. Therefore, routinely collecting this data could be an effective way for Trusts to identify and address these kinds of issues. As Professor Gavin Davidson noted:

> *It's great that the Trusts were able to provide that data. And there is maybe a wider point about what data is being collected, how it's being analysed and reported across the whole of Northern Ireland. There are many other aspects of the implementation of the Act which do need routine data as well. (**Professor Gavin Davidson**, QUB)*

Anecdotal evidence was also shared by care home providers, some of whom commented that they felt Trusts often did not hold an adequate record of emergency provisions. They suggested that this was possibly due to a high turnover of staff, and it had consequences in terms of the number and duration of emergency provisions.

> *Once they're in place (the emergency provisions) they might never get reviewed. It's very hard to get them to get the proper one put in place. So, it's a very slow process after it. (**Yvonne Diamond**, Responsible Person at Wood Green Healthcare)*

> *We did have a situation where we had somebody on emergency provisions for a year and the Trust were saying "that can't be", "oh, we don't know who the key worker is". It went round lots of people to try and find out who was actually responsible … And we have got a care plan and all in place, but it's getting the paperwork in a timely manner. (**Linda Graham**, Regional Manager at Spa Nursing)*

Care home managers' complaints did not only refer to emergency provisions and their duration. They also raised issues regarding extension reviews:

> *Managers are constantly chasing key workers … The final log came from the Trust and it had six people on it, and I had 42 in the home with DoLs and we knew they had DoLs, but they didn't have their log up to date. We emailed and said "the log's not right" so they have it updated. But it's us having to chase all of that all the time. (**Linda Graham**, Regional Manager at Spa Nursing)*

> *This lady said she wanted to go home the nurses redirected her, offered her reassurance, but primarily took her by the arm and started to walk her back up the ward. There was a deprivation of liberty in place that had expired nearly 18 months before, and when I flagged*

> *that up and the staff nurse rang the care manager, the care manager nearly died on the other end of the phone. (**Dr Kevin Moore,** Director of Nursing at Dunluce Healthcare)*

The routine collection of more extensive data would provide further information to review internally and externally how the process is operating. Professor Gavin Davidson recommends the completion of additional work on routine monitoring, collection and presentation of data to track concerns.

> *There probably is a bit of work to be done about what should be continually collected and presented. I'm thinking England and Wales, for instance, there are I think big concerns about how the compulsory powers are disproportionately used in people from ethnic minorities and so on. So, there are concerns about just making sure we're recording the basic sort of characteristics so we can track any concerns. (**Professor Gavin Davidson**, QUB)*

In conclusion, the requirement to improve and expand the collection and centralisation of data should not only refer to dedicated MCA teams but also involve the coordination of Trusts, care homes and the DoH. The routine collection and centralisation of data is an essential tool for better practice.

Finally, issues may arise regarding the way DoLS are impacting different socioeconomic groups, and a further collection of data broken down by section 75 groups would be a departure point to identify the prevalence of such issues.

Phased implementation

When stakeholders were asked what improvements they would make to the Act, most responded that it needed to be fully implemented. They argued that the phased implementation was creating issues for everyone involved, with a range of challenges arising. Debbie Sharpe, Head of the MCA unit at the DoH, explained that the original plan had been to roll out the Act in full. However, by 2019, it became clear this would not be feasible because there was no functioning government at the time. As a result, the necessary processes and resources were not in place to support full implementation. Dr Danielle McIlroy (Lecturer at QUB) argued that despite the conditions for full implementation not existing, there was a pressing need to address the Bournewood Gap due to the legal risks associated with leaving it unaddressed.[164]

[164] The Bournewood gap meant that Northern Ireland needed mental capacity legislation. A major concern arising from the Bournewood case was that existing mental health legislation in the UK and Northern Ireland had become incompatible with Article 5 of the ECHR. See Department of Health (2007) Bamford review - A comprehensive legislative framework.

Sharpe acknowledged the challenges of phased implementation, noting that key partners involved in implementing the Act had raised concerns with the department about the complications of operating a dual system. In response, her team is working "to develop an up-to-date MCA implementation plan that will enable the department to understand the cost, resource and training need of full MCA implementation that will inform future decisions on full commencement." The department echoed this commitment in a recent consultation document, where it confirmed that future plans for full implementation are being developed.[165]

Professor Gavin Davidson believes that the current dual legal framework is a very complicated one. Although the guidance of the DoH clearly states that the MHO prevails in situations when the MHO can be used, "there are situations where it could be argued that it could be difficult to determine what the relevant legal framework is."

Stakeholders identify hospitals as the main area of confusion, where both the MCA and MHO are frequently applied. As the current DoH guidance indicates, the MHO must be used when it can be used.[166] However, in certain situations hospitals must use the MCA for certain patients, leading to confusion. Practitioners often highlight challenges around transfers between homes, hospitals, and care homes.

Regarding this overlap, Phil Hughes (Professional MCA Advisor at the DoH) notes that "some patients, in a very short space of time, will be processed through both pieces of legislation." Both Hughes and Rosaline Kelly (Senior Nurse Professional Practice, RCN) describe cases where patients are initially detained under the MHO as they arrive from their homes into hospital—perhaps due to delirium or a rapid decline in capacity or mental wellbeing. Initially, the MHO framework applies, but if a transfer to a care home is later necessary as the patient recovers sufficiently to leave hospital, the MCA must be used when the threshold for the MHO is no longer met.

Kelly and Hughes explain that before such transfers, patients must remain in hospital, even if the criteria for MHO detention have expired. At that point, a shift to the MCA may be required to justify depriving the patient of liberty and keeping them in hospital prior to transfer. In these cases, Kelly and Hughes argue that it is difficult for staff to determine which legislation should be applied, whether they have the legal authority to act, and if they are protected from liability.

[165] Department of Health (2024) Consultation on commencement of provisions under the Mental Capacity Act (Northern Ireland) 2016 relating to Acts of Restraint; page 7.

[166] Department of Health (n.d) Mental Capacity Act Background.

In cases where hospital patients need to be transferred to a care home following detention, the responsibility for applying the correct legal framework and completing the forms for a DoL authorisation often rest with the hospital nursing staff.

Rosaline Kelly (Senior Nurse Professional Practice, RCN), who has helped develop training for nurses, explains that the MCA and MHO enable practitioners to **take different actions** with patients and residents. She states that

> *For the workforce at the minute, it's difficult because they're using different pieces of legislation that allow them to do different things. So, the MHO is allowing them to treat without consent, and the MCA isn't. It's only allowing you to deprive them of their liberty. And I think there's a bit of a misconception that it allows you to treat the person, and it doesn't. So, the sooner we move to full implementation, the better. (**Rosaline Kelly**, Senior Nurse Professional Practice, RCN)*

Nurses interviewed as part of this research pointed out the importance of training to make carers aware that the actions that can be done with a patient deprived of liberty can vary enormously as compared with someone detained under the Order. If nurses are unaware of these differences, they will be at risk of liability. Moreover, the risk that a situation like this could occur is fuelled by the continuing operation of both pieces of legislation. Kelly also argues that phased implementation has led to confusion because it has reinforced a misconception among the workforce that the MCA is limited to DoLS. She warns that delaying full implementation could lead to a "huge shock" when everyone involved in caring for people in other settings—such as the community, home care services or schools—realises that the MCA also directly applies to them. In relation to this, Lynn Elliot (Director at Home Instead Down & Lisburn) emphasised the **lack of clear guidance regarding situations that occur in individuals' homes**.

Another issue arising from the partial implementation of the Act is the **absence of Independent Mental Capacity Advocates (IMCA)**, for which the Act secures provision, but which is an element that has yet to be enacted. Katherine McElroy (Principal Practitioner for Advocacy at the Patient and Client Council, PCC) believes there was an opportunity to implement IMCAs at the commencement of the Act, which would have fostered a better environment to safeguard P's best interests amid family and institutional dynamics. She explains that IMCAs could represent P's interests, particularly in cases involving challenging family relationships. McElroy notes that one Trust has contacted her office on a number of occasions, asking PCC to "almost step in as mediator," a role that they could not take on. She argues that adequately trained IMCAs could provide valuable support in these and other situations. McElroy concludes that

the advocacy issue "should have been a priority and should still be a priority before anything else is addressed."

Phil Hughes (Professional MCA Advisor at the DoH) describes two additional difficulties arising from the phased implementation of the Act. The first relates to the **police powers** under Part 9 of the Act, which have yet to be implemented. Hughes states that the police position is that they are currently unable to assist patients detained under the MCA with their transport to hospital, as they lack the legislative framework that would protect them when implementing restraint during such actions. Despite active collaboration between the DoH, the PSNI, the NIAS, and Trust staff to safely convey individuals from their homes to hospital, Hughes claims phased implementation is causing significant issues in situations like these. Additionally, Hughes points out that Review Tribunal processes have to address referrals under both the MHO and the MCA. This has resulted in the Review Tribunal having to establish new processes for MCA referrals while operating a dual system, adding additional complexities for Trust staff.

Stakeholders have indicated that **resourcing issues** may be delaying the full implementation of the Act. Hughes mentioned that full implementation would be desirable but noted that the DoH needs "to get the resources, both financial and manpower, to do that," as well as to monitor examples of successful implementation of similar legislation in other European countries.

Professor Davidson also referred to resourcing issues, although he believes they are not substantial. Davidson argues that the most significant transition for the MCA has already taken place with the introduction of provisions covering areas previously excluded from the MHO. Thus, he believes the transition to full implementation should not be excessively burdensome. However, he acknowledges that, given the current financial landscape, the DoH may have many competing priorities. He also suggests that the MCA is a very innovative piece of legislation, which may cause anxiety due to lack of precedents but asserts that this should not be a source of concern, as the MCA effectively incorporates everything the MHO does, and in his opinion, it "does it better."

In conclusion, there is widespread agreement among stakeholders regarding the urgent need to work towards the full implementation of the Act, as they discussed various challenges stemming from its phased implementation. The MCA represents the

first attempt at creating fusion legislation between mental health and mental capacity,[167] which may explain the hesitance of relevant authorities to advance the implementation of such groundbreaking and untested law.

Nevertheless, all stakeholders agreed that the MCA is superior to the MHO, and from an operational standpoint, there is no justification for further delaying full implementation. They acknowledged that while this transition may require additional resources—both financial and in terms of workforce development—such needs could conflict with other pressing priorities. However, the aspects of the Act that would require the most resources have already been implemented. Moreover, there is no assurance that the DoH's financial situation will improve in the near future, and therefore, if resources are the main obstacle to full implementation, this obstacle will not suddenly disappear.

Until the Act is fully operationalised, practitioners will continue to face significant challenges in navigating between two legislative frameworks designed to address similar circumstances.

Training

Practitioners are working with a new set of legal documents and rules, which shapes how they must fulfil their professional duties—in ways not required before. It is therefore essential that they gain a thorough understanding of the legal framework in which they are currently operating. In this regard, Debbie Sharpe (Head of the MCA unit at the DoH) acknowledges that training is the cornerstone of the MCA, "and has been since day one." Stakeholders generally reported satisfaction with the level of training provided by the DoH and Trusts around the MCA. However, they also suggested that additional training is necessary in several specific areas.

Many stakeholders, particularly within the nursing profession, emphasised the importance of addressing the **practical aspects of working within the legal framework** of the Act through scenario-based training. The MCA is a legal document that must be interpreted through real-life situations to safeguard practitioners and P.

The need for training and clarity is especially important for nurses in hospitals that are currently working under the dual system (the Order and the Act). As Rosaline Kelly (Senior Nurse Professional Practice, RCN) pointed out, the Order and the Act do not

[167] Harper, C., Davidson, G., and McClelland, R. (2016) 'No Longer 'Anomalous, Confusing and Unjust': The Mental Capacity Act (Northern Ireland) 2016', International Journal of Mental Health and Capacity Law, 22: pages 57-70; page 68.

only differ in regard to the conditions of entry to their protections, but also on the type of actions that D can perform in relation to P. Understanding such differences is essential for nurses and social care workers in general.

Melissa Rutledge, a Registered Nurse in the SHSCT, praised the recent training she received from the Trust, stressing that it is helpful to "discuss your own experience and then learn from that." Similarly, Linda Graham (Regional Manager at Spa Nursing) argues that learning scenarios that are relatable to situations in a care home environment are key to developing staff knowledge. Yvonne Diamond (Responsible Person for Wood Green Healthcare) echoed this view, noting the need for training that is "specific, offering very clear guidance on what to do in specific situations."

The training designed by the Regional Training group and delivered by Trusts is generally perceived as positive and of high quality. Nevertheless, stakeholders are calling for more training. There is a strong demand for more "on the ground," "practical," and "applicable" training that focuses on real examples and situations. The necessity of conducting training to instil confidence in professionals cannot be underestimated. Aisling Byrne (Responsible Person at Blair Lodge) offers an insightful perspective on the value of training:

> *I would say there is a real desire for more guidance, more training, especially within the run up to the Adult Safeguarding Bill potentially being brought into Northern Ireland as well. It's concerning that we are in a position where there isn't enough guidance around two new acts that can potentially affect the provider and the individual. There isn't enough training around the MCA and then we bring in an Act that makes staff, or the provider, or both, liable under the Safeguarding Bill. It is concerning.* ***A lot of staff will just say, why would I want to work in healthcare?*** *(**Aisling Byrne**, Responsible Person at Blair Lodge)*

As Byrne assesses, the MCA has increased the risk of liability for carers if they do not properly implement the safeguards mandated by the legislation. Additionally, these liability risks may increase with a forthcoming 'Adult Safeguarding Bill'.[168] Byrne is concerned that, without adequate reassurance and support, these risks could have a detrimental effect on staffing levels. Potential carers may be apprehensive about taking on roles in social care due to concerns regarding their own liability.

Byrne, who works in a home for individuals with learning difficulties, observes that most of the staff members that work in her home do not have a background or educa-

[168] Recently, the Health Minister has introduced the Adult Protection Bill to the Assembly. See Department of Health (2025) Health Minister introduces Adult Protection Bill to Assembly.

tion in the areas of health and social care. Therefore, if there are no additional incentives to pursue a career in social care, combined with increased risks, there are reasonable concerns that staffing levels will be affected compromising the safety of residents. In this context, training and guidance are vital for reducing uncertainty and ensuring that staff feel both safe and supported in their roles.

The department's Head of the MCA unit (Debbie Sharpe) acknowledges that, despite ongoing training and a strong focus on it, the MCA is "very new and very complex legislation." She emphasised the need for collaboration and engagement to create an impact, noting that this legislation has required a culture change, a process that takes time. Stakeholders have also highlighted that the Act is a "living thing"—that is not static; it is a recent and innovative piece of legislation that continually presents new challenges and situations. Consequently, close cooperation among the department, Trusts, and stakeholders is essential to continuously reshape, reformulate, and deliver effective training. Both the department and Trusts appear to recognise this necessity.

In conclusion, training on the MCA must evolve and adapt to the new situations that frequently arise during its implementation, as it remains a new and innovative piece of legislation. The value that stakeholders place on real-life situations and practical examples raises the question of whether more of these should be included in the Code of Practice.

It is important to note that there appears to be no feeling of having "enough" training; stakeholders consistently advocate for increased resources to be dedicated to this area. The turnover of staff in social care is high, with many carers lacking previous experience in health and social care, and therefore being unfamiliar with their legal obligations. Given these challenges, the necessity of ongoing, continuous and responsive training must be recognised by the DoH and Trusts.

Nominated person[169]

Participants in this research agreed that the nominated person was a vast improvement to 'the nearest relative' referred to in the MHO. However, they observed that many aspects of the nominated person's role are still not well understood, either by the nominated person themselves or by others who are emotionally invested in the wellbeing of P.

[169] Department of Health (2019) Mental Capacity Act (Northern Ireland) 2016, Deprivation Of Liberty Safeguards Code Of Practice; chapter 9 (Nominated person).

During the safeguarding process, the nominated person must be consulted as part of the Best Interests Determination Statement. This approach differs from the MHO. Professor Gavin Davidson explains that the nominated person role contrasts significantly with that of 'the nearest relative' referred to in the MHO. While the nearest relative has decision-making powers, including applying for hospital detention or discharging the patient, the nominated person is a consultant but without decision-making authority.[170] The level of responsibility and decision-making power of the nearest relative could be problematic, as they are not always familiar with the legislation, and acting in that role could have a negative impact on the relationship with their relative. Moreover, while the choice of who is 'the nearest relative' follows a set legal order, it does not guarantee that this person has sufficient knowledge of P, or even that they would act in their best interests.

Professor Gavin Davidson highlights the benefits of the nominated person role. First, since the nominated person is "nominated" and P can participate in the selection process, when possible, this increases the likelihood that this person knows P well and will act in his or her best interests. This also increases P's involvement in the process. Second, the nominated person does not make decisions regarding P's care, which protects P, the nominated person, and their relationship. Although there is a statutory requirement to consult the nominated person, the ultimate decision rests with the practitioner conducting the assessments.

In addition, since 'the nearest relative' was based on a set order and criteria, it failed to "accommodate the realities of human relationships", which meant that "the MHO 1986 can impose a nearest relative upon a patient in circumstances where said relative is entirely unsuitable to perform that role".[171] As a result, concerns were raised that the fact that people were prevented from choosing or changing their 'nearest relative' under the MHO contravened "Article 8 right to private and family life under the ECHR".[172] In contrast to this, the nominated person is, where possible, selected by P, and if P lacks capacity to choose, the nominated person will be selected given due consideration to the suitability of the person to perform the role.

[170] The powers of the nearest relative are limited by medical assessment and judgement. See NIDirect (n.d) Your rights in health.

[171] Potter, M. (2020) 'Chapter 11 Mental Health Law' (pages 405-435). In White, C., Northern Ireland Social Work Law, London: LexisNexis.

[172] Potter, M. (2020) 'Chapter 11 Mental Health Law' (pages 405-435). In White, C., Northern Ireland Social Work Law, London: LexisNexis.

While these changes are generally positive, they also present certain challenges. Rosaline Kelly (Senior Nurse Professional Practice, RCN) notes that "lots of times, the nominated person believes that they are the decision maker." This misconception arises from a misunderstanding about the aims of the Act. The nominated person's role is to contribute to determining P's values, beliefs, and views as part of the assessment of best interests, which aims to discern what P would choose if they had capacity. The nominated person supports this process by providing relevant information. Kelly points out that it is often "a challenge for the professionals involved to make sure that the nominated person understands what their role actually is", adding that broader public awareness efforts, as well as direct engagement with nominated persons to clarify their responsibilities, would be valuable.

Concerns were also raised about the impact of the nominated person on relationships among families and friends of P. Davidson notes that "you could argue from the perspective of the other people who are involved in that person's life that this is privileging one person over others." Similarly, Katherine McElroy (PCC) observed that the role of the nominated person can cause not only confusion but also conflict within family dynamics. She emphasised the need to clarify this role for families, especially in cases where siblings have differing views on the best course of action. According to McElroy, the nominated person's role may lead to considerable confusion, tension, and even aggravation in such situations.[173]

The legislation secures a significantly greater role for the nominated person than for any other individual in P's personal circle.[174] For instance, the nominated person holds the right to apply to the Review Tribunal to assess the case of an individual deprived of liberty—a right unavailable to anyone else in P's personal circle. Section 45 of the Act allows the nominated person to apply to the Tribunal. This right permits the nominated person to act without consent, and even if the person has capacity to apply to the Tribunal, the nominated person may still apply with P's agreement. In contrast, when asked about the rights and role of others to apply to the Review Tribunal (such as family members or friends), Maura McCallion (Division Head at the OAGNI) clarified: "Unless they're the nominated person, I don't see any. There's no particular role for them, other than that they could, for example, approach the Attorney or the DoH" and request that they consider referring a case to the Tribunal.

[173] This issue would also apply to the nearest relative under the Order.

[174] Such as friends, relatives and carers that are not the nominated person.

In line with other stakeholders, Dr Danielle McIlroy views the role of the nominated person as a positive development, as it allows individuals with capacity to appoint someone they choose—an improvement over provisions in the MHO. In addition to the recommendations of other stakeholders, she emphasises the importance of encouraging conversations around the implications of the Act with the general public. Dr McIlroy's perspective reinforces the need to increase public awareness about the MCA (as noted in the previous section), stressing that it is relevant to everyone, as anyone may one day face a loss of capacity to make a specific decision. Preparing for such situations can significantly improve outcomes for those deprived of liberty, ensuring better service delivery, care arrangements, legal protections, and overall support ("we can all appoint a nominated person, and Form 22[175] can be referred to for guidance", she notes).

Despite the concerns raised by stakeholders, the nominated person role has been hailed as a key improvement of the Act over provisions in the MHO. The role of nominated person contributes to protections and, most importantly, it helps to increase the level of participation of P in their own care and safeguarding process. However, stakeholders stress that work should be done to explain the role of the nominated person, and that efforts must continue to involve others (friends and relatives) in the process. Additionally, the general public should be involved in conversations around the Act to increase awareness and perhaps to prepare for future situations pertaining to the issue of capacity.

Public accessibility

Stakeholders have noted that in their engagements with members of the public, they have observed outdated perceptions around mental health and mental capacity legislation that do not align with the MCA, particularly on the roles and responsibilities that friends and family have in supporting a person who lacks capacity. Generally, stakeholders noted that the public is unaware of the guiding principle that the individual lacking capacity should be at the centre of the decision-making process, with decisions determined by their wishes, values, beliefs, and best interests.

Therefore, participants in this research have emphasised the need to improve communication with those affected by a DoL, including friends and relatives. In addition, an

[175] Department of Health (2019) MCA(NI) 2016 - Form 22 – Appointment, revocation, making of a declaration or revoking a declaration in relation to nominated person (Guidance).

increase in public awareness of the content and principles of the Act would be desirable. As Rosaline Kelly pointed out:

> *It's not just about people in care homes, it's everybody's business; it will affect all areas of health and social care, and we all need to understand it. And it may come to us someday, if any of us might need these safeguards. So, we want people to be well educated in it for all these reasons. (**Rosaline Kelly**, Senior Nurse Professional Practice, RCN)*

For this reason, Kelly recommends expanding the publicity and educational programmes aimed at the general public about the Act, in order to increase awareness and understanding of it. Professor Gavin Davidson echoed Rosaline Kelly's emphasis on the need for public awareness, highlighting it as a priority for the DoH. Davidson noted that understanding the MCA and planning for advanced care are essential topics, yet most people only confront them when they have no other choice. At that stage, lack of prior planning can make the situation considerably more difficult.

Several stakeholders have said that current communication with individuals involved in the DoLS process can be improved, made more accessible and less intimidating. Connie Mitchell, Home Manager at Aughnacloy House, highlighted that communications, especially with nominated persons—who are often older adults—are frequently too formal, intimidating, and even frightening. She pointed out that letters or communications to the nominated person, which often come directly from the Review Tribunal at the Department of Justice (DoJ), can resemble correspondence from a court, causing confusion. Mitchell suggested that this communication style should be reconsidered to make it less daunting—especially for older people.

Katherine McElroy (Principal Practitioner for Advocacy at the PCC) also stresses that communication with the people involved in the DoLS process should improve. According to McElroy, members of the public often do not understand the process that begins when one of their loved ones is suspected of lacking capacity. McElroy stressed that most of the people who contact the PCC do so because they do not understand what's happening.

> *They have been told that their loved one is going to be assessed under the MCA, and they don't understand what that means for them as a family and for their loved one. They probably have been given paperwork, or they've probably been given leaflets, but how it practically impacts on them as a family member or their loved one is something that they find very difficult because there are so many stakeholders involved, you know there could be social workers, there could be mental health practitioners and there's maybe a DoLS assessor and there's people in the nursing home or whatever. They're overwhelmed. (**Katherine McElroy**, Principal Practitioner for Advocacy at the PCC)*

COPNI has not had access to samples of communications from the DoH, Trusts, or the DoJ's office with individuals involved in the DoLS process and so, cannot assess their adequacy. However, for the purposes of good practice, there should be a re-consideration of how information is shared with loved ones of individuals deprived of liberty—particularly those who, while not designated as nominated persons, are invested in the wellbeing of the individual.

CONCLUSIONS AND RECOMMENDATIONS

From the first stages of its design, the advancement of the MCA in Northern Ireland was met with enthusiasm by academics, practitioners, care professionals, public authorities, and legal experts. All stakeholders regarded the MCA as a progressive piece of legislation that would clearly address the practical and human rights issues of vulnerable people and those who lacked capacity.

Despite the difficulties described throughout the present research, and which are to be expected of any legislation of the scale of the MCA, this opinion remains the same. The positives of the MCA clearly outweigh the negatives, and the new legal framework provides a range of protections for everyone involved in the process that were absent before its enactment.

Among the positive aspects highlighted by stakeholders is that the Act provides a legal framework that expands protections by increasing accountability. The Act guarantees that any person that deprives another one of his or her liberty must follow a legal process that is outlined in the available guidance and is underpinned by a set of principles. Failure to follow this safeguarding procedure will risk liability. The risk of liability has encouraged care professionals and providers to be more conscious of following the established legal process. Similarly, this has resulted in an awareness on the part of health professionals that they are inserted in a legal framework which will protect them, provided that they apply it adequately.

Throughout this research, all stakeholders involved have stressed that the introduction of the Act has resulted in greater involvement of care providers in the legal process, and greater awareness of the need to follow the rules. Rather than feeling threatened by the new legal framework in which they have been inserted, care professionals understood that this framework was also their main source of legal protection. As a result, care providers seem to have understood the need to be fully engaged with the legal process, which consequently increases the protection for individuals under their care.

For stakeholders, the MCA constitutes a vast improvement to the MHO. First of all, expanding the scope and protections of legislation to other settings is seen as a crucial improvement for staff and individuals. Second, the role of the nominated person is seen as a clear improvement compared with the MHO's 'nearest relative' role. Third,

the principles of the MCA manifest respect for autonomy and self-determination insofar as is practical, and developing a legislative framework to advance these principles is seen as positive and necessary. Fourth, the guidance annexed to the legislation for care providers and practitioners was welcomed as an essential protection for both professionals and individuals.

The value of the training provided by the DoH has also been positively acknowledged by stakeholders. In particular, training is regarded by care providers and practitioners as a vital tool for adhering to the legal requirements of the Act. Stakeholders argued that training should be grounded (even more) in the real situations that care providers regularly face and further address practical issues. There is and will be for the foreseeable future, an extraordinarily high demand for training due to the high turnover of care staff who are required to be familiar with the Act.

While positive aspects of the MCA outweighed the negatives for stakeholders, challenges remain. The MCA is a work in progress, and the process of adaptation to it is still ongoing. Difficulties regarding resources and grey areas that are subject to interpretation continue.

To begin with, stakeholders suggested that emergency provisions seem to extend beyond their desirable duration. The delay seems to lie with the assessment process. That is, between the moment in which the Trust has determined that a DoL is needed and the submission of a Trust Panel application. The duration of this period depends on the capacity of the Trusts, which currently hold exclusive responsibility to complete forms and process Trust Panel applications.

In the near future, it is likely that the number of people who will require a deprivation of liberty will increase. As with most healthcare services, the prospect of demographic ageing presents the issue of demand outpacing supply. The quality of the implementation of the legislation depends on the available resources, both financial and in terms of workforce. The current financial and workforce environment is challenging and will remain challenging in the future. Stakeholders have raised issues around emergency provisions, extension activity, as well as the availability of funding and workforce. This makes discussions (and actions) about improving the efficiency of the operational process of the DoLS inevitable. If no changes are made to the operational process of the DoLS or the legal status of the 'acid test,' it is difficult to imagine that the system will be able to maintain (let alone reduce) the number of emergency provisions to a sustainable level.

The legislation does not determine the maximum length of emergency provisions. Neither does it specify the detail of the Best Interests Determination Statement. Indeed, stakeholders have argued that the level of depth of this assessment often depends on the practitioner. If the workload is excessive and resources cannot keep up with demand, solutions may lie in applying certain protections such as these more flexibly.

While some solutions are being explored, which could include the reinterpretation of Article 5 of the ECHR, it is essential that the sustainability of the system is guaranteed, and that public authorities and practitioners are supported in their delivery of the DoLS. It seems inevitable that some operational changes will be required to keep pace with increasing demand. This could include involving managing authorities (i.e. care homes) in aspects of the DoLS process that are currently the sole responsibility of Trusts, in particular those related to the completion of some of the Trust Panel application forms.

The attitude of managing authorities interviewed as part of this research towards participating in the DoLS process was not uniform. Some of them rejected the idea outright, arguing that their workload levels would not permit them do so. Others, however, seemed to be in favour of having a role. Therefore, it may be possible to involve in the DoLS process the care providers that want to participate at an early stage, which in turn could alleviate pressures on Trusts.

Similarly, participants in this research have raised concerns over the limited resources available to the Trusts to fulfil their obligations in relation to the MCA. Within these constraints, some suggested that certain processes which are less essential may be having an impact on other more essential areas of work. For instance, concerns were raised about the number and level of recurrence of extensions. In many cases, these extensions take four hours of work and may amount to 400 hours of work every month in each Trust. The vast majority of these extensions only reaffirm that the circumstances of the person have not changed. In addition, it seems that P, the nominated person, friends, relatives and carers do not perceive the extension reviews as something that adds any value to P, especially when circumstances remain the same. Having extensions as safeguards for P is valuable, but the current number and periodicity of them can impact on other more essential safeguards, such as the capacity of Trusts to review emergency provisions, complete forms and issue Trust Panel authorisations quickly. In addition, the number of extensions appears to be increasing at an

annual rate close to 10%. Indeed, this trend may become more pronounced, as evidenced by the BHSCT, where the number of extensions surged by 86.5% from 2023 to 2024.[176]

Additionally, there was a view among research participants that public authorities could work to improve the quality and quantity of the data collected in order to have better oversight of the implementation of the Act, to more easily identify issues, and to facilitate analysis of processes. Stakeholders mentioned, for instance, the lack of information in terms of section 75 characteristics. It is extremely important to gather information on how the Act is impacting different sections of society to avoid risks of misuse and discrimination, and in particular, to understand the extent of the use of emergency provisions. Implementation of the Act could be better scrutinised by stakeholders if public authorities were to gather and regularly release relevant information. Regarding information handling, care home representatives suggested that the information that Trusts had in relation to individuals under their care was insufficient or contained mistakes.

Significantly, this research identified concerning regional disparities between Trusts in statistical terms, as well as abrupt changes in the number of DoLs recorded by Trusts throughout the years. There is no plausible explanation for such differences in the proportion of live authorisations in place across Trusts and over the years. While the Act is a work in progress, and public authorities are in the process of adapting to it, consistency in the interpretation of the Act and the Code of Practice is desirable. Stakeholders have suggested that the criteria used to determine whether a DoL is needed or not has varied across regions and through the years. The available data seems to support the validity of this concern.

Stakeholders routinely referred to the pressures that the DoH and Trusts were facing. These pressures were both financial and workforce related. It was observed that Trusts were under strain from the sheer number of applications and that the capacity of Trusts to respond was hindered by staffing issues. A key factor identified was that social workers had been assigned almost full responsibility to complete forms, despite the Act and the Code of Practice providing six other professions with the authority to complete forms. Pressures on Trusts were also attributed to the availability of medical staff to deliver the DoLS.

An issue highlighted by all stakeholders interviewed, and that seems to be creating issues at many levels is the phased implementation of the Act. This included, above all,

[176] According to information provided by BHSCT to COPNI.

issues of interpretation of the legislation when it intersects with the MHO. In particular difficulties were raised regarding occasions when different pieces of legislation must be applied to very similar situations in hospitals. Evidence has been shared by stakeholders that for care professionals, this is confusing, inconsistent and can lead to dangerous situations, due to the different types of intervention enabled by the two pieces of legislation. All stakeholders agreed that it is essential to carry out the necessary steps to fully implement the Act as early as possible.

Finally, throughout this research, COPNI has been witness to the great efforts of all stakeholders involved in the implementation of the Act and their dedication to improving the lives of vulnerable people. COPNI is grateful to all research participants and acknowledges their hard work and commitment to keeping vulnerable individuals in our society safe. Hopefully, the discussions in this report provide the basis for further reflection and the necessary action to ensure the great promise of the Mental Capacity Act is realised, so as to better serve the health and safeguarding needs of our citizens.

APPENDIX 1. HSC TRUSTS MCA MODELS

SHSCT MCA service delivery model

The SHSCT MCA operates a hybrid model consisting of a core MCA Team who outreach to community teams across all service areas involved in MCA work. Additionally, the STDA Team which sits within the MCA Team, is hospital-based, and receives in-reach support from the core MCA Team. Medical support is provided through a sessional arrangement.

The core MCA team is multidisciplinary in nature, comprising social workers, ASWs, OTs, and a nurse trainer. The STDA team consists of an MCA coordinator, ASWs, and a PT nurse. The admin team is led by a Band 6 manager with six staff.

Whilst the majority of staff within the MCA service are now permanent, additional support is provided by two bank staff employed in 2019 to support implementation, and who have extensive experience and expertise in MCA and operational processes.

Core MCA business occurs within multidisciplinary community teams with support from the main MCA Team as required. This consists of a Monday–Friday duty system, quality assurance processes, a buddy system, and involves outreach to teams at times of identified deficits, e.g., staff shortages. Fortnightly MCA Implementation meetings are held and attended by relevant community and acute teams.

Underpinning the MCA Team are two trainers (one social worker and one nurse) who develop and deliver an extensive multidisciplinary/multi-agency training programme in keeping with DoH regional requirements. This includes bespoke training to meet service needs, and a quarterly review of the programme.

Trainers provide regular discussion opportunities to explore complex cases and assist with embedding MCA processes. A bi-monthly MCA Champions Forum also operates.

Relevant MCA information is provided on PageTiger and accessible via a central Trust SharePoint system.

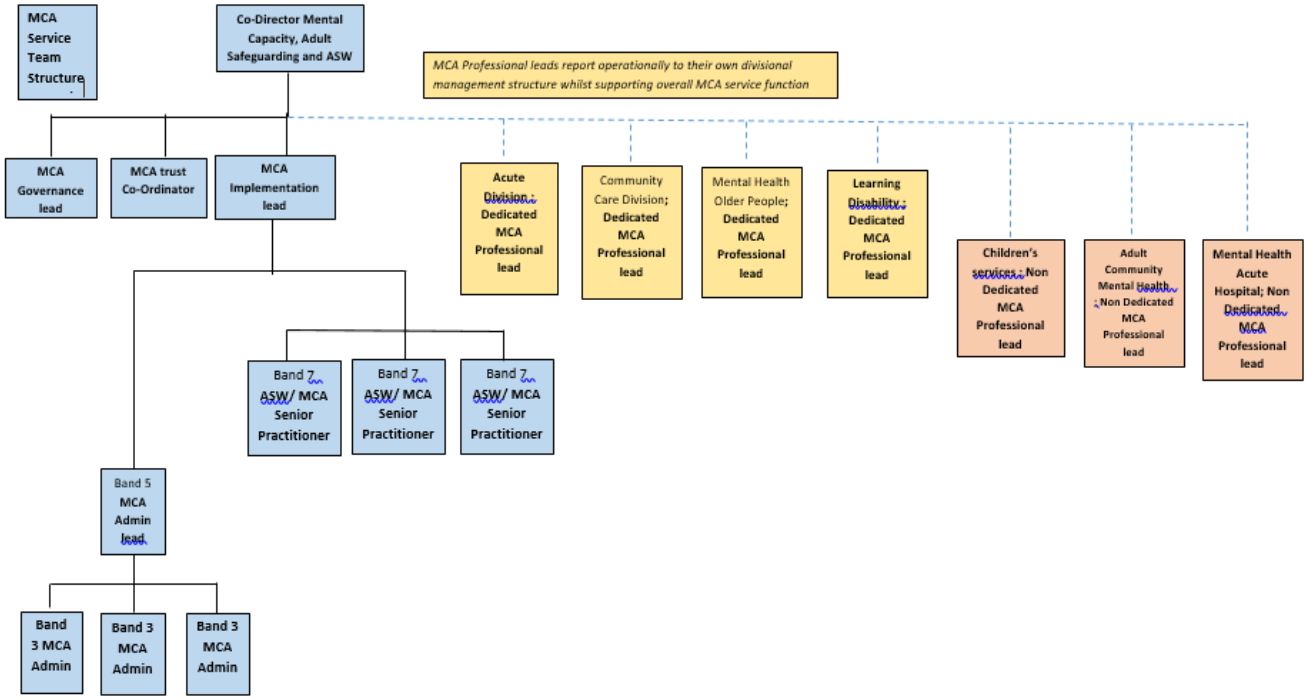
Trust Panels usually operate twice a month with a maximum of ten TPAs per day. The admin team coordinates this process, and members of the central MCA team usually, but not exclusively, sit on them.

NHSCT MCA service delivery model

The NHSCT is currently in the process of changing components of its MCA service model. These changes are at an advanced stage and recruitment is due to progress the agreed upon changes. However, in terms of the current service model, the NHSCT model deploys a “divisional” approach to MCA service delivery. Currently, responsibility for and delivery of the Mental Capacity Act sits within each individual division/service (see diagram below).

Within this model, responsibility for completion of MCA related forms/tasks sits with the ‘named worker’ for P, or in the absence of an attached named worker, responsibility sits within the team to which P is allocated for MCA related activity. Within each division, there are then dedicated MCA “leads” who support in the delivery of MCA activity within that area. In some instances, these leads are fully ‘dedicated’ positions, whereby MCA is the only function of their role. In other instances, the MCA is a component of their role. ‘Non-dedicated’ MCA leads traditionally sit within areas/services which have a limited level of engagement with the MCA.

There is also a small “central” team within the model comprised of admin staff, three MCA Leads and a small group of Senior Social Work practitioners who provide dual support to MCA and ASW within the division.



BHSCT MCA service delivery model

The Belfast Health and Social Care Trust (BHSCT) operates a centralised model of delivery for Deprivation of Liberty Safeguards (DoLS) through its Mental Capacity Act (MCA) Service, which has been fully operational since June 2022. The MCA Service is responsible for all DoLS assessments across BHSCT upon referral from core teams. Dedicated, specialist DoLS staff within the MCA Service undertake all DoLS work – and the feedback with regard to the MCA Service has been overwhelmingly positive from staff Trust-wide, patients and their families.

The MCA Service consists of two core teams, with all staff recruited on a permanent basis to these teams:

a. Acute DoLS Team – An approved social work-led team primarily responsible for Short-Term Detention Authorisations (STDA) in hospital settings. Staff also undertake duties on the Approved Social Work (ASW) rota under the Mental Health (Northern Ireland) Order 1986. Referrals from acute sites are received via EPIC and actioned within 1–2 working days.

b. Community DoLS Team – A multi-disciplinary team of Senior Practitioners and DoLS Practitioners from various professional backgrounds, including general nursing, psychiatric nursing, social work, approved social work, and occupational therapy. 48% of Community TPAs are completed by general and psychiatric nursing

staff, 10% by Allied Health Professional (AHP) staff and 42% by social work and approved social work staff. The recruitment to this team represents a multi-disciplinary approach to DoLS, adding the value of experience from multiple disciplines to its processes. Community referrals for Trust Panel Authorisations are received via EPIC and processed within 14–28 days, from receipt to Trust Panel decision.

The MCA Service also includes a team of 12 Sessional Medics, overseen by a full-time Consultant Psychiatrist, who conduct medical assessments for community DoLS applications.

Once a case is referred to the Community DoLS Team, the MCA Service retains responsibility for all aspects, including Attorney General or Review Tribunal work, extensions, Section 50 reviews and Section 48 reviews.

Trust Panels are managed and delivered through the MCA Service. Additionally, the MCA Service delivers all MCA and DoLS training across BHSCT, provides support, advice, and case consultations to core teams and manages implementation matters. It is linked to the ASW Service through a shared Service Manager and sits within the Mental Health and CAMHS Division as a corporate service operating across the entirety of BHSCT.

WHSCT MCA service delivery model

The Western Trust has a Mental Capacity Act Core Team. The core team supports outlying services and staff within acute settings in completing MCA documentation. This model focuses on a multidisciplinary approach to completing the core work.

The Western Trust has developed processes to support the processing of applications through the Trust Panel Application, Extension, Section 48 and 50, and Short-Term Detention Authorisation processes, including supporting processes for the Attorney General and Review Tribunal.

SEHSCT MCA service delivery model

The South Eastern Trust operates a hybrid delivery model for MCA DoLS across a central MCA Team and community Programme of Care teams.

The central MCA Team is composed of an Acute & Community Practitioner section, a Courts & Governance section, and a Business Systems section. The MCA Team is multi-disciplinary and includes medics, approved social workers, social workers, nurses and admin/management staff. The MCA Team is responsible for both Trust Panel applications where the referral originates from hospital (for people discharging from hospital into the community) and all extensions to Trust Panel DoL authorisations. The MCA Team is also primarily responsible for completion of Rule 6 reports to the Review Tribunal.

In terms of deprivation of liberty in hospitals, the MCA Team is responsible for authorisation of short-term detentions. Approved social work and nursing staff within the MCA Team take forward all statutory assessments in relation to short-term detentions (apart from the relevant medical reports which are completed by the medics on the ward).

MCA Team responsibilities and services provided include:

- Trust Panel applications on discharge from hospital
- All extensions to deprivation of liberty authorisations
- Engagement with the Attorney General's office in relation to Form 7 notifications
- Engagement with the Review Tribunal in relation to Attorney General referrals and s48 Trust referrals
- MCA Helpdesk (email and telephone) for operational queries
- MCA Business Systems section (email and telephone) for coordinating and processing DoLS applications, extensions, s50s and s48s
- Coordination of Trust Panels which operate on a weekly basis
- Gateway to and liaison with DLS on matters that require legal advice
- Monitoring training registers to ensure sufficient numbers of trained staff
- Ad hoc internal audits
- Representation on all regional MCA groups (including SE Trust Chair and secretariat of the Regional Leads meetings)

Most of the staff in the MCA are permanent employees. Demand can fluctuate between months and bank staff provide additional support as and when required.

MCA training resources are provided to staff through the Learn HSCNI service. MCA Team leads also provide bespoke training to acute and community colleagues on request and in response to emerging issues. This ensures that there are sufficient numbers of appropriately trained staff to operate DoLS.

Community Programme of Care teams are responsible for all Trust Panel applications to authorise deprivations of liberty in the community (apart from those that originate in hospitals). Community teams are responsible for the ongoing review of the appropriateness of a DoL in between statutory extension review points. Whilst MCA Team staff generally complete Rule 6 forms for the Review Tribunal, if a case should require an oral hearing, community team staff responsible for that person's care are normally the witnesses as they are best placed to provide the detailed background and explanations for decision making in relation to that person's care. Updates and developments in relation to DoLS are cascaded from the MCA Team to acute and community teams through Workstream and Champions meetings (currently under review).

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