COPNI Commissioner for Older People for Northern Ireland

4th October 2024

Mental Capacity Act Unit
Department of Health
Room D2.10, Castle Buildings
Belfast
BT4 3SQ
By email: MCAimplementation@health-ni.gov.uk

Re: Consultation on commencement of provisions under the Mental Capacity Act (NI) 2016 relating to Acts of Restraint

Dear Sir / Madam

I am writing to you regarding the commencement of provisions relating to Acts of Restraint under the Mental Capacity Act (Northern Ireland) 2016. The Commissioner for Older People for Northern Ireland (COPNI) welcomes this step taken by the Department towards full implementation of the Act.

The office of the Commissioner does not have first-hand experience on the practical aspects of the MCA (such as implementing Deprivations of Liberty or Acts of Restraint). However, during the past few months, this office has commenced research to evaluate and review the implementation of the Mental Capacity Act (in particular, the Deprivation of Liberty Safeguards commenced by the Regulations of 2019). As part of this research, this office has had regular communication with Trusts, the Department, nurses, care providers and other stakeholders in relation to the practical implementation of the Act.

Although the experience of all these stakeholders varies, most of them have highlighted the difficulties created by the phased implementation of the Act, which involves in many instances that health professionals and care providers must operate with two different pieces of legislation that regulate the same situations. In addition, as the consultation document references, the Act makes provision for Acts of Restraint that must otherwise be regulated by more costly and time-consuming ways.

Nevertheless, although the commencement of these provisions is a positive step, phased commencement of the Act will continue to pose difficulties in regard to the additional safeguards that must be completed to perform Acts of Restraint. It will be the case that some of the safeguard provisions pertaining to Acts of Restraints will not be in place at commencement (such as the absence of Independent Mental Capacity Advocates).

While COPNI is not routinely involved in cases involving Acts of Restraint, we have reviewed the Act and liaised with stakeholders. As a consequence, we can provide a broad response to the questions asked by the Department in the consultation document with the hope that it will be useful in the final drafting of the Code of Practice.

Is the draft Code of Practice clear at differentiating between restraint, seclusion, and DoL?

The definition of seclusion is clear, but the distinction between Deprivation of Liberty and Act of Restraint could be further clarified in the Code of Practice. This distinction is always blurred since Acts of Restraint that are sustained in time amount to a Deprivation of Liberty. Considering this, further guidance could be offered to D in the Code of Practice as to when Acts of Restraint are or are not Deprivations of Liberty.

The Code of Practice of the Deprivation of Liberty Safeguards provides an example of a situation in which a person can be restrained while not being subject to a Deprivation of Liberty. The example involves a patient in a hospital ward who is assumed by the health workers to only lack capacity on a temporary basis and is at immediate risk of serious harm. However, this surely will not be the only situation or circumstance in which a person who is not subject to a Deprivation of Liberty could be restrained.

More importantly, this scenario could occur in other settings, not just in hospitals. Stakeholders have shared with COPNI the difficulties in evaluating fluctuating capacity. For residents of care homes, Deprivations of Liberty are only ever in place on a temporary basis (always subject to revision). There are individuals whose Deprivations of Liberty are removed because they regain capacity. Therefore, it is difficult for staff to judge when an Act of Restraint does not amount to a Deprivation of Liberty if they

are both temporary by definition. Although a Deprivation of Liberty should be more sustained than an Act of Restraint, it may be difficult for D to judge in which situations an Act of Restraint should not amount to a Deprivation of Liberty (in settings like care homes). This could be further explained in the Code of Practice to help staff make decisions based on whether or not Acts of Restraint may, in fact, be a Deprivation of Liberty.

The Deprivation of Liberty Safeguards Code of Practice provides an example of an act of restraint that would not be a deprivation of liberty. Similarly, it seems appropriate that the Code of Practice that deals with Acts of Restraint should provide clarification through examples. In addition, it could be clarified if a Deprivation of Liberty always presupposes any form of restraint, or if a Deprivation of Liberty can be in place with no provision on Acts of Restraint in P's care plan.

Is the guidance clear defining restraint in the Code of Practice?

Although the definition of restraint is clear, COPNI's engagement with care providers has raised questions over whether actions like "distraction" and "redirection", which are in many instances aimed at restraining a person who lacks capacity from leaving, could also be included in the definition of restraint.

For instance, if a person can be redirected or distracted, often none of the different forms of restraint listed in section 2.4 of the Code of Practice are necessary (mechanical, physical, medical, restrictive choice or withholding information), but the goal and result are the same (preventing the person from leaving). It could be argued that redirection and distraction are one of the techniques used in care homes to stop residents from leaving and may be forms of restraint ("intended to restrict P's liberty of movement, whether or not P resists", 2.3). One example of this was provided to COPNI by a care home manager, who discussed the situation of one resident. If that resident, who was under constant supervision and control, attempted to leave the care home, they would be physically stopped, but the person never attempted to leave. However, the person did sometimes express eagerness to leave, and in those cases, the person would be redirected or distracted by the staff ("it is raining outside", "would you like to have a cup of tea first", "remember that you have to finish this off", etc.). The care

home manager, at one point, believed that the person required a Deprivation of Liberty, but the Trust advised that it was unnecessary.

This difference of opinion is partly due to the restrictive definition of restraint that does not include distraction and redirection as forms of restraint. They could, however, be considered as types of restraint, although of a less intrusive nature. Restraint can vary in intensity (for instance, withholding information is arguably less intrusive than physical restraint, although the aim is the same, which is preventing P from leaving). Yet, if a resident of a care home is not free to leave, any technique used for that purpose is a restrictive practice, although clearly the intensity of the restriction varies.

In this example, the person was not free to leave, although none of the restraining forms listed in section 2.4 of the Code of Practice were necessary to stop the person from leaving, which led to confusion between the care provider and Trust. The Trust possibly interpreted that since the redirection techniques did not fit into any of the types of restraint listed in section 2.4 of the Code of Practice, this person was not, effectively, being “restrained” (and therefore was not “unfree to leave”). This was clearly not the case, because the person was effectively not free to leave. As such, consideration should be given to including “redirection” and “distraction” (when used as a form of restraint) in the list of techniques in section 2.4 of the Code of Practice.

Is the guidance clear explaining the restraint conditions to be protected from liability?

In this area, the guidance is reasonably clear, but it could be more specific in two areas.

The guidance is clear about the options for D to do an Act of Restraint on P, when P is a care home resident who is deprived of liberty and the restraining options are detailed in P’s care plan. D can do whatever is listed in the care plan, and that way D will be protected from liability. However, it would be important to specify through examples in the Code of Practice which options are available for D when a Deprivation of Liberty is not in place, that is, in emergency situations in which additional safeguards have not

been completed in time and a care plan is not available. A range of examples that clarify these situations would surely help health and social care workers.

A useful second clarification would involve a clear description of how D would be protected from liability if doing an Act of Restraint that is not specified in P's care plan when P is deprived of liberty. It is clear in the Code of Practice that if P is not deprived of liberty, D can do an Act of Restraint if the restraint condition is met. However, if P is deprived of liberty, then the Act of Restraint for P should be defined in P's care plan. Therefore, the Act of Restraint that D could do, should only be one of the Acts or Restraint specified in the care plan.

However, one can think of situations in which additional forms of restraint not included in the care plan may be needed. What are the options for D in that case? For instance, P's care plan may include "withholding information" as a reasonable, measured, and appropriate form of restraint for P, but it may be that in a certain occasion, physical restraint is needed to avoid serious harm. That action would exceed the provisions of P's care plan. Will D be protected from liability in this case? The Code of Practice could detail the range of options and protections available for D in situations like this.

Is the draft Code of Practice clear on "Acts of Restraint"?

The guidance in the Code of Practice is very clear on what constitutes an Act of Restraint, although this definition is dependent on the definition of "restraint" and the "restraint condition", which as stated above, may benefit from further clarification.

Risk to P and risk to others

A final clarification could be offered as regards the risk criteria. According to section 2.7 of the Code of Practice, the restraint condition requires a risk criterion to be met, that is, that D should have reasonable belief that failure to act would create a risk of harm to P. Moreover, section 2.9 states that "Harm to P could also include harm to another person where there is resulting harm to P". However, the prevention of serious harm condition (POSH) of the Deprivation of Liberty Safeguards (as stated in the DoLS Code of Practice) states clearly that the POSH condition is met when there is a serious risk of harm for self or others.

Therefore, there is a qualitative difference between a Deprivation of Liberty and an Act of Restraint in terms of risk of harm, even though both aim to prevent harm caused in situations in which P lacks capacity. D could restrain P if P is deprived of liberty to prevent serious harm to P or to others. Yet it seems clear (according to the Code of Practice of the Acts of Restraint) that D would not be able to do an Act of Restraint on P (if P is not deprived of liberty) unless there is a risk of harm to P, but not if there is (solely) a risk of harm to others. The Code of Practice should further clarify this issue, describing the options available for D when P is not deprived of liberty and D has reasonable belief that P lacks capacity, and failure to act would create a risk of harm to others.

I hope that you find this response helpful.

Kind regards,

Dr Ángel Leira Pernas
Policy and Research Officer
Commissioner for Older People for Northern Ireland