



## Consultation Response Form

*This consultation seeks stakeholder views on the commencement of sections 9(4)(a) and 12 of the [Mental Capacity Act \(Northern Ireland\) 2016](#) (MCA) in relation to 'Acts of Restraint', and an accompanying Code of Practice. Please see accompanying consultation document for more information.*

### **Response Form (If not responding online via Citizen Space)**

Please indicate your answers by placing an X next to your selection. You may also provide further comments in any text boxes provided.

Please send responses using this document electronically to the email address below, or via post to the address below.

#### **Email address**

[MCImplementation@health-ni.gov.uk](mailto:MCImplementation@health-ni.gov.uk)

#### **Postal Address**

Mental Capacity Act Unit  
Department of Health  
Room D2.10, Castle Buildings  
Belfast  
BT4 3SQ

**Please note the deadline for responses is 17.00 on 1<sup>st</sup> December 2024.**



## About you

*The Department of Health (DoH) is committed to protecting your privacy. For more information about what we do with your personal data please see our consultation privacy notice.*

*When completing this section, you only need to answer the questions that are relevant to you.*

1. Are you responding

as an individual? (Please complete questions 2-6)

on behalf of an organisation? (Please complete question 7)

(Required)

2. Are you a child / young person (under the age of 18)?

Yes

No

3. Are you a person with experience in working under the Mental Capacity Act (NI) 2016?

Yes

No

Prefer not to say

4. Do you have lived experience, or close hand experience, of mental capacity issues?

Yes

No

Prefer not to say



5. Do you work with individuals who lack capacity or in the sector related to this?

- Yes
- No
- Prefer not to say

6. If you answered yes to question 5 do you work in:

- Statutory Health and Social Care Sector?
- Voluntary or Community sector?
- Education?
- Other?
- Prefer not to say

If other, please specify:

This is the end of this section for those answering as an individual.

7. If you are responding on behalf of an organisation, please provide the name and address of the organisation and your position.

**Royal College of Psychiatrists NI**

Signed on 28<sup>th</sup> November 2024 on behalf of RCPsych NI by: Dr Julie Anderson Chair RCPsych NI & Vice President RCPsych – and – Professor Gerry Lynch RCPsych NI Legislation Lead

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## Commencement of sections 9(4)(a) and 12

**1. Do you agree with the Department's proposal to commence sections 9(4)(a) and 12 of the Mental Capacity Act (Northern Ireland) 2016?**

Yes

No

If no, please offer further detail regarding this below.



**2. Has the fact that sections 9(4)(a) and 12 have yet to be commenced directly impacted you, either personally or in your place of work?**

Yes

No

If yes, please offer further detail regarding this below.

Members have been involved in Court applications for Declaratory Orders.

In their Clinical practice, Members have been both concerned about and adversely affected by the absence of Statutory Guidance on Restraint, which has resulted in situations within Mental Health Service settings escalating in other unhelpful ways.

**3. What positive impacts do you foresee in the commencement of sections 9(4)(a) and 12?**

Member Clinical Practice will be positively affected and improved by clear Guidance with legislative protection in the use of Restrictive Practice. However, we stress that this must also be in conjunction with improved training and staff resourcing.



**4. What negative impacts do you foresee in the commencement of sections 9(4)(a) and 12?**

It is recognised that the MCA Forms to date have resulted in an overly bureaucratic and cumbersome process and the concern is that this will be replicated within the paperwork associated with this commencement, thereby further overloading the now scarce staff resource.

There is a potential for further heavy leaning on the Psychiatry profession, whereas capacity and authorisation of Restraint should be the business of the Multi-Disciplinary Team with Psychiatry involvement sought only when psychiatric expertise is necessary (e.g. in cases of severe, enduring and complex mental illness). For example, if a person needs Restraint in a Care Home or Learning Disability setting, we would ask: who does the paperwork? Will Psychiatrists be required to authorise every case? It is not clear who will be expected to authorise it. We already know from experience that when there is a clear potential for confusion as to who does the authorising - Psychiatry seems to become the default. This would be untenable with the Psychiatry workforce size.



**5. Do you foresee any significant operational challenges caused by the commencement of sections 9(4)(a) and 12?**

Yes

No

If yes, please offer further detail regarding this below.

This simply cannot be safely introduced without adequate training and staff resources. We cannot stress that enough.

We foresee significant operational challenges around additional paperwork, further increasing pressure on Staff time. There are already significant operational challenges in relation to completion of MCA related paperwork.

There is also uncertainty about what Restrictive Practices/Restraints are covered under Deprivation of Liberty (DoL) authorisation, and what are not. Whilst we recognize that you can have Restraint without DoL, most acts currently authorised by a DoL include an element of restraint or restrictive practice. The Code of Practice (CoP) as it is currently written does not provide guidance as to when the additional safeguards for restraint are necessary when the person is already subject to a DoL. We are also aware of situations currently described in certain settings as Restraint within Care Plans which are not Restraint at all, but which in fact constitute supportive and enabling measures. An example might be that of gently holding the hand of a person with dementia while personal care is being delivered to encourage them from resisting essential care. It is vitally important that such conflated misunderstanding is addressed and corrected in order to avoid over capture of irrelevant situations within this statutory driven process. Such issues need to be carefully considered and addressed pre introduction in order to avoid inevitable system swamp.



**6. Do you have any further comments in relation to the commencement of sections 9(4)(a) and 12 of the Mental Capacity Act (Northern Ireland) 2016 that you feel DoH should consider?**

Yes

No

If yes, please offer further detail regarding this below.

The CoP does not say clearly when Emergency provisions can be used and it must give better guidance. For example, in acute hospital settings you can use emergency provision to stop a person leaving - but what if the person is repeatedly leaving? Clear guidance is needed for such as this. Consistency between the various documents (CoP, Departmental Guidance documents, Documents produced by professional bodies such as [Three Steps to Positive Practice](#)) is vital.

The same terminology should be used – we note for example that ‘Chemical Restraint’ is used in Regional Guidance, whereas ‘Medical Restraint’ is used in the CoP . The same terminology should be used throughout.

**7. Is the guidance within the Code of Practice clear at defining ‘restraint’?**

Yes

No

If no, please offer further detail below on what you think needs added.

All Restraint is a Restrictive Practice, but not all Restrictive Practice is Restraint – yet 2.4 mixes up Restraint with all the Restrictive Practices, leaving the difference between these unclear. Definitions which differ from the Regional Guidance and the RCN Three Steps to Positive Practice document are being used here. These other 2 preexisting documents – and the Regional Guidance in particular - need to be studied carefully and reflected in a totally consistent way within this document. For example, Psychological Restrictions are defined here differently from Restraint in the Regional Guidance; there is insufficient information on when the use of medication is considered Restraint; Care Home Residents may receive occasional PRN medication for agitation which is technically Restraint - but 2.3 and 2.4 are not detailed enough to address such a commonly enough found scenario. This is bound to lead to confusion. There needs to be both internal and external congruence achieved within this Document prior to commencement and this will require Clinician input.



**8. Is the guidance within the Code of Practice clear at explaining the restraint conditions that must be met to be protected from liability?**

Yes

No

If no, please offer further detail below on what you think needs added.

2.7 refers to harm and not serious harm. Clearer Guidance is needed as to what constitutes harm – for example, is it physical/psychological? - with Clinical examples added to illustrate.

More guidance is needed on the least restrictive option in 2.8, as that can vary from person to person and hence must be considered on an individual basis and what is the least restrictive option/what would cause the least distress, should be regularly reviewed. It is essential that the CoP reflect critical detail such as this.

The Regional Guidance and the RCN Three Steps to Positive Practice preexisting documents – and the Regional Guidance in particular – should be referenced as indicative of contemporary current best practice (albeit that the latter is without a Statutory footing and is subject to the internal processes of the RCN) – with consistent terminology used between all three.

**9. Do you feel the draft Code of Practice is clear on ‘Acts of Restraint’?**

Yes

No

If no, please offer further detail below on what you think needs added.

2.13 is especially inadequate. It addresses Carers in Domestic settings in an unacceptably vague manner and offers them no clear guidance as to what a Carer can and cannot do and to what extent professionals must be involved by Carers. Suggesting that it may be useful to speak to a Professional for guidance is woefully inadequate and unfair to Carers. We would ask how are Parents to be trained for this on the basis of the little that is contained here?

Again the CoP should offer guidance on what is harm and what is serious harm.



**10. Do you feel the draft Code of Practice is clear at differentiating between restraint, seclusion and deprivation of liberty?**

Yes

No

If no, please offer further detail below on what you think needs added.

The definition of Seclusion is confusing and worse still contradictory and differs from other documents in the field and needs clarified.

The appropriate legal framework is not identified – and there is overlap and confusion as to what is authorised under DoL and when additional Restraint safeguards must be used.

The definition of Restraint is vague and requires examples. The definitions of and distinctions between: Restraint, Restrictive Practices and Seclusion need to be much clearer and clinical examples need to be supplied.

Is there any additional paperwork - ie forms to be filled in - any difference between patients already on DoL and having long term Restrictive Practice on them and patients not on DoL and having active Restraint?

What does implementation look like in practice?

## 11. Do you have any other comments on the proposed Code of Practice?

There is no mention of training or resources in this and it is critically important that this is addressed in order to learn from previous MCA related commencements.

The document is silent on how often additional safeguards need to be explored and reviewed.

As stated, you can have Restraint without DoL, but all DoL Authorisations contain an element of Restraint. The RCN Three Steps to Positive Practice document needs to be looked at, with practical content incorporated in relation to such distinctions.

We know from caselaw that Parents cannot consent to a DoL – but can they consent to Restraint say for a 16/17 year old?

The commencement again highlights the ongoing problem with regard to the Under 16s being excluded from the MCA and the question of their revised legislative protection being left unaddressed.

A CoP must be a tool for Clinicians as to how the Law should be put into practice by them and future versions must have extensive Clinical input in order to add the detail required to secure a practical use for this document. This version is not viable as written as it does not provide adequate detail or clinical guidance.



## Impact Assessments

**12. Do you have any comments in relation to the completion of any Impact Assessments/Screenings (Human Rights, Equality, Regulatory, Rural Needs and Article 2 of the Windsor Framework) completed by the Department in relation to these provisions being commenced, as discussed in this consultation.**