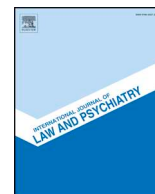




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Mental health and capacity laws in Northern Ireland and the COVID-19 pandemic: Examining powers, procedures and protections under emergency legislation



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ABSTRACT

This article examines the changes made to mental health and capacity laws in Northern Ireland through temporary emergency legislation, known as the Coronavirus Act 2020. The purpose of the legislation was to respond to the emergency situation created by the COVID-19 pandemic, in particular the increase pressure placed on health services in the United Kingdom. An overview is provided of the government's rationale for the changes to Northern Ireland mental health and capacity laws, as well as exploring how they are likely to be operationalised in practice. Consideration is also given as to how such changes may impact upon existing human rights protections for persons assessed as lacking mental capacity. It is argued that it is important that regular parliamentary oversight is maintained in relation to the potential impact and consequences of such changes during the period they are in force. This should be done in order to assess whether they remain a necessary, proportionate and least restrictive response to the challenges faced in managing mental health and capacity issues in Northern Ireland during this public health emergency.

1. Introduction

On 31 December 2019, the World Health Organization (WHO) was informed that a number of cases of pneumonia of unknown origin had been identified in the city of Wuhan in China (World Health Organization, 2020a). It soon became apparent that a coronavirus – which causes respiratory illness in human beings – was likely to be implicated. Within a few weeks, cases of human-to-human transmission were increasing exponentially within and across borders. At the end of January 2020, the WHO declared a Public Health Emergency of International Concern (PHEIC) pursuant to the International Health Regulations (World Health Organization, 2016). This facilitated an internationally coordinated response to what became known as COVID-19, which was attributable to a new coronavirus, SARS-CoV-2. On 11 March 2020, the WHO declared COVID-19 to be a global pandemic (World Health Organization, 2020b, 2020c).

In the United Kingdom (UK), the first cases of COVID-19 were reported at the end of January and involved visitors to England (Ball, Wace, & Smyth, 2020). The first case of a person contracting COVID-19 within the UK occurred at the end of February (BBC News, 2020a). As

the risk grew, an initial set of Health Protection Regulations were adopted to enable action to be taken by the UK government to minimise the spread of COVID-19 in the population (The Health Protection (Coronavirus) Regulations 2020 (UK SI 2020 No. 129)). At the same time, the government and their scientific advisors continued to support what was described as a 'herd immunity' approach to managing the disease. This involved allowing the virus to spread naturally through the British population in order to build up population immunity (Conn & Lewis, 2020).

By mid-March, however, the findings from pandemic modelling by experts at Imperial College revealed that such an approach would soon overwhelm capacity to manage COVID-19 cases within the National Health Service (NHS). Indeed, there were very real concerns that if the government did not take immediate mitigation measures, then the UK might face more than 500,000 deaths from COVID-19 (Ferguson et al., 2020). In the wake of such findings, the UK government switched tack and announced a range of new lockdown measures designed to restrict people's movements involving social distancing, working from home and only undertaking essential travel, leading to the cancellation of large social and sporting events (Doherty, 2020). By the end of March,

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both the Prime Minister Boris Johnson and the Secretary of State for Health and Social Care Matt Hancock were in self-imposed isolation with COVID-19 symptoms, as were several members of the government leadership team involved in managing the response to the pandemic (Proctor & Weaver, 2020).

In order to place the lockdown measures on a legislative footing, the UK government introduced the Coronavirus Bill into the UK Parliament on 19 March 2020 (UK Parliament, 2020a). In putting forward the Bill, it was clear the UK government was seeking a wide range of legal powers to manage the lockdown measures, as well as to address a myriad of issues that had arisen in relation to responding to the COVID-19 pandemic. With this in mind, the decision was taken to replace the initial Health Protection Regulations passed in February, which had drawn on health protection powers available under the Public Health (Control of Disease) Act 1984 (UK Public General Acts 1984 c. 22). Instead, the preferred way forward now was bespoke primary legislation. It was argued that this approach would provide the UK government and the devolved administrations with greater flexibility and a wider range of regulatory options to respond to the pandemic, as well as enabling the UK Parliament to undertake more detailed scrutiny of the use of government powers ‘in the round’ (Institute for Government, 2020).

The purpose of the legislation was ‘to respond to an emergency situation and manage the effects of the COVID-19 pandemic’, given that it was likely to lead to a ‘reduced workforce, increased pressure on health services and death management processes’. In doing so, the aims were to increase the health and social care workforce; to ease the burden on frontline staff in health and other public bodies; to contain and slow the spread of the virus; and to manage the deceased in a respectful and dignified manner (UK Parliament, 2020b). In drafting the legislation, the decision had also been taken that there would be a UK-wide approach, save where specific measures were required in the devolved administrations. Following a short period of scrutiny by both Houses, the Bill was quickly passed by the UK Parliament in the face of minimal opposition. The Coronavirus Act 2020 (Coronavirus Act) received Royal Assent on 25 March 2020. The Act is due to expire two years from this date, subject to a limited number of exceptions. In contrast to other emergency legislation such as the Civil Contingencies Act 2004, the Act’s parliamentary review mechanisms are more limited and spread over an extended period. They involve bi-monthly government reporting, in addition to the UK Parliament being able to express its views (at six months) or vote (at twelve months) on whether the Act should remain in force (UK Public General Acts 2004, c. 36; UK Public General Acts 2020, c 7, ss 89 & 90).

Health is a devolved matter to Northern Ireland under constitutional arrangements in the UK. Therefore, it is ordinarily a matter for the Northern Ireland Executive and Assembly to make policy and law in the area (Northern Ireland Act 1998, UK Public General Acts 1998, c. 47). Given the need for a UK-wide approach, the Assembly adopted a consent motion to permit legal measures for managing the COVID-19 pandemic in Northern Ireland to be included in the Coronavirus Act (Northern Ireland Assembly, 2020a). Given the urgency of the situation, there was little opportunity for the Assembly to engage in detailed scrutiny of the Coronavirus Bill before it was passed by the UK Parliament and the Act came into force (Northern Ireland Assembly, 2020b; Walker & Butler, 2020). Once the Act was in force, the Northern Ireland government quickly moved to adopt its own Health Protection Regulations, which set out the approach to be taken to lockdown measures locally. They were brought into force at 11 pm on 28 March 2020 (The Health Protection (Coronavirus, Restrictions) Regulations (Northern Ireland) 2020, NI SR 2020 No. 55). Specific measures contained in the Health Protection Regulations include powers to enforce the closure of schools and businesses, restrictions on people’s movement without ‘reasonable excuse’ and enforcement powers for the Police Service of Northern Ireland (ss 5(1) & (2)). These Regulations are required to be reviewed by the Northern Ireland Department of Health every twenty-one days to determine whether the measures

should remain in place. While regular reviews continue to take place (McCormack, 2020a), the Northern Ireland Executive has also published its plan for exiting lockdown, outlining its principled and incremental approach to easing the restrictive measures imposed through the Regulations. In doing so, the Executive reaffirmed its commitment to North-South, as well as East-West, co-operation in managing the pandemic (Northern Ireland Direct Government Services, 2020; Northern Ireland Executive, 2020).

The article focuses on examining the changes made to mental health and capacity laws in Northern Ireland through section 10 and Schedules 10 and 11 of the Coronavirus Act (emergency legislation). We proceed by providing a brief overview of such laws, before going on to explore the policy rationale for such changes, as well as elaborating on how key aspects are likely to be operationalised in practice. We also consider how these changes may potentially impact upon existing human rights protections for persons assessed as lacking mental capacity in Northern Ireland. In undertaking this examination, we acknowledge that it is necessarily at a preliminary stage given the recent implementation of such legislative changes. A more detailed critical analysis of their impact and consequences can only be made following the end of the public health emergency. With this caveat in mind, we argue that it is important that regular parliamentary oversight is maintained in relation to the potential impact and consequences of such changes during the period they are in force. This should be done in order to assess whether they remain a necessary, proportionate and least restrictive response to the challenges faced in managing mental health and capacity issues in Northern Ireland during the COVID-19 pandemic.

2. Mental health and capacity laws in Northern Ireland: An overview

In this section, we first provide a brief overview of historical and political developments impacting upon constitutional arrangements and devolved powers in Northern Ireland. This will provide the necessary context in which to situate our examination of key aspects of Northern Ireland mental health and capacity laws. It will also set in contrast the changes introduced to such laws through emergency legislation, which are examined in more detail in the following sections of the article.

2.1. Historical and political context

Northern Ireland is a devolved nation of the UK comprising six counties in the North-East of the island of Ireland. While the jurisdiction was formally created in 1921, its constitutional status, including whether it should remain part of the UK or form part of a united Ireland, was one of the factors in a violent conflict, commonly known as ‘The Troubles’. This conflict lasted for over twenty-five years in the twentieth century, with its legacy continuing to resonate in Northern Ireland up until the present day (see McGarry & O’Leary, 1995; McGrattan, 2010; McKittrick & McVea, 2012). During this period, devolved government in Northern Ireland was suspended. Direct rule was imposed which involved the UK government assuming primary responsibility for governmental decision-making in Northern Ireland (Institute of Government, 2020). In 1998, a peace accord was reached – known as the Good Friday Agreement (or Belfast Agreement) – which provided for the re-establishment of devolved power-sharing institutions. The Agreement was based on the principle of consent in the context of the constitutional position of Northern Ireland and a right to self-determination subject to the consent of the majority in Northern Ireland and Ireland (Good Friday/Belfast Agreement, 1998).

Due to the nature of politics in Northern Ireland, the devolved government has collapsed on a number of occasions in the past twenty years since the peace accord, which has led to periods of direct rule being re-imposed by the UK government. In January 2020, it was restored again following an agreement between the main political parties.

Nevertheless, political tensions continue to persist over the border between Northern Ireland and Ireland. Most recently, such tensions have been exacerbated by the UK's decision to leave the European Union (colloquially known as Brexit), given that the North-South border on the island of Ireland has now become the sole land border between the UK and the European Union. Indeed, it is the border question which has also led to a range of difficulties in facilitating a coordinated response to the COVID-19 pandemic on the island, although there is now evidence of increased North-South cooperation across a range of public health measures ([Memorandum of Understanding, 2020](#); [Scally, 2020](#)).

2.2. Mental health and capacity laws: Reform and implementation

There are two key pieces of legislation that are relevant to examining mental health and capacity laws in Northern Ireland: the Mental Health (Northern Ireland) Order 1986 (MHO) (Northern Ireland Orders in Council 1986 No. 595 (N.I. 4)) and the Mental Capacity (Northern Ireland) Act, 2016 (MCANI) (Acts of the Northern Ireland Assembly, 2016, 2020 c. 18). For present purposes, we exclude consideration of the potential impact upon the criminal justice provisions of the MHO and MCANI. The MHO has been in force since 1986 and has been described as 'traditional mental health legislation' ([Harper, Davidson, & McClelland, 2016](#)). It provides for involuntary treatment of 'mental disorder', which is defined as 'mental illness, mental handicap and any other disorder or disability of mind' (MHO, Article 3(1)). This is based on diagnosis and risk; presence of mental illness or severe mental impairment; and failure to detain leading to substantial risk of serious physical harm to self or others (MHO, Articles 3 & 4). The MHO is accompanied by a short Code of Practice, and what is known as the GAIN Guidelines, which set out detailed information about the provision of mental health care in line with the MHO ([Guidelines on the Use of the Mental Health \(Northern Ireland\) Order, 1986](#)).

In the early 2000s, the Bamford Review began what would be a lengthy examination of law, policy and provisions affecting people assessed with mental health needs and learning disabilities in Northern Ireland. The Review produced a number of reports, including one which recommended comprehensive reform of mental health and capacity laws in Northern Ireland. Such law reform was to be grounded in a rights-based approach in which the key principles of respect and autonomy were embedded ([Northern Ireland Department of Health, 2007](#); [Davidson, McCallion, & Potter, 2003](#)). Following the completion of the Bamford Review's work, there ensued a further lengthy period of consultation and Executive review before a draft proposal for legislative reform – the Mental Capacity Bill – was eventually introduced into the Northern Ireland Assembly in 2015. Following detailed scrutiny, it was eventually passed and received Royal Assent in 2016. Since such time, the Northern Ireland Department of Health has been working on a phased implementation and, once the Act is fully implemented, the MHO will be repealed.

The MCANI is an innovative, ground-breaking piece of legislation both in the UK and internationally ([Campbell, Brophy, Davidson, & O'Brien, 2018](#)). Northern Ireland has opted for a form of 'fusion legislation', bringing together capacity and mental health law across medical specialities (see [Dawson & Szmukler, 2006](#)). What this means is that impairment of decision-making capacity and best interests are the only criteria to be used when making decisions across health and social care ([Lynch, Taggart, & Campbell, 2017](#)). At the heart of this reform of mental health and capacity laws is a recognition of both the moral and legal importance of a person's autonomy and rights. It applies in all circumstances where a person's autonomy might be compromised on health grounds. It acknowledges the importance of recognising 'parity of esteem' between mental and physical illness. The aim is to treat mental and physical illness equally under the law, with the objective of reducing stigma associated with separate mental health legislation.

Notwithstanding this innovative rights-based approach to fusing mental health and capacity laws in Northern Ireland, it has nevertheless

attracted criticism on the grounds that the MCANI is not fully compliant with the Convention on the Rights of Persons with Disabilities (CRPD) (UN General Assembly, 24 January 2007, A/RES/61/106). Article 1 of the CRPD clarifies that the term 'persons with disabilities' includes persons with mental and intellectual impairments'. The MCANI has been criticised on the grounds that it does not recognise 'legal capacity' as set out in Article 12 of the CRPD, which affirms that persons with disabilities have the right to recognition everywhere as persons before the law. The United Nations Committee on the Rights of Persons with Disabilities has interpreted legal capacity under Article 12 as including the capacity to be both a holder of rights and an actor under the law ... which entitles a person to full protection of his or her rights by the legal system'. In the circumstances, legal capacity and mental capacity should be viewed as 'distinct concepts', with the latter referring to 'the decision-making skills of a person'. Therefore, 'perceived or actual deficits in mental capacity must not be used as justification for denying legal capacity' ([United Nations Committee on the Rights of Persons with Disabilities, 2014](#), paras 12–13). The approach to supporting a person assessed as lacking mental capacity in exercising their legal capacity forms part of broader academic debates about whether, and to what extent, compliance with the CRPD is achievable under domestic law (see [Arstein-Kerslake & Flynn, 2016](#); [Donnelly, 2016](#); [Flynn, 2013](#); [Harper et al., 2016](#); [McSherry & Wilson, 2015](#); [Series, 2015](#); [Stavert, 2018](#); [Szmukler, Daw, & Callard, 2014](#)).

The first phase of the MCANI implementation programme was commenced on 2 December 2019. This involved the introduction of the Deprivation of Liberty Safeguards (DoLS) scheme through the DoLS Regulations, which was accompanied by a Code of Practice (Mental Capacity (Deprivation of Liberty) (No. 2) Regulations (Northern Ireland) 2019, NI SI 2019 No. 199; [Northern Ireland Department of Health, 2019b](#)). The DoLS Code of Practice reiterates that, under the MCANI, mental capacity is to be presumed and the burden of proof (balance of probabilities) is on those seeking to assert incapacity to show otherwise and on the basis of reasonable belief, taking account of the factors noted below. The test for capacity is whether or not a person aged 16 years or over is unable to make a decision for themselves because of 'an impairment of, or disturbance in the function of the mind or brain', whether temporary or permanent and whatever its origin (MCANI, s 3(1) & (2)(a)). A determination of incapacity is time and decision specific (MCANI, s 3(1)), and any intervention must be taken on a best interests basis (MCANI, ss 2 & 7; DoLS Code of Practice, Chapter 7). Factors to be taken into account in determining whether a person has the capacity are based on a functional assessment which includes their ability to understand, use, weigh and appreciate, communicate and retain the information relevant, or required, to (the process of) making the decision in question (see MCANI, s 4, DoLS Code of Practice, Chapter 5).

The statutory principles set out in the MCANI underpin the operation of the DoLS scheme (MCANI, ss 1 & 2). In line with such principles, the DoLS Code of Practice makes clear that if a person is assessed as lacking capacity to make a decision, they should nevertheless be included as far as possible in any discussions about deprivation of liberty and to be able to make their views and opinions known. They are entitled to know, and be given, all the information, used in any assessments. No assumptions can be made about a person and they have the right to make unwise decisions. As far as is possible, they must be supported to make any decision regarding their care and treatment (MCANI, s 5; DoLS Code of Practice, paras 3.2–3.11). They can ask a 'nominated person' to let people know what they would want and what would be in their best interests (MCANI, s 69). Where a person does not appoint a nominated person, then one can be appointed from a 'default list' which are prioritised in the following order: carer, spouse or civil partner, child, parent, brother/sister, grandparent, grandchild, aunt/uncle; niece/nephew, provided they are aged 16 years or over (MCANI, s 73; DoLS Code of Practice, para 9.21). If a person is to be deprived of their liberty, then all necessary legal safeguards should be put in place

and they have the right to challenge new and existing authorisations made under the DoLS scheme to what is known as the Review Tribunal. During the first phase of implementing the MCANI, the Review Tribunal can only consider a specified range of authorisations made under the DoLS scheme, such as a Trust panel authorisation, interim authorisation, Trust panel extension authorisation, short-term detention authorisation or an extension authorisation (DoLS Code of Practice, paras 14.2–15.5).

The DoLS Code of Practice also makes clear that an application for a DoLS authorisation is only required when a person is deprived of their liberty, as opposed to having their freedom restricted. In short, the deprivation of liberty has to be necessary to protect a person from harm, be proportionate and be in their best interests. The criteria for determining whether there has been a deprivation of liberty is whether the person in question is under continuous supervision and control, and whether they are free to leave. This draws on the ‘acid test’ set out by Baroness Hale in *Cheshire West (P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council; P and Q (by their litigation friend the Official Solicitor) v Surrey County Council* [2014] UKSC 19, paras 48, 59; DoLS Code of Practice, paras 2.6–2.18). In the event that a person is deemed to have met the criteria, then a suitable authorisation must be sought under the DoLS scheme. With the exception of needing to receive life-saving medical treatment, deprivation of liberty of a person lacking capacity for medical treatment in a hospital setting requires a ‘short-term detention authorisation’. This form of authorisation can be put in place by two specified healthcare professionals for fourteen days, which can be extended for a further fourteen days based on specified criteria (DoLS Code of Practice, paras 12.3, 12.9–12.12, 2.19–2.22; MCANI, Schedule 2).

Outside the hospital setting, a DoLS application can be authorised by a suitably constituted Trust panel, whether the person is based at a care or nursing home, day centre, respite facility, any other health or social care setting or in a private home (DoLS Code of Practice, para 7.21). The panel must make a decision about a DoLS authorisation within seven working days after the Trust has received the application (DoLS Code of Practice, para 11.3). The use of the term ‘Trust panel’ in this context refers to the fact that the entity charged with making DoLS authorisations is situated within one of the five Trusts which manage hospitals and other health and social care facilities in Northern Ireland. The Trusts form part of the Northern Ireland health service known as Health and Social Care, which is equivalent to the National Health Service in England, Wales and Scotland ([Health and Social Care Online, 2020](#)). To be properly constituted under the DoLS scheme, the panel must consist of members appointed by the relevant Trust comprising three ‘suitably qualified persons’: one medical practitioner, one approved social worker and one other healthcare professional, who could be a registered nurse or midwife, registered dentist, occupational therapist, speech and language therapist, practitioner psychologist. In addition, panel members must have undertaken the requisite training in making formal assessments of capacity under the MCANI, as well as specific training for sitting on these panels (DoLS Regulations, Reg 2; DoLS Code of Practice, paras 14.4–14.5).

We recognise that the DoLS scheme which operates in England and Wales has attracted significant criticism to date ([Bartlett, 2014](#); [Fanning, 2016](#); [Law Commission, 2017](#); [UK Parliament, 2018](#)), and will shortly be replaced with the Liberty Protection Safeguards Scheme (see Mental Capacity (Amendment) Act 2019, UK Public General Acts 2019, c. 18; [Series, 2020](#)). However, it is too soon to draw any firm conclusions about the effectiveness or otherwise of the operation of the Northern Ireland DoLS scheme, given it has only been operational since early December 2019. Besides being premature, any such assessment is now further complicated by the introduction of changes to the scheme brought about by the emergency legislation to address the COVID-19 pandemic. Key aspects of the DoLS scheme which are impacted by such changes include which ‘suitably qualified persons’ can now making formal assessments of capacity; the role and functions of the nominated

person; how applications are now to be made for DoLS authorisations; the composition and methods of decision-making by Trust panels making DoLS authorisations; and the appeal mechanisms to the Review Tribunal. We now turn to consider these changes in more detail in the following sections of the article.

3. Changes to NI mental health and capacity laws under emergency legislation

3.1. Purpose and general remit

The Coronavirus Act 2020 introduces changes to both the MHO and the MCANI. Following the passing of the emergency legislation, these changes were brought into force by statutory instrument on 30 March and 2 April 2020 respectively (see Mental Health (Northern Ireland) Amendment Order 2020 (NI SI 2020 No. 46); Mental Capacity (Deprivation of Liberty) (Amendment) Regulations (Northern Ireland) 2020 (NI SI 2020 No. 57). These statutory changes were accompanied by two Emergency Codes of Practice which provide more detailed guidance as to how these changes will work in practice. Both offer a similar rationale for the changes. First, there is a need to address the consequences arising from a likely reduced workforce of health and social care professionals as a result of illness suffered due to the COVID-19 pandemic. Second, the changes are designed to mitigate this impact. Third, pursuing mitigation in this way will ensure that persons can still be either compulsorily admitted and detained under the MHO, or be legally deprived of their liberty while still ensuring safeguards are in place under the MCANI ([Northern Ireland Department of Health, 2020a](#); [Northern Ireland Department of Health, 2020b](#)).

Specific reference is made to the use of detention powers in both Emergency Codes of Practice. Although recognising that the COVID-19 pandemic has necessitated rapid health emergency planning, it is made clear that the use of such powers should not be seen *prima facie* as operating pursuant to the MHO’s emergency provisions, without further justification. In the case of detention powers under the MHO, it is also emphasised that due processes and proper safeguards must be adhered to (MHO Emergency Code of Practice, para 6). Similarly, in the case of the MCANI, reference is made to the fact that even where a person may have tested positive for COVID-19, they ‘cannot be detained, deprived of liberty or secluded without proper processes and legal support’. The Code also emphasises in bold type that ‘if a person who lacks capacity is isolated and therefore prevented from leaving it is likely that the person is deprived of liberty.’ This necessitates adherence to ‘legal processes’, including the DoLS scheme (MCANI Emergency Code of Practice, para 9).

Given such emphasis, it is surprising that no further detail is provided as to what is meant by the need to adhere to ‘legal processes’, apart from the DoLS scheme. While it is our view that the use of existing mental health and capacity law is much more appropriate in the case of persons assessed as lacking capacity with COVID-19 who either needs medical treatment or who may pose a risk of transmitting COVID-19 infection to others, it is important to keep in mind that there is a range of ‘legal processes’ that could potentially be used in the context of a public health emergency. For example, this could include the use of the new health protection powers in Part 1A of the Public Health (Northern Ireland) Act 1967 (Acts of Northern Ireland Parliament, chapter 36). Such powers were imported into the 1967 Act through s 48, Schedule 18 of the Coronavirus Act 2020 and they provided the legal basis for the adoption of the Northern Ireland Health Protection Regulations in late March 2020, which imposed lockdown measures locally in response to the COVID-19 pandemic. The new Part 1A provisions mirror many of the general health protection powers contained in Part 2A of the Public Health (Control of Disease) Act 1984 which applies in England and Wales, but they are focused on addressing the COVID-19 pandemic. With this in mind, the term ‘infection or contamination’ is defined in Part 1A as an ‘infection or contamination with coronavirus which

presents or could present significant harm to human health', in circumstances where 'coronavirus' means 'severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)' (s 25A(2)). Regulations which would seek to enable these special restrictions or requirements would need to be proportionate and in response to an imminent threat to public health, which could include making provision for persons with coronavirus to be detained, quarantined or otherwise kept in isolation for the protection of the public health in specified circumstances (s 25D).

It is also emphasised in both Emergency Codes of Practice that the usual 'legal processes' which apply in the case of use of the MHO and the MCANI, should continue to be used in the first instance. Making use of the emergency provisions should be seen as a matter of last resort, in circumstances where there is no other option (e.g. MCANI Emergency Code of Practice, para 6). To the authors' knowledge, there has been little use made of these provisions to date. We do recognise that there are, or will be, circumstances where the use of the emergency provisions might be justified, particularly where, for example, a significant COVID-19 outbreak occurs in a closed mental health unit, resulting in a substantial depletion of the available psychiatric care workforce (Campbell & Grierson, 2020). It is nevertheless important that where the use of the provisions is contemplated or take effect, then the Emergency Codes' exhortation that a person's human rights should remain at 'the forefront of decision making' during this emergency period should be adhered to, with specific reference to the protections provided by Article 2 (right to life); Article 3 (prohibition against inhuman and degrading treatment); Article 5 (the right to liberty and security); and Article 8 (the right to respect for private and family life) as enshrined in the European Convention on Human Rights (ECHR) (see MHO Emergency Code of Practice, para 2; MCANI Emergency Code of Practice, paras 1, 8).

4. Changes to the Mental Health (Northern Ireland) Order 1986

4.1. Workforce

In the context of healthcare staff numbers being low due to sickness or isolation, the emergency provisions allow for an 'approved social worker', who makes the application for involuntary admission to hospital, to be replaced by a 'relevant social worker', if the former is not available (MHO Emergency Code of Practice, para 22). In addition, a 'responsible medical officer', who provides the medical reports for continued detention for assessment and then treatment, can also be replaced by a 'relevant medical practitioner', in circumstances where it would be impractical to wait for the former to be available (MHO Emergency Code of Practice, para 38).

While the MHO Emergency Code of Practice provides minimum experience requirements for both the relevant social worker and the relevant medical practitioner, both healthcare professionals are stepping into roles they might not have relevant experience of, given the legal requirements in this regard set out in the MHO. In addition, there is no mention within the MHO Emergency Code of the need for specialised training to perform this role. This presents a number of potential risks. For example, a prescribed form authorising the detention may be incorrectly completed due to inexperience, or a 'replacement' for the approved social worker and/or responsible medical officer may misinterpret the law or act in error when applying the criteria for detention. Both events would have obvious implications for whether detention powers are being used appropriately in accordance with the law, as well as giving rise to a potential interference of a patient's human rights, specifically under Articles 3, 5 and 8 of the ECHR.

4.2. Time limits

The time limits within the MHO provide important safeguards for the patient in relation to the detention powers exercised being

proportionate and the least restrictive option (MHO Emergency Code of Practice, paras 1.8, 5.26). The MHO provides precise periods of time for each stage of compulsory admission to be reviewed and reported on by the responsible medical officer, who reviews detention in the form of providing reports through completion of further prescribed forms and, ultimately, the Review Tribunal (MHO, Art 71). If these time limits are breached, then detention under the MHO would ordinarily lapse. The MHO Emergency Code of Practice extends a number of these time limits. As an example, the initial period of detention under the MHO is for assessment and, prior to the changes introduced via the emergency provisions, can last for a period of fourteen days in total from the date of admission (MHO, Arts 9(7), (8)). During this period the patient can appeal their detention to the Review Tribunal. This assessment period has now been extended to twenty-eight days (MHO Emergency Code of Practice, para 34). By extending the assessment time limit there could be a delay to an appeal before the Review Tribunal and the implication is that a patient could be detained for longer than is necessary. This again raises the prospect of a potential interference of the patient's human rights on the grounds noted previously. It also begs the question as to whether these time extensions are actually required in the present circumstances. As there are already modifications addressing potential sickness in the workforce, which allow others to step into the roles usually performed by the approved social worker and responsible medical officer, it is not clear why any additional measures are required in order to ensure that the original statutory time limits are met.

4.3. Monitoring

Individual Health and Social Care Trusts must monitor the use of emergency provisions on an individual basis and prepare a report on whether or not their use was appropriate in a given set of circumstances. This report is to be forwarded to the Northern Ireland Department of Health within fifty-six days following the end of the emergency period with temporary prescribed forms having been created to assist in this monitoring exercise (MHO Emergency Code of Practice, para 21; Annex A). There is also a requirement to inform the patient and the nearest relative that the emergency modifications are being used (MHO, Art 32; MHO Emergency Code of Practice, paras 19–21). While disclosure about the use of the provisions is to be welcomed in the interests of transparency, the question is whether this retrospective monitoring will be sufficiently robust, or even appropriate, in terms of dealing with an issue of this magnitude, namely, the compulsory detention and treatment of a patient. While there are few details provided as to how Trusts will monitor the use of the emergency provisions in practice, or justify their use, it will inevitably require additional work and perhaps more staff. This can hardly be the desired outcome, given the objective in introducing such provisions was in large part to mitigate the impact of the COVID-19 pandemic on an already depleted workforce.

4.4. The Review Tribunal

During the COVID-19 pandemic, the approach taken by UK Courts and Tribunals has been to minimise risk to judges, Tribunal members, legal representatives and the parties (Courts and Tribunals Judiciary, 2020a; Northern Ireland Department of Justice, 2020; Northern Ireland Lord Chief Justice's Office, 2020). In practice, this has resulted in a shift to remote hearings where possible (e.g. *Re A (Children) (Remote Hearings)* [2020] EWCA Civ 583; *Re B (Children) (Remote Hearing: Interim Care Order)* [2020] EWCA Civ 584). The Review Tribunal is an independent judicial body, which hears and determines applications appealing decisions made under the MHO and the MCANI on specified grounds. As a result of the COVID-19 pandemic, the Tribunal has also been conducting remote hearings, predominantly by telephone. In the context of mental health, the obvious issue is whether or not this is the appropriate environment for an acutely ill patient to challenge their

detention. Although there has been positive support overall on the part of the UK judiciary and the legal profession for the shift towards remote hearings in the wake of the COVID-19 pandemic (Harrison, 2020), a report on a recent hearing before the Court of Protection which deals, *inter alia*, with DoLS authorisations under mental capacity legislation in England and Wales, called into question whether it was an equally positive experience for applicants or their family members (Kitzinger, 2020; Ruck Keene, 2020). Clearly, more empirical research is needed which examines the experiences of those challenging detention (or deprivation of liberty) under UK mental health and capacity laws, including in Northern Ireland (Courts and Tribunals Judiciary, 2020b). This would enable a more nuanced examination of the experiences of applicants and supporting family members/friends, as well as other parties to remote hearings, including whether the right to a fair trial under Article 6 of the ECHR is engaged.

5. Changes to the Mental Capacity (Northern Ireland) Act 2016

5.1. Medical reports

Under the DoLS Regulations, an application for a DoLS authorisation to a Trust panel must contain a medical report (DoLS Regulations, Reg 11). While this requirement remains, the MCANI Emergency Code of Practice goes on to state:

...there may be circumstances where it is deemed that a deprivation of liberty is necessary and not putting one in place would cause an unacceptable risk of harm to P [the person]. If it is not reasonably possible to carry out a medical examination, D [the doctor] can rely on the emergency provision in the absence of the additional safeguard of trust panel authorisation (MCANI Emergency Code of Practice, para 17).

The above statement presumably refers to section 56 of the MCANI which sets out what constitutes an 'emergency'. This situation will arise if, at the time when the doctor making the report determines what would be in the person's best interests, that person (a) knows that the safeguard in that section is not met, but reasonably believes that to delay the report until that safeguard is met would involve an unacceptable risk of harm to the person; or (b) does not know whether the safeguard is met, but reasonably believes that to delay the report until it is established whether the safeguard is met, would involve an unacceptable risk of harm to the person. While this does not strictly represent a change to the existing law, its inclusion in the MCANI Emergency Code of Practice has the potential to be (over) relied upon during the COVID-19 pandemic, as it would lessen the burden on an already under-pressure workforce. This (over) reliance could, in turn, lead to a reduction in confidence in the ability of the MCANI, and the DoLS scheme, to provide safeguards and protect persons from arbitrary decision-making in line with Article 5 of the ECHR, notwithstanding claims to the contrary in the Emergency Code.

5.2. Training

Even prior to the emergence of the COVID-19 pandemic, the implementation of the DoLS Scheme has required a substantial change in working culture for many healthcare professionals in Northern Ireland. Indeed, it was recognised that training was needed to understand the nature, scope and practice of the new scheme. Training became a legal requirement for a range of healthcare professionals who would be working in the area (DoLS Regulations, Reg 2(3)). As noted previously, the DoLS Regulations provide that only 'suitably qualified persons' are to conduct formal assessments of capacity (see Reg 2(2)). However, one of the changes set out in the MCANI Emergency Code of Practice is the removal of the need for the 'suitably qualified person' making formal assessments of capacity, or participating in Trust panels, to have relevant training and experience in capacity (MCANI Emergency Code of Practice, para 47). This dispensing of training and the likelihood of

minimal, if any, practical experience in working with the DoLS scheme on the part of healthcare professionals who may now be called upon to provide formal capacity assessments under the emergency provisions, raises the potential for incorrect interpretation and application of the DoLS Regulations, and the MCANI more generally.

5.3. Trust panels

The composition of Trust panels which determine DoLS authorisations has now been changed under the emergency provisions. As noted previously, the panels are usually constituted under the DoLS scheme to include one medical practitioner, one approved social worker and one other 'suitably qualified person' (DoLS Regulations, Reg 41(1)(b)). The emergency provisions dispense with the requirement for a medical practitioner and an approved social worker, instead allowing for any three 'suitably qualified persons' (MCANI Emergency Code of Practice, para 52). Bearing in mind the infancy of the DoLS scheme, it is only the medical practitioner and the approved social worker, out of the 'suitably qualified persons', who will have had sufficient professional experience in dealing with mental health and capacity laws prior to the DoLS scheme coming into force. With the removal of the requirement for specialised training under the emergency provisions, a Trust panel could conceivably be composed of three healthcare professionals from disciplines that are neither sufficiently experienced, nor trained in assessing capacity under the MCANI, particularly with regard to what constitutes deprivation of liberty under the DoLS scheme. The absence of experience and training raises the potential for incorrect application of the DoLS Regulations. Depending on an individual's circumstances, this could also raise concerns about a potential infringement of their human rights under Article 5, as well as Articles 2, 3 and 8 of the ECHR.

5.4. Monitoring

As with the MHO Emergency Code of Practice, there is also a requirement for individual Trusts to monitor the use of the MCANI Emergency Code of Practice and to report to the Northern Ireland Department of Health no later than three months following the end of the period of emergency (MCANI Emergency Code of Practice, para 24). As noted previously, concerns about exactly how this monitoring will take place in the case of the MHO Emergency Code of Practice are also mirrored with respect to the MCANI Emergency Code.

5.5. Review Tribunal

Since 2 December 2019, the Review Tribunal has also been empowered to review DoLS authorisations and applications for the appointment or removal of nominated persons under the MCANI. As noted previously, the Tribunal is currently conducting remote hearings and there are similar concerns about how such hearings will work in the context of considering applications for DoLS authorisations. Arguably, matters coming before the Tribunal during the COVID-19 pandemic might be more serious than has been the case to date, particularly where existing safeguards in relation to such applications have been relaxed under the MCANI Emergency Code of Practice. This begs the question as to whether remote hearings will always be appropriate in the circumstances.

6. Mental health and capacity laws, human rights and emergency powers

The changes made to Northern Ireland mental health and capacity laws under emergency legislation reflect the fact that the UK government, as well as the devolved administrations, are confronting an unprecedented public health emergency. This has necessitated the implementation of a range of legal measures in response to the COVID-19 pandemic and to minimise the spread of the disease to the population.

Notwithstanding the importance of mounting an appropriate legal response in the circumstances, it is also vital that human rights protections are adhered to, particularly given the level of restrictions that have been imposed on the UK population through the legislation. As has been forcefully argued by Michelle Bachelet, the United Nation's High Commissioner for Human Rights:

Lockdowns, quarantines and other such measures to contain and combat the spread of COVID-19 should always be carried out in strict accordance with human rights standards and in a way that is necessary and proportionate to the evaluated risk ... COVID-19 is a test for our societies, and we are all learning and adapting as we respond to the virus. Human dignity and rights need to be front and centre in that effort, not an afterthought (United Nations, 2020).

It is important to note that the UK government has not derogated from its human rights obligations under Article 15 of the ECHR during the COVID-19 pandemic. When the Coronavirus Bill was first introduced into the UK Parliament, it was accompanied by a statement from the Secretary of State for Health and Social Care confirming compatibility with the ECHR, as required under s 19(1)(a) of the Human Rights Act 1998 (UK Public General Acts, 1998, c. 42). In support of such statement, the UK Department of Health and Social Care submitted a memorandum to the UK Parliament's Joint Committee on Human Rights identifying that Articles 2, 3, 5 and 8 of the ECHR were potentially engaged as a result of the changes to be made to Northern Ireland mental health and capacity laws. After a rather cursory analysis, the Department concluded that the changes did not infringe such rights but were instead 'sensible and pragmatic precautions' in circumstances where the legislation, when enacted, would not 'fundamentally reduce the important level of scrutiny that is given where deprivation of liberty is under consideration' (UK Department of Health and Social Care, 2020a, para 25).

In a subsequent summary impact assessment submitted to the UK Parliament, the Department nevertheless recognised that the changes to Northern Ireland mental health and capacity laws would involve a reduction in the 'protections for persons deprived of liberty' and this 'always carries the risk of negative reaction. However, considering the current position, it is not unlikely that the public reaction will be mostly positive. The move is widely supported across the HSC [Health and Social Care]' (UK Department of Health and Social Care, 2020b, para 73). We find this to be a troubling assertion to make, in the absence of evidence of public support for a reduction in such protections. It also represents a challenge to the democratic legitimacy of these changes, given the extended public consultation and parliamentary review processes that were undertaken in the drafting of the MCANI, which was underpinned by a rights-based approach to ensure appropriate protections were in place for those assessed as lacking mental capacity in Northern Ireland.

Notwithstanding the UK government's position, academic and stakeholder concerns have been raised about the potential reach of the emergency legislation, and its potential impact upon human rights protections. Ruck Keene (2020) has argued that the overall 'bare bones' approach of the UK government with respect to ensuring the Coronavirus Act's compatibility with the ECHR means that the options for persons with impaired decision-making capacity have in effect been 'dramatically reduced' in the UK. Specifically, in relation to the changes made to detention powers under Northern Ireland mental health and capacity laws, the British Institute of Human Rights has argued that they have the potential to adversely impact upon an already vulnerable group, operating to reduce existing safeguards, which will likely take place in the absence of suitable support mechanisms and sufficiently robust review processes. It remains unconvinced by the blanket assertions by the UK government to the effect that the changes to detention powers are unlikely to interfere with a person's human rights under Articles 3, 5 and 8 of the ECHR, given evidence to the contrary arising from poor treatment and outcomes for those with mental illness in the UK prior to the emergence of the COVID-19 pandemic (British Institute

of Human Rights, 2020, 8).

The Institute has also argued that the potential for a breach of Article 14 (protection against discrimination) should have been taken into account by the UK government in considering the impact of the emergency legislation upon vulnerable groups, which includes those assessed as lacking capacity. This is an important consideration in the Northern Ireland context, given the fact that the Equality Act 2010 has not been extended to the jurisdiction (UK Public General Acts 2010, c 15). What this means is that persons with a protected characteristic, such as mental disability, have a more limited range of options for legal challenge and protection in Northern Ireland than would be the case elsewhere in the UK. Indeed, Northern Ireland remains non-compliant with the CRPD in the absence of being able to provide this broader range of equality provisions for persons with mental disabilities (Northern Ireland Human Rights Commission, 2017). More generally, the Institute also doubted whether public authorities (including decision-makers and service providers) were sufficiently well trained in the context of a public health emergency to fulfil their obligations under section 6 of the Human Rights Act 1998 to 'respect, protect and fulfil people's human rights in their decision-making, policy and practice'. This is against a background where 'most frontline staff across the NHS, social care and other sectors receive almost no human rights training and guidance is patchy at best' (British Institute of Human Rights, 2020, 8). While understanding of the need for emergency measures in responding to the COVID-19 pandemic, both the Northern Ireland Human Rights Commission and the Equality Commission of Northern Ireland have also recognised the risks posed by the emergency legislation to the human rights of vulnerable groups, including those assessed with a disability such as mental impairment (Equality Commission for Northern Ireland, 2020; Northern Ireland Human Rights Commission, 2020).

It remains to be seen whether any legal challenges alleging infringement of one of more of Articles 2, 3, 5, 6, 8, and 14 of the ECHR would succeed in relation to changes made to Northern Ireland mental health and capacity laws as a result of the emergency legislation. However, it would be important to keep in mind that the European Court of Human Rights would be likely to offer a wide margin of appreciation in relation to legal measures adopted by states to deal with a public health emergency (McBride, 2020). The right to life under Article 2 places a positive obligation on states to implement (preventative) measures to protect life. In the particular circumstances of a given case, it could be argued that there was an alleged failure on the part of the state to inform a person about the risks posed by COVID-19 and to take appropriate preventive action leading to an interference with their right to life under Article 2. However, the Court would no doubt take into account the extent of knowledge about the risks and the difficult operational choices that the state might need to be made in terms of managing such risks, particularly in the context of a public health emergency such as the COVID-19 pandemic (McBride, 2020). With respect to the prohibition against inhuman or degrading treatment under Article 3, the Court has set a high threshold in relation to establishing a breach with Article 3, particularly in the mental health context (Ruck Keene, 2020).

In considering whether there has been an unauthorised deprivation of liberty contrary to Article 5 of the ECHR, the Court has made it clear that account must be taken of a range of factors in the circumstances of a given case including the type, duration, effects and manner of implementation of the measure in question (*De Tommaso v. Italy* [GC] [2017] 65 EHRR 19). An exception may be permitted where such deprivation is temporary and due to the need to prevent the spread of infectious disease (Article 5(1)(e)). However, the Court has emphasised that it would be important that any such measure could be justified as a necessary, proportionate and the least restrictive option in the circumstances (see *Enhorn v Sweden* [2005] ECHR-I, 56529/00). In relation to a potential interference of a person who lacks capacity's right to respect for private and family life under Article 8, the Court has

helpfully indicated that this right encompasses both physical health and psychological integrity (*Bensaid v United Kingdom* [2001] ECHR 82; *Dordević v Croatia* [2012] ECHR 1650). However, Article 8 is a qualified right and an exception also applies where it can be established that the alleged interference was for the ‘protection of health’ (Article 8(2)).

6.1. COVID-19 outbreaks in care homes

While we have considered how the DoLS scheme applies in the context of the hospital setting during the COVID-19 pandemic, how might this apply in the case of DoLS authorisations outside such setting, such as for residents in nursing and residential care homes? It is a particularly pressing question at the current time, given evidence that care homes across the UK have become ‘hotspots’ for the spread of COVID-19 (Booth, 2020; Coker, 2020). This has proved to be particularly problematic in the Northern Ireland context, with well over half of all COVID-19 deaths in the first wave of the pandemic occurring in such settings (McCormack, 2020b). In relation to the risk posed by COVID-19 in Northern Ireland care homes, we focus solely on DoLS authorisation for present purposes, rather than any other potential legal issues that might arise in relation to potential civil or criminal liability, or non-compliance with quality assurance requirements (RQIA (Northern Ireland), 2020; Erwin, 2020).

In focusing on this particular issue, it would be important to take account of both patients lacking capacity who have been discharged from a hospital to what is known as a ‘step-down’ facility, such as a care home, and those persons lacking capacity who are already resident in such facilities. In the first case, the initial rationale for the hospital discharge may have been that the person was likely to be at much less risk of contracting COVID-19, in addition to the fact that the discharge was likely to create additional bed capacity for those suffering from COVID-19 who require hospital admission (Propper, Stoye, & Zaranko, 2020). Whilst an inpatient, the person would most likely have been subject to a DoLS authorisation on the basis of a best interests assessment that they did not have capacity to recognise their current care needs. However, in the event of a transfer to a care home, there would be an urgent need to revisit the DoLS authorisation for that person in order to establish whether suitable safeguards were in place, including those addressing the risk of COVID-19 infection.

In relation to persons lacking capacity already resident in Northern Ireland care homes, many are elderly which is a recognised high-risk group for contracting COVID-19. As discussed previously, the relative infancy of the DoLS scheme means that it may be the case that some such residents do not as yet have the relevant DoLS authorisation in place. Where this is the case, it could lead to a prima facie assertion that care homes would be in breach of the MCANI and the DoLS Regulations. However, care homes could seek to rely upon MCANI emergency provisions providing protection from liability, even if additional safeguards have not been met in the particular circumstances. This would be on the grounds that all reasonable steps had been taken to put such safeguards in place. Persons in charge of care homes where the person has been deprived of their liberty would need to be able to establish that they have a reasonable belief that the person lacks capacity, that it is in their best interests to deprive them of their liberty, and that the prevention of serious harm condition has been met (MCANI, ss 9–11, 65–67; DoLS Code of Practice 2019, Chapters 4, 7 (paras 7.17–7.20), 10). Where this has been satisfied, then the deprivation of liberty could be treated as authorised, even if this had not as yet been formally authorised by a Trust panel, although it would be expected that an application for DoLS application would be made as soon as possible. As highlighted previously, it would be important to reach this decision on a case-by-case basis involving an individual resident’s circumstances, rather than those in charge of care homes using this as a general approach for not putting safeguards in place to manage the risk posed to residents from COVID-19 (Northern Ireland Department of Health, 2020c).

Given the exponential rise in infections and deaths from COVID-19

of residents in care homes in Northern Ireland, a more pressing question is whether the barring of visits by family members and/or their continued residence in such facilities represents a potential infringement of their human rights under Articles 2, 3, 5 and 8 of the ECHR. In terms of family visits, a recent judgment by the Court of Protection (England & Wales) found there was no interference in an elderly resident’s rights under Articles 5 and 8 in light of the refusal on the part of the care home to reinstate in-person family visits and to instead only permit indirect contact. Given the risk posed by COVID-19, the Court found that this approach represented a ‘balanced and proportionate way forward’ in the circumstances (*BP v Surrey County Council & Anor* [2020] EWCOP 17 at [36] per Hayden J). In another case, an application was made alleging interference with Articles 5 and 8 arising from a care home’s refusal to allow an elderly, terminally ill resident who lacked capacity to leave the facility in order to be cared for at her daughter’s home. In this case, the Court of Protection decided that the resident should be able to live with her family on the basis of a best interests assessment under s 4 of the Mental Capacity Act 2005 (UK Public General Acts, 2005 c. 9). The Court also found that the refusal on the part of the care home to allow the resident to leave the facility represented a disproportionate interference with her Article 8 rights. In handing down judgment, Justice Lieven was at pains to make clear that no arguments had been put to the Court that the resident should not be allowed to leave the care home because of the risk posed by COVID-19 or that the public interest in not allowing her to leave the home outweighed her best interests or Article 8 rights (*VE v AO (by her litigation friend, the Official Solicitor), The Royal Borough of Greenwich and South East London CCG* [2020] EWCOP 23 at [34]–[42] per Lieven J).

Both cases were decided in the absence of COVID-19 testing being available to residents in the care homes in question at the time, so the Court of Protection was unable to reach a conclusion as the extent of the risk posed to the residents, as well as to those caring for them. Notwithstanding a call by the Northern Ireland Deputy First Minister for universal testing to be instituted in care homes in early May, it appears that it will take until the end of June 2020 for this to be completed (BBC News, 2020b, 2020c). This stands in stark contrast to the position in Ireland, for example, where all such testing had been completed by May 2020 (McMahon, 2020). As highlighted previously, the reported death rate in care homes has been an escalating problem, which suggests that residents in such facilities might bear the brunt of the first wave of the COVID-19 epidemic in Northern Ireland. Without further pro-active intervention, it raises serious concerns about the extent to which ‘public authorities’ (per s. 6, Human Rights Act 1998) with responsibility for Northern Ireland care homes have taken appropriate preventative measures to protect residents from the deadly risk posed by COVID-19 pursuant to the right to life under Article 2 of the ECHR.

Conclusion

During the first wave of the COVID-19 pandemic in Northern Ireland, hundreds of people have died from the disease with residents in care homes being disproportionately represented in the overall death toll. It is to be hoped that the combination of an expanded COVID-19 community testing programme, and the implementation of a contact tracing strategy, will now result in a better understanding of the nature and extent of the spread of the disease in Northern Ireland (Northern Ireland Department of Health, 2020d). This will enable a more pro-active approach to be taken to controlling the spread of COVID-19 in the community, as well as anticipating subsequent waves, in the future. As noted previously, the Northern Ireland Executive has also now published its strategy for easing lockdown measures as well as its coronavirus recovery plan, setting out the guidelines that will inform its approach. Notwithstanding such plan, the need for caution remains given persisting uncertainty about the ongoing risk posed by COVID-19 to the Northern Ireland population. While an effective vaccine to

inoculate the population against the virus would bring more certainty to the situation, it is unlikely that this will be forthcoming in the short to medium term (Thompson, 2020).

In the circumstances, the changes made to Northern Ireland mental health and capacity laws through emergency legislation look set to stay in place for the foreseeable future, and up to a maximum of two years. With the length of time these changes are likely to be in place, there is always a danger of 'mission creep' whereby what was initially viewed as a temporary measure in a time of public health emergency becomes a normalised part of everyday practice in the field of mental health. This should be resisted as what they represent is a deviation from accepted legislative parameters involving matters such as involuntary treatment and detention and deprivation of liberty, for persons assessed as lacking capacity. Such parameters were agreed following extensive stakeholder consultation, as well as detailed executive and parliamentary reviews, in the lead up to the adoption of the MCANI in 2016.

Much of the legislative focus in responding to the first wave of the COVID-19 pandemic in Northern Ireland has been on addressing concerns about health and social care workforce shortages and resources, as well as meeting hospital surge capacity. However, it is important that action taken by key decision-makers as a result of changes made under emergency legislation constitute a necessary, proportionate and least restrictive response in the circumstances. In this regard, the Northern Ireland Assembly, as well as its specialist committees, the Committee for Health and the Ad Hoc Committee on the COVID-19 Response, have an important role to play. The MCANI is in the early stages of implementation with the majority of the provisions yet to come into force. It will therefore be some time before the long-nurtured vision of an innovative, internationally leading piece of legislation, which fuses both capacity and mental health law across all medical specialities in health and social care, is fully operational. With the world watching, it is important that political leaders in Northern Ireland provide sufficient financial support and resources to allow for the realisation of this vision. This is in addition to ensuring that the changes made to mental health and capacity laws through emergency legislation to address the COVID-19 pandemic are only in force for as long as is absolutely necessary and that adequate human rights protections remain in place during this period for those assessed as lacking capacity in Northern Ireland.

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None.

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