

IMPLEMENTATION OF THE MENTAL CAPACITY ACT (NORTHERN IRELAND) 2016: SOCIAL WORKERS' EXPERIENCES

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ABSTRACT

The Mental Capacity Act (Northern Ireland) 2016 was enacted by the Northern Ireland Assembly in May 2016. The first phase of the Act came into operation during 2019 and includes provisions for Deprivation of Liberty Safeguards (DoLS). When fully implemented this legislation will integrate mental capacity and mental health legislation into a single piece of legislation, for people aged 16 years and over. Given the recent introduction of Trust Panels as a new mechanism for DoLS, this study is the first of its kind. This small-scale exploratory study is a survey of 33 social workers who have made DoLS applications to Trust Panels. The findings illustrate social workers' experiences of applying for Trust Panel authorisation for interventions amounting to deprivation for liberty with adults who lack the capacity to make the relevant decisions.

The findings report on the social workers' level of experience in undertaking applications, their views about training for Mental Capacity Act work, and their perceived confidence levels for this work. The factors that have helped or hindered practitioners are also highlighted. The data collection was undertaken during the COVID-19 pandemic, and the impact of changes to work practices during this time are acknowledged. The study makes recommendations for further developing training, practice, and research.

Keywords: mental capacity, legislation, social workers, assessment, deprivation of liberty, Northern Ireland.

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I. INTRODUCTION

The Mental Capacity Act (Northern Ireland) 2016 was enacted by the Northern Ireland (NI) Assembly in May 2016. When fully implemented the Act will provide a comprehensive legal framework, based on mental capacity, and replace the current mental health legislation, for people aged 16 years and over. The Act is predicated on the basis that people have mental capacity to make decisions. It provides a statutory framework to promote and protect the rights of those who lack capacity to make decisions, or for those who currently have the

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relevant capacity but wish to make arrangements for a time in the future when they lack capacity.

The first phase of the Act came into operation during 2019 and includes provisions for Deprivation of Liberty Safeguards (DoLS). A deprivation of liberty occurs when a service user is in a place where care or treatment is being provided; they are not free to leave; and are under continuous supervision and control. Deprivation of liberty under the Act can be authorised in two ways, either by a short-term detention authorisation (STDA) for up to 28 days in hospital settings, or by a Health and Social Care Trust Panel for community settings and longer-term deprivation in hospital settings. There are five Health and Social Care Trusts in NI, and they are the main statutory providers of health and social care.

The DoLS include arrangements for the assessment of mental capacity and determination of best interests. Health and Social Care (HSC) staff with relevant training and experience can make an application to HSC Trust Panels, who determine whether the DoL is authorised. To support the implementation of the new DoLS procedures, training was commissioned by the Department of Health in Northern Ireland and comprises of: Level 1 (guidance on completing forms); Level 2 (overview of Deprivation of Liberty); Level 3 (Deprivation of Liberty Safeguards); Level 4a (Formal Assessment of Capacity-Theory); Level 4b which is optional (Formal Assessment of Capacity – Practical); and Level 5 for those who wish to sit on Trust Panels. To be suitably qualified under the Act individuals must complete Levels 2, 3 and 4a in order to carry out assessments and make an application to a Trust Panel (Department of Health 2022a).

The process by which applications are made to Trust Panels for approval for intervention, which amounts to deprivation of liberty, involves a number of steps, which are specified in the Act and further explained in the Deprivation of Liberty Safeguards Code of Practice (Department of Health, 2019). Following completion of the capacity assessment, medical assessment and best interests determination, the applicant will make an application to the Trust Panel for their independent full consideration of the person's circumstances to determine whether the application should be authorised. The Trust Panel consists of an experienced Approved Social Worker (who chairs the panel), an experienced medical practitioner and one other professional. All members must have received the necessary mandatory training and support from the Trust to undertake this role.

The provision of Trust Panels came into operation on 2nd December 2019, and their remit may have far reaching implications for upholding the rights of service users. The safeguards contained within the Act protect the rights and promote the interests of individuals that lack the relevant capacity, and aim to ensure they are given the care they need in the least restrictive way. This includes trying to ensure that people in their own homes, care homes and

hospitals receive services in a way that does not inappropriately restrict their freedom.

II. RATIONALE FOR THE STUDY

Given the recent introduction of Trust Panels as a new mechanism for DoLS, this study is the first of its kind. There is no other directly comparable research in Northern Ireland. There has been some research in Northern Ireland focusing on the operation of Mental Health Review Tribunals (Campbell, 2008) and in other jurisdictions (Maylea and Ryan, 2017; Gosney *et al.*, 2019; Macgregor *et al.*, 2019; Markham, 2020) but so far very little research on the implementation of the Act. There is some research from other countries about how similar laws and safeguards have been implemented (Hinliff-Smith *et al.*, 2017) including a study that focused on social workers (McDonald, 2010). Studies have shown variations in understanding the complexities of mental capacity legislation by health and social care professionals (McDonald, 2010; Hinliff-Smith *et al.*, 2017; Marshall & Sprung, 2018). While training provides for knowledge of theory and legislative principles, there are challenges in application of the legislation in everyday practice (Jenkins *et al.*, 2020). The literature also highlights inconsistencies in implementing mental capacity law in different care settings and by different professionals. These practice issues are compounded by the level of complexity involved in the decision-making process, subjectivity in assessing capacity, and challenges in balancing competing tensions between rights and risks (Hinliff-Smith *et al.*, 2017; Macgregor *et al.*, 2019; McDonald, 2010).

This study was conducted in the catchment of one of five Health and Social Care Trusts in Northern Ireland. Northern Ireland is a province within the UK and shares a border with the Republic of Ireland. It has a population of approximately 1.9 million people (NI Statistics and Research Agency, 2020). The Trust in which the service evaluation took place is geographically the largest in NI with a population of approximately 470,000 and 12,000 employees serving both urban and rural communities.

At the inception of this study in May 2020, approximately 200 DoL cases had been reviewed by Trust Panels in the Trust. The majority of these were legacy cases; in other words, people whose care arrangements involved deprivation of liberty before the implementation of the Act. Anecdotal evidence suggested that Panels rejected some applications due to lack of sufficient information to enable the Panel to make a decision. The applications involve multi-disciplinary teamwork, with substantial input from social workers. As such, the need for timely research was identified to further inform the implementation of the new Act.

The objectives of this study were therefore to:

- Explore social workers' experiences of applying for Trust Panel authorisation for interventions amounting to deprivation of liberty with adults who lack the capacity to make the relevant decisions.
- Examine factors that have helped or hindered social workers in undertaking this role.
- Explore social workers' perceptions of their competence and confidence in making applications to Trust Panels.
- Provide suggestions for further developing training, practice, routine data collection and any further research that may be needed.

III. METHODOLOGY

The study was located in one Health and Social Care Trust in Northern Ireland and was undertaken during the COVID-19 pandemic. The need for social distancing and the pressures on front-line staff, were important considerations in the project design. The study was supported by the Trust's Mental Capacity Act Leads, who provided advice about the relevant issues and the research design. The study was a small-scale survey of social workers that have made DoLS applications to Trust Panels. The study population comprised social workers who have completed MCA training (as required by the Department of Health) and made applications to the Trust Panels for authorisation of DoL and/or STDAs. It was envisaged that approximately 50 social workers would be eligible to participate. Since the exact population was unknown and the survey was anonymous, all social workers in the Trust received an invitation to participate subject to meeting the eligibility criteria. Furthermore, the questions posed in the survey meant that those who had not completed applications to Trust Panels and/or STDAs would not have the knowledge or experience that would enable them to respond meaningfully.

Survey methodology was selected as it enabled anonymous participation, was accessible remotely and had the ability to respond to the study objectives. The survey contained a mixture of qualitative and quantitative questions. The survey content was developed in collaboration with MCA Leads. It was initially piloted by three social workers to explore reliability, face and content validity.

Data collection commenced with an invitation email and participant information being sent to a social work distribution list hosted by the Trust's Social Care Governance Department. Respondents completed the anonymous online survey hosted on Survey Monkey. The survey was opened for a 4-week period to maximise response rates and enable participants to complete the survey at a time that was convenient to them.

Quantitative data were analysed using Excel to provide descriptive statistics. Qualitative data were analysed thematically using NVivo. A coding frame and nodes were developed, and the thematic analysis initially conducted separately by the research team to explore intercoder consistency/agreement and identify potential researcher bias. The research received ethical approval from the School of Social Sciences, Education and Social Work Ethics Committee at Queen's University Belfast and the Trust's Research Governance Committee.

Personal and public involvement is a key aspect of social work research, and opportunities for wider involvement were considered. As this project is about professional tasks the key people to involve were social workers undertaking MCA work, so our project advisory group comprised three social work professionals with experience of undertaking and managing this work. There is also a clear and immediate need for the experiences of service users and carers involved in these processes to be explored, but the focus of this study was on the social workers' experiences.

IV. RESULTS

A. Respondents and their roles

Thirty-three social work professionals completed the survey, from approximately 50 social workers that were eligible to participate in the study. This was an exploratory qualitative study that focussed on in-depth experiences and understanding of MCA processes in different service areas. There was less emphasis on gaining a representative sample (due to the small population), but the survey completion rate represented a 66% response rate and is a valid sample size. Respondents were from a range of age groups, with the largest group aged 45-54 (36%, n=12). Most respondents were female (82%, n=27) with 18% male (n=6), (other genders options were provided in the survey). This is similarly representative of the makeup of the social services workforce in Northern Ireland (85% female and 15% male, Department of Health, 2022b). All respondents indicated their ethnicity as white, which is representative of the population of Northern Ireland, with 96.6% of people being white (NISRA, 2022).

Respondents were asked how long they were qualified as a social worker, and this ranged from 2.4 -36 years with an average of 16 years. Over 90% of respondents were qualified more than five years. Over one-third were qualified more than 20 years. Nearly half (45%, n=15) were employed as social workers, while over half were in more senior social work positions such as social work manager or senior social work practitioner (55%, n=18). Nearly three-quarters (70%, n=23) were in their current posts less than five years. Three-quarters (75%, n=25) of respondents worked full-time. Most respondents (97%, n=32) worked in adult services, with just under half (48%, n=16) working in community integrated care teams.

Most respondents (94%, n=31) indicated that they had completed post-qualifying training, achieving both Social Care Council Professional Awards and academic awards. All social workers in Northern Ireland are required to complete a generic, competence-based undergraduate degree, following which they are mandated to engage in Continue Professional Development (CPD), in order to maintain their professional accreditation. CPD options are offered through a range of taught programmes to enhance social work professional practice and competence. Social workers at different stages of their career may choose to embark on formal assessed professional development to consolidate

undergraduate learning or to specialise in courses which are specific to their area of work.

Social workers working in mental health settings who wish to be considered for the role of Approved Social Worker (ASW) by their employing Health and Social Care Trust, are required to complete a Mental Health (Approved Social Worker) Programme delivered in partnership between the HSCT and an academic institution, through which they achieve both Social Care Council Professional Awards and academic awards. This training is required for social workers to undertake the role of Approved Social Worker under the Mental Health (Northern Ireland) Order 1986 and the Mental Capacity Act (Northern Ireland) 2016. The ASW role in Northern Ireland enables social workers to exercise specific statutory functions under the mental health and mental capacity legislation, to make decisions that may affect a person's liberty. Just under a quarter of respondents (24%, n=8) were qualified as Approved Social Workers (ASW), with an average of 14 years' experience.

B. Undertaking Trust Panel Applications

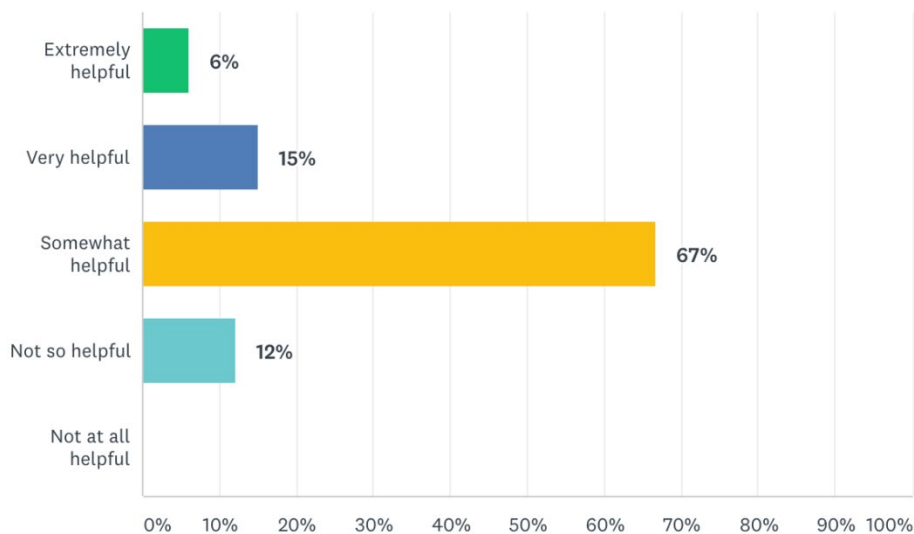
Over half of the respondents (52%, n=17) had completed 5 or fewer applications to Trust Panels; this rises to just over two-thirds when adding in those who have undertaken 6-10 applications (64%, n=21). One-fifth (15%, n=5) have completed between 11-20 applications. Two respondents have completed 30-35 applications while another two have completed approximately 70 applications each.

C. MCA training & preparation for MCA work

To undertake MCA assessments relevant professionals must undertake the Department of Health's Mental Capacity Act Training Levels 2, 3, and 4 (<https://www.health-ni.gov.uk/mental-capacity-act-training>). (Level 1 is instructional guidance on how to complete the forms). In addition, those who sit on Trust Panels (and consider applications) must also undertake Level 5 training. Most respondents (97%, n=32) had completed the Department of Health's MCA Level 1-4 training. Nearly half of respondents (48%, n=16) have completed only the Department of Health training, while a further five respondents (15%) said they had completed additional 'informal training' and a further 11 (33%) have also undertaken additional formal training such as MCA Level 5 training, Short Term Detention Authorisation Training, ASW and ASW re-approval training.

Respondents were asked about their experiences of MCA training, including how well the training prepared them, how confident they felt after completing the training and their current confidence levels about undertaking MCA applications. They were also invited to comment on other activities that may have contribute to their preparation for MCA work.

D. Perspectives on training



Respondents were asked to comment on how well the training prepared them for making applications to Trust Panels. The bar chart above shows that most respondents (88%) found the training to be helpful to varying degrees. One-fifth (21%, n=7) reported the training to be either very or extremely helpful, while over two-thirds said it was somewhat helpful (67%, n=22). Only 12% (n=4) found it not so helpful and no one reported that it was not helpful.

Most respondents (82%, n=27) provided additional comments about the contribution of training to their preparedness for undertaking MCA work. The benefits of training reported by a quarter of respondents (27%, n=9) indicated that it was good, it helped to clarify expectations around the social work role, and provided information about completing applications:

"I completed training at the very start of the role out for MCA and found it useful and clarified my role in capacity assessments and applying to panel."

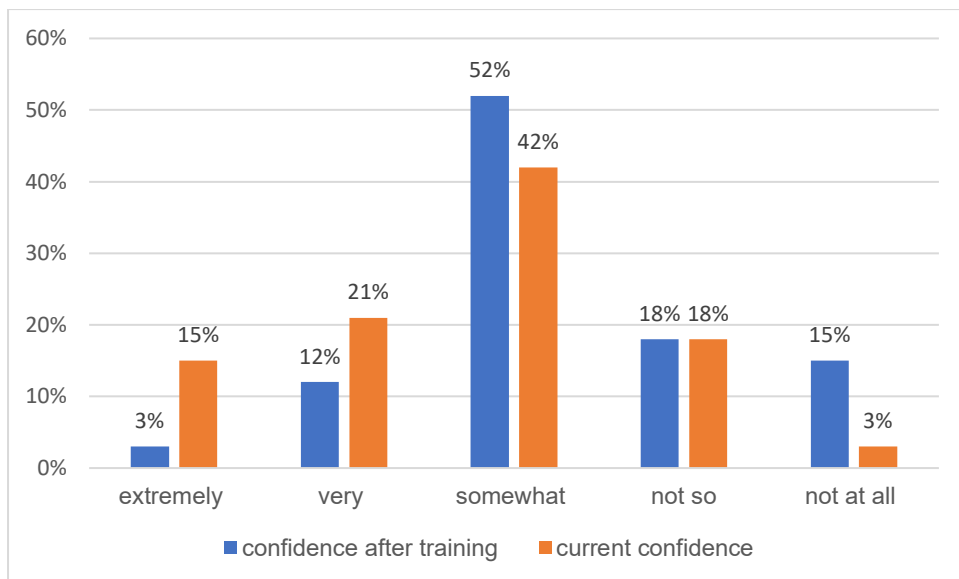
Support from trainers was noted, as was collaboration and discussions with others in the training forum. Some respondents said that the training helped them to feel more confident about undertaking MCA work.

Over half of respondents (58%, n=19) highlighted difficulties with the training, such as it being too basic, intense, or repetitive, or did not like online delivery. Other challenges noted the lack of application to practice, and the need for guidance on completing a capacity assessment. Several felt it was too rushed given that there was lots of information to retain, and would have benefitted from being delivered over a longer time period:

"Did not focus on skills required to undertake capacity assessment. Very basic compared to the content expectations."

"Very theoretical. No practice content. It only provided background to MCA and not the practical application of same i.e., how to do assessments, complete forms etc."

E. Confidence levels after completing training and currently



Respondents were asked how confident they felt after completing the training and also about their current confidence levels. The bar chart above illustrates that just over two-thirds (67%) reported feeling confident (somewhat (42%), very (12%) or extremely (3%)) after completing the training, with this increasing to nearly four-fifths (78%) for current confidence levels about undertaking MCA work. While there were increases in the number of respondents who currently felt extremely confident (rising from 3% to 15%) or very confident (rising from 12% to 21%) compared to after completing training, similarly there was a decline in those who reported feeling not at all confident (reducing from 15% to 3%).

For those who were very or extremely confident, this was attributed to 'putting it into practice' and with increasing experiences of undertaking applications to Trust Panels. It should be noted that two respondents who had completed less than 5 applications reported being very confident, similar to those who completed many more assessments and reported being very or extremely confident.

Some who felt somewhat confident, indicated they had more to learn and needed to gain more experience of making applications. Confidence levels were also impacted by evolving changes to MCA implementation and revisions required for submissions to panels (15%, n=5):

"Unfortunately, it feels like an ever moving goal post ...what was correct one week is now incorrect."

"Confidence has been affected by the changing information requirements on the forms."

"I feel somewhat confident however the advice and information to be included or not is constantly changing and it is very difficult to keep on top of it all."

The MCA training was made available from September 2019 and this retrospective study was completed in January 2021. As such there may have been a period of time between respondents undertaking the training and participating in this study. It is acknowledged that asking respondents retrospectively about confidence levels and the contribution of training, may be affected by recollections of how they felt. It is challenging to determine the degree to which the training and/or subsequent activity (such as putting it into practice, support from managers etc) may have contributed to increasing confidence levels. It is likely that it would have been a mixture of both the training and subsequent experiential learning as reported by respondents. However, 88% of social workers did report that the training was useful, with some stating it did help them to feel more confident, so it did contribute in some way to growing confidence levels. Simultaneously contextual changes to the implementation of MCA legislation and associated policy and practices, may also have impacted confidence levels.

F. Other systemic factors

Other factors contributing to respondents' perceived confidence were reported in the study. The most reported issue (30%, n=10) was the currency of training, due to on-going procedural changes that impacted the Trust Panel application process. This points to the need for refresher training and continued support:

"It was only useful to a point as things in MCA changed so rapidly that the original training now bears no relation in how MCA work is completed as per Attorney General's requirements."

Other issues were reported about the implementation of the MCA, such as challenges with completing documentation to the appropriate standard, and the demands placed upon social workers with the additional workload created by MCA work:

"I felt out of my depth- it was a lot of information and a lot of additional work on my existing workload.... I felt very uncomfortable due to the nature of the work, legal documents to be written to a very high standard- not that I would not be able to do this- but the time and effort this would take. Furthermore, in a busy office environment, with constant interruptions, I felt it would be impossible to complete these to a high level of accuracy."

"...the number of forms was overwhelming..."

Six respondents acknowledged that practical application of the training (learning by doing) was an important aspect of building confidence, which was outside of the remit of the MCA training because it was not skills based:

"I had the basics but knew it would be on the job learning."

In addition, nine respondents noted that having prior experience of undertaking capacity assessments contributed to their confidence levels. This was not necessarily related to having additional qualifications or training:

"Prior to the implementation of MCA, I completed capacity assessments...my level of confidence completing the role mostly came from this experience and the support of my team rather than the training specifically."

When asked about what else helped to prepare them for undertaking TPA/STDA work, four themes emerged. These were:

- Shadowing other staff undertaking capacity assessments/MCA work (n=9)
- Discussing cases and peer support from colleagues (n=8)
- Seeing exemplars and examples of completed forms that had been submitted to panel (n=6)
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- Role plays and mock panels (n=3)

These responses had a common theme of the importance of the application of knowledge, theory and skills in practice, the 'doing' of MCA work.

G. Time spent on MCA activity per application

Respondents were asked how long it took them (on average) to complete a Trust Panel application. The legal framework for Deprivation of Liberty provided by the Act is supported by a set of forms. It is a requirement that all relevant forms are completed, as a statutory requirement under the legislation (all listed in the table below are statutory). Department of Health guidance recommends that all forms be used. Form 1 is a statement of incapacity, form 2 a best interests determination statement, form 4 is the care plan, form 5 is the application for Trust Panel Authorisation.

Mental capacity assessments are situation specific, as capacity is unique to the individual service user, so this determines whether forms are to be used. Form 7 must be used in applications where the individual lacks capacity about whether an application should be made to the Review Tribunal. (Where the service user has capacity about whether to apply to the Review Tribunal, then Form 7 does not need to be completed). This is predicated on the basis that they understand that someone will always be checking on them as part of their care arrangements, their liberty is restricted, and a meeting can take place to determine whether that should be permitted. The inclusion of Form 7 ensures a decision by the Panel can be challenged, even when service users do not have capacity, as required under the European Convention of Human Rights. This study did not find instances of Form 7 not being used.

The different tasks of the process were segregated out in the survey to show each step of the application process. The average time taken, and the range of each activity is reported in the table below:

Activity	Average	Range
Preparation & tuning-in	2 hours 15 minutes*	30 minutes - 7.5 hours*
Consultation with nominated person	53 minutes	20 minutes - 3 hours
Capacity assessment	58 minutes	20 minutes - 2.5 hours
Care Plan	1 hour 7 minutes	15 minutes - 4 hours
Completion of Form 1	1 hour 20 minutes	15 minutes - 5 hours
Completion of Form 2	1 hour 26 minutes	20 minutes - 4 hours
Completion of Form 4	1 hour	10 minutes - 4 hours
Completion of Form 5 & 7	55 minutes	5 minutes - 4 hours
Total	11 hours 23 minutes*	4 hours 15 minutes - 30 hours**

* Please note that there were two respondents (not included in this table) who reported that preparation took much longer (3 days), but this is perhaps for exceptionally complex cases, and so have not been included in the average/range.

** One respondent reported that completing an application took four to five days, but this is perhaps in exceptionally complex cases and so has not been included in the average/range.

H. Short-term detention authorisations

The survey contained a section of questions about the undertaking of short-term detention authorisations, however none of the respondents had completed these so this theme could not be explored. STDAs are only required for deprivation of liberty in hospital settings and, until the MCA is fully implemented, the Mental Health (Northern Ireland) Order 1986 is still to be used when relevant, mainly for compulsory admission for assessment and treatment related to mental disorder and risk. The new MCA legislation is being rolled out in stages, requiring an overlap with the 1986 Order, to ensure legal provisions for detention and treatment of people with mental disorders. This means that the circumstances in which a STDA would be required are relatively narrow – a person lacking the relevant capacity, who required in-patient treatment, amounting to deprivation of liberty, for their physical health. It is still important to note that none had been completed.

I. Factors that assist with undertaking Trust Panel Applications

Respondents were asked to identify the most helpful factors to aid completion of Trust Panel Applications. Prompts were provided and some respondents

noted that all of these were helpful, and these were perhaps unsurprisingly prominent themes:

- Knowing service users in advance (55%, n=18):

"Knowing service users and their backgrounds. I can complete a Trust panel application for a service user on my own caseload in a much shorter amount of time rather than completing for another member of the team who is not trained."

- Having timely access to prior information such as service users notes, case files, care plans and previously completed assessments (52%, n=17).

- Being able to engage with others involved in service users' care, such as family members, carers/staff, nominated persons, named worker, (64%, n=21):

"Talking to key worker where they live, having access to recent reviews /incident reports or care plans."

Other helpful attributes identified include support from managers and the MCA Leads, access to relevant multi-disciplinary professionals and individuals' Northern Ireland Electronic Care Record (NIECR). This is an electronic system of people's medical records, including referrals, investigations, appointments, test results, and encounters across the health and social care system in Northern Ireland, which can be accessed by health and social care professionals):

"Sometimes the hospital paperwork has errors as well as the capacity assessment referral forms - NIECR is what I use which is correct."

"I value the support of [MCA Lead] to quality assure my paperwork at initial states. [I] appreciate the continued efforts of [MCA Lead] to keep practitioners informed regarding changes of paperwork and feedback from Attorney General."

J. Challenges in completing applications to Trust Panels

When asked about the challenges in completing applications for Trust Panel Authorisation, the main theme related to the additional work involved. Many commented that while already working at full capacity, this is additional work and has led to an increase in workload, and this has created tensions with competing priorities on existing cases.

The impact of this was illuminated by reports of social workers feeling overwhelmed, overburdened, stressed, under significant pressure and conflicts over work-life balance. There was also a sense of lack of recognition about the intensity of this work and the interface with other tasks associated with service user needs:

"Time. MCA is an addition to an already overburden of work, it is complex time consuming and the nature of it requires a significant amount of preparation and review".

"Time constraints and other work pressures. They are intensive pieces of work to complete whilst still trying to manage a full case load."

One person commented on difficulties completing an application due to lack of experience that was compounded by not undertaking applications on a regular basis. Others reported having to undertake applications for other staff that had not completed the MCA training (also referenced in above quotes):

"Many staff are completing the application for their own and other's caseloads which I don't think is being fully accounted for in caseload weighing".

"Also being asked to complete for colleagues that have not been trained as yet which adds to my work load without easement or recognition".

Another significant theme involved the complexities involved in the MCA the process of making an application and completing the paperwork (perhaps not unrelated to issues of time and workload). Social workers reported ongoing changing expectations about the requirements for submission, the volume and complexity of paperwork:

"Trying to find a balance between the time constraints associated with the paperwork required [was] very difficult when trying to balance daily work load pressures. I also feel the turn around time in trying to get paperwork submitted to panel very tight due to the length of time it takes to complete paperwork alongside other work."

"The layout of the forms are not user friendly, and some of the information is quite repetitive."

"TIME!! and the extensive paperwork. Not only is it the application that is required, but also for one placement I am required to complete CMA's, summary of need reports, funding request report, care plan, financial paperwork in addition to the application.... At times, I could have 3 patients that require a placement and therefore experience significant pressure in keeping up with all that is required."

The COVID-19 pandemic was also highlighted as creating additional challenges (and workload) compounding already demanding and complex work (42%, n=14). Examples reported included staffing issues (with colleagues off sick, shielding or isolating), and the pressure placed upon remaining staff. The limitations of social distancing and the less favourable circumstances of using zoom to undertake assessments (compared to face-to-face engagement) were also noted. There was recognition too of the impact of the pandemic on care home staff, while prioritising care of residents could mean delays in MCA applications being completed. In addition, issues for service users that are exacerbated by the pandemic have placed increasing pressure on social workers, to support service users dealing with mental health issues and the impact of shortages in others support services:

"Impact of the pandemic has definitely being a challenge in completing the applications. At present our team are down staff due to a number of long-term sick leaves and in relation to Covid-19. This has added additional pressures on remaining staff members. That combined with the impact of the pandemic on our service user group, mental health, and increased shortage of services has made day to day work immensely pressurized in all respects."

"... being unable to meet family face to face due to pandemic, use of PPE impacting on communication with service users, multi-disciplinary working. Continuity of care due to part time working/short staff."

"Pandemic has slowed down capability to complete capacity assessments. Not all assessments can be through zoom. Staff in care homes are overwhelmed by COVID 19 impact... Everyone is working hard during pandemic however 'pool' of assessors is low amongst some areas."

Furthermore, some illustrated how social distancing requirements affected engagement and communication with service users and assessment work. In a subsequent part of the survey three respondents discussed the impact of working (and undertaking TPAs) during the pandemic on their health and well-being:

"Having to enter care homes where Covid-19 is prevalent."

K. MCA support and management

Most of the respondents (78%, n=26) affirmed that their line manager had also completed MCA training. Everyone who responded to the question (91%, n=30) indicated that MCA work was discussed with managers in supervision. For some this was a mainly administrative function in terms of ensuring training was up-to-date, workload management, and checking if outstanding applications were completed. For others input was more extensive with managers providing support and constructive feedback. Others referenced the role of group supervision and support from the MCA leads:

"My line manager who is also an ASW is very supportive re MCA role and gives constructive feedback on my role. She advocates for additional hours to be paid for work completed 'Out of Hours that cannot be managed during normal working hours'."

Most respondents (82%, n=27) also confirmed that managers audit or quality assure their MCA activity. There was consensus from respondents that work was overseen by management, with some acknowledgement of difficulties staff faced in undertaking this work:

"Yes, all MCA forms are quality assured and this is beneficial."

"Managers are always aware of changes to meet requirements. It all feels a little trial and error at the minute."

"Despite being quality assured by manager, some MCA assessments have been sent back for more information or amendments."

It is not the Panel's remit to check if the right forms are filled out correctly. Nor is there a prerequisite for a panel decision that all forms have been submitted, completed by the correct personnel, and timelines adhered to. Their task is to adjudicate whether the criteria for authorization (of detention) are met. Despite having oversight from management (prior to submission) this response suggests that a lack of information means the Panel cannot determine that the

grounds for detention have been met, hence the view of the respondent (as an applicant to the panel) that further information could be sought.

L. Perspectives on supervision

Most respondents reported favourably on the provision of supervision. Over three-quarters (76%, n=26) indicated that it was helpful, (14% said it was extremely helpful, 28% very helpful and 34% somewhat helpful), particularly in providing support to complex cases, sharing good practice and assisting with the application process. Just over one-fifth (21%, n=7) said it was 'not so' or 'not at all' helpful.

Two-thirds of respondents (64%, n=21) noted that supervision provided opportunities for reflective practice, discussions about ethical issues/values or an educative component. This was described in terms of getting feedback and guidance, second opinions, time to reflect or express feelings about this work, and was said to be particularly useful when working on complex cases:

"Supervision allows for discussion of MCA and DOLS. This enables me to seek feedback and guidance if I am unsure or need guidance."

"To ventilate about demands on time and frustration at the amount of changes to the forms which are constantly being changed by the Trust."

"In peer supervision I have the opportunity to share my learning and also learn from others - we discuss ethical dilemmas in addition to best practice examples and challenges in the MCA work."

Others noted that this type of activity was either limited or absent from their supervision:

"These aspects are not discussed in supervision."

"Yes, we can reflect on all that, it does not change the basic - we need staff to do these."

The respondents in the study had different managers, so this may account for different approaches to supervision. Some may have been situated in multi-disciplinary teams, so they may have reflected on their line manager who may not have been a social worker, involved in or responsible for MCA work.

Six respondents felt that time and workload pressures were not addressed by supervision, therefore reducing its helpfulness somewhat:

"With time being the biggest constraint and pressure in completing the assessment it can sometimes feel somewhat pointless raising it as a concern in supervision as everyone is under pressure and it feels that little can be done to alleviate"

"Supervision is not going to help, we need staff to do the MCA work."

M. How MCA work impacts upon social workers' wellbeing

Two thirds of respondents (66% n=22) reported that MCA work negatively impacted their well-being. There was consistency amongst most respondents in reporting feelings of being under pressure, stressed and anxious. These feelings were often attributed to the additional demands of MCA work (on top of existing work roles), and other social work activity either competing for MCA time or being delayed, ultimately leaving social workers feeling stressed about their workload:

"MCA work has had a negative impact on my well-being - there was no consideration given to staff - it has affected my confidence due to feeling of not being able to keep on top of my work load."

"It has extended the working day and reduced my time for rest and relaxation. Over time this could lead to compassion fatigue and potential sickness."

"It is very stressful the constant changes are difficult to manage as a team leader it has directly led to staff members being off with work related stress, the increase in work load feels unmanageable and appears to continue."

Five social workers commented positively about MCA work. This was described as a sense of enjoying the work, yet time pressures were simultaneously reported in some responses, suggesting this was a limitation to the positive wellbeing experienced:

"Mental capacity awareness is integral to all of my practice. [I] welcome MCA work to add accountability, governance and person centred approach to my practice. I consider that this legislation provides practitioners with 'protection' of evidence-based practice to share decision-making processes with clients/ carers/ others."

"I enjoy completing the Trust panel applications. I think the process of gathering the information is important and worthwhile, and puts the service user right at the focus of all decisions. If the application process is conducted in a meaningful way I believe it creates better outcomes for service users, however if it becomes a tick-box exercise and a red-tape matter the meaning is lost."

When asked what employer supports or approaches to self-care might help, respondents overwhelmingly commented on employer supports (rather than self-care), and comments reaffirmed the challenges experienced by social workers in undertaking MCA work.

Nearly one-third (30%, n=10) highlighted that workload needs to be addressed. MCA activity was viewed as additional work that impacted existing workload (with competing priorities) and impacted on colleagues in the team and service users. Respondents felt that it would be helpful if there was recognition of this as extra work that is often time consuming, alongside protected time allocation, weighting or easement from other roles to attend to MCA work:

"I think there needs to be a firm acknowledgement that MCA is over and above our normal work load and this needs to be calculated when case loads are being allocated."

"Reduced caseload when completing MCA work, time off ward, positive feedback."

"A method that truly captures the workload of individual workers."

Six respondents suggested the need for a team specifically to undertake MCA work:

"In reality there is enough work from MCA for a separate team to complete, this may not have been apparent at first implementation but it is becoming increasingly obvious that this is the only course to address the workload associated with MCA."

Other suggestions included the involvement of other disciplines to complete MCA work, so it is not *"always falling to social work"* and enhanced supervision, including group supervision. The current context was raised and input from the MCA team has been recognised in this study:

"Recognition of the changing climate we practice within and the fact we are developing case law and practice as we progress through implementation."

"Monthly meetings with the MCA Team. Not just meetings when something new is introduced in relation to MCA. Although that is important also."

N. Suggestions for improvements in MCA work

The final questions invited respondents to make suggestions to improve MCA work, (such as further support, training, practice development or research). The feedback from respondents reiterates points made in response to previous questions. Again, the possibility of a dedicated MCA team was highlighted, as was the need for sustainability in terms of the model of work, and addressing ongoing staffing issues (such as filling posts for teams with reduced complement) particularly with MCA as additional workload.

The need for revisions to the submission of applications process and expectations of what is achievable was noted:

"We need a specialist team of staff to complete these. Furthermore, the Forms are being edited all the time and even the edited versions are sometimes incorrect. I had to move my last MCA forms twice and the forms had changed twice in the time it took me to complete them. This was time consuming."

"MCA work is a very big task and would require a team that specifically focuses on this as impossible for staff to on top of their other work commitments."

"Needs acknowledged and recognised that this is an additional role added without extra time etc. given to assist with this. Management need to acknowledge this and not dismiss the stress this can cause to staff."

Other types of support and adaptations to the process were proposed. With reference to administration this included updating trust systems with forms and guidance, and ceasing to make further changes to forms.

Suggestions for training and practice development were also prominent (33% n=11), with requests for ongoing training, expanding training to include how to undertake capacity assessments and best interests, the provision of annual updates, refresher training, sharing exemplars when changes occur (to the MCA process) and extending the provision of training to other settings/professions.

Further ideas included the addition of MCA work to the Professional in Practice (PIP) Programme (a post-qualifying Professional Development Framework for social workers in Northern Ireland), MCA newsletter, a buddy system for practitioners, opportunities for shadowing MCA work for newly trained staff, the provision of written information for service users and carers explaining the MCA process, and a forum (or other means) to be regularly briefed about regional changes and information from the Attorney General.

The survey was undertaken at a time when MCA work was still relatively new. While it is likely to be a core task for social workers the processes are still evolving. The findings reflect a snapshot point in time and as developments are ongoing, it may also be the case that respondents are not aware of progress. However, being kept updated about areas that are new or 'in progress' would be useful for practitioners.

V. DISCUSSION

Respondents generally found the training helpful, and most were 'somewhat' to 'extremely' confident about undertaking MCA work. Benefits and difficulties with training were noted, but as the respondents experienced different types of training, we cannot comment specifically on the impact of any one type of training. However, the application of training to practice is important. The literature suggests that if mental capacity training is not interactive and applied to practice, then training may not be that effective (Jenkins *et al.*, 2020). Social workers are already trained in the processes of assessment, including considering capacity, and report writing, so they are not learning entirely new skills. Specific MCA training is therefore building on core social work skills and experience. It is reassuring nonetheless that most found the training helpful and most felt some degree of confidence in undertaking the MCA role. Limitations of the training highlighted by participants illustrate ways in which it could be improved. In-person delivery may have been helpful, as would delivering the training over a longer time period, given the complexities of MCA work and intensity of the training. Making the theory and legislation more relevant to practice, would also enhance provision. This could include skills-based training via role plays of mock panels or capacity assessments. Refresher training that is agile to a changing landscape of processes and procedures would also be beneficial. This would enable social workers to keep abreast of ongoing changes that impact their MCA work.

While training was reported to have had some effect, the study found other factors that contribute to confidence levels. These included the currency of training, changes with implementation at a regional level, the number of applications completed to date, familiarity with the documentation and application process, and the impact of MCA work on existing workload. In addition, other experiences were influential, such as shadowing staff undertaking MCA work, discussion of cases, support from colleagues, seeing exemplars of completed forms, mock panels and role-plays. These activities serve to embed and apply the theory to practice, further highlighting the need for ongoing consideration of how learning activities and training are applied to the practice context (Jenkins *et al.*, 2020).

The study found that only a small number of social workers have completed a lot of applications, with variations evident across the cohort of respondents. Additionally, there were variations in the time reported for undertaking elements of the Trust Panel application process. Some timings may be unusual, but potentially there are a variety of explanations for that. This was a specifically designed survey, so respondents' interpretation of some questions may have varied. Timings may have been estimates or for some respondents based on a specific case. Interpretations about what needed to be included, the degree of familiarity with the service user and the application process could also account for variations. For example, respondents who reported taking longer may have included a range of activity necessary for completing the forms, such as reading case files, time spent with service users, contacting, and discussing service users' needs with family, carers, and other professionals, dealing with more complex issues, lack of familiarity with the Trust Panel process, and working through the Code of Practice. For those who reported taking several days, this may have included awaiting information from others (the time taken from the process commenced to completion). Shorter times may reflect respondents who have undertaken more Trust Panel applications, have experience of completing the assessments and forms, and/or have prior knowledge of the service user, or these respondents interpreted the question as simply filling in the form. Variations will also arise because people work at different rates.

The study set out to explore social workers' experiences of undertaking Short-Term Detention Authorisations (STDAs). However, none of the respondents reported having undertaken STDAs so we could not report on this. The Project Advisory Group advised that the lack of responses was due to an extremely small workforce engaged in the process; there are only a few social workers who complete the STDA as the authoriser.

The study highlighted the attributes that aided social workers in undertaking Trust Panel applications. These included relationships with service users and other professionals, core skills of engagement and assessment, and practice that is person-centred and informed by professional social work values. These

skills, values and relational ways of working are of central importance to the effective social work practice (Winter, 2019).

Challenges in undertaking MCA work were also evident. Time constraints and workload pressures were the most prominent theme, and for some respondents this could be compounded by lack of experience or undertaking applications infrequently. Some social workers reported feelings of being overwhelmed. The nature of the Trust Panel/MCA work may also contribute to the potential stress involved. This is especially so because it involves formal legal requirements, complex issues, interventions that involve deprivation of liberty and so what can be difficult, professional decisions for which the social worker is responsible and accountable. It is important that practitioners are supported to prevent potential consequences of getting it wrong or experiencing burnout (McDonald, 2010; McFadden *et al.*, 2018).

Most of the respondents' managers were trained in MCA work. Supervision was helpful when opportunities to discuss MCA work were provided. Social workers benefit from reflective practice, getting feedback and guidance, particularly when dealing with ethical issues or complex cases. It is important that MCA work forms part of the discussions in supervision particularly around caseload management. The research illustrated social workers operating in different roles, with some working more closely at the MCA interface (for example specialist roles), while others are undertaking MCA work within generic roles. While it is important that MCA is prioritised and meets legislative requirements, it must be considered alongside other tasks in workload management.

Employer supports and self-care activity

There were unambiguous concerns reported about the workload generated by MCA work. There was a process (prior to implementation), to estimate the amount of additional work that would be involved, but respondents were repeatedly describing their MCA work as additional to their existing work, without additional time being protected for it. They also highlighted the implications this had on their existing work and, in some cases on their work/life balance. It may be that the impact of MCA is not evenly distributed across all of health and social care, so the areas and workers who are experiencing the most additional work should be prioritised for resources and support. It is also important to acknowledge that this additional work is in the context of services that are already under considerable pressure.

Prior to this study being concluded a programme of service improvement for MCA work has been progressing within the Trust. Training has been rolled out across a range of MCA activities including capacity assessments, best interest decisions, form filling, and application of criteria for referral to the Tribunal. A MCA Professional Forum (operating monthly) and a buddy system have been established, and shadowing is available upon request. The addition of MCA work to the PIP programme is a regional issue that merits consideration. There is regional literature for service users (provided by the Department of Health)

and the Trust also has an amended version of this. A MCA Newsletter is being progressed and this help to keep practitioners informed about service improvements that have or will be implemented with regards to MCA work.

There is also the general challenge of implementing any new legislation or major change and how it can affect staff. Work is also ongoing to recruit additional staff. While the possibility of creating a dedicated MCA team was reported in the study, there are no plans to create a separate MCA team, mainly as the MCA is relevant to everyone working in health and social care, so there would be a concern about locating this expertise in a specialist team. Supervision must ensure that workload is manageable and that it enables MCA work to be prioritised. Investment is a contributing factor; so mental health funding must deliver on the needs of service users and ensure staff can respond appropriately. The issue remains that while the overall prevalence of mental health issues within the population of Northern Ireland is estimated to be 25% higher than the rest of the UK, this is not matched by 25% higher funding. Despite this higher level of need, the Northern Ireland Affairs Committee (2019) also highlighted that the proportion of spending within health and social care on mental health services was much lower in NI (5.2% in 2016-17) than in England (13% in 2016-17).

There are also some aspects of the MCA that may create additional concerns for staff. The general approach in the MCA is to provide protection from liability for people who are intervening if all the relevant safeguards are in place. This is different from the previous legal framework, the Mental Health (NI) Order 1986, which mainly provided powers to intervene. The level of external scrutiny, including having to apply to a panel for authorisation, is also increased. It could be argued that these changes are positive and are aimed at better protecting and promoting the rights of service users, but they may also have unintended effects on staff if they are not appropriately resourced and supported. The complexity of the issues and processes may also create further potential stressors for professionals, and these may also mean that service users and carers may not find these processes and safeguards easy to understand and indeed a challenge. It should also be noted that this survey was conducted relatively soon after initial implementation and in the wider context of the pandemic, so the timing and context could have added to the reported stress. On the other hand, many of the applications in this period would have related to people who had already been receiving care which amounted to deprivation of liberty, and so may not have involved the added complexity of identifying and planning the necessary care and support. It is also the case that the survey was completed by a relatively small number of respondents and in one Trust area and so may not be generalizable to all relevant professionals and across all Trusts. However, the survey findings do highlight some important experiences and issues that should be considered and further explored for the full implementation of the Act.

VI. CONCLUSION

The aim underpinning this new legislation is that the safeguards (including making applications to Trust Panels for authorisation) will better protect the rights of service users and carers. However, whether this aim is being achieved is not yet known and this does need to be explored from the service users' and carers' perspectives.

This study provides an insight into the experiences of social workers undertaking MCA work, and the roll out and impact of the new legislation upon social work practice. The results of this study have the potential to inform improvements in training and practice; specifically, the importance of applied training, the workload issues that staff are experiencing, and the complexity of the issues and processes involved. It may also provide useful suggestions for what data should be routinely collected and monitored. The central issue, though, is whether these additional safeguards are effective in protecting and promoting rights and further research is needed to explore that, and to identify how this area of practice develops over time. Future research that expands upon these findings, explores alternative viewpoints or changes over time would be a useful addition to the evidence base for social work practice.

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