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Mental Health (Northern Ireland) Order 1986

Code of Practice

July 2026

V3

Police Service of Northern Ireland

Northern Ireland Ambulance Service Health and Social Care Trust

The views of people with lived experience

"As a person who has been detained in a Mental Health Inpatient Unit in Northern Ireland, I welcomed the opportunity to share power with professionals as equals in the co-production of this Code. The result has been to create a fairer, more balanced, interpretation of the Mental Health Order. This review was not designed by systems but by people.

The experience of people living with mental disorders who have experienced care and treatment under the Order and their carers, including their family members and loved ones, has guided the revision of the Code. We were active participants throughout the review. We co-produced, not experts doing to or doing for, but doing with – equals sharing power.

The Code has been designed to be user friendly and supports the use of more appropriate language whilst recognising the limitations we must work within as the Order still informs practice. The patient information leaflet will help us understand better what we should expect if we are taken to a place of safety and how long we can be kept there.

As the Code will be more accessible and made available through the Department's website, patients and their families will be able to access it more easily and also find the section of information they need by clicking on the contents page. There is a new section on human rights, and the principles have been updated to support a more person-centred approach.

Helping design the additional forms gave us the opportunity to share with the professionals the extremely stressful impact it has on patients when they are brought to a place of safety. The Code addresses some of these concerns by aiming to reduce the length of time we should have to stay in a place of safety, by guiding the professionals it should only be for as long as necessary and no more than 48 hours.

We welcome the joined-up approach recommended by the Code and look forward to experiencing stronger communication and decision making between the police, ambulance service and the HSC Trusts. It is only with true interagency working that we will experience better outcomes for ourselves and our families.

Training should be made available to staff across the main agencies who work with people with lived experience of mental health problems.

Everyone, including carers and families, needs to know about the Code and all the communication channels that work together to share information and help professionals make the right decisions".

John Morgan, Regional Service User Consultant.

Acknowledgments

A significant amount of time, energy, and commitment has been invested by the wide range of people involved in the Cawdery Work Stream 2. This dedicated group worked collaboratively to review and update the Code, and their contributions have been invaluable. The work included participation from people with lived experience; carers of individuals with mental health issues and/or a learning disability; Trust representatives across multidisciplinary professional groups; and representatives from the Royal College of Psychiatrists, the Royal College of Nursing, the British Association of Social Workers, the Police Service of Northern Ireland, the Northern Ireland Ambulance Service, the Northern Ireland Fire and Rescue Service, the Department of Justice, and legal advisors representing Health and Social Care organisations and Police services. Their commitment, thoughtful engagement, and willingness to participate in difficult and sensitive conversations is highly commendable.

We are particularly grateful to the people with lived experience, and their carers, who took part in consultation events and provided written responses throughout the consultation process.

Introduction

The Code of Practice ("the Code") was revised and updated in accordance with Article 111 of the Mental Health (Northern Ireland) Order 1986 by the Department of Health after consulting the Regulation and Quality Improvement Authority for Northern Ireland and such other bodies as appeared to the Department to be concerned.

The revision has been undertaken at a time when our mental health services continue to be under considerable pressure. Inpatient services are consistently operating close to 100% bed occupancy levels in adult mental health inpatient units and the regional child and adolescent unit is at full capacity. Our community services continue to deal with high levels of referrals. This environment creates a number of challenges for patients, families, services and staff delivering mental health services. The lack of timely access to inpatient treatment results in protracted delays for patients and increased levels of risk in the community that are difficult for the agencies and staff involved to manage. Lack of access to sufficient community-based alternatives for patients at a time of crisis may contribute to increased requests for hospital-based care.

This updated Code has been facilitated through a multiagency working group including the Department of Health, the Police Service of Northern Ireland, the Northern Ireland Ambulance Service, Health and Social Care Trusts, People with Lived Experience, Primary Care Representatives, Royal College of Psychiatrists, Royal College of Nursing, British Association of Social Workers, Strategic Planning and Performance Group, and engagement across the mental health sector including the Public Health Agency.

The group considered related legislation and guidance including:

- DoH Mental Health Strategy 2021-2031
- The Mental Health (Northern Ireland) Order 1986 ("the Order")
- Human Rights Act 1998 ("HRA")
- The Mental Health Order Guide 1986 ("the Guide")
- Code of Practice 1992 ("the 1992 Code")
- Guidance & Audit Implementation Network ("GAIN") guidance
- Regional Interagency Protocol on the Operation of Place of Safety and Conveyance to Hospital 2019 ("Regional Interagency Protocol")
- Regional Interagency Guidance on Dealing with Persons who go missing from Emergency Departments
- Mental Capacity Act (Northern Ireland) 2016 ("MCA")
- The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986

To inform the rewrite of the Code, it is anticipated that, on the approval of this version, the 1992 Code, the Guide, the Regional Interagency Protocol and the Guidelines and Audit Implementation Network (GAIN) Guidelines on the Use of

The Mental Health (Northern Ireland) Order 1986 (October 2011) will be stood down.

The Code now contains additional detail in relation to police powers and places of safety, human rights and RQIA roles and responsibilities. It also includes active links to other documents which the reader should find helpful, including both prescribed forms that must be used, and non-prescribed regionally agreed best practice recording formats that should be used when implementing the Order.

This revised version of the Code has been written in a way that enables the reader to more easily find the information they need to guide their practice. This means there may be duplication across different chapters, but if the reader needs to reference their role or the role of other agencies, these can be more easily located.

The implementation of the Code's interagency working arrangements will be monitored through the Right Care Right Person ("RCRP") Silver Operational Group during the first year of implementation, following which its compliance across agencies will become the main function of the RCRP Regional Governance Group chaired by the Police Service of Northern Ireland and Strategic Planning and Performance Group. The RCRP locality groups, described at paragraph 1.75, will provide oversight of implementation progress, challenges, areas of best practice and disagreements at a local level. In addition, the RCRP Health and Social Care operational implementation group will support the development of operational guidance to support staff in fulfilling their roles. Each organisation will also have their internal operational procedures.

There are limits to the changes possible within the rewrite of the Code as terminology used within the Order remains the legislative basis upon which decisions must be made; therefore, the definitions of "severe mental handicap" and "severe mental impairment", including the term "severe impairment of intelligence and social functioning", remain within this revised version. However, the Department acknowledges that some of these terms are now considered outdated and potentially offensive, and do not reflect contemporary clinical or social understanding of mental health and learning disability. Their continued use in this Code does not imply endorsement, but rather reflects the current statutory language that professionals are required to work within.

To support inclusive practice, the following glossary of equivalent or preferred terms is provided for reference:

Legal Term (1986 Order)	**Preferred Modern Equivalents**
Severe Mental Handicap	Severe Intellectual Disability or Severe Learning Disability
Mental Handicap	Intellectual Disability or Learning Disability

Mental Impairment	Cognitive or Intellectual Impairment
Mental Disorder	Mental Illness / Mental Health Condition
Patient	Person with Lived Experience / Service User (in informal contexts) and includes patients in the community as well as in hospitals

Professional and vocational staff should use the more appropriate language, except where it is not legally permissible to do so in all communication, both verbal and written.

This approach aligns with the Department's commitment to equality, dignity and inclusion, and supports the implementation of Section 75 of the Northern Ireland Act 1998 and the United Nations Convention on the Rights of Persons with Disabilities. The term "patient" is used throughout the Code to describe a person experiencing, or appearing to be experiencing, a mental disorder and includes patients in the community as well as in hospitals (except in relation to Part VIII of the Order). Patients should be provided with choice and be involved as far as possible in all decisions about their care and treatment. Cognisance should also be given to their experiences throughout their recovery journey.

Practitioners should consult the SHARE Guidelines.[1] These guidelines aim to:

- increase staff confidence in gaining consent and sharing information to promote and improve safety in mental healthcare; and
- enhance a partnership approach between professionals, the individual at risk, agencies and carers involved.

Where reference is made to a specific Article, it is an Article from the Order unless otherwise stated.

Other legislation which must be taken into consideration:

- Children (Northern Ireland) Order 1995
- Children's Services Co-operation Act (Northern Ireland) 2015
- Disability Discrimination Act 1995
- Health and Personal Services Order (Northern Ireland) 1972
- Police and Criminal Evidence (Northern Ireland) Order 1989
- Provision of Health Services to Persons Not Ordinarily Resident Regulations (Northern Ireland) 2015
- The Health & Social Care Reform Act 2009
- The Human Rights Act 1998
- The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) (Amendment) Regulations (Northern Ireland) 2020
- The Northern Ireland Act 1998
- The Race Relations (Northern Ireland) Order 1997

[1] SHARE Guidelines Northern Ireland | Department of Health

- Sexual Offences (Northern Ireland) Order 2008
- UK Data Protection legislation including Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data (United Kingdom General Data Protection Regulation) (Text with EEA relevance) and the Data Protection Act 2018.

Guidance which should be considered includes:

- Advance Care Planning: For Now and For the Future | Department of Health
- DHSS – Promoting Quality Care. Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services (as revised 2010)
- A guide to individual rights | ICO
- CAMHS Pathway
- DHSS Carer and Discharge Guidance. Circular HSS (ECCU) 3/2010
- Review Tribunal | Department of Justice
- MARAC-Professionals-A5-Booklet.pdf
- Mental Health Strategy 2021-2031
- Northern Ireland Adult Safeguarding Partnership (NIASP) publications
- PPANI – Public Protection Arrangement for Northern Ireland Guidance to agencies on public protection arrangements (PPANI) Article 50, Criminal Justice (Northern Ireland) Order 2008.
- Preventing Harm to Children from Parents with Mental Health Needs HSC (SQSD) 02-10
- UK GDPR guidance and resources | ICO
- UN Convention on the Rights of the Child (UNCRC)
- Up to date professional guidance and case law should inform practice.

Training requirement to support implementation of the Code

Cawdery Workstream 3 will set out the specific training requirements and the training plan for Health and Social Care staff and the Police Service of Northern Ireland in relation to the Cawdery related aspects of the Code, including Chapter

3 Police Powers and Places of Safety, conveyance considerations and the use of the Risk Matrix.

Training programmes should include cultural issues, acknowledge the needs of ethnic minorities and support trauma informed practice.

HSC Trusts, the PSNI and NIAS will deliver training that reflects the Code requirements and best practice guidance, to their workforce to support them to deliver their roles and responsibilities as detailed in the Code.

The regional Approved Social Worker programme will continue to deliver training that reflects the Code requirements and best practice guidance.

Academic bodies will include the Code in their graduate and post-graduate courses.

All professional training programmes that refer to the Code should ensure their training is updated to reflect the updated Code.

Please see Annex 2 for a full list of all the web links referred to in the footnotes.

If you cannot access any of the online documents mentioned in this Code, please email the Department of Health at **mcaimplementation@health-ni.gov.uk** and we will provide the information in an alternative format.

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1 INTRODUCTION

Purpose of the Code

1.1 Article 111 of the Mental Health (Northern Ireland) Order 1986 (referred to throughout the Code of Practice as 'the Order') requires the Department of Health (the DoH/the Department) to prepare, and from time to time revise, a Code of Practice (the Code) to be published for the guidance of Health and Social Care Trusts (Trusts/HSC Trusts), Trust staff and others in respect of various matters dealt with in the Order. Article 111(1) defines the purpose of the Code as being:

(a) for the guidance of medical practitioners, Trusts, staff of hospitals and ASWs in relation to the admission of patients to hospitals and the reception of patients into guardianship under this Order; and
(b) for the guidance of medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder.

1.2 Article 111(2) states:

"The code shall, in particular, specify forms of medical treatment in addition to any specified by regulations made for the purposes of Article 63 which in the opinion of the Department give rise to special concern and which should accordingly not be given by a medical practitioner unless the patient has consented to the treatment […]".

1.3 Article 63 provides that the Department may by regulation specify forms of treatment requiring both the patient's consent and a second medical opinion.

1.4 The Order does not impose a legal duty to comply with the Code; therefore, the Code does not have the force of law and is not legally binding. However, it represents authoritative guidance on the application of the Order and related practices.

1.5 The Code is intended for use by medical practitioners, Approved Social Workers (ASWs), Trust staff, and other professionals involved in the care, treatment, and detention of individuals under the Order.

1.6 While compliance with this Code is not a statutory duty, a failure to follow it may be relied upon in legal proceedings as evidence of maladministration, departure from accepted standards, or failure to comply with human rights obligations. Courts and tribunals may consider whether a departure from the Code was reasonable and justified in the circumstances of a case.

1.7 All professionals are therefore expected to be familiar with this Code and to apply its principles and procedures in their day-to-day practice.

1.8 A Memorandum of Understanding shall be agreed between the DoH, the Department of Justice (the DoJ), HSC Trusts, the Police Service of Northern Ireland (PSNI), the Northern Ireland Ambulance Service (NIAS) and the Regulation and Quality Improvement Authority (RQIA) to support the implementation of the Code and effective interagency working.

1.9 As required by the Order, the Department will keep the Code under review and will revise it as appropriate in the light of experience.

Scope of the Code

1.10 The scope of the Code is prescribed by the provisions of Article 111 of the Order and the guidance it contains addresses the matters specified in that Article, in addition to guidance in relation to the use of police powers, conveyance responses and RQIA roles and responsibilities.

1.11 The Code does not purport to be all-embracing; its intention is to provide guidance in straightforward language on matters of day-to-day practice which it would not be appropriate to deal with in primary or secondary legislation. It offers advice on what is generally agreed to be good professional practice in relation to the procedures laid down in the Order. The Department hopes that this will enable members of different professional groups to work together on practical issues that may straddle professional boundaries. It is not concerned with questions of professional judgement which are more appropriately dealt with in clinical and other textbooks.

1.12 The Code applies to all patients, including those under 18 years old. Where specific guidance in respect of younger patients is considered appropriate, this is provided. However, reference must be made to the Children (Northern Ireland) Order 1995[2] to inform practice.

1.13 The Code describes legislative functions and duties and provides guidance (paragraphs 1.1 to 1.6 explain the status of this guidance). Whilst the whole of the Code should be followed, please note that where 'must' is used, it reflects legal obligations in legislation (including other legislation such as the HRA) or case law and must be followed. Where the Code uses the term 'should', departures from the Code's advice should be documented and recorded. Where the Code gives guidance using the terms 'may', 'can' or 'could', the guidance in the Code is to be followed wherever possible.

[2] Children (Northern Ireland) Order 1995

Figure 1: Terminology used throughout the Code

Terminology	How it is to be understood	Exceptions
must	Reflects legal obligations which it is essential to follow.	No exceptions
should	For those to whom this is statutory guidance	Any exceptions should be documented and recorded including the reason for this. Patients, their families and carers, regulators, commissioners and other professionals may ask to see this.
may/could/can	Reflects guidance to be followed wherever possible	Good practice but exceptions permissible

References

1.14 Appropriate provisions of the Order are referred to throughout the Code by Article and paragraph numbers respectively. All professionals concerned with the operation of the Order should be familiar with the provisions of the Order relative to their duties and responsibilities. Other legislative provisions referred to in the text are identified.

1.15 References to "Forms" are references to the forms[3] prescribed by Regulation 7 of The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986.

1.16 References to “recording formats” are references to best practice recording formats that have been specifically designed to support implementation of the Order and Code and should be used when referred to. They are not prescribed forms.

Principles

1.17 The Code must be read with regard to the broad principles that patients with a mental disorder should:

[3] Mental Health NI Order 1986 Prescribed forms | Department of Health Regulations (Northern Ireland) 1992

- Be treated and cared for in such a way as to maintain their dignity.
- Receive respect for and consideration of their individual qualities and background - social, cultural, and religious.
- Have their needs taken fully into account notwithstanding the fact that, within available resources, it may not always be practicable to meet those needs.
- Receive any necessary treatment or care with the least degree of control and segregation consistent with their safety and the safety of others.
- Be discharged from any form of constraint or control to which they are subject under the Order immediately when this is no longer necessary.
- Be treated or cared for in such a way as to promote their self-determination and encourage personal responsibility to the greatest possible degree consistent with their needs, wishes and abilities.
- Be supported to participate as much as possible in decisions about their care, and particular consideration should be given to patients who have communication difficulties and/or complex needs.

1.18 Regard should also be given to the principles of treatment detailed in paragraph 9.3. All actions under the Order should comply as fully as possible with the UN Convention on the Rights of Persons with Disabilities (UNCRPD)[4] and the Human Rights Act 1998.

1.19 This means that all patients should be as fully involved as practicable, consistent with their needs and wishes, in the formulation and delivery of their care and treatment. They should be informed about the nature, purpose and likely outcome of any proposed treatment. This applies equally to young patients and to patients who are receiving care or treatment on a compulsory basis. Where physical difficulties such as sensory impairment impede such involvement, reasonable steps should be taken to attempt to overcome them. It means that patients should have their legal rights drawn to their attention, consistent with their capacity to understand them. Where they cannot understand, their rights should be explained to their carers, relatives or friends as appropriate, and the benefits of engaging advocacy services should be fully considered and utilised as appropriate. Finally, it means that, when treatment or care is provided in conditions of security, patients should be subject only to the level of security appropriate to their individual needs and only for so long as it is required.

Good communication with the patient, family, carers and nearest relatives

1.20 Good communication with the patient is essential across all interventions with mental health services, including the admission for assessment process. Communication needs should be clearly identified and where practicable, arrangements put in place to meet these. In particular:

[4] UN Convention on the Rights of Persons with Disabilities (UNCRPD)

- Where the patient has difficulty either in hearing or speaking, the assistance of staff, such as, where practicable, speech and language therapists or those with sign language, or with specialist communication skills, should be engaged in the process[5].
- Where the person does not speak English sufficiently to engage in complex discussion, professional interpreters[6] should be considered. The potential disadvantages of a patient's relative/friend/carer being asked to interpret should be considered.
- Verbal and written communication should be in plain language to promote understanding and engagement.
- Where the person lacks capacity to make decisions about their care and treatment and would benefit from having an advocate working with them, this should be considered and secured where appropriate.
- When the patient has fluctuating capacity, and the risks are such that a delay in assessment cannot be justified, it should proceed.
- Where the patient is still unwilling or unable to communicate adequately (despite assistance from interpreters) the decision to proceed should be based on whatever information can be obtained from other sources.
- It is not desirable for a patient to be interviewed through a closed door or window except where this is necessary to avoid serious risk to other people. Where there is no immediate risk of physical danger to the patient or to others, powers in the Order to secure access (Article 129) should be considered.
- It can be difficult to accurately assess someone's mental state if they are intoxicated or under the influence of drugs. However, the fact that the individual has taken alcohol or other substances should not delay any medical examination being carried out for the purpose of the medical recommendation. Where the patient is under the effects of sedative medication, or the short-term effects of drugs or alcohol, a decision based on a medical assessment should be made as to whether the interview should be postponed. If it is not realistic to wait, the decision to proceed with the application will have to be based on whatever information can be obtained from all available reliable sources.
- The patient should ordinarily be given the opportunity of being interviewed in private, but if there is a risk of physical violence, the medical practitioner and the applicant can insist on another person being present. If the patient would like another person (for example a friend) to be with them during the interview and any subsequent action which may be taken, they should be assisted in securing that person's attendance unless the urgency of the case or some other proper reason makes it inappropriate to do so.
- Patients must receive information in a format that is suitable for their individual needs, level of ability and age, including easy read versions.

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[5] RCSLT Good Communication Standards
[6] BSO Information for HSC Staff and Practitioners

Good communication within and between agencies

1.21 Open communication between agencies will be key to sharing relevant information about the patient's circumstances, their needs and associated risks. The Right Care Right Person (RCRP) data sharing agreement sets out what information should be shared, how it should be shared and the governance arrangements. It is important that all relevant information is shared in line with best practice guidance. Effective sharing should improve outcomes for patients, including those who move across Trusts and belong to transient communities.

Definitions

1.22 Article 2 of the Order defines "patient" as a person suffering or appearing to be suffering from a mental disorder. The term "patient" is used throughout the Code to describe a person experiencing or appearing to be experiencing a mental disorder and includes patients in the community as well as in hospital.

1.23 The Order makes provision with respect to the detention, guardianship, care and treatment of patients with a mental disorder. "Mental disorder" and related expressions are defined in Article 3 for the purposes of the Order. The definitions are not meant to delimit psychiatric practice outside the terms of the Order. It is not obligatory for the expression "mental disorder" to be used in psychiatric practice only in accordance with the legal definition. To avoid confusion, however, it is generally better to use some other term for conditions which fall outside this definition.

1.24 "Mental disorder" is defined in Article 3 as meaning "mental illness, mental handicap and any other disorder or disability of mind". "Mental illness" and "mental handicap" are then defined individually. The great majority of cases to which the Order applies will fall into one or other of these categories. Mental illness means a state of mind which affects a patient's thinking, perceiving, emotion or judgement to the extent that they require care or medical treatment in their own interests or in the interests of other persons.

1.25 A patient with a mental disorder may be subject to any of the compulsory powers in the Order provided the other requirements of the Order are satisfied.

1.26 There may occasionally be a case to which the Order should apply, and which falls within the general definition, but which may not exactly fit the definition of either "mental illness" or "mental handicap". An example would be a person who had sustained brain injury in adult life causing a disability similar to that defined within "severe mental handicap" and who satisfied the other criteria of the Order. In such a case, the apparent severe mental handicap is not strictly speaking "a state of arrested or incomplete development of mind". The effect of including "any other disorder or

disability of mind" in the general definition of "mental disorder" is to avoid semantic difficulties of this kind when cases, which properly and necessarily fall within the terms of the Order, are being considered. This does not mean that all patients with brain injury should be treated or managed within a particular regime. Brain injury does not always cause intellectual impairment; it can result in various forms of mental disturbance. The nature of the mental disorder will determine the appropriate regime of treatment or management.

1.27 Mental handicap is defined as a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning.

1.28 The definitions of "severe mental handicap" and "severe mental impairment" include the term "severe impairment of intelligence and social functioning". It is considered that this is not meant to restrict these definitions to persons whose intelligence level, as measured by psychological tests, falls below a particular figure. The Department recommends that when determining the diagnosis of severe mental handicap and severe mental impairment, the assessments should take into account the total impairment both of intelligence and of social functioning.

1.29 Severe mental handicap is defined in the same way as mental handicap, except that it includes severe instead of significant impairment of intelligence and social functioning. The distinction between the two categories is thus one of degree and it is entirely a matter for professional judgement as to whether a person exhibits "significant" or “severe” impairment of intelligence and social functioning. A range of disciplines can be involved in the assessment of intelligence and social functioning.

1.30 To meet the criteria for a severe mental impairment, the patient’s presentation must be associated with "abnormally aggressive or seriously irresponsible conduct". The purpose of this definition is to limit the application of the long-term powers of compulsory detention (detention for treatment) of patients with a mental handicap to those whose handicap is severe and who exhibit abnormally aggressive or seriously irresponsible behaviour. It ensures that mental handicap can never by itself be sufficient ground for long term detention in hospital.

1.31 The consequences of the Order for a person with a mental handicap are thus determined by the category into which their handicap falls. A person who has a mental handicap would be included in the definition of a mental disorder and therefore may be admitted for assessment, detained for 48 hours under the medical practitioners' holding power, held for 6 hours under the nurses' holding power, or removed to a place of safety for 48 hours (the short-term compulsory powers).

1.32 However, they may not be detained for treatment or placed under guardianship (the long-term compulsory powers) unless they are classified as severely mentally impaired or severely mentally handicapped respectively.

1.33 Patients who have a learning disability may also have a mental disorder.

Exclusions

1.34 Article 3(2) states that no person shall be treated under this Order as suffering from a mental disorder, or from any form of mental disorder, by reason only of personality disorder, promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol or drugs. This does not mean that people experiencing these conditions are unable to access treatment. They should be able to access care and treatment on a voluntary basis. This means that it will not be possible to exercise powers of compulsion on the grounds of any of these conditions alone. However, if the condition co-exists or is associated with a mental disorder as defined in the Order, and all other relevant criteria are satisfied, the powers in the Order may be exercised.

Expressions used in the Code

1.35 Medical practitioners appointed by RQIA for the purposes of Part II and Part IV of the Order are commonly known as Part II and Part IV medical practitioners respectively and are referred to as such throughout the Code. Doctors are the only professional group that meet this requirement.

1.36 The responsible medical officer **(RMO)** is the Part II medical practitioner in charge of the patient's assessment or treatment (or who provides certain medical recommendations required by the Order for the purposes of guardianship).

1.37 Approved Social Workers **(ASWs)** are social workers specially trained in dealing with patients who have a mental disorder and are appointed by a Trust to act as an ASW for the purposes of the Order.

1.38 The glossary defines some of the expressions and words used in the Code.

1.39 Gender neutral terms are used throughout.

Human rights

1.40 The Code must be implemented in full compliance with the HRA, which incorporates the European Convention on Human Rights[7] (ECHR) into

[7] European Convention on Human Rights

domestic law. The HRA gives effect in the UK to certain rights and freedoms guaranteed under the ECHR and places a duty on public authorities to respect and protect patients' human rights. A wide range of bodies carrying out public functions, including the delivery of public services by private and contracted-out providers, have legal obligations to respect and protect human rights. This means:

- putting human rights principles and standards into practice;
- aiming to secure the full enjoyment of human rights for all; and
- ensuring rights are protected and secured.

1.41 Patients' human rights should be at the core of all decision-making patient centred processes.

1.42 In some instances, competing human rights will need to be considered, which may require finely balanced judgements. Decisions that interfere with a patient's rights will need to be justifiable as necessary and proportionate in the circumstances of the specific case. Any interference with human rights should be kept to the minimum whilst providing the patient with the necessary care and treatment.

1.43 Such decisions and the reasons for them should be clearly documented.

1.44 All public authorities, including mental health professionals and others tasked to carry out functions under the Order, are now required under domestic law to:

- interpret the Order, as far as it is possible to do so, in a way that is compatible with the ECHR;
- ensure that practice is guided by and compatible with the HRA; and
- take account of relevant domestic and European case law in relation to these matters in their practice.

1.45 The individual rights and freedoms enshrined in the ECHR are now part of domestic law and enforceable in courts throughout the UK including NI courts. These rights include the right to:

Article 2	Life
Article 3	Freedom from torture and inhuman or degrading treatment or punishment
Article 4	Freedom from slavery, servitude and forced or compulsory labour
Article 5	Liberty and security of the person
Article 6	A fair and public trial
Article 7	No punishment without law
Article 8	Respect for private and family life, home and correspondence
Article 9	Freedom of thought, conscience and religion
Article 10	Freedom of expression

Article 11	Freedom of assembly and association
Article 12	Marry and found a family
Article 14	Not be discriminated against in the enjoyment of any of these rights

1.46 While some of these rights, for example Articles 3 and 4, are considered absolute (i.e. they cannot be interfered with), others such as Articles 5 and 8 are limited or qualified, meaning that interference can be justified in certain circumstances.

1.47 Those tasked to carry out duties and functions under the Order should consider the following list of considerations before proceeding with any action:

- Is there a clear legal basis upon which to act?
- Does the decision to act involve any protected rights under the HRA?
- Is there any other way in which you could pursue your aim, which would have less impact on the protected right?
- Is the intervention necessary to achieve a legitimate aim (e.g. the patient's safety)?
- Is the proposed action proportionate and the least restrictive option available?
- Has the patient's capacity and wishes been considered?
- Have alternatives been fully considered and deemed insufficient to meet the patient's needs?
- Are plans in place to ensure the restrictions will be in place for the shortest time necessary?

1.48 Detention and restraint have direct implications for Articles 3, 5, and 8 of the ECHR and should only be used when strictly necessary, lawful, and proportionate. Any detention under the Order must meet the Winterwerp v Netherlands [1979] ECHR 4[8] criteria:

- A true mental disorder must be established by objective medical expertise.
- The disorder must be of a kind or degree warranting compulsory confinement.
- Continued confinement must be based on the persistence of the disorder.

1.49 Detention must be the **least restrictive option** available and be subject to regular, independent review.

[8] Winterwerp v Netherlands 6301/73 [1979] ECHR 4

Data protection

1.50 UK Data Protection Legislation including The UK General Data Protection Regulation (GDPR) and the Data Protection Act 2018 together form a framework for regulating the processing of personal data in the UK.

1.51 HSC Trusts and other statutory agencies are data controllers and need to ensure data protection compliance in relation to the processing of data in connection to the Order and the Code. This includes ensuring compliance in relation to the patient's rights[9] under data protection law, particularly the patient's right to be informed about the processing of their personal data.

1.52 It is recommended that any data sharing arrangements are set out within a data sharing agreement, and that the sharing is done in a way that complies with the data protection principles, particularly that only information that is necessary, relevant and proportionate is shared, and that the method of sharing ensures the security of such sensitive data.

Access to legal support

1.53 All patients detained or treated under the Order have a fundamental right to understand, exercise, and challenge decisions affecting their liberty, treatment and wellbeing. The provision of timely legal advice is a critical safeguard against unlawful detention and supports informed decision-making. Consideration should be given to the following:

- Article 5(4) ECHR: Right to challenge the lawfulness of detention before a court.
- Article 6 ECHR: Right to a fair hearing.
- Review Tribunal (NI): Statutory forum to challenge detention or treatment under the Order[10].
- The Bournewood case [2004][11] and Stanev v Bulgaria [2012][12] establish the right to independent representation where liberty is restricted.

1.54 All patients detained under the Order must be informed of their right to legal representation upon admission and should be:

- offered contact details for local mental health solicitors, The Law Centre Northern Ireland[13] and the Children's Law Centre;[14]

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[9] A guide to individual rights | ICO
[10] Review Tribunal | Department of Justice
[11] HL v UK 45508/99 [2004] ECHR 471
[12] Stanev v Bulgaria 36760/06 [2012] ECHR 46, [2012] MHLO 1
[13] Home | Law Centre Northern Ireland
[14] Children's Law Centre

- supported to apply for legal aid if required to challenge detention or appeal to the Tribunal; and
- given time and privacy to consult a solicitor or lay representative which enables adequate preparation for the case to be presented and patient engagement.

1.55 Trusts should ensure that the patient information they provide includes information on how the patient or their family can access specialist mental health advisors and Tribunal and Appeal information. Trusts should also ensure arrangements are in place for the provision of patient information.

Access to advocacy

1.56 Advocacy is a right for all people using mental health services, not only those in detention. Mental health advocacy services play a pivotal role in supporting patients to have their voice heard, participate in the decision-making processes about their care and treatment and influence the decisions made. Specially trained advocates can support patients who have been detained or are subject to deprivations of liberty. Peer advocates can, among other functions, provide an insight into the experience of engaging in mental health services, build confidence and help patients to express their wishes.

1.57 Advocacy involvement should be routinely offered, including times when decisions are being made in relation to the patient's care pathway, especially when detention is being considered, at review and when treatment options are being considered. This approach ensures that patients are supported to exercise their rights and are not required to navigate important decisions in isolation.

Family and carers

1.58 When family and carers have the right information, they may be able to more appropriately support the patient. They should also be provided with information about the supports that are available to them as carers and, where appropriate, their right to a carer's assessment. Services should adopt a professional approach where there is an assumed inclusion of family and carers unless otherwise justified. The SHARE Guidelines provide useful information in understanding the benefits of family inclusive practice whilst ensuring the patient's right to confidentiality is fully considered and respected.

Mental health crisis intervention

1.59 In addition to interventions under the Order, there are a range of options for intervention in an emergency. When considering these options, consideration should be given to the level of restriction and associated best practice guidance. Options include:

- **Use of restraint**
  Where restraint is required to manage an emergency situation, HSC staff should follow the guidance on the use of restraint which can be found in the Regional Policy on the use of Restrictive Practices in HSC Settings.[15]

- **Emergency provisions under the MCA**
  Can be used for those patients that are believed to lack capacity in relation to deprivation of liberty or short-term detention care arrangements.

- **Common law intervention**
  It is not generally appropriate to rely on common law powers, based on the doctrine of necessity, when responding to patients who need an immediate response to provide them with care and protection if their circumstances are covered by the either the Order or the MCA. This includes the admission and detention of patients. However, there may be some situations, such as preventing a patient from absconding from an ambulance or preventing a patient from harming themselves, that need an immediate response from HSC staff, police, community, or voluntary staff or members of the public. Common law intervention should be short-lived, proportionate to protect people from the immediate risk of significant harm, and trigger consideration of further interventions under the Order. Staff should, as with all professional decision-making processes, reflect in the patient's records the immediate risk of significant harm and the reason they decided to intervene. See: Black v Forsey 1998 and Sessay, R (on the application of) v South London & Maudsley NHS Foundation Trust & Anor [2011] EWHC 2617 (QB) (13 October 2011)[16].

- **Reliance upon Article 129 to gain entry to search for and to remove patients**
  This may be inappropriate in an emergency situation due to the time it can take to obtain the necessary warrant. The police may use their power of entry under Article 19(1)(e) Police and Criminal Evidence Order (PACE) (NI) Order 1989 for the purposes of saving life or limb or preventing serious damage to property; however, this does not confer on the police any power to remove the person to a place of safety or to detain them. The power is limited to actions strictly necessary to **protect life or limb**. This means the officer's actions, including entry and any search of the premises, should be proportionate and directly related to addressing the immediate threat. To remove the person to a place of safety requires a warrant under Article 129(1).

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[15] Regional Policy on the use of Restrictive Practices in HSC Settings (Nov 2023)
[16] Black_v_forsey_UKHL_1988 and Mental Health Law in England: Sessay Judgment Explained

In Syed v DPP [2010][17] the High Court ruled that Section 17(1)(e) of the Police and Criminal Evidence (PACE) Act 1984 did not justify entry where there was a general concern for the welfare of someone within the premises and therefore officers were not in the execution of their duty when purporting to rely on Section 17(1)(e) to service entry against the wishes of the person who answered the door. The provision under Section 17(1)(e) is similar to that under Article 19(1)(e) of the PACE (NI) Order 1989. The decision to exercise a constable's discretionary power of entry under Article 19(1)(e) must be made in accordance with the statutory purpose. This is an operational consideration that rests with the PSNI.

The right of entry without any warrant should be limited to cases where there is an apprehension that something serious is otherwise likely to occur, or perhaps has occurred, within the private dwelling. Concern for welfare is not sufficient to justify an entry within the terms of Article 19(1)(e). Further information in relation to the use of warrants can be found in Section 3.

- **NI Fire and Rescue Service (NIFRS) powers of entry**
  Under The Fire and Rescue Services (Northern Ireland) Order 200618 and The Fire Safety Regulations (Northern Ireland) 201019 (Article 18 Powers of Entry) an authorised officer may enter premises in a situation that causes or is likely to cause a person to die, be injured or become ill (Article 8). The NIFRS officer may enter premises, by force, if necessary, without the consent of the owner or occupier of the premises. The details of how NIFRS will support partner agencies should be set out in a Memorandum of Understanding between PSNI, NIAS and NIFRS.

Mental Capacity Act (NI) 2016: capacity and deprivation of liberty

1.60 Capacity to make decisions is time and decision specific, and support should be provided, when necessary, to maximise decision making by the patient. Patients need relevant information to be shared in a way they can understand and retain, so they can use it to make a decision. The information should be shared in a place and at a time when the patient is most likely to understand and retain it. Professionals should anticipate whether the patient is likely to find any of the information being discussed distressing, and if so, be considerate when sharing it.

1.61 The following principles of the MCA should be used to inform practice:

[17] Syed v Director of Public Prosecutions | England and Wales High Court (Administrative Court)
[18] The Fire and Rescue Services (Northern Ireland) Order 2006
[19] The Fire Safety Regulations (Northern Ireland) 2010

- **Presumption of capacity**: every adult has the right to make their own decisions and must be assumed to have the capacity to do so unless it is proved otherwise. This principle applies to children who are Gillick competent and 17 to 18 year olds.
- **Individuals supported to make decisions**: a person must be given all practicable help before anyone treats them as not being able to make their own decisions.
- **Unwise decisions**: just because an individual makes what might be seen as an unwise decision, they should not be treated as lacking capacity to make that decision.
- **Best interests**: an act done or decision made under the MCA for, or on behalf of, a person who lacks capacity must be done in their best interests.
- **Least restrictive option**: anything done for, or on behalf of, a person who lacks capacity should be the least restrictive of their basic rights and freedoms.

1.62 These principles are designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. They ensure that individuals have the opportunity to make their own choices and that any decisions made on their behalf are in their best interests.

1.63 If a person meets the criteria for detention under the Order, then the Order framework must be applied, even if the person's circumstances would also meet the criteria for detention under the MCA.

1.64 In all other situations, the MCA must be used where the criteria are met. The MCA was passed in May 2016 and the first phase of commencing the Act was completed in two stages: research provisions commenced on 1 October 2019 and provisions in relation to deprivation of liberty and money and valuables in hospitals and residential care and nursing homes commenced on 2 December 2019.

1.65 As at March 2026, Part 9 police powers and Part 12 use of restraint have not been enacted. However, Part 15 of the MCA provides powers to apply for a warrant to gain access to premises where a patient who is liable to be detained under the MCA in circumstances amounting to a deprivation of liberty is residing. The Act provides a statutory framework for people who lack capacity to decide for themselves and for those who now have capacity but wish to prepare for a time in the future when they lack capacity. When the Act is fully commenced, the Order will no longer apply to anyone over the age of 16. The Order will continue to apply to under 16 year olds and, in doing so, staff should refer to the Children (Northern Ireland) Order 1995 to guide their decisions. To manage the phased commencement of the MCA, the Order will remain in operation for all to whom it applies, and a dual system will exist with both the Order and the MCA providing statutory frameworks for deprivation of liberty.

Safeguarding

1.66 When working with patients with a mental disorder or learning disability, staff should be aware of their responsibilities to act in a way that addresses safeguarding concerns. They should:

- consider the needs and welfare of patients (adults, children and young people) who may be vulnerable, and offer them help if their rights are being abused or denied;
- act promptly on any concerns about a patient, or someone close to them who may be at risk of abuse or neglect, or is being abused or neglected; and
- act promptly if patient safety or dignity is, or may be, seriously compromised.

Equality

1.67 Section 75 of the Northern Ireland Act 1998 places a statutory obligation on public authorities to carry out their functions with due regard to two main duties:

(1) A public authority shall in carrying out its functions relating to Northern Ireland have due regard to the need to promote equality of opportunity—

(a) between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;
(b) between men and women generally;
(c) between persons with a disability and persons without; and
(d) between persons with dependants and persons without.

(2) Without prejudice to its obligations under subsection (1), a public authority shall in carrying out its functions relating to Northern Ireland have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial groups.

1.68 The needs of minority ethnic communities, including Irish Travellers, should be considered in the development and delivery of mental health services.

1.69 HSC statutory providers must ensure the services they directly provide or commission for patients are based on person centred approaches and promote equality of opportunity as stated above. They must have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial groups. Provision of services must include consideration of the patient's physical and mental health strengths and needs, any known disabilities, age, gender, spiritual needs, cultural needs, sexual orientation, and responsibilities for dependants.

Duty to reduce inequalities

1.70 Under section 2 of the Health and Social Care (Reform) Act (Northern Ireland) 2009, the Department has a duty to develop policies, and commission services, to improve health and social wellbeing, and reduce health inequalities between people in Northern Ireland. The guidance provided within the Code supports improved health and social wellbeing and reduces health inequalities through clearer understanding of the roles and responsibilities of the key agencies involved in providing care, treatment and support to patients, agreed decision making processes, clearer lines of communication and guidance in relation to information sharing and communication between agencies.

HSC Trust responsibilities

1.71 HSC Trusts have an obligation to follow the law and a statutory duty of quality to ensure that care meets required standards[20] and are responsible for the systems, policies and the environment in which care is provided and maintaining proper governance and risk management. They have a critical responsibility in delivering mental health services, ensuring professional conduct and maintaining quality care for patients.

1.72 In meeting these responsibilities, Trusts should:

- provide clear lines of accountability which support the appropriate support and management of staff;
- ensure that the necessary resources, working environment, training, support and systems are in place to enable staff to comply with their duty of care, professional standards of conduct and practice and any relevant statutory duties;
- provide a working environment that upholds ethical practice and is committed to standards and providing good quality services;
- have effective systems in place to support the workforce;
- have systems in place to listen to patient and carer feedback to shape and improve service provision to practise and deliver better outcomes;
- implement effective governance systems to monitor and improve the quality and safety of mental health services, including those provided in places of safety;
- work with Commissioners to provide more suitable places of safety;
- develop internal operational guidance for places of safety and Emergency Departments (EDs), which includes the process for completion of Medical Assessments (**Form 3**), handover arrangements from police to HSC and escalation processes;

[20] The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

- work to ensure sufficient availability of ASWs to provide a responsive 24 hour, seven day a week service capable of meeting demand, both in terms of a one-hour verbal response to requests for ASW assessments and an agreed response time for face-to-face interviews; and
- in partnership with the DoH and Strategic Planning and Performance Group (SPPG), should work towards agreeing a response time for face-to-face ASW assessments.

1.73 No individual member of staff should be solely responsible for the safety, care and treatment of patients who have been assessed as meeting the criteria for admission for assessment under the Order and, because of either delayed access to an appropriate bed or delays in conveyance, is subject to a protracted delay. Trust senior managers must be made aware of these incidents and assume a supportive role in effecting a timely admission. This will include oversight and redirecting of the appropriate resources to manage the situation safely and effectively.

Escalation processes for disagreements

1.74 Typically, the agencies and professional groups involved in implementing the Order and this Code agree on how to best support the patient. However, disagreements may occasionally arise between professionals or agencies regarding the most appropriate way to manage the processes involved in supporting the patient. Each agency should have internal escalation procedures that clearly outline the types of situations that require further consideration by senior decision makers and senior managers. These escalation processes are vital not only for managing individual cases effectively, but also for creating opportunities to learn from experience.

1.75 As the Code is closely linked to the Northern Ireland RCRP initiative, the governance arrangements[21] to support the effective implementation of RCRP will also consider the interface issues between the HSC Trusts, NIAS, primary care and the PSNI as they implement the Code. This is particularly relevant to conveyance and police powers, under Articles 129 and 130, and the arrangements to support the patient through these processes.

[21] RCRP Governance Arrangements

2 COMPULSORY ADMISSION TO HOSPITAL FOR ASSESSMENT

Introduction

2.1 Part II of the Order sets out the circumstances in which, and the procedures through which, patients can be compulsorily admitted to and detained in hospital. It does not, however, deal with admissions through the courts or transfers from prisons or remand centres, which are covered in Part III.

2.2 The Order makes a very clear distinction between admission to hospital for assessment and detention in hospital for treatment. The distinction is emphasised by the fact that where the assessment is not followed by detention for treatment, the assessment period can be disregarded for certain purposes. Thus, except in the case of judicial proceedings (as defined in Article 10(6)), a person has the right to decline to answer questions about any such periods without prejudice to themself. Any legal or contractual obligations to disclose information to any person does not apply to such periods. In the occupational and employment fields, such periods or the failure to disclose information about such periods is not a legitimate ground for unfavourable treatment. In addition, any disqualification, disability, prohibition or other penalty of a legal or statutory nature attaching to liability to be detained, other than under the Order itself, does not apply to such periods (Article 10).

2.3 The admission for assessment procedure is initiated by the applicant with the support of a medical recommendation (Article 5(1)). The procedure is laid down in Articles 4 to 8 of the Order. Detention for treatment is initiated by a Part II medical practitioner appointed by RQIA on completion of the assessment process, and the criteria are stringent. The procedure is laid down in Articles 12 and 13 of the Order.

Application for admission for assessment

2.4 An application for admission for assessment may be made either by the patient's nearest relative or by an ASW (Article 5(1)). The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 prescribe the forms to be used in the application process. Applications must be made on a prescribed form: **Form 1** is used where the application is made by the nearest relative and **Form 2**[22] if the ASW is the applicant. No application can be made unless the applicant has seen the patient within the previous two days (Article

[22] It is a requirement of the legislation that prescribed forms and other reports are immediately submitted to RQIA by HSC Trusts. These may be sent electronically.

5(2)) and unless it is founded on and accompanied by a medical recommendation.

2.5 Although the application form and medical recommendation are addressed to the responsible authority which is the receiving Trust, they will in practice normally be taken with the patient to the receiving hospital in the case of an immediate admission or, in other cases, may be taken or sent directly to that hospital ahead of the patient.

2.6 In Trust to Trust admissions, where a patient has been assessed in the community and has to move to another Trust area to an allocated bed as there are no available beds in the patient's Trust area, there is an expectation that transfers will be agreed, supported and managed at Trust level. In exceptional circumstances, if there is any difficulty in having a patient admitted to that hospital, the Department may by order in writing direct that the patient is admitted (Article 28(3)).

2.7 The application, founded on a medical recommendation, is central to the admission for assessment procedure. Applications and medical recommendations must be made on the appropriate prescribed forms, and care must be taken to ensure that these are completed correctly. While inaccuracies may be subsequently corrected, any significant irregularity in the documentation may invalidate the authority to admit the patient (Article 11). The scrutiny and amendment of documents is dealt with in paragraphs 4.14 - 4.24.

2.8 It is good practice for the professionals involved in the application for admission process to be present at the same time (although it may be advantageous for each to interview the patient separately). Everyone involved should be aware of the need to provide mutual support. They should also, where there is a risk of the patient causing serious physical harm, consider calling for police assistance and should know how to use that assistance to minimise the risk of violence. HSC staff, when dealing with situations in HSC settings where restrictive practices may be involved, should follow the Regional Policy on the use of Restrictive Practices in HSC Settings.

2.9 When it is not possible for the professionals to be present at the same time, they should communicate clearly with each other about their assessment of the patient's circumstances and their decision in relation to making the medical recommendation or application.

Choice of applicant

2.10 Application for admission to hospital for assessment may be made by:

- the patient's nearest relative (Article 5(1)(a));
- an ASW (Article 5(1)(b)); or

- a person appointed by the County Court to act as the nearest relative (Article 36).

The nearest relative

2.11 The nearest relative is defined in Article 32 of the Order by reference to a list of relationships in paragraph (1) of that Article, a caring relative taking priority over a non-caring relative (whatever their position on the list). Guidance on how the nearest relative is determined is set out in the back of the application form (**Form 1**). They have an important part to play in the application to admit to hospital, even if they are not the applicant. They are normally the person who is closest to the patient and will usually be aware of the circumstances surrounding the possible need for admission.

2.12 A list in order of precedence of the persons who are entitled to be regarded for the purposes of the Order as the patient's relative is contained in Article 32(1) as follows:

(a) spouse or civil partner[23] (same sex couples and civil partnerships have the same legal rights and responsibilities as different sex married couples)
(b) child
(c) parent
(d) brother or sister
(e) grandparent
(f) grandchild
(g) uncle or aunt
(h) nephew or niece

2.13 The nearest relative is then defined as the first person listed who is caring for the patient or, if the patient is already in hospital, was caring for the patient before admission. For example, if a patient is being cared for by a grandchild, that grandchild would be the nearest relative within the meaning of the Order even though a son or daughter was still alive. The definition is, however, subject to the remaining provisions of Article 32 which cover a wide variety of special circumstances and may require professional discussion which should be reflected in the social work report. Article 32 provides that:

i. If the patient has relatives, but none are or were caring for them, then the nearest relative is simply the first person listed.
ii. Where there are two or more persons in one category, the elder or eldest is preferred.
iii. “An “illegitimate person” is treated as the legitimate child of their mother and their father (if their father has parental responsibility for the child within the meaning of the Children (NI) Order 1995 (see Article 32(2)(b)).

[23] The Marriage (Same-sex Couples) and Civil Partnership (Opposite-sex Couples) (Northern Ireland) Regulations 2019

iv. To determine relationship, a half-blood relative is treated as a whole-blood relative but, within the same description of relative, a whole-blood relative is preferred.

v. Where the person, who would otherwise be the nearest relative, is under 18 years of age, that person is disregarded unless they are the spouse/civil partner or parent of the patient.

vi. Where there is a permanent separation or desertion and the person, who would otherwise be the nearest relative of the patient by virtue of their being their spouse, is no longer living with the patient, that person is disregarded.

vii. Where a person who would otherwise be the nearest relative ordinarily lives outside the United Kingdom, the Channel Islands, the Isle of Man or the Republic of Ireland, that person is disregarded unless the patient also ordinarily resides outside those countries.

viii. For the purposes of the Order, the term spouse includes a person who is living with the patient as though they were married or, if the patient is already in hospital, had been so living with them before admission, and has or had been so living for not less than 6 months.

ix. A person with whom the patient ordinarily resides and has been so resident for at least 5 years, but who is not a relative and cannot be regarded as a spouse in the terms of (viii) above, is treated as the nearest relative within the meaning of the Order if they are caring for the patient or, where the patient is already in hospital, was caring for the patient before admission.

2.14 A patient's father does not automatically take precedence over the patient's mother, but the elder of the two will take precedence. Care should therefore be taken to establish who the nearest relative is before, for example, an application for assessment or guardianship is made. To assist those involved, some notes of guidance have been included on the reverse of the respective prescribed application forms (**Form 1 and Form 13**).

2.15 The SHARE Guidelines provide useful information that guides staff when communicating with nearest relatives, families and carers.

2.16 The Order confers various functions on the patient's nearest relative such as making applications for admission, exercising the right to discharge the patient and making applications to the Tribunal. These and other rights and powers of the nearest relative are mentioned in more detail as they arise throughout the Order. It is open to the nearest relative of a patient who is detained or subject to guardianship to authorise under Article 35 some other person to perform their functions under the Order. If they wish to do so they must obtain the written agreement of the person who is willing to act in this capacity, and they must also give a notice to the responsible authority

(normally the receiving Trust) using the prescribed form (**Form 20**)[24] formally assigning their functions as nearest relative.

Children and young persons in care

2.17 The wording of Article 33 of the Order was replaced by amendment in the Children (NI) Order 1995 ("the 1995 Order") and now states:

*"Where a patient who is a child or young person is in the care of a HSC trust by virtue of a **care order** within the meaning of the Children (Northern Ireland) Order 1995, the ...trust **shall be deemed to be the nearest relative** of the patient in preference to any person except the patient's spouse or civil partner (if any). A care order includes emergency protection order, care order or interim care order."*

2.18 If a child is voluntarily accommodated, the Trust does not have parental responsibility. A parent with parental responsibility does not lose it. Given the complexities around identification of persons who may have parental responsibility, practitioners should refer to Part II of the 1995 Order and reference should be made to:

- Article 5: Parental responsibility for children.
- Article 6: Parental responsibility means all the rights, duties, powers, responsibilities and authority which by law a parent of a child has in relation to the child and his property.
- Article 7: Acquisition of parental responsibility.

2.19 Practitioners may require advice from children's social work colleagues or from the Directorate of Legal Services in determining those with parental responsibility.

Nearest relative acting as applicant

2.20 Where the nearest relative is proposing to act as the applicant, the professionals involved in the case should offer them any assistance or advice required. That advice should include such elements of the guidance for ASWs in paragraphs 2.23 to 2.41 of the Code as are appropriate. The nearest relative should also be made aware of the relevant form (**Form 1**)[25] and how it should be completed. Alternatives to compulsory admission, such as voluntary admission, guardianship, or continuing medical, nursing and social work involvement outside hospital, should be discussed with them by the professionals involved.

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[24] It is a requirement of the legislation that prescribed forms and other reports are immediately submitted to RQIA by HSC Trusts. These may be sent electronically.
[25] As above.

2.21 There will, of course, be occasions when the nearest relative does not wish, or is unable, to make the application. Applying for admission at a time of crisis can be a stressful experience. On occasions, an application by the nearest relative may be regarded by the patient as rejection by their family. Where the nearest relative is reluctant to initiate the application procedure, the medical practitioner should consult the ASW and explain to the nearest relative the ASW's power to make an application.

2.22 ASWs are qualified to address these relationship and procedural issues. Their role is described more fully below. It is envisaged that, in many cases, the nearest relative will continue to play a significant part in the application process, even where the ASW acts as applicant. However, a nearest relative should not be forced to make an application for admission under the Order because of a delay in obtaining the services of an ASW.

ASW responsibilities when acting as applicant

2.23 Trusts provide a 24-hour ASW service. They should issue guidance to ASWs on:

- What amounts to a "request to consider application from the nearest relative".
- How to respond to repeated requests where the condition of the patient has not changed significantly.
- How to respond to a request made on behalf of a nearest relative by a medical practitioner or other professional whether employed in the statutory, private or voluntary sector.

2.24 The DoH Approved Social Work Quality Standards (Approved Social Work Quality Standards) require Trusts to meet certain criteria in the provision of their ASW Service.

2.25 Article 40 of the Order places a duty on the ASW to make an application where they are satisfied that an application ought to be made and that it is necessary or proper for the application to be made by them as it is *"the most appropriate way of providing the care and medical treatment"* (Article 40(2)). The practical guidance in this part of the Code applies where the ASW is acting under Article 40 but is generally applicable where they are considering an application at the request of the nearest relative.

2.26 ASWs often find themselves operating with limited and insufficient resources, particularly when decisions about admission for assessment are being made. In these circumstances, ASWs should clearly record the impact of lack of appropriate resources.

2.27 To satisfy themself that it is necessary and proper for an application to be made, the ASW should interview the patient in person. At the start of the interview, they should identify themself to the patient, to nearest relatives, and to members of the family and other professionals present; explain in

clear terms their role and the purpose of their visit; and check that the other professionals have explained their roles. ASWs should at all times carry documents identifying themselves as ASWs.

2.28 Before making an application, the ASW is required under Article 40(2) to interview the patient in a suitable manner, which includes taking account of any physical, mental or cognitive difficulties the patient may have, such as sensory impairment or linguistic difficulties. First language should also be considered.

2.29 The ASW must attempt to identify the patient's nearest relative and ensure that their statutory obligations to the nearest relative are fulfilled. In addition, the ASW should where possible:

(a) ascertain the nearest relative's views about the patient's needs and their (the nearest relative's) own needs in relation to the patient; and
(b) inform the nearest relative of the reasons for considering an application for admission under the Order and the effects of making such an application.

2.30 Article 36 does not allow the patient to make an application in relation to having a nearest relative appointed, as the wording is that the "applicant" seeks an order that they (the applicant) exercise the functions of the nearest relative. The grounds for making such an order are listed in Article 36(3) and include at sub-paragraph (a) *"that the patient has no nearest relative within the meaning of this Order, or that it is not reasonably practicable to ascertain whether they have such a relative, or who that relative is".*

2.31 The decision in HM's Application [2014] NIQB 43[26], however, established that Articles 32 and 36 could be read in a Convention compliant way such that:

(i) a patient can apply to the Court to have their nearest relative replaced; and
(ii) can do so on the ground that the nearest relative of the patient is otherwise not a suitable person to act as such (as per the amendments to the 1983 Act) (paragraph 55 of the judgment).

2.32 ASWs should assist the patient with this application to the Court to have a nearest relative appointed and this is applicable in both guardianship and detention processes that they may be involved in.

2.33 The implications of TW v Enfield Borough Council Court of Appeal, 27th March 2014 judgement[27] are also relevant as the ASW can consider the suitability of the NR

[26] HM's Application [2014] NIQB 43
[27] TW -and-Enfield Borough Council Court of Appeal, 27th March 2014

2.34 The important principle arising from the TW case was that there is more to the determination of what is "reasonably practicable"; it involves a balancing of rights because the obligation to consult the nearest relative might give rise to a conflict between a patient's right to liberty under Article 5 of the ECHR, and their right to respect for private life and correspondence under Article 8 of the ECHR as pertaining to confidentiality of their medical history and file.

2.35 Section 11(4) of the Mental Health Act 1983[28], in the Court's determination, imposed on an ASW an obligation to strike a balance between those competing rights. In circumstances where the duty to consult the nearest relative would interfere with the patient's Article 8 rights, the decision as to whether it was reasonably practicable to consult the nearest relative would depend on whether it was justified and proportionate in the circumstances.

2.36 The ASW should consider all the circumstances of the case including:

- The benefit to the patient of involving their nearest relative.
- The patient's wishes, taking into account whether they have the capacity to decide whether they would want their nearest relative involved and any statement of the patient's wishes they had made in advance.
- Any detrimental effect that involving the nearest relative would have on the patient's health and wellbeing.
- Whether there is a good reason to think that the patient's objection may be intended to prevent information relevant to the assessment being discovered.

Nearest relative objects to application for admission for assessment

2.37 If the nearest relative objects to an application being made and the ASW wishes to proceed with the application, they must consult a second ASW before they make the application (Article 5(4)). The second ASW should interview the patient and record their conclusions on the second ASW report. If after consultation the first ASW decides to proceed, they must record the nearest relative's objection on the application for assessment. Alternatively, they may apply to the County Court to have an acting nearest relative appointed on the grounds that the nearest relative has unreasonably objected to the making of an application (Article 36(3c)). The second ASW should use the **Second ASW Report Best Practice Recording Format**[29] to record their decision within a maximum of five days.

2.38 The ASW should take into account any wishes expressed to them by relatives of the patient and any other relevant circumstances when deciding whether or not to make an application (Article 40(1)(b)). It may be

[28] Mental Health Act 1983
[29] Second ASW Report Best Practice Recording Format

appropriate in certain cases to have regard to any views expressed by particularly close friends.

2.39 The ASW should consult the medical practitioner in attendance and, whenever possible, other professionals who have been involved with the patient's care.

2.40 When the ASW has decided whether they should make an application for admission, they should tell (giving the reason):

- the patient;
- the patient's nearest relative (whenever possible); and
- the medical practitioner(s) involved in the assessment.

2.41 It is considered best practice for both the medical practitioner and the ASW to be present at the same time, even if they choose to interview the patient separately.

Approved Social Work (ASW) report

2.42 Where the ASW makes the application, they should have satisfied themself that, in all the circumstances, the statutory criteria for admission for assessment have been met and the admission is appropriate. It is good practice for the ASW to complete a report outlining the circumstances of the application and risks identified that should be made available to the admitting medical practitioner as soon as possible, preferably on admission. The ASW should follow up with a more detailed report completed on the regionally agreed format, as linked below, within the regionally agreed maximum five working days timeframe. The ASW should also complete a report when they decide not to make application, setting out clearly the reasons for this decision.

2.43 The **ASW Recording Formats** can be located at the links in the footnote below.[30]

Social circumstances report

2.44 If an application is made by the nearest relative, no social worker may have been involved before it is made. In this type of case, Article 5(6) requires the Trust to arrange for a social worker, who need not be an ASW, to interview the patient and provide the RMO with a report on their social circumstances.[31] The social worker undertaking this task should have participated in training and have the competence to fulfil this role.

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[30] ASW Recording Formats: MHO(a); MHO(b) and Guidance for MHO(b)
[31] Social Circumstances Report (SCR)

2.45 The report will deal with matters such as the past history of the patient's mental disorder, their present condition and the social, familial and personal factors bearing on it, the wishes of the patient and their relatives, and medical opinion. The social worker making the report will need to consult those professionally involved in the case and will consider other options for giving the patient the care and treatment they need, such as guardianship, admission as a voluntary patient, day care, out-patient treatment, community psychiatric nursing support, primary health care support and support from friends, relatives and voluntary organisations.

2.46 The social worker's report should be done as soon as practicable as it should be available to the RMO as early as possible during the assessment period.

Promoting Quality Care

2.47 The ASW and social work reports should also contribute to a comprehensive risk assessment under Promoting Quality Care (PQC) or someone's mental health care pathway where these are being used.

2.48 PQC guidance describes the principles of best practice to assist individual mental health and learning disability care professionals, multidisciplinary teams and the organisations within which they work, to make decisions about managing the potential risk that patients may cause harm to themselves or others (including the staff who care for them, their families, carers or the general public).[32]

Regional Mental Health Care Pathway

2.49 The Regional Mental Health Care Pathway[33] was developed for people who require mental health care and support. The Care Pathway recognises that all treatment and care need to be highly personalised and recovery orientated. The purpose of the Care Pathway is not only to provide guidance on the steps of care to be delivered, but it is designed also to enhance the quality of service experience and promote consistency of service delivery across Northern Ireland.

2.50 At the heart of this Care Pathway is the recognition that people, whether they are using, supporting or providing a service, have a positive contribution to make. The development and implementation of this Care Pathway will promote a genuine partnership approach in mental health services. Central to the Care Pathway is a desire to ensure that everyone has the opportunity to experience the very best care and therefore it has been co-produced in a style that promotes: hope; partnership; personal participation; input into all key decision making; confidence in the support

[32] Promoting Quality Care – Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services – May 2010
[33] Regional Mental Health Care Pathway

provided; better outcomes which enables personal recovery; and family focused approaches.

2.51 The Care Pathway recognises that mental health care should receive parity of esteem with physical health care services in terms of priority and resources. Although aspects of this Care Pathway are challenging to implement immediately, due to resource constraints, it does commit HSC services to make better use of existing resources and to secure additional resources to address gaps in service provision.

Medical recommendation

2.52 The medical recommendation which will accompany an application for assessment must be made on **Form 3**,[34] The medical practitioner providing the medical recommendation must have examined the patient not more than two days before the date on which they sign the recommendation (Article 6). They should, if at all possible, be someone who already knows the patient (Article 6(b)), and preferably the patient's own GP. A partner, locum, or any other medical practitioner is not barred from providing the recommendation.

2.53 It is recognised that, due to other clinical pressures and priorities, GP response times can vary. If the medical recommendation is to be significantly delayed, or it is not reasonably practicable for the GP to attend (for example, due to GP competing demands), a risk assessment should inform next steps.

2.54 In cases of urgent necessity, another medical practitioner trained to act under Part II of the Order can undertake this medical assessment. Urgent necessity in such cases refers to the measure of risk to the patient or others due to any delay in assessment.

2.55 The outcome of the risk assessment should guide decision-making, specifically regarding the decision to wait for a GP or arrange an assessment with another medical practitioner.

2.56 A medical practitioner on the staff of the hospital to which the patient is to be admitted cannot provide the recommendation except in a case of urgent necessity (Article 6 (c)). The reason the medical practitioner on the staff of the hospital should not provide the medical recommendation, except in cases of urgent necessity, is to preserve independence in the assessment process and is therefore an important patient safeguard. Close relatives, business partners and others (see Schedule 1 to the Order) are NOT permitted to give the medical recommendation. Service pressures should not dictate urgent necessity.

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[34] It is a requirement of the legislation that prescribed forms and other reports are immediately submitted to RQIA by HSC Trusts. These may be sent electronically.

2.57 The criteria for application and medical recommendation for admission for assessment are set out in Article 4(2) and (3) of the Order. Article 4(2) provides that an application may be made in respect of a patient on the grounds that:

(a) They are suffering from mental disorder of a nature or degree which warrants their detention in a hospital […]; and
(b) Failure to detain them would create a substantial likelihood of serious physical harm to themself or to another person.

2.58 Article 4(3) of the Order provides that an application must be founded on a medical recommendation which includes:

(a) a statement that, in the opinion of the recommending medical practitioner, the grounds set out in paragraph 4 (2)(a) and (b) apply;
(b) the grounds, including a clinical description of the mental condition, for their opinion that the detention is warranted; and
(c) the evidence for their opinion that failure to detain the patient would create a substantial likelihood of serious physical harm.

2.59 The statements in the medical recommendation governing the criteria for admission for assessment are statements of opinion and must be supported by statements that indicate that the patient may have a mental disorder, and evidence that there is a substantial likelihood of serious physical harm to the patient or to others.

2.60 A specific diagnosis of the form of mental disorder is not required, as part of the purpose of the assessment is to determine this. However, the words *"of a nature or degree which warrants his detention in hospital"* are intended to restrict the use of admission for assessment to patients who are thought to have a mental disorder which would justify detention in hospital for assessment.

2.61 **Form 3**[35] provides for these statements which, in the case of the diagnosis, should include a clinical description of the patient's mental condition and should indicate why the patient cannot suitably be cared for outside hospital, or be treated in a day-hospital, or as an out-patient, or be admitted as a voluntary patient. The interpretation to be placed on the term *"a substantial likelihood of serious physical harm*" is contained in Article 2(4) and the medical practitioner's statement must, therefore, include evidence for at least one of the following:

[35] It is a requirement of the legislation that prescribed forms and other reports are immediately submitted to RQIA by HSC Trusts. These may be sent electronically.

i. that the patient has inflicted, or threatened or attempted to inflict, serious physical harm on themselves;
ii. that the patient's judgement is so affected that they are, or would soon be, unable to protect themself against serious physical harm and that reasonable provisions for their protection is not available in the community;
iii. that the patient has behaved violently towards another person/ persons; or
iv. that the patient has so behaved in a manner that other persons were placed in reasonable fear of serious physical harm to themselves.

2.62 It is not necessary to wait until the patient has injured themself or others before admitting them to hospital.

2.63 It will be for the medical practitioner to decide whether the evidence for one or more of the above is sufficient to warrant admission for an assessment, but clearly a patient who was simply making a nuisance of themself or indulging in anti-social behaviour, would not meet the criteria.

2.64 The assessment of a patient may legitimately involve consideration of any prognosis of future deterioration of the patient's mental health and the known history of their mental disorder. Some examples of what may be considered in assessing the nature of the serious physical harm are:

i. Uncontrolled over-activity likely to lead to exhaustion.
ii. Gross neglect of hygiene and personal safety which would create a hazard to the patient or others.
iii. Serious and protracted neglect of diet which would lead to malnutrition.
iv. Disinhibited behaviour likely eventually to lead to serious physical harm to the patient, their family or other persons.

2.65 The medical practitioner's responsibility goes beyond diagnostic assessment and includes assessment of the need for an admission for further assessment in hospital. In this they should co-operate with the applicant and consider both the need for detention and the possibility of alternative measures and how they might be taken. When the applicant is the nearest relative, the medical practitioner should advise them that they can discuss the position with an ASW.

2.66 The medical practitioner should specifically address the legal criteria for admission under the Order and set out in their recommendation those aspects of the patient's symptoms and behaviour which satisfy the criteria.

2.67 If an application for assessment is to be made, the medical practitioner should contact medical staff in the hospital to which the patient is to be admitted, to discuss any possible difficulties or uncertainties about admission, ensure that a bed will be available and advise of the anticipated time of arrival of the patient at the hospital.

Alternatives to application for admission

2.68 Before making a recommendation or proceeding with an application, the professionals involved should consider what is needed for the patient's care and protection and (where this applies) for the protection of others. All reasonable options should be considered, including voluntary admission[36], alternatives to admission (which may include the patient remaining in the community supported by community-based services), and guardianship.

2.69 Where admission is necessary and the patient has the capacity to agree, voluntary admission is to be preferred to compulsory admission under Part II of the Order. However, a compulsory admission should be considered where the statutory criteria have been met and there is evidence to suggest a strong likelihood that the patient will change their mind about voluntary admission, prior to admission to hospital, resulting in a substantial likelihood of serious physical harm to themself or to other persons.

2.70 In considering a voluntary admission, the patient should be given information about what this means, including that they would be free to leave the hospital if they remained as a voluntary patient. Patients should not be pressurised to remain as voluntary patients and, if they do want to leave, a reassessment of their situation should take place to enable them to do so, or if the criteria for admission for assessment are met, this process is commenced.

2.71 If it is decided not to apply for admission, the professional concerned, which may be either a health or social care professional, should decide what action is needed to meet the patient's needs, including the possible provision of other health and social services, and should decide how to implement that action. The professionals concerned with the patient's care should be fully involved in the taking of decisions, notably the RMO, medical staff, and keyworker.

2.72 The professionals should ensure that they, the patient, and (with the patient's consent, as far as possible) the nearest relative and any other closely connected relatives, have a clear understanding of any alternative arrangements and who will be responsible for ensuring that they are put in place. Such arrangements should be recorded in writing and copies made available to all those who need them, subject to the patient's right to confidentiality.[37] Professionals should consult the SHARE Guidelines when sharing information with others.

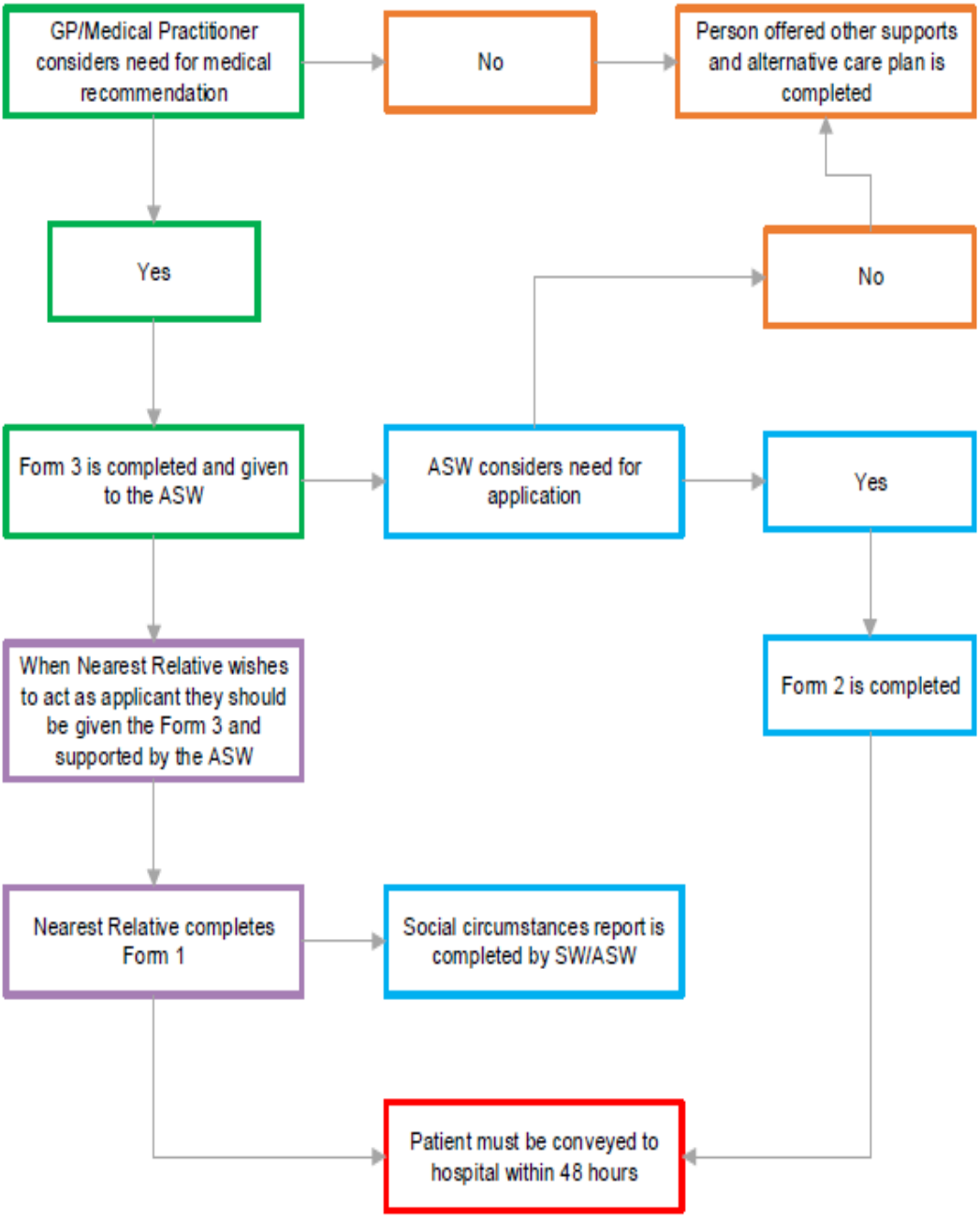
2.73 The ASW should discuss with the patient's nearest relative the reasons for not making an application. The ASW should advise the nearest relative of their rights to apply and suggest that they consult the medical practitioner

[36] HL v UK 45508/99 [2004] ECHR 471

[37] Alternative Care Plan - ASW Assessment under the Mental Health Order 1986

if they wish to consider this alternative. Where the ASW has been acting at the request of the nearest relative, they must give that relative a written statement of the reasons for not applying for the patient's admission (Article 40(4)). The statement should contain sufficient details to enable the nearest relative to understand the decision, whilst at the same time preserving the patient's right to confidentiality. A copy of the statement should be retained by the ASW.

Flowchart 1: Application for assessment



Disagreements

2.74 For an application for assessment to succeed there must be agreement between the applicant and the medical practitioner. Where this is difficult to achieve, consultation with colleagues should be considered, including multi-disciplinary team members and other community staff.

2.75 Where there is a difference of professional opinion about an application, it is essential that the professionals do not abandon the patient and their family. They should explore and determine an alternative plan and ensure that the patient and family are kept informed. Such a plan should identify a named professional who will have responsibility for ensuring its implementation. It should be recorded in writing and copies made available to all those who need them, subject to the needs of confidentiality.

Admission of children and young persons under the age of 18 years

2.76 Part II of the Order applies equally to children and young persons under the age of 18 years. There are, however, additional matters of importance which should be considered when patients under the age of 18 years are admitted to hospital, whether on a voluntary basis or on an application for assessment.

2.77 The interface between the Order and The Children (Northern Ireland) Order 1995 requires full consideration when making decisions in relation to the care and treatment of children and young people. The person(s) who have parental responsibility (as determined through consideration of Part II of the 1995 Order), need to be considered when determining who the patient's nearest relative is. Parental responsibility means all the rights, duties, powers, responsibilities and authority which, by law, a parent of a child has in relation to the child and his property. Consideration should be given to when a parent has parental responsibility but the child/young person is at risk, or there are safeguarding concerns.

2.78 Article 3A, as updated by the MCA, states that the duty of a person responsible for the treatment or care (or both) of a patient under 16, is to have as a primary consideration the patient's best interests when making decisions about their treatment or care. In determining the child's (C's) best interests (Article 3B), they should consider C's age, or any other characteristic of C's, including any condition that C has, which might lead others to make unjustified assumptions about what might be in C's best interests.

2.79 Evidence of the considerations in 3B should be recorded in the child's notes, in addition to the outcome of decision-making considerations. Article 3C details the requirements and duties of HSC Trusts in relation to the provision and availability of independent advocates for children. Article 3D states the duties of hospital managers to ensure that (subject to the child's

needs) the child's environment in the hospital is suitable, having regard to his or her age.

2.80 Practice for this age group should be guided by the following principles:

- Young people should be kept as fully informed as possible about their care and treatment; their views and wishes must always be taken into account.
- Unless statute specifically overrides, young people should be regarded as having the right to make their own decisions (in particular, treatment decisions) when they have sufficient "understanding and intelligence". It is considered best practice to reference the Gillick competence test[38] in determining these decisions.[39]
- Any intervention in the life of a young person, considered necessary by reason of their mental disorder, should be the least restrictive possible and promote as far as possible contact and connection with family, friends, community and school.

2.81 The legal framework governing the admission to hospital (and treatment) of young people under the age of 18 years (and in particular those under the age of 16) is complex and it is the responsibility of all professionals and the Trusts to ensure that there is sufficient guidance available to those responsible for the care of children and young people.

2.82 Staff who normally work within adult services may not have working knowledge of the Children Order and therefore may benefit from additional guidance and support when navigating the interface of both pieces of legislation.

2.83 Whenever the admission to hospital (and care and treatment in hospital) of a child under the age of 16 years is being considered, the following questions need to be asked:

- Does the child have competence to consent to the admission? The rights of parents to determine such matters end when a child achieves sufficient intelligence and understanding to make their own decision.
- What is the capability of the child to make their own decisions in terms of emotional maturity, intellectual capacity and psychological state?
- Who is legally responsible for decisions affecting the child, and who has the authority to make such decisions? Those assuming professional responsibility for the care of a child or young person should always request copies of any statutory orders (care order, guardianship order, contact arrangements etc.) for reference on the ward.
- Who has parental responsibility? More than one person can have responsibility at any one time, including situations where the child is

[38] Gillick v West Norfolk AHA
[39] Consent to treatment - Children and young people - NHS

'Looked After'. A child is defined as Looked After by an authority when they are:

(a) in the care of the authority; or

(b) provided with accommodation by the authority (Article 25 of the Children (NI) Order 1995).

2.84 If an HSC Trust has parental responsibility for a child, it retains parental responsibility until that child reaches 18 years of age, or dies, or the Order granting parental responsibility is revoked by Court Order.

2.85 It is best practice that the Executive Director of Social Work should be informed of any Looked After Child (LAC) being considered for admission or admitted to hospital. The Executive Director of Social Work may in certain circumstances be required to give permission/authority for a prescribed/ intended treatment.

2.86 Article 174 of The Children (Northern Ireland) Order 1995 – Children accommodated in hospitals should be considered. The obligation is that the hospital (HSC Trust) shall notify the responsible authority's Children Services. The responsible authority is defined in the Health and Social Care Act (Northern Ireland) 2022[40] as the HSC Trust covering the area where the child normally resides.

2.87 The obligation (Article 174 (6)) is then upon the HSC Trust Children Services to:

(a) take such steps as are reasonably practicable to enable it to determine whether the child's welfare is adequately safeguarded and promoted while they are accommodated by the trust; and

(b) consider the extent to which (if at all) any functions under this Order should be exercised with respect to the child by it or another trust.

2.88 Article 174 is intended to protect children's rights and ensure their welfare needs are met. See also Article 175 - *Children accommodated in certain homes and in private hospitals.*

2.89 To fulfil these duties, there should be close working arrangements between HSC Trust Children Services and Mental Health Services. Children Services' staff should be included in decision making processes so they can share their working knowledge of the child and their family circumstances, as well as sharing their expertise in relation to the application of the Children Order.

[40] Health and Social Care Act (Northern Ireland) 2022

Voluntary admission of children

Figure 2: Legal presumption of capacity for children of different age groups

Age group	Legal presumption
Under 16	Cannot consent independently unless found Gillick competent.
Age 16–17	Presumed to have capacity to consent, but parental rights may still apply.
18 and over	Treated as adults under the Order; full capacity assumed unless assessed otherwise.

2.90 Anyone aged 16 to 18 years who has capacity in relation to an admission to hospital decision can admit or discharge themself as a voluntary patient to or from hospital, irrespective of the wishes of the person(s) with parental responsibility.

2.91 Where a child under the age of 16 consents, they may be admitted to hospital as a voluntary patient provided they are Gillick competent (see 2.80 above) to decide about their admission to hospital for assessment of their mental disorder.

2.92 If a child who is Gillick competent objects to being admitted for treatment, their admission can only be on a formal basis where the criteria for admission for assessment criteria have been met (Article 4).

2.93 Where the child under the age of 16 is not Gillick competent, a person with parental responsibility can consent to the admission on the child's behalf if they are acting in the best interests of the child, as long as all other persons with "parental responsibility" have agreed to the admission. See: Re RN (Deprivation of Liberty and Parental Consent) [2022] EWHC 2576 (Fam), para.34.[41]

2.94 Where there is a dispute between the competent child and the person(s) with parental responsibility, the views of the person(s) with parental responsibility should be accorded serious consideration and given due weight. "*The Court will only become involved if there is a dispute between the parent and the responsible authority or between the parents themselves, as to what is in the child's best interests*", per HHJ Burrows (sitting as a High Court Judge) in Lancashire CC v PX [2022] EWHC 2327 (Fam).[42]

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[41] Re RN (Deprivation of Liberty and Parental Consent) [2022] EWHC 2576 (Fam) (note UK Supreme Court judgment on 2 June 2026 - A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998)

[42] Lancashire CC v PX {2022} EWHC 2327 (Fam) (as above)

2.95 It is always preferable for children and young people admitted to hospital to be accommodated with others of their own age group in children's wards or adolescents' units, separate from adults. If, exceptionally, this is not practicable, discrete accommodation in an adult ward, with facilities appropriate to the needs of children and young people, offers the most satisfactory solution.

Police support during a community assessment

2.96 Most requests for an assessment for compulsory admission do not come via the police. In circumstances where the GP and ASW are the first attenders, police support should only be requested when the reason for police attendance is consistent with their statutory functions (protection of life and property, preserving order, preventing the commission of offences, taking measures to bring offenders to justice)[43] and based on an assessment of the risks associated with the specific circumstance and should be informed by the ASW and conveyance agency's risk assessments. Risk to staff should also be clearly communicated and inform the decision for police support. Careful consideration should be given to the legal powers which the police have available to safely manage any assessment conducted in private premises. The Risk Matrix (Figure 5) at paragraph 3.92 provides guidance to when police should be involved.

2.97 The police have limited powers without a warrant, unless the person is behaving in a manner which would engage their statutory functions. Police presence in a private dwelling is regarded as a serious matter and the justification required will be assessed on a case by case basis. Powers over free movement around private dwellings will depend on the individual circumstances and it must not be assumed that there is power to enter and control a patient without the requisite legal threshold being met. For example, police should not be called for the following, nor would their presence automatically mean they could prevent the individual doing the following:

- denying access to the property
- moving between rooms in the premises
- the individual picking up knives, cutlery, boiling kettles or picking up hot drinks
- accessing areas where there are windows/balconies
- leaving the premises

Unless the specific context of such an action suggests that there is a threat to life or a crime will be committed or an arrestable offence under the PACE (NI) Order 1989.

[43] Police (Northern Ireland) Act 2000

2.98 If a pre-planned community assessment is taking place and it is anticipated that police will be required to assist, then partners should consider applying for a warrant. Although not always possible, pre-planned responses are preferable and will allow agencies to better prepare their responses.

2.99 If during a community assessment an individual leaves the premises and a warrant has not been obtained, it should not automatically be assumed that an Article 130 detention will take place. The police constable must be separately satisfied that the criteria for Article 130 are met.

2.100 Open communication between agencies will be key to sharing relevant information and the risks surrounding the patient.

Conveyance to hospital of patients detained under Article 4

2.101 The duly made application for assessment is sufficient authority for the patient to be conveyed to hospital by the applicant, by a person authorised by them, or by the Trust if it is requested to do so by the applicant in a case of difficulty (Article 8(1)).

2.102 Once the application is completed, every effort should be made by the agencies directly involved, including the Senior Management Team (at Director level) of the residing Trust, to ensure the patient is transported to the hospital as quickly as possible. This enables the patient to access the necessary assessment, care, and treatment without undue delay.

2.103 The patient must be admitted to hospital within two days. **The two days should be interpreted as 48 hours**. Or such longer period not exceeding 14 days, as a Part II doctor may certify on **Form 4**, in exceptional circumstances (Article 8(1)). Each case should be dealt with on an individual basis and the professionals involved should decide if the circumstances are exceptional and meet the criteria for a **Form 4**. Decision-makers are dealing with an individual's right to liberty, and therefore the period should not be extended to account for bank holidays etc.

Protracted delays

2.104 Delays can have a negative impact on the patient, their family, and the staff involved. They also increase risks to patients who have been assessed as needing hospital-based care due to the risks they may pose to themselves or others. In the absence of an appropriate psychiatric bed or timely conveyance, the Senior Management Team of the residing Trust, working closely with all other services involved, should make arrangements to ensure that the patient receives appropriate care and support in the interim. HSC Trusts should be aware that an unreasonable

delay in effecting an admission, once an application has been completed, could be considered unlawful detention.

2.105 Repeat assessments can place additional stress on the patient, their family and carers and can only be justified if the patient's circumstances have changed sufficiently to warrant a further reassessment. When a patient has been delayed for more than 48 hours due to exceptional circumstances, **Form 4** (Article 8 (1)) assessment should be requested to extend the period of time available to convey the patient to hospital.

2.106 Protracted delays should also be reported to the RCRP locality governance group.

2.107 While being conveyed to hospital the patient is deemed to be in legal custody (Article 131(1)). Should the patient abscond while being conveyed to hospital, they may be retaken and conveyed to the hospital within the time permitted for their admission, by the person who had custody of them immediately before they absconded, or any constable or ASW (Article 132 (1)). The patient cannot be retaken after the expiration of the period within which they could be retaken under Article 29 (Article 131(2)).

2.108 The authority to admit the patient to hospital and detain them there expires if they are not admitted within 48 hours beginning with the date on which the medical recommendation was signed. In exceptional circumstances this period of 48 hours can be extended up to 14 days (Article 8(1)) but only if the applicant gets a certificate in the prescribed form (**Form 4**)[44] from a Part II medical practitioner stipulating the number of days to which it can be extended and giving reasons for the extension. This could arise if, for example, there were problems locating the patient or if, being violent, they shut themselves in and more time was needed to deal with the situation.

2.109 If under exceptional circumstances, a patient is being transported out of the area in which they have presented, Trusts should provide additional assistance as part of support for any carers to visit and contact the patient, and/or encourage the carer to have a carer's assessment. This is particularly relevant when the patient is a child or young person.

2.110 The carer support and carer assessment are not immediate actions for the ASW and will not normally be the responsibility of the ASW unless they are already involved with the patient through their case work. There should be a clearly identified staff member responsible for maintaining contact with the carers. Best interest consideration should be given to the opinion for children to be accompanied by a parent or responsible adult.

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[44] It is a requirement of the legislation that prescribed forms and other reports are immediately submitted to RQIA by HSC Trusts. These may be sent electronically.

2.111 All relevant information pertaining to the patient's mental and physical health and wellbeing and safety needs must be made available to the out of their Trust area hospital, prior to or on admission - including the patient's risk assessment, biographical details, mental and physical health history.

Conveyance by the nearest relative

2.112 Where the nearest relative is the applicant, they should be advised that the assistance of an ASW in conveying the patient to hospital is available on request. Where the nearest relative as the applicant intends to exercise their authority themself, or to authorise some other person unfamiliar with admission procedures to convey the patient, the medical practitioner and other professionals involved in the case should offer them any advice and assistance required. That advice should include the guidance for ASWs set out in the following paragraphs.

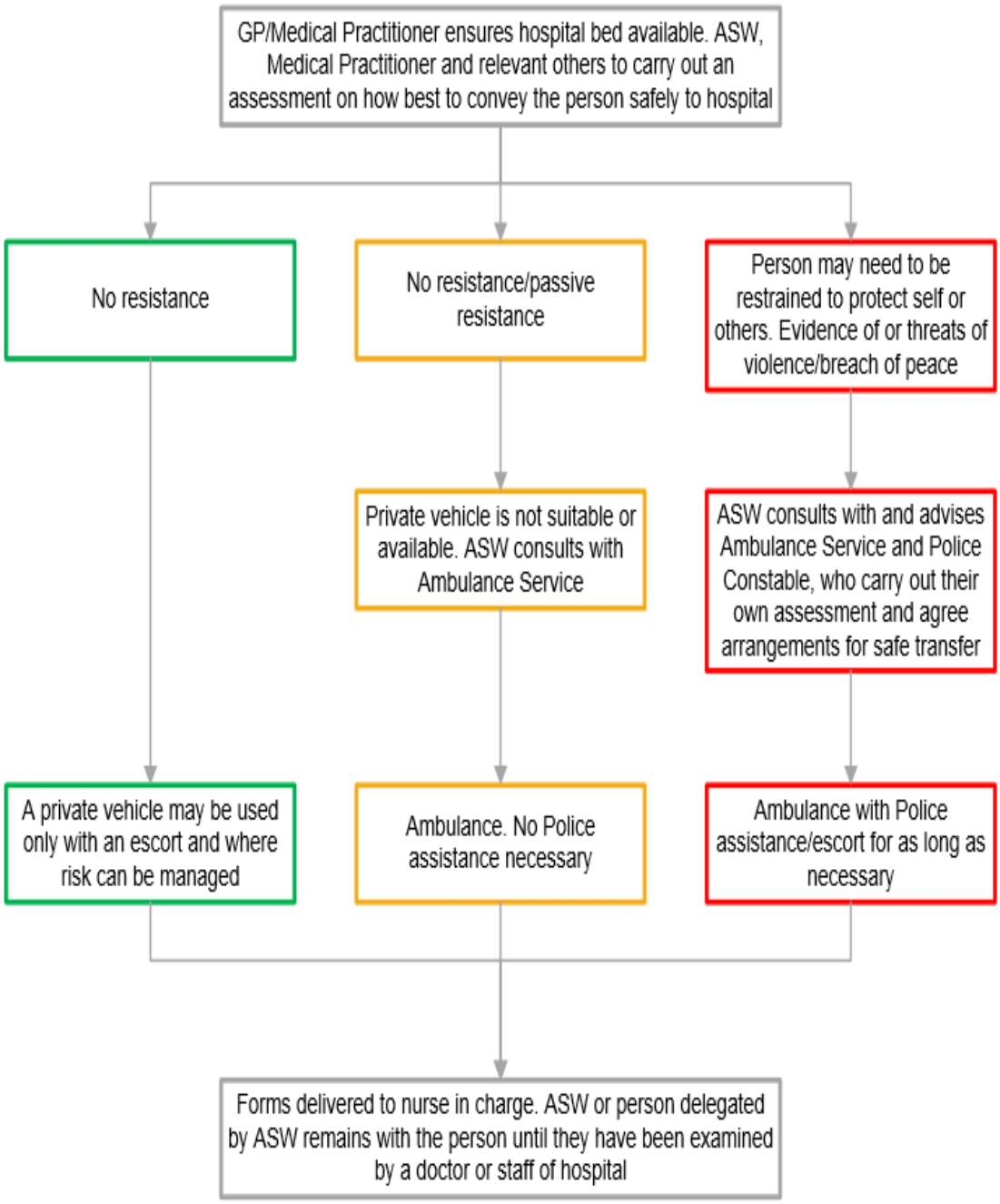
2.113 Where the patient is to be conveyed to hospital by ambulance, the medical practitioner should make the necessary arrangements and explain them to the nearest relative.

Conveyance responsibilities of an ASW (conveyance in relation to Article 129 or Article 130 is covered in Section 3)

2.114 Where an ASW as the applicant, has been asked by the nearest relative for assistance or has been appointed by the Trust to exercise its duty, in a case of difficulty, to convey the patient to hospital, the ASW has a professional responsibility for ensuring that all the necessary arrangements are made for the patient's conveyance to hospital and that the patient is properly admitted to the hospital. In planning the patient's conveyance to hospital, the ASW should, whilst ensuring that the legalities are observed, favour the most humane and least threatening mode of transport consistent with the needs and the safety of the patient and their escort.

2.115 Where the decision is that the patient should be conveyed to hospital by ambulance, the medical practitioner should normally make the necessary arrangements with NIAS or the identified conveyance agency.

Flowchart 2: Safe Conveyance to a Psychiatric or Learning Disability Hospital



2.116 When deciding on the most appropriate method for transporting a patient, the ASW should consult with the transport agency involved, the police (when their involvement is required), the patient and (as appropriate) their carer/nearest relative. The decision should be made following a risk

assessment carried out on the basis of the best available information. Factors to be considered include:

- the availability of different transport options
- roles and responsibilities of the agencies involved
- the distance to be travelled
- the wishes and views of the patient
- the patient's age and gender
- cultural sensitivities
- any physical disability the patient has
- any cognitive impairment or intellectual disability the patient may have
- any risks to the health and safety of the patient
- the nature of the patient's mental disorder and their current state of mind
- the likelihood of the patient behaving in a violent or dangerous manner
- the likelihood that the patient may attempt to abscond and the risk of harm to the patient or other people were that to happen
- the impact that any method of transporting the patient will have on the patient's relationship with the community to which they will return
- the capability of the child to make their own decisions in terms of emotional maturity, intellectual capacity and psychological state
- the effect on the patient of who accompanies them (consider support of family or friends)

2.117 When possible, preplanned responses are preferable, especially when there is anticipated or actual violence towards others, including staff involved in the assessment and conveyance process.

2.118 In the preplanning stage, all agencies involved or requested to be involved, will share the relevant information they have on the patient and the presenting circumstances, including: history of violence; presenting risks and behaviours; availability of each agencies' resources to respond at agreed times; names of staff to be involved in managing the response; and staff attending the incident and contact details.

2.119 In a pre-planned situation, if the patient's behaviour is likely to be violent or dangerous, assistance should be requested from the police and the appropriate warrant (refer to Chapter 3 for more detail on warrants) sought from a lay magistrate. Where practicable, given the risk involved, an ambulance service (or similar) vehicle should be used, even where the police are assisting. The police will accompany the ambulance when deemed necessary.

2.120 The ASW is permitted to delegate the task of conveying the patient to another person (e.g. ambulance personnel or possibly the police). People authorised by the applicant to transport patients act in their own right, and not as the agent of the applicant. They have the powers, authorities, protection and privileges which a constable has (Article 131) and act on

their own initiative to restrain patients and prevent them absconding, if absolutely necessary. The ASW is, however, responsible for ensuring that the patient is conveyed in a lawful and humane manner and should be ready to give the necessary guidance to those asked to assist.

2.121 It will often be best to convey the patient by ambulance. The ASW will need to risk assess to decide if they should accompany the patient. If the patient would prefer to be accompanied by another professional (perhaps better known to them) or by a responsible relative, the ASW may ask that person to escort the patient, provided they are satisfied that in doing so they are not increasing the risk of harm to the patient or others.

2.122 The patient should not be conveyed to hospital by car unless the ASW is satisfied the patient will not endanger themself or others on the journey. There should **always** be an escort for the patient other than the driver.

2.123 The ASW should inform the receiving hospital, giving the likely time of arrival, to ensure that the patient is expected and that arrangements have been made for their acceptance and for receiving the admission documents.

2.124 The ASW must ensure that the admission documents arrive at the receiving hospital at the same time as the patient. If the ASW is not travelling in the same vehicle as the patient, the documents should be given to the person authorised to convey the patient with instructions for them to be presented on arrival at the hospital to the nurse in charge of the ward into which the patient is to be admitted.

2.125 If the ASW is not travelling with the patient, they should arrive at the hospital at the same time as the patient or as soon as possible afterwards. They should ensure that the admission documents have been delivered, that the admission of the patient is under way and that any relevant information in their possession is passed to appropriate personnel in the hospital. If it is not practicable for the ASW to remain in the hospital until the patient has been medically examined, they should remain contactable to inform the medical assessment, if necessary.

2.126 Where a patient is admitted for assessment on the application of an ASW who has not consulted the patient's nearest relative, the ASW must inform the nearest relative as soon as is practicable (Article 5(5)). Where a patient who is subject to guardianship under the Order is admitted for assessment, the Trust must inform the guardian as soon as is practicable (Article 8 (3)).

2.127 A patient who has been sedated for the purpose of being conveyed to hospital should be accompanied by a nurse, medical practitioner or ambulance person who is sufficiently skilled in resuscitation techniques and the observation of drowsy or sedated patients.

Conveyance by ambulance or NIAS vehicle in relation to community assessments (conveyance in relation to Article 129 or Article 130 is covered in Section 3)

2.128 When it is decided that an ambulance or a NIAS vehicle is the most appropriate means of conveyance, where possible, gender issues should be addressed, i.e. it is preferable that one of the people accompanying the patient is of the same gender as the detained person.

2.129 Once the medical recommendation has been made and an ASW application for assessment (detention) has been signed, the Order gives the ASW responsibility for making arrangements to have the patient transferred to hospital.

2.130 The ASW can delegate the task of conveying the patient to hospital and this task is normally delegated to conveyance agency staff unless there are pressing reasons for other transport arrangements to be made, or the support of police is required along with the ambulance service personnel.

2.131 On arrival at the scene, the conveyance agency staff should carry out a risk assessment in conjunction with the medical practitioner undertaking the medical assessment, ASW (and police if they are present). Any ongoing police involvement to assist with conveyance, including travelling in the ambulance, should be based on the assessment of the risks pertaining to that circumstance.

2.132 Conveyance staff should make reasonable attempts to assist a patient who may be passively resistant with persuasion, coaxing and/or physical guidance. However, where ongoing physical restraint is required due to the level of violence or unpredictability of the patient, police assistance should be sought in taking and conveying the patient to hospital.

2.133 Generally, urgent calls in relation to mental health problems or suicide attempts are prioritised by Ambulance Control via the Ambulance Medical Priority Dispatch System (AMPDS) according to their status on the continuum from immediately life threatening through to low risk. It is therefore important that the police constable, medical practitioner undertaking the medical assessment or ASW making the request articulates the risks pertaining to a particular situation when requesting an ambulance, including the risk of further deterioration of the patient's mental health; distress to the patient and family members; any risks associated with a protracted wait; and any risk of absconding or harm to the patient or others.

2.134 Given the responsibility for arranging conveyance falls to the ASW, they have been included in the list of health care professionals who can book non-emergency transport. When booking, the ASW must make it clear that they are seeking assistance with conveyance of a patient under the Order, explain the risks to the patient and others in relation to conveyance

arrangements and ask for a 1/2/3/4-hour response from the NIAS call handler who will allocate resources dependant on availability. However, it should be noted that GPs have the facility to bypass the AMPDS system to make a "GP urgent" request for an ambulance within a specific timeframe. It may on occasion be appropriate for the GP to use this facility. See Additional Guidance for Healthcare Professionals requesting an ambulance.[45]

2.135 It is not uncommon for conveyance staff to attend patients with mental health problems who are not detained and have capacity to refuse transport. On these occasions, with the patient's consent, NIAS personnel will complete a comprehensive physical health assessment and attempt to maintain patient safety by ensuring the patient remains with a responsible person where possible. The patient should then be referred to their own GP / Out of Hours (OOH) service. It is not reasonable for NIAS personnel to remain on scene for protracted periods of time while awaiting the medical or ASW assessments.

Conveyance by police (conveyance in relation to Article 129 or Article 130 is covered in Section 3)

2.136 If police detain a person under Article 130, an ambulance should be called to convey the detained patient to a place of safety. If a detained patient is conveyed in an ambulance they should be accompanied by a police officer. It is recognised that police may decide to convey in a police vehicle if NIAS notifies the police of a significant delay. The police should be satisfied that they can manage the detained patient and there is no conflicting medical need which would require an examination from a medic or paramedic before conveyance. Ultimately, the decision to use a police vehicle will rest with the constable at the scene after discussion with other agencies involved and their supervisor, if necessary and practicable.

2.137 Should the circumstances arise where a patient needs to be conveyed in a police vehicle, and they also need medical supervision, if the conveyance service is available, a sufficiently trained member should accompany the person in the police vehicle to ensure the appropriate support is available for medical emergencies. The ambulance should follow behind to ensure the immediate availability of additional support equipment if needed.

2.138 Each agency will undertake their own risk assessment to inform discussions with the other agencies involved and agree the most appropriate means of transport.

[45] Additional Guidance for Healthcare Professionals requesting an Ambulance

3 POLICE POWERS AND PLACES OF SAFETY

3.1 To support navigation of this section of the Code, it firstly addresses the place of safety police powers as this area of practice was identified in the Cawdery Coroner's report as requiring additional guidance for both police and HSC agencies. It then deals with the remaining warrants under Article 129(2), 129(3) and 129(4). This guidance is interim and will be updated when more appropriate places of safety are identified.

Place of safety

3.2 Several considerations, as set out below, apply to both Articles 129 and 130 place of safety processes.

- HSC Trust point of contact for advice.
- Definition of places of safety.
- Conveyance to the place of safety.
- How long the patient can be detained in the place of safety.
- What happens when a patient is detained in the place of safety.
- Police duty to inform a responsible person residing with the person or nearest relative when they bring a patient to a place of safety.
- Continued police involvement in the place of safety.
- Transfer of responsibility from police to HSC staff.
- Medical assessment of patients under the influence of alcohol or drugs.
- Who can make the Part II medical assessment under Article 4, in accordance with Article 6.

HSC Trust point of contact for advice

3.3 When considering the use of police powers to detain people under the Order, if detention is not necessary the less restrictive alternatives to detention should be considered. When deciding whether to use Article 129 or 130 powers, the police may benefit from seeking advice in cases where they are unsure that the circumstances are sufficiently serious for using these powers. Health and/or social care professionals may be able to identify alternative options. Trusts provide HSC advice contact points[46] for police and other agencies who may need advice in relation to their response. It is advisable that police and other agencies make use of this resource when decisions are being made around the use of powers under the Order. Best practice guidance to inform the discussions between agencies using the HSC advice line should be referred to. The **Record of Decision Making for Staff by HSC Advice Line Best Practice Recording Format**[47] should be used to inform discussions.

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[46] HSC advice contact points are available through the RCRP Locality Governance Groups

[47] Record of Decision Making for Staff by HSC Advice Line

Definition of a place of safety

3.4 A place of safety means any hospital, of which the managing HSC Trust is willing temporarily to receive persons who may be taken there under the Order, any police station, or any other suitable place the occupier of which is willing temporarily to receive the person (Article 129(7)). Commissioners and Trusts should work together to provide suitable places of safety.

3.5 Each Trust notifies the DoH of their designated places of safety. A list of these can be found at HSC Trust Designated Places of Safety.[48] The occupier of a multiple residency, such as a care home, should be the manager of the facility. When determining the most appropriate place of safety to bring the patient to, consideration should be given to their physical and mental health needs, the level of risk they present to themself and others, and the need for urgent care and support. The patient's views on where they would like to be brought to as a place of safety should also be considered.

Patient's own home or any other suitable place

3.6 The patient's own home or another environment such as a GP surgery may be a suitable place of safety providing the occupier is a responsible person willing to keep the person safe until the medical practitioner and ASW can attend and assess. This particularly applies where the individual's residence is a registered residential care or nursing home, or a supported housing scheme where 24-hour care staff are available. In addition to the occupier, a partner, spouse or other caring relative may also help to keep the patient safe in a private dwelling until the medical practitioner and ASW can attend. This option should be based on the agreement of the occupier, care provider and the police assessment of the risks.

3.7 Considerations include:

- The patient is not in need of immediate medical attention.
- Access to means to self-harm / harm others.
- The presence of children or caring responsibilities.
- There has been no threat of violence (particularly towards the carer) and no concerns of domestic abuse.
- There should be a responsible carer over 18 years, or staff member, who is willing and able to keep the patient safe.
- There has been no threat of violence (particularly towards the carer).
- There is a low risk of absconding.
- The occupier or responsible person is not intoxicated or does not otherwise appear to have limited capacity to undertake the role.

[48] HSC Trust Designated Places of Safety.

HSC Trust designated place of safety

3.8 Emergency Departments are the most frequently sought places of safety, providing care and treatment to patients who have sustained injury, are suspected of having taken substances, or have other pressing medical needs, in addition to their mental health needs. It is incumbent on Trusts to ensure that the staff in their designated places of safety have the knowledge and resources to fulfil the place of safety function, keep the patient safe, provide continual supervision, prevent the patient from absconding and respond in line with the regional guidance.

3.9 On arrival at the place of safety, the patient should be booked in at reception. The patient should remain within the building and under continual supervision, either from police or HSC staff, until they have been assessed. It is not appropriate for patients to sit in a police vehicle awaiting a medical assessment. Neither should they be contained in a police vehicle in situations where their behaviour presents such high level of risk to others that they could not safely be managed within an identified place of safety, such as an Emergency Department. In these circumstances, a custody suite should be considered. These patients should be brought to an alternative place of safety where their behaviours can be managed to enable the assessment to take place.

Custody suite

3.10 A custody suite should only be used when the risks are such that the patient could not be managed in any other environment, or a serious crime has been committed, and it is deemed necessary to keep the patient in police custody until their mental health condition has been more clearly determined. Taking someone to a police station can wrongly convey the impression that the patient has committed a criminal offence.

Conveyance to the place of safety

3.11 When Article 129(1) or Article 130(1) is invoked, the police take the lead role in conveyancing decisions as the patient is in their legal custody and the medical assessment **(Form 3)** and ASW assessment **(Form 2)** have not taken place. Police, medical practitioner, NIAS and ASWs, when they are involved, should work together to agree the best mode of transport for patients managed under Article 129(1) or Article 130(1) that will support safe and timely conveyance to the place of safety.

3.12 Ideally, persons subject to Article 129 or 130 should be conveyed to the place of safety by a NIAS vehicle or a contracted conveyance vehicle, except where the delay in obtaining a suitable vehicle would escalate an already difficult situation. The police should accompany the patient in the vehicle to the place of safety in order that they remain in lawful custody.

3.13 Where it is necessary, because of the risk involved, police may decide to convey the patient in a police vehicle. In these situations, if a conveyance agency is involved, it may be necessary for a sufficiently trained member of the conveyance service to ride in the same vehicle with the patient, with the appropriate equipment to deal with medical emergencies. In such cases, the conveyance vehicle should follow directly behind to provide any further support that is required. Where possible, gender issues should be addressed, i.e. it is preferable that one of the accompanying conveyance personnel should be of the same reported gender as the patient.

3.14 The decision in relation to the best mode of transport for conveyance should be made following a risk assessment based on the best available information. Factors to be considered include:

- The availability of different conveyance options
- Roles and responsibilities of agencies involved
- The distance to be travelled
- The wishes and views of the patient
- The patient's age, gender and ability
- Cultural sensitivities
- Any risks to the health and safety of the patient
- The nature of the patient's mental disorder and their current state of mind
- The likelihood of the patient behaving in a violent or dangerous manner
- The likelihood that the patient may attempt to abscond and the risk of harm to the patient or other people were that to happen
- The effect on the patient of who accompanies them
- The support of family or friends

3.15 A patient who has been sedated for the purpose of being conveyed to the place of safety must be accompanied by a nurse, medical practitioner or conveyance staff member who is sufficiently skilled in resuscitation techniques and the observation and management of drowsy, comatose or sedated patients is within their scope of practice.

How long can the patient be detained in the place of safety?

3.16 The maximum period a patient may be detained under Article 129 or Article 130 is 48 hours; however, within that time period, the patient should be kept in the place of safety for the shortest time necessary. The imposition of consecutive periods of detention under Article 130(2) is unlawful. The maximum 48-hour period begins at the time of arrival at the place of safety (including if the person needs to be transferred between, for example, a custody suite and Emergency Department). If there is a delay in the patient's details being registered, police should provide the exact date and time of arrival so this can be recorded on both police and HSC systems. The ASW service should be already involved with patients subjected to Article 129(1) and be prepared to follow up with their ASW

assessment where needed. The ASW service should be alerted by place of safety staff to the arrival of patients detained under Article 130, so this can be considered as part of their workplan and reduce the likelihood of delays in responding.

What happens when a patient is detained in the place of safety?

3.17 When a person is brought to a place of safety under Article 129 or 130, the power to detain them is provided by Article 129(5) and Article 130(2) respectively. The nurse in charge and medical practitioner should review with the police and conveyance service staff the patient's medical needs and the risks they present to themself or others. Place of safety staff should work within the current 4-hour priority for action target to see and treat all patients. When this target is breached, the patient's circumstances should be escalated to the identified senior decision maker to review and, where possible, realign resources to address this breach. The breach should also be reported to the Right Care Right Person locality governance group. Police and place of safety staff will share information to ensure the patient's care and treatment needs are met in addition to managing any associated risks.

3.18 The **Regionally Agreed Place of Safety Recording Format (POS1)**[49] should be completed and should therefore show the time of arrival, assessment details, risks to self and others, and the date and time the patient is discharged from the Article 129(1) or Article 130 detention.

3.19 Where it is deemed necessary to move a patient from one place of safety to another, as there is no specific power to do this within the Order, this decision must be clearly justified and documented, setting out the reasons why the transfer was necessary and explaining why the transfer is in the patient's best interests. The maximum period the patient can be detained remains 48 hours.

3.20 It is important to note that the decision to discharge a patient from Article 129/130 is a separate decision to the need for continued police presence. Police presence should not be necessary for those patients who are low risk and only when assessed as necessary for medium risk patients. Police presence can be ceased and the management of the patient taken over by HSC staff. The person remains under detention until the decision is made to discharge from Article 129/130. A decision to cease police presence should be made jointly with HSC senior decision makers as soon as the HSC organisation is in a position to take responsibility for the patient, and it is expected that this will occur at the earliest possible opportunity when the risk is assessed as being low or medium, as described above. It is the responsibility of each HSC to have plans in place to facilitate a handover for these patients.

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[49] Regionally Agreed Place of Safety Recording Format

3.21 HSC staff should inform the patient of their rights in the place of safety and provide them with the information leaflet at the link below.[50] The patient should also be fully informed about how their personal data will be processed (see Data Protection section at paragraph 1.50 and associated Information Commissioner's Office guidance on the right to be informed[51]). It is important that any information provided to the patient can be understood by the patient or their representative.

Police duty to inform a responsible person residing with the person or nearest relative when they bring a patient to a place of safety

3.22 Where a patient is removed by a constable, it shall, where practicable, be the duty of the constable who has so removed them without delay to inform some responsible person residing with the patient and their nearest relative, of their removal to a place of safety. Where the patient is under 18, where appropriate and practicable, people who have parental responsibility, if known, should also be informed. The relevant HSCT Children's Gateway team should also be informed and where removal occurs outside of office hours, the Regional Emergency Social Work Service (RESWS) should be informed. If it is known that the patient is a Looked After Child, it is important that the constable should consult with HSCT Children's Gateway services or RESWS before informing others.

Continued police involvement in the place of safety

3.23 The need for continued police support once the patient has been conveyed to the place of safety should be continuously monitored and agreed between police and place of safety staff. The Risk Matrix below will assist in this assessment (paragraph 3.92). Any need for ongoing police involvement should be based on risks associated with normal policing responsibilities and on the understanding that, where no criminal activity is suspected and there is no risk to life or limb, continued police involvement cannot be justified. Police presence should not be solely dependent on the patient's level of intoxication but informed by the agreed risk assessment.

Transfer of responsibility from police to HSC staff

3.24 Based on the risk assessment set out in the Risk Matrix, it may be appropriate that police remain with the patient in the place of safety to provide the necessary care and control. The requirement for ongoing police involvement should be periodically reviewed until either the assessment is complete or there is no longer a requirement for police support. There should be no requirement for police to remain if the patient is assessed as presenting low to medium risk and can therefore be managed by HSC staff.

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[50] Patient Information Leaflet
[51] Right to be informed | ICO

3.25 When the police have shared the relevant information with HSC staff in the place of safety and these staff are satisfied that they can manage the patient's care and any associated assessed risks, there is no requirement for the police to remain with the patient. Before the police leave the place of safety, the responsible HSC staff in the place of safety should have the resources to deal with any behavioural disturbance or with the risk of the patient absconding. Trusts have a responsibility for providing the necessary arrangements to care for patients who present with low to medium levels of risk.

3.26 The decision for police to withdraw from the place of safety will be made collaboratively with HSC staff managing the patient's care and take into full consideration the patient's associated risks to self and others. Disagreements on how the patient should be managed should be escalated to the senior decision makers who are normally the nurse in charge, the medical practitioner in charge and the duty inspector in the police. Escalation Processes as set out in the Right Care Right Person Governance Arrangements should be referred to.[52]

3.27 Should police assistance be required after the agreement that HSC will take responsibility for the patient, the police should be contacted via 999 in an emergency situation.

Place of safety guidance to securing timely medical assessment of patients

3.28 The place of safety should have guidance on how to make decisions when deciding on how best to secure the medical assessment, contact the patient's GP, out of hours GP service or refer to the Northern Ireland Local Enhanced Service[53] and next steps when a GP cannot attend (when a Forensic Medical Officer or Place of Safety medical practitioner may be the RMP). The guidance should also indicate if the patient is not registered with a GP, or is outside their usual practice area, the DoH's arrangements should be followed. The assessment (and the resulting recommendation) should be undertaken as soon as possible once a request has been made.

3.29 In the majority of situations there is agreement between HSC Trust staff and police as to how to proceed when there is a delay in securing a timely medical assessment. In situations where this agreement cannot be reached, the staff involved should escalate their concerns for the patient's safety through their internal escalation processes and the interagency Right Care Right Person Governance Arrangements where necessary.

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[52] RCRP Governance Arrangements

[53] GPs carrying out medical recommendations for seriously mentally ill patients (Form 3)

The decision to step down Article 129(5) or 130(2)

3.30 The decision to step down Article 129(5) or Article 130(2), before the medical assessment and ASW assessment under the Order have taken place, should be made by the senior decision makers in the place of safety, based on their own examination, collateral history, and all available information, including relevant past history. The decision to step down Article 129(5) or 130(2) would have to be based on the finding that there was no mental disorder. Senior decision makers are normally the consultant in charge of the patient or the senior doctor on shift. The decision makers can, on a case-by-case basis, determine if either one of them can make the decisions required. HSC senior decision makers have overarching care and treatment responsibilities for the patient whilst they are in their care.

3.31 Once Article 130(2) is stepped down, the patient must be informed of this and kept updated on their care plan. If ongoing treatment is required, they should be advised of their right to remain for such treatment and encouraged to do so. Should the patient decline to remain, their decision should be clearly documented, with evidence that they have the capacity to make this choice.

Medical assessment of patients under the influence of alcohol or drugs

3.32 It can be difficult to accurately assess someone's mental state if they are intoxicated or under the influence of drugs. However, the fact that the patient has taken alcohol or other substances should not in itself be used as a reason to delay any medical assessment, mental health staff assessment or medical treatment. The capacity of the patient to be interviewed effectively should be determined, including where the patient is a child or young person. Any decision to delay the attendance of the medical practitioner or ASW will extend the period of detention for the patient and should therefore be justified and recorded. The maximum period of detention remains 48 hours regardless of the issues associated with intoxication.

Article 130: Persons in a public place who appear to the police to have a mental disorder

3.33 Police decision making around applying or not applying any of the provisions under Article 130 (and on selecting the most suitable place of safety) should be in line with the principles of the National Decision-Making Model.[54] Throughout the process it is essential that all agencies communicate their decisions to the other agencies / agency representatives involved. The **Regionally Agreed Place of Safety**

[54] National Decision-Making Model

Recording Format should be used to reflect the decision-making processes and outcome.

3.34 Article 130(1) is an emergency power which allows for the removal of a person by a police constable, to a place of safety, when:

- the person is in a place to which the public have access;
- the person appears to the constable to be suffering from mental disorder;
- the person appears to be in need of immediate care and control; and
- the constable thinks removal is necessary in the interests of that person, or for the protection of others.

3.35 There is no warrant associated with Article 130 as this is a preserved power under Schedule 2 of the PACE (NI) Order 1989.

3.36 Article 130(1) provides the power to remove the person to a place of safety and Article 130(2) provides the power to detain the person in the place of safety for a period not exceeding 48 hours.

3.37 The purpose of detention under Article 130 is:

- to enable the patient to be examined by a medical practitioner;
- to enable the patient to be interviewed by an ASW; and
- to make any necessary arrangements for his/her care and treatment.

3.38 If the police constable decides the criteria for Article 130 are not met, they should record their decision and, where appropriate, provide the patient with information on agencies who may be able to assist them. Please see paragraph 3.79 which covers when police may transport a patient to hospital where that patient is not detained under Article 130. In the case of a child or young person, consideration should be given to safeguarding issues.

3.39 **'A place to which the public have access'** includes places to which members of the public have open access, access if a payment is made, or access at certain times of the day. It does not include private premises, such as the person's own place of residence or private homes belonging to others. It is not appropriate to encourage a person outside in order to use Article 130 powers.

3.40 If the criteria for the use of Article 130(1) are met, the police should use these powers to bring the person to the nearest most appropriate place of safety. The most appropriate mode of transport and any support needs during conveyance should be considered.

3.41 If the person is already a voluntary inpatient in a psychiatric hospital, the police should not be called to a hospital ward to use their Article 130 powers. For inpatients, a nurse or medical practitioner should instead use

their holding powers if it is considered necessary to detain the person and HSC staff should follow the guidance contained in the **Regional Policy on the use of Restrictive Practices in HSC Settings**.[55]

3.42 HSC Trusts should ensure in all circumstances that their responsibilities to the patient are addressed before requesting police involvement. This includes their role as set out in the regional guidance. It may be appropriate in some circumstances, based on a joint risk assessment, for the police to attend a place of safety if the person is in the grounds, or another public part of the place of safety hospital, such as a part of the Emergency Department to which the public have access, in which case the police may use Article 130(1) if they think it is necessary for them to do so.

Medical assessment

3.43 As soon as practicable, and preferably within the 4-hour place of safety target, the patient should be assessed by a medical practitioner, supported by the liaison team where appropriate. The appropriate care pathway will be based on whether the medical assessment determines that the patient has a mental disorder.

The patient <u>does not</u> have a mental disorder

3.44 If the medical practitioner determines that the patient <u>does not</u> have a mental disorder, Article 130(2) must be stepped down immediately, as to further detain the patient would be unlawful.[56]

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[55] <u>Regional restrictive practices policy</u>

[56] Article 5(1)(e) of the ECHR: a person may be lawfully deprived of their liberty only where they are of "unsound mind".

1. The person must be reliably shown, by objective medical expertise, to be suffering from a true mental disorder
2. The disorder must be of a kind or degree warranting compulsory confinement
3. The validity of continued detention depends upon the persistence of that disorder

(Winterwerp v Netherlands, 1979) Where these conditions are not met, detention becomes arbitrary and therefore unlawful under Article 5.

In Varbanov v Bulgaria, the Court held that detention without a contemporaneous medical assessment confirming mental disorder was unlawful, emphasising that deprivation of liberty must be grounded in current and objective medical evidence, not assumptions or past behaviour (Varbanov v Bulgaria, 2000). This principle applies equally to continued detention once an assessment has taken place and found no disorder.

In Hutchison Reid v United Kingdom, the Court reiterated that continued confinement must be justified by the ongoing presence of mental disorder; detention cannot be maintained once that justification ceases (Hutchison Reid v UK, 2003).

The patient does have a mental disorder

3.45 The medical assessment, potentially supported by the mental health liaison team, may conclude that the patient has a mental disorder. In these circumstances further consideration is needed to determine if:

- **The patient does have a mental disorder and is consenting to engage in the care and treatment plan appropriate to managing their needs and associated risks**. (There is a legal requirement for an ASW to interview the patient, even when the patient is consenting to care and treatment. Following the ASW interview, Article 130(2) should be stepped down unless the ASW indicates otherwise).

- **The patient does have a mental disorder and is not consenting to engage in services and is presenting with risks to themself or others.** A medical assessment (Article 6) and ASW interview is required to determine if the statutory criteria for admission for assessment are met; and for consideration of their care and treatment. As the GP, or alternative medical practitioner identified by the Place of safety senior decision makers, and ASW service will have been informed of the arrival of the patient to the place of safety under Article 130, a follow up referral should be made immediately, and it is best practice for the ASW and medical practitioner to do a joint assessment when possible. If the patient has been detained under Article 130(2), regardless of the outcome of this medical examination, there is still a legal requirement for an ASW interview to take place, and for the patient's care and treatment plans to be put in place by the most appropriate service.

Medical examination in relation to Form 3 (Note: this medical assessment does not have to be a separate medical assessment and can be a continuation of the one referred to above)

3.46 The medical practitioner providing the medical recommendation (**Form 3**), must have examined the patient not more than two days before the date on which they sign the recommendation (Article 6). They should, if possible, be the patient's medical practitioner or a medical practitioner who has previous acquaintance. A partner, locum, or any other medical practitioner is not barred from providing the recommendation.

3.47 A medical practitioner on the staff of the hospital to which the patient is to be admitted cannot provide the recommendation except in a case of urgent necessity (Article 6 (c)). This is to preserve independence in the assessment process and is therefore an important patient safeguard. Close relatives, business partners and others (Schedule 1) are NOT permitted to give the medical recommendation. Service pressures should not dictate urgent necessity.

3.48 It is recognised that due to other clinical pressures and priorities, GP response times can vary. If the medical recommendation is to be significantly delayed (for example, due to GP competing demands), a risk assessment by the responsible medical practitioner in the place of safety should be completed to inform next steps.

3.49 Urgent necessity, although not defined in the Order, relates to the measure of risk to the patient or others due to any delay in assessment (and the consequent delay in conveyance to an acute mental health or learning disability hospital). The outcome of the risk assessment should guide decision-making, specifically regarding the decision to wait for a GP or arrange an assessment with another medical practitioner. This decision will be based on the extent of perceived risk.

3.50 Possible outcomes of the medical examination include:

- The patient does not need hospital-based treatment, the statutory criteria are not met, and the patient can be supported in the community. In these circumstances, a care and treatment plan is agreed where necessary.
- Admission for assessment in hospital is necessary, and the patient is consenting to a voluntary admission. The admission should be arranged on a voluntary basis.
- Admission for assessment to hospital is necessary, the statutory criteria are met, and **Form 3** is signed.

ASW involvement with patients after their arrival at a place of safety under Article 130

3.51 The ASW service may not always be involved with patients before they have been brought to a place of safety through Article 130 police powers. Therefore, the ASW service should be alerted by HSC staff in the place of safety to the arrival of a patient under Article 130(1) at the point of arrival. On receipt of this alert, the ASW should begin the collation of information to inform their interview with the patient if necessary. The ASW should, as far as practicable, plan to undertake a joint assessment with the medical practitioner as it is considered best practice for both the medical practitioner and the ASW to be present at the same time, even if they choose to interview the patient separately.

3.52 Where the outcome of a medical assessment is that the statutory criteria for admission to hospital for assessment are met, the ASW shall undertake an assessment and sign **Form 2,** when appropriate. The ASW should refer to the guidance provided in Chapter 2 of this Code to inform their practice.

3.53 The purpose of detention under Article 130(2) is to enable the patient to be examined by a medical practitioner, to be interviewed by an ASW and for any necessary arrangements to be made for his/her care and

treatment. Therefore, when the patient is detained under Article 130(2), there is a legal requirement for an ASW interview.

3.54 As stated previously, if the place of safety medical practitioner determines that the patient does not have a mental disorder, Article 130 should be stood down, and the patient can decide to accept treatment and care on a voluntary basis or leave the place of safety without an ASW interview.

3.55 ASW service should work to a verbal response within one hour of the request for ASW assessment.

Outcome of the medical examination and ASW interview

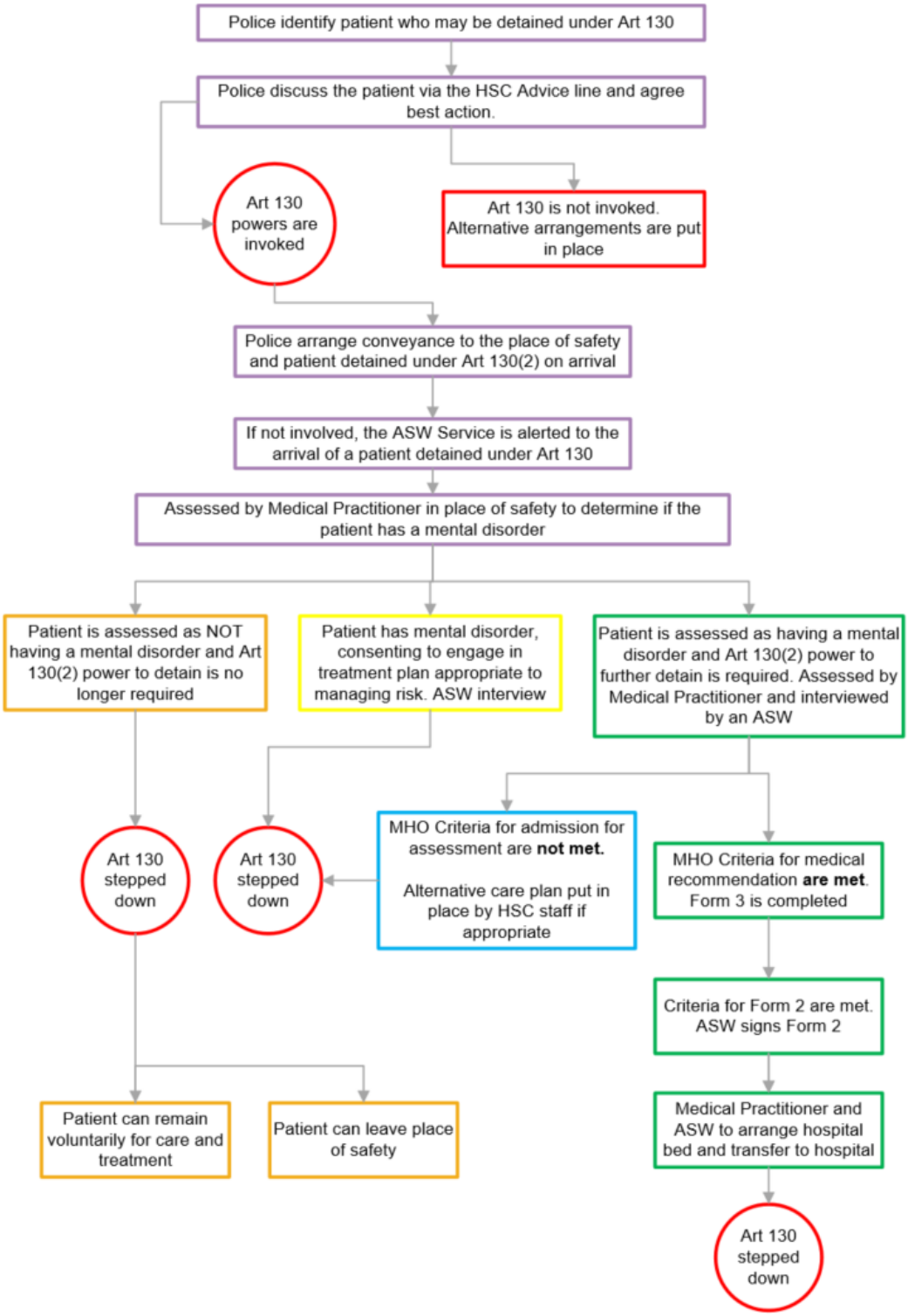
3.56 The **statutory criteria are met** for the medical recommendation and the application for admission for assessment. In such cases, the ASW and medical practitioner should ensure that place of safety staff, police and any other practitioners or services involved are advised of the outcome of their assessments. As soon as the medical recommendation **(Form 3)** and ASW application **(Form 2)** are signed, Article 130(2) is stepped down, and the patient is supported through the normal conveyance and admission process within 48 hours (Article 8) and Chapter 2 of the Code.

3.57 If the medical practitioner and ASW determine that the **statutory criteria are not met** for an application for admission, then an **Alternative Care Plan**[57], drawn up by the ASW to address the patient's needs, should be formulated involving the patient as far as possible and their carer where appropriate. Once this decision is made, the powers of Article 130(2) cease. Alternative care could include a voluntary hospital admission, admission to a crisis service, home treatment service or follow up by community mental health services.

[57] Alternative Care Plan - ASW Assessment under the Mental Health Order 1986

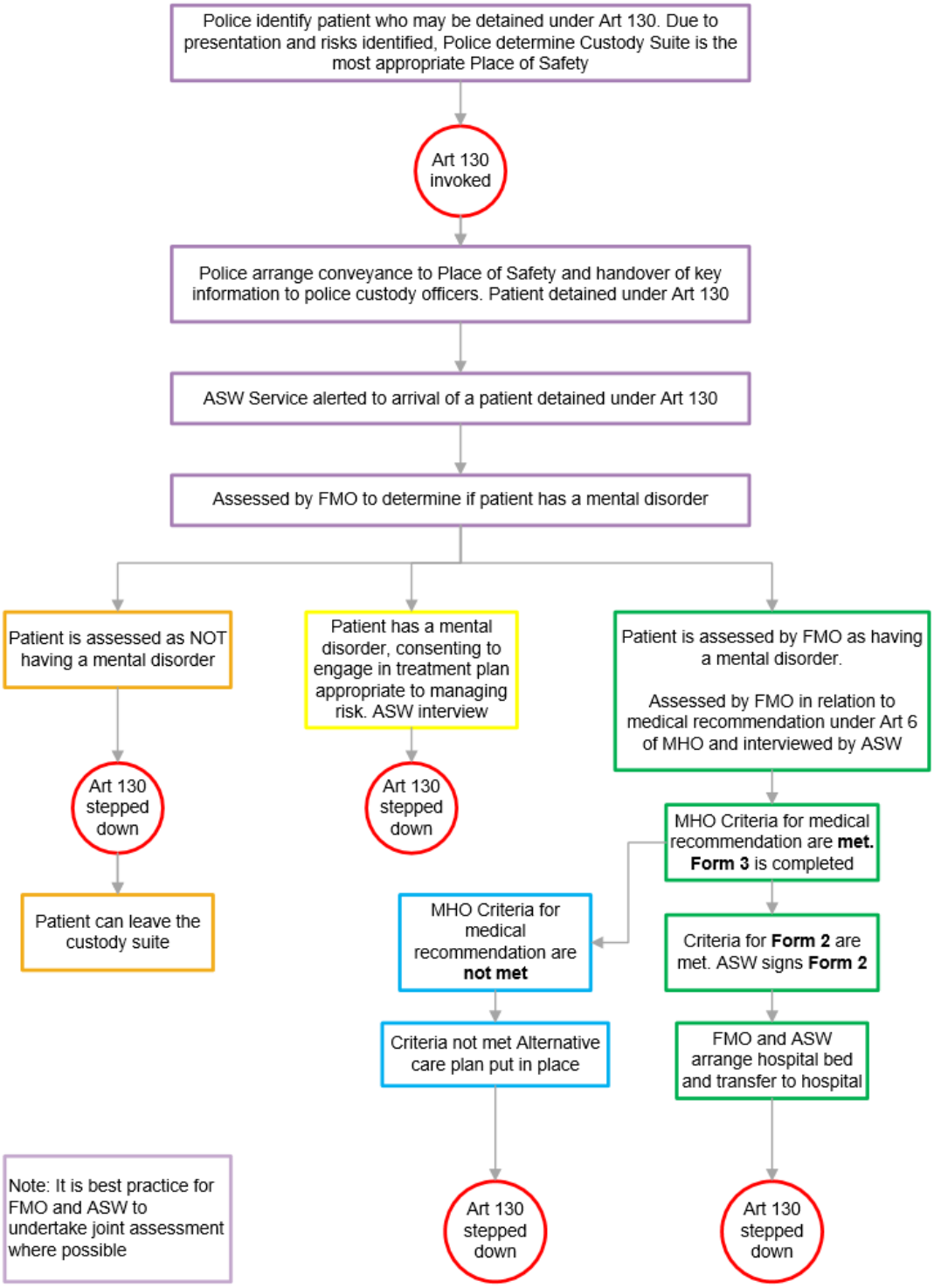
Flowchart 3: Best practice process for Article 130 (when the place of safety is a designated HSC setting such as an Emergency Department)

If an agreement is reached between police and HSC staff, police may hand over responsibility to HSC staff and leave whilst the detention period for assessment, under Article 130(2), continues for a maximum of 48 hours.



Flowchart 4: Best practice process for Article 130 when the place of safety is a Custody Suite

Custody suites should only be used when the risks associated are so high they cannot be managed in another environment. This is normally influenced by the risk the patient presents to others.



Warrants

3.58 Decisions by the police to be involved in patient situations will be on a case-by-case basis, informed by the risks identified. Requests for their involvement should only be made when the risks identified clearly indicate the need for their input, as guided by the Risk Matrix. If a pre-planned community assessment is taking place and it is anticipated that a warrant for police assistance is required, then HSC partners should consider applying for a warrant. Although not always possible, pre-planned responses are preferable and will allow agencies to better prepare their responses.

3.59 Access to the premises can be effected lawfully and without warrant if the owner, a co-owner or a co-occupier of the premises gives permission for entry. A reasonable judgement is required when determining owner and occupier status, and consent to entry, and there is no requirement to consider legal documents. If there are two opposing views, then it is best practice to apply for a warrant.

3.60 A warrant cannot be issued on foot of Article 129(2) or (3) unless admission has been refused or such refusal is anticipated. If admission is refused or likely to be refused, and no permission for entry is given by the owner/co-owner/co-occupier, then a warrant should be sought.

3.61 When an application for assessment has been fully completed and consent for police to enter the premises is given, a warrant is not required as Article 8 provides the authority to take the patient and convey them to hospital. A fully completed application involves the completion of a **Form 1** or **2** (including the necessary signature) and the completion of a **Form 3** (including the necessary signature).

3.62 When an application for assessment has been fully completed and police are already in the property and consent to access is then withdrawn, a warrant is not needed as Article 8 provides authority to take the patient and convey them to hospital.

3.63 There may be a scenario where an application for assessment has not been fully completed and police are not in the property and their assistance is required. In such cases, if consent for police to enter is denied, and there is no other lawful basis for entry, then a warrant is needed to provide authorisation for them to enter the premises.

3.64 Police will make a decision in relation to accepting the delegation to convey the patient based on the information provided.

3.65 Where an application for assessment has not been fully completed and, during the process of assessment, consent for the ASW and medical practitioner to be present is withdrawn, the ASW and medical practitioner

should leave the premises. If there is no other lawful basis for entry, a warrant will be required for the medical practitioner to regain entry with police assistance and to remove the patient to a place of safety to allow an assessment to take place.

3.66 Should consent be withdrawn for either the medical practitioner, the police or the ASW to be present during the assessment process, it is reasonable, if possible, to discuss the matter further with the patient and explain the reasons for them being there to see if they could be persuaded otherwise. Professional judgement should be used to decide if an attempt at persuasion is wise and justified. Any attempt at persuasion must not be in any way forceful or prolonged.

Article 129(1) warrant to search for and remove patient to a place of safety

3.67 The Article 129(1) warrant[58] (see links to the relevant documents in the footnote below) should be sought when there is reasonable cause to suspect that a person believed to be suffering from mental disorder and:

(a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control; or
(b) being unable to care for themself is living alone.

3.68 For an Article 129(1) warrant to be issued, *a complaint on oath made by an officer of a Trust or a constable*, outlining the circumstances of the case and why a warrant is needed, must be made to a lay magistrate. Given the nature of the information required, the ASW will normally be in a better position to satisfy the lay magistrate, take the lead in and make the application. They will also be able to provide advice to police on the mental wellbeing of the patient and their associated risks. The Warrant Article 129 Information Template[59] may be used to inform requests made to lay magistrates in addition to the warrant complaint.

3.69 The Article 129(1) warrant enables the police, accompanied by a medical practitioner:

- to enter, if need be, by force, any premises specified in the warrant in which that person is believed to be; and
- if thought fit, to remove them to a place of safety with a view to the making of an application under Part II of the Order, or of making other arrangements for their care and treatment.

3.70 However, warrants do not give the ASW access to private premises and, if this is denied, the patient may need to be brought to a place of safety to

[58] Article 129(1) Complaint for entry to premises and removal of person to place of safety and Article 129(1) Warrant of Search and Entry
[59] Warrant Article 129 Information Template Recording Format

enable the ASW assessment to be completed. If the patient consents to the ASW undertaking their assessment, this can happen in the place they have been located, as this can be desirable for the patient and a more practicable option for the professionals involved.

3.71 It is important to note that the decision to remove a person to a place of safety does not automatically engage the power to detain that person at the place of safety. These are two separate powers which need to be considered separately.

3.72 An Article 129(1) warrant permits access to the property in question and is the power given to a constable to **remove the person.** Article 129(5) is the **detention** power once the person has been removed to a place of safety that enables them to be detained there for up to 48 hours; however, they should be detained there for as short a time as necessary. The prescribed forms can be accessed through the links in Annex 1.

Record of decision-making in relation to place of safety

3.73 A record of the decision-making process and handover from police to HSC place of safety staff should be made on the **Regionally Agreed Place of Safety Recording Format (POS1)**.[60] Requirements for the support and management of the patient in a place of safety under Article 129(1) are the same as those for a patient brought to a place of safety under Article 130, apart from the requirement for an ASW interview.

3.74 The patient will be detained under Article 129(5) on arrival at the place of safety and the 48 hours will commence from this point.

Medical assessment

3.75 Refer to paragraphs 3.43 to 3.50 and substitute Article 130 and 130(2) with Article 129(1) and 129(5).

ASW involvement with patients after their arrival at a place of safety under Article 129(1)

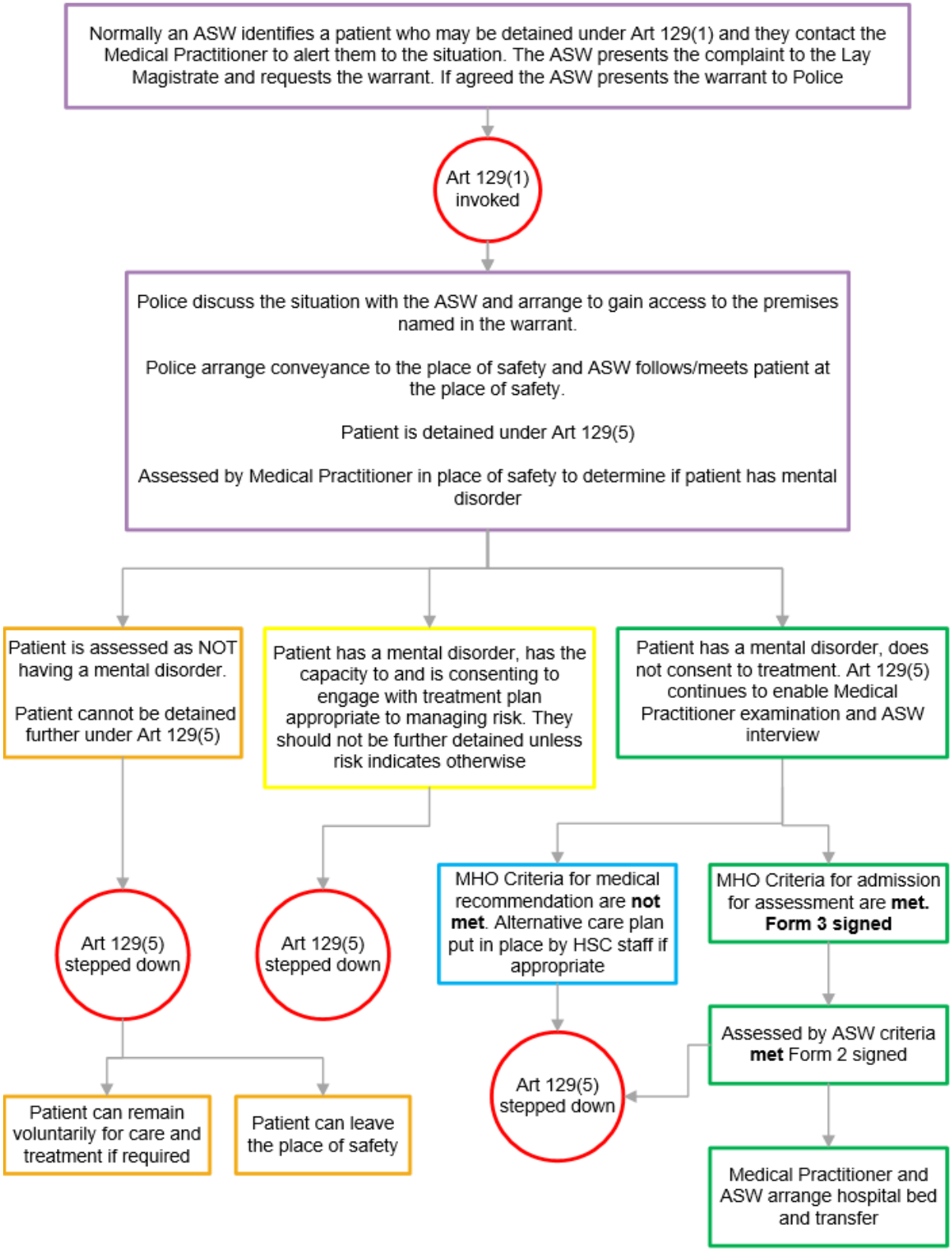
3.76 The ASW service will normally have been involved in securing an Article 129(1) warrant and will therefore be aware of the patient's arrival at a place of safety. Where the ASW service has not been involved in obtaining and executing the warrant, it should be alerted by HSC staff in the place of safety to the arrival of a patient under Article 129(1) at the point of arrival. On receipt of this alert, the ASW will begin their assessment based on the information they have available to them in preparation for a potential request for an ASW interview. ASW service should work to a verbal response within one hour of the request for ASW assessment.

[60] Regionally Agreed Place of Safety Recording Format

3.77 The purpose of obtaining the Article 129(1) warrant is to remove the patient with a view to making an application under Part II in respect of the patient, **or** to providing other care or treatment. The detention powers under Article 129(5) enable the patient to be detained for no longer than 48 hours to enable further examination if required. It is recommended that consenting patients should be supported to engage with mental health services through routine processes.

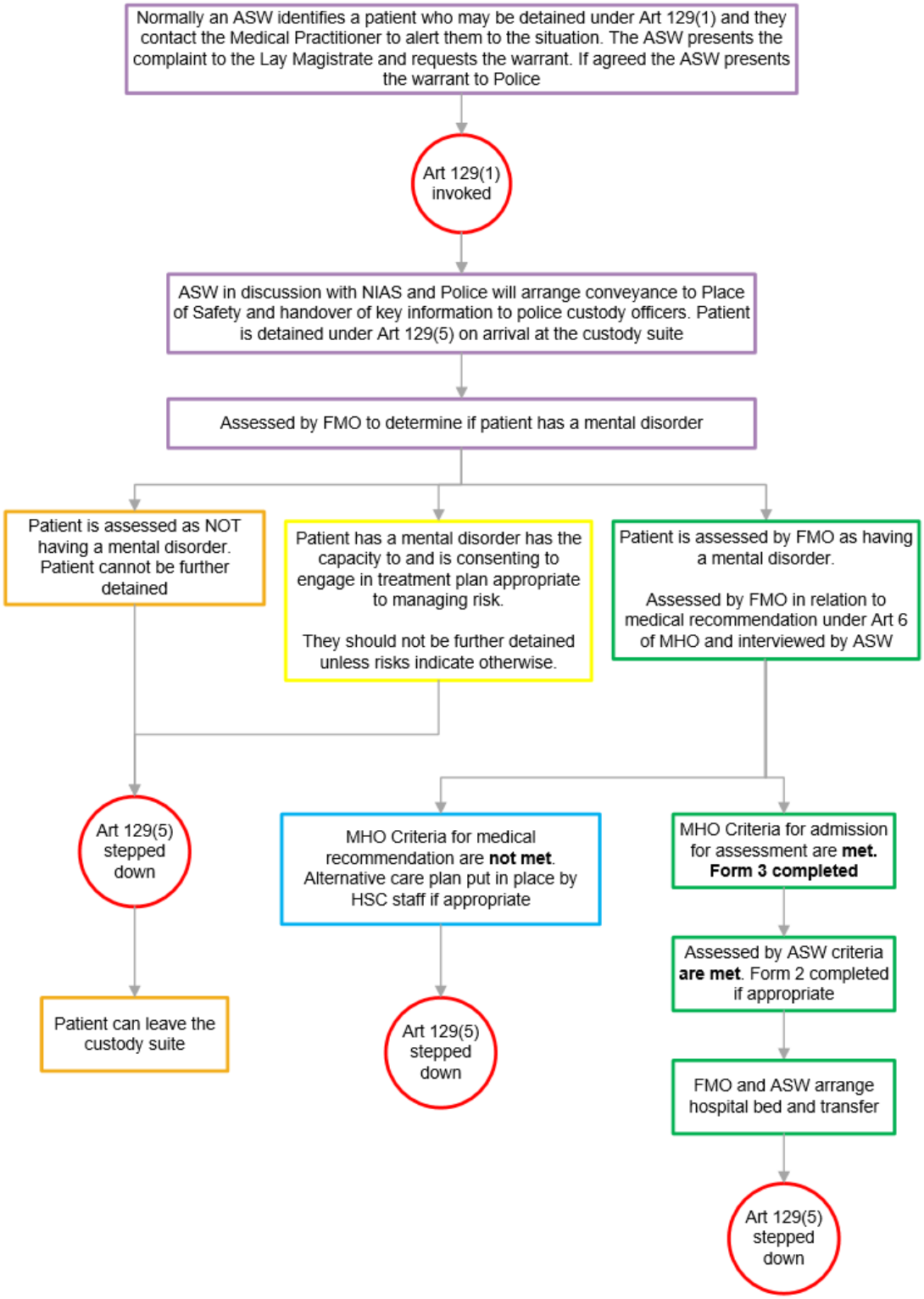
3.78 Patients should not be detained unnecessarily under Article 129(5) awaiting an ASW assessment when their care and treatment is more appropriately met through routine mental health services or the medical assessment outcome is that the criteria for detention are not met. This should mean that patients can access services, such as mental health liaison services, in a timelier manner.

Flowchart 5: Best practice process for Article 129(1)/129(5) when the place of safety is a designated HSC setting such as an Emergency Department



Flowchart 6: Best practice process for Article 129(1) when the place of safety is a Custody Suite

Custody suites should only be used when the risks associated are so high they cannot be managed in another environment. This is normally influenced by the risk the patient presents to others.



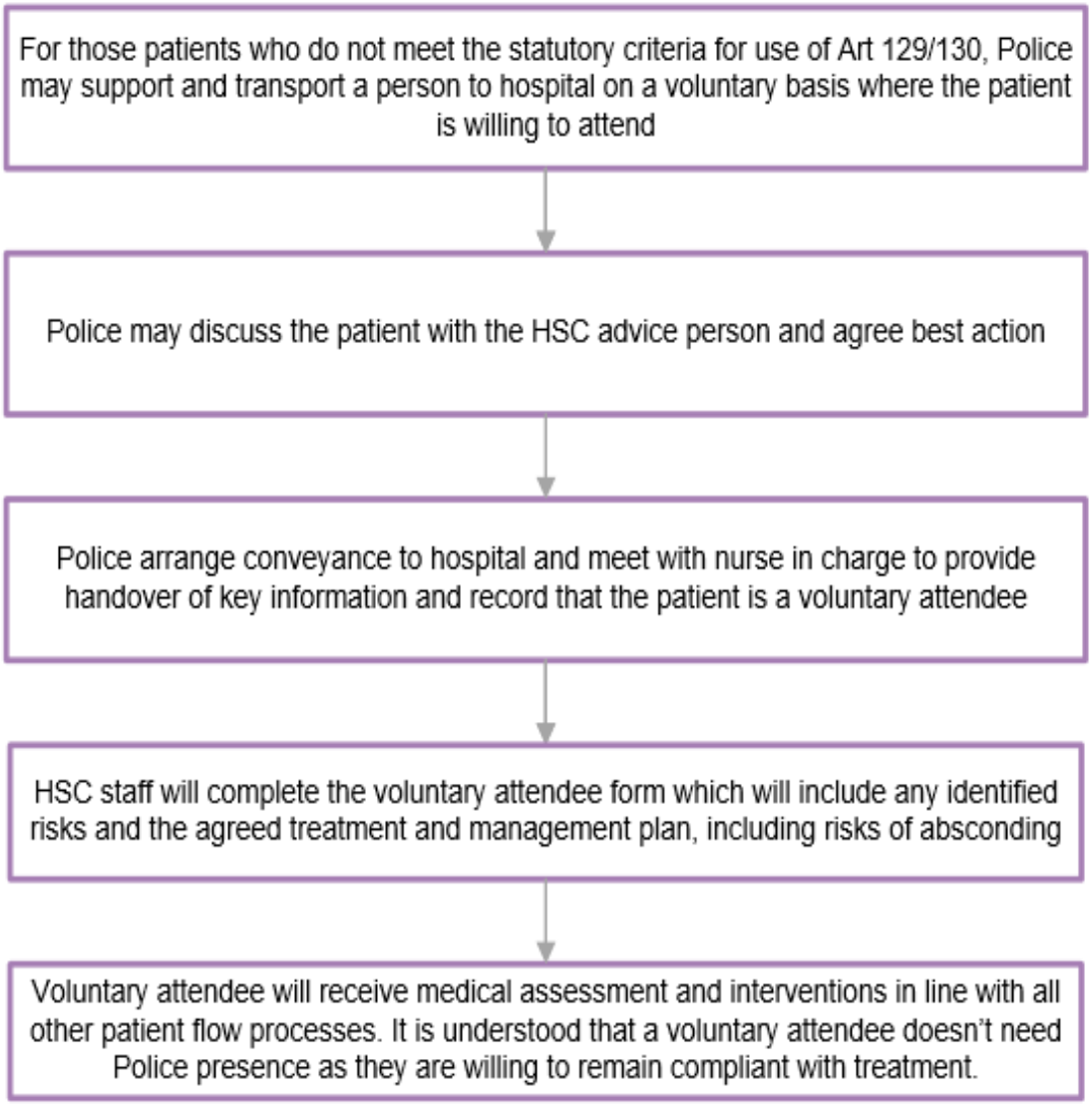
Voluntary attendee

3.79 Police may support and transport a patient who is seeking medical support in relation to their physical or mental health to hospital on a voluntary basis. This could be because the statutory criteria to use Article 129(1) or 130(1) are not met but the patient is willing to attend an Emergency Department for treatment. On these occasions, it is equally important to record and communicate the necessary information, including the fact that the patient is a voluntary attendee, and assessment of risk between the police and HSC staff so that HSC staff can, where appropriate, manage the associated risks to the patient or others. This will include the risk of leaving. The **Voluntary Attendees – Risk Assessment for HSC Staff in Emergency Departments** should be completed by HSC staff.[61]

3.80 The **Best Practice Voluntary Attendee PSNI Recording Format (VOL1)**[62] should be completed by the police. If a voluntary attendee leaves a place of safety before the assessment and treatment are completed, the regional guidance should be followed. As soon as the police bring a patient to an Emergency Department or elsewhere as a voluntary attendee, once they hand over information there should be no need for the police or conveyance staff to remain.

[61] Voluntary Attendees - Risk Assessment for HSC staff in Emergency Departments
[62] Best Practice Voluntary Attendee PSNI Recording Format

Flowchart 7: Voluntary attendee



Article 129(2) warrant

3.81 Article 8 sets out how a duly completed application for assessment (**Forms 1 or 2 plus 3**) in accordance with Part II shall be sufficient authority for the applicant, or a person authorised by the applicant, to take and convey the patient to the hospital specified in the application.

3.82 However, where access to the place in which the patient is located is refused, an Article 129(2) warrant should be sought. See links to the relevant documents in the footnote below.[63]

[63] Document relating to Article 129(2) Complaint for entry to premises and removal of person and Document relating to Article 129(2) Warrant of Search and Entry

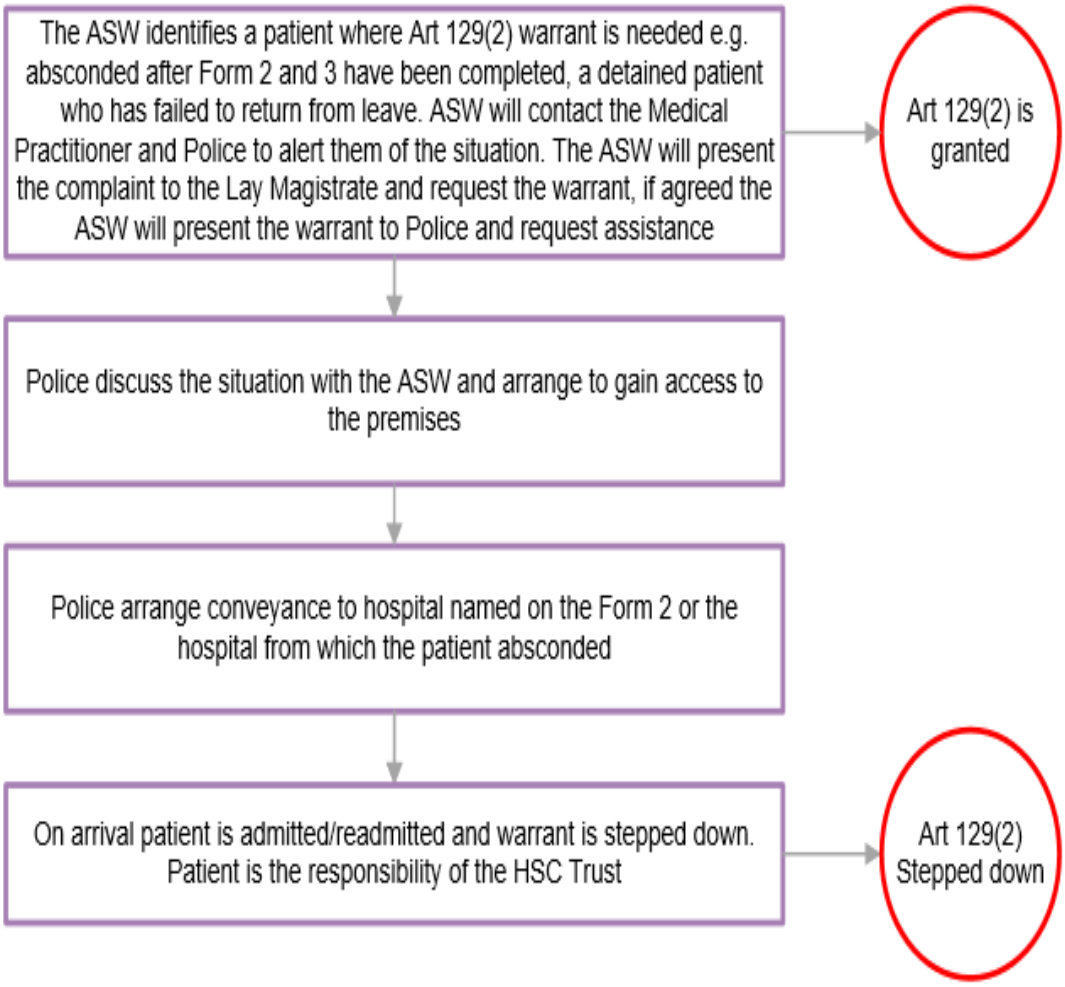
3.83 The Article 129(2) warrant provides the necessary authority when:

- there is reasonable cause to believe that a patient who, under this Order, is liable to be taken to any place, or to be taken into custody or to be retaken, is to be found on any premises; and
- **admission to the premises has been refused** or a refusal of such admission is anticipated.

3.84 The warrant authorises any constable accompanied by a medical practitioner to enter the premises, if need be by force, and remove the patient.

3.85 Article 129(2) is invoked when **Forms 2 and 3** have been completed, the patient has absconded, and assistance is needed to locate them and bring them to hospital. It can also be invoked when a detained patient is on leave from hospital and refuses to return.

Flowchart 8: Best practice process for Article 129(2)



Article 129(3) warrant

3.86 If it appears to a lay magistrate, on complaint on oath made by any person authorised by or under section 88 of the Mental Health Act 1983 or Article 8 of the Mental Health (Care and Treatment) (Scotland) Act 2003 (Consequential Provisions) Order 2005, to take into custody in Northern Ireland any patient who may be so taken:

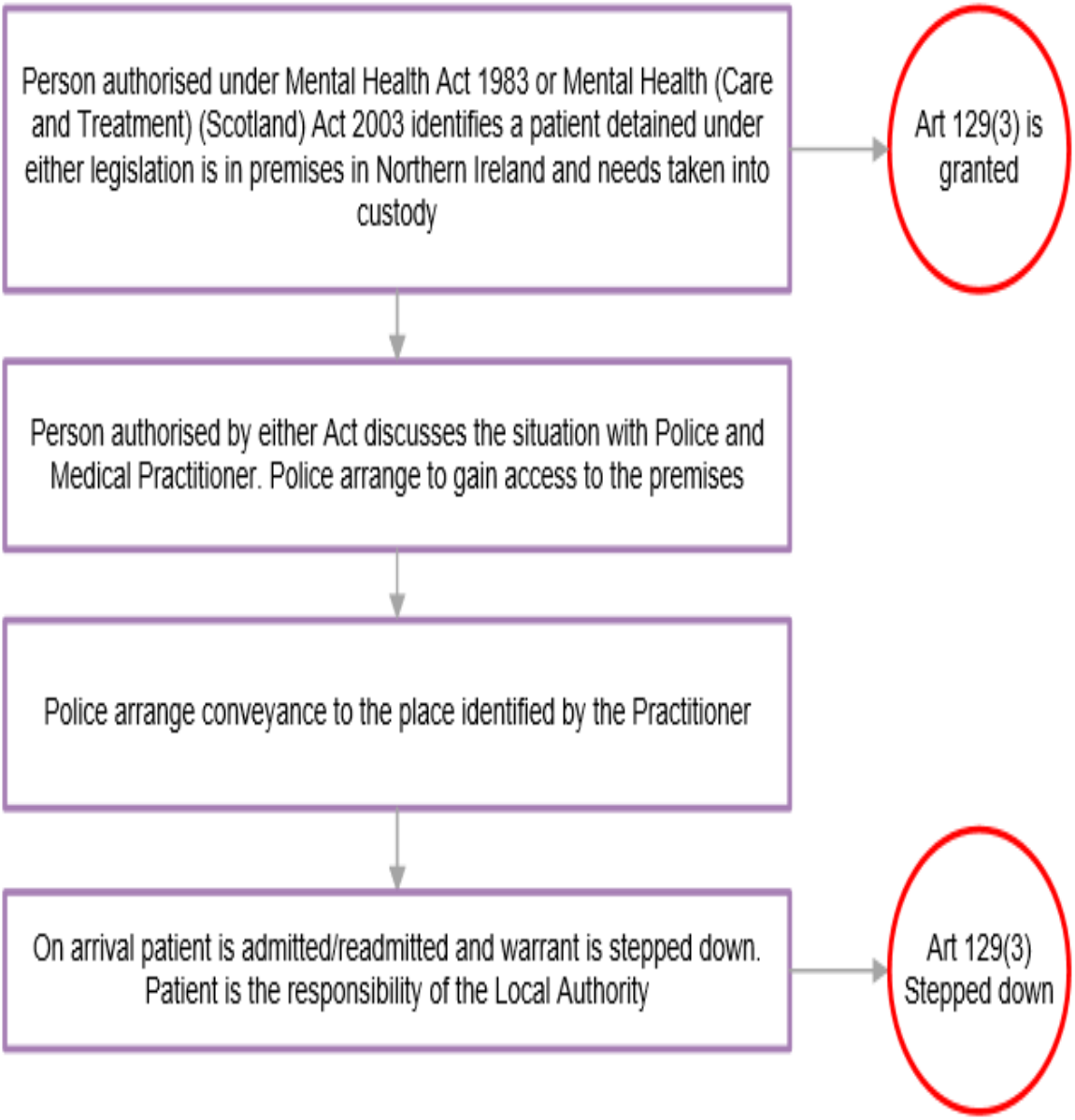
- that there is reasonable cause to believe that a patient who may be taken into custody by virtue of either of the aforesaid enactments, is to be found on any premises; and
- that admission to the premises has been refused or that a refusal of such admission is anticipated,

the lay magistrate may issue a warrant authorising any constable named therein, accompanied by a medical practitioner, to enter the premises, if need be by force, and remove the person liable to be taken as aforesaid.

3.87 This warrant is solely for access to and removal of patients who were detained in England, Wales or Scotland and are in any premises in Northern Ireland. Following the execution of the warrant, a decision will be required to determine where the patient should be brought to. This may be a return to their jurisdiction of origin, an admission into a local Northern Ireland hospital, or into custody. See links to the relevant documents in the footnote below.[64]

[64] Document relating to Article 129(3) Complaint for entry to premises and removal of person and Document relating to Article 129(3) Warrant of Search and Entry

Flowchart 9: Best practice process for Article 129(3)



Article 129(4) warrant

3.88 Article 129(4) is concerned with those patients for whom an application for admission has been made but it has not been possible for the applicant to convey the patient to the hospital or to acquire the necessary assistance to do so. It is most likely that Article 129(4) is intended to provide for cases in which the application for assessment was made by the nearest relative who is unable to get the patient to hospital for assessment, and they require assistance from the Trust. In these situations, the nearest relative should be supported to seek the warrant. The warrant is also available to ASWs. However, as ASWs are agents of Trusts they should not have any difficulty

requesting Trust assistance without a warrant. See links to the relevant documents in the footnote below.[65]

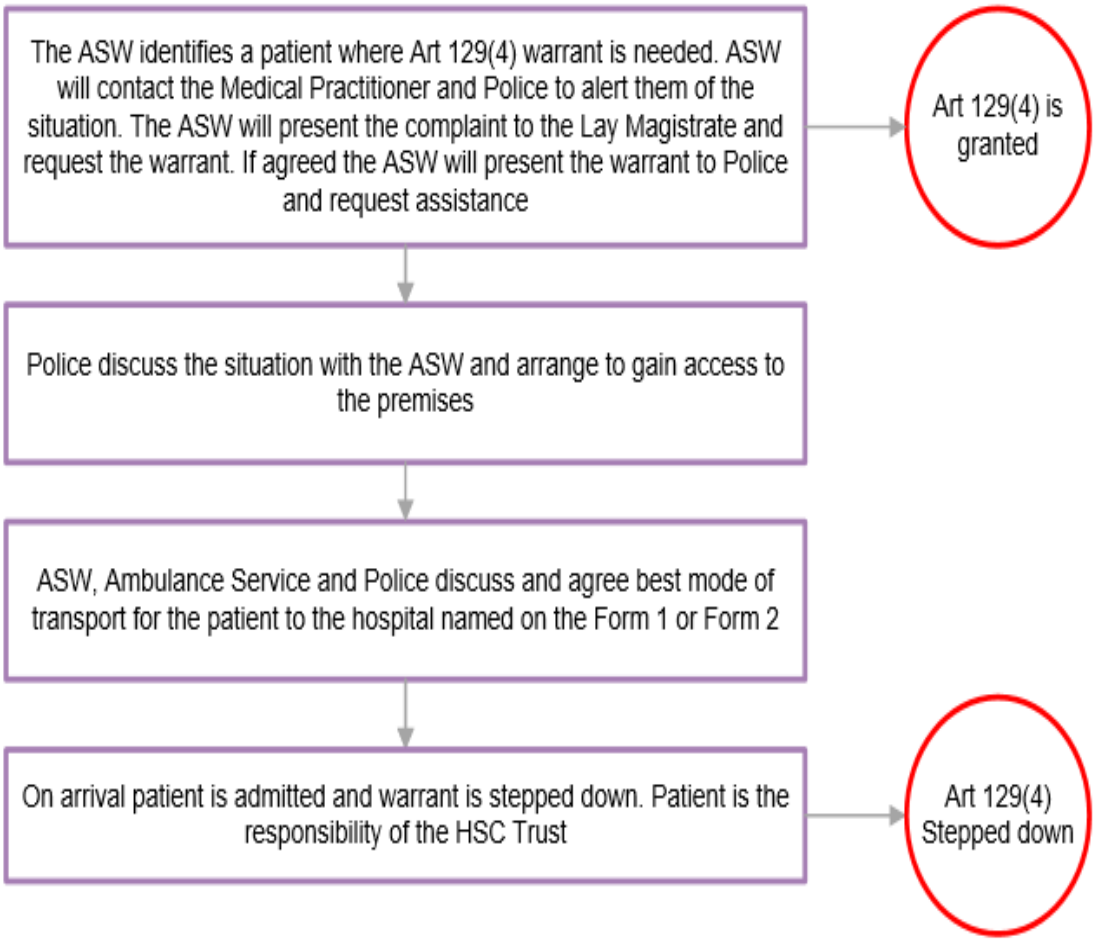
3.89 If it appears to the lay magistrate, on complaint on oath made by a person who has made an application for assessment in relation to the patient:

- that the application has been duly completed in accordance with Part II;
- that there is reasonable cause to believe that the person is to be found on the premises;
- that it is not reasonably practicable for the patient to be taken and conveyed to the hospital specified in the application by the applicant or a person authorised by them; and
- that the Trust has been requested to do so but has failed to do so,

the lay magistrate may issue a warrant authorising any constable named therein, accompanied by a medical practitioner, to enter, if need be by force, the premises and to take and convey the patient to the hospital specified in the application.

[65] Document relating to Article 129(4) Complaint for entry to premises and removal of person to hospital and Document relating to Article 129(4) Warrant of Search and Entry

Flowchart 10: Best practice process for Article 129(4)



Summary of Article 129 warrants

Figure 3: Types of warrants and who can request

Warrant Type	Who can request
Articles 129(1) and Article 129(2)	An officer of a Trust or a constable.
Article 129(3)	Any person authorised by or under section 88 of the Mental Health Act 1983[66] or Article 8 of The Mental Health (Care and Treatment) (Scotland) Act 2003 (Consequential Provisions) Order 2005.[67]
Article 129(4)	Any person who has made an application for assessment, including the nearest relative.

[66] Mental Health Act 1983
[67] The Mental Health (Care and Treatment) (Scotland) Act 2003 (Consequential Provisions) Order 2005

3.90 Warrants under each of the subcategories are intended to provide different powers and these should be considered separately.

Figure 4: Warrant powers

Warrant	Gives police and medical practitioner the power to enter the premises, if need be, by force	Remove the patient	Who can make request for warrant
129(1)	Yes	Yes – to a place of safety	Officer of the Trust Police Constable
129(2)	Yes – if entry has been refused or refusal is anticipated	Yes	Officer of the Trust Police Constable
129(3)	Yes - if entry has been refused or refusal is anticipated	Yes	Any person authorised by or under Mental Health Act 1983 / Mental Health (Care and Treatment) (Scotland) Act 2003[68]
129(4)	Yes	Yes - take and convey to hospital named in application	Person who has made an application for admission for assessment – can be ASW or nearest relative

3.91 If there is denial of access and an anticipated likelihood of resistance, aggression, violence or absconding on the part of the patient, the powers afforded by these warrants significantly improve the abilities of the police to proactively deliver a safe conclusion without allowing matters to escalate to the point where a patient is arrested and/or an attending professional or anyone else is injured.

Risk Matrix to inform decision making in relation to requesting police involvement

3.92 The Risk Matrix set out below will be used to inform requests for police involvement. The matrix is not intended to replace professional decision making and should be used only as an aid to inform decisions. Each agency will be required to undertake their own risk assessment and then, through discussion with other agencies, come to an agreed interagency level of associated risk. The Risk Matrix will inform assessments throughout all interactions with the patient. Police and HSC staff should disclose and discuss any known risks and be clear about any handover of responsibility.

[68] Mental Health (Care and Treatment) (Scotland) Act 2003

Figure 5: Risk Matrix

PREVIOUS HISTORY OF PERSON	CURRENT CIRCUMSTANCES	ACTIONS REQUIRED (HSC TRUSTS / NIAS)
LOW RISK – Police assistance is unlikely to be required		
Person has a history of: - violence; - active self-harm; - absconding; - other risk behaviour indicators currently present (other than very mild substance use). History is: - infrequent AND historic; **OR** - irrelevant due to circumstances.	Person is ***NOT:*** - presenting with behaviours likely to cause serious physical harm to others; - actively self-harming; - presenting in a manner which would suggest a risk of absconding; or - displaying any other risk behaviour indicators ***at present*** (other than very mild substance use).	HSC Trusts excluding NIAS: - provide reassurance and explanation to person; - offer support to person; - offer physical support for conveyance, e.g. providing assistance out of chair to get into vehicle etc.; - utilise family / friends to encourage person; - consider use of support worker model with staff trained in physical intervention; and - consider escort model to support person through conveyance. NIAS: - support the compliant/disoriented patient from their location, especially if immobile; - move patient into carry chair or trolley to transport to the ambulance using normal ambulance moving and handling techniques; - apply seat belts; - close the ambulance door; - build rapport and trust with patient; - re-assure the patient regarding the need for transport and the safety of this process; - use negotiation, influence and persuasion techniques to ensure the patient feels safe to travel; and - involve family members, carers, neighbours etc. who may be able to influence the patient's decisions.

MEDIUM RISK – Police assistance MAY BE required		
More than infrequent history of violence or more than AOABH[69], involving weapons, sexual violence, violence towards HSC staff or a vulnerable person **OR** ***LOW RISK patients*** who have disengaged from treatment and where there are MEDIUM RISK threats when disengaged	Person currently presenting with ***some*** behavioural indicators (including substance use) **OR** Some recent criminal / medical indicators that the individual may be violent OR poses a risk of absconding OR is a threat to their own or anyone else's safety	HSC Trusts excluding NIAS: - provide reassurance and explanation to person; - offer support to person; - offer physical support for conveyance e.g. providing assistance out of chair to get into vehicle etc; - utilise family / friends to encourage person; - consider use of support worker model with staff trained in physical intervention; - consider escort model to support person through conveyance; - consider use of medication to reduce levels of anxiety / distress to person NIAS: - support the compliant/disoriented patient from their location, especially if immobile; - move the patient into carry chair or trolley to transport to the ambulance using normal ambulance moving and handling techniques; - apply seat belts; - close the ambulance door; - build rapport and trust with patient; - re-assure the patient regarding the need for transport and the safety of this process; - use negotiation, influence and persuasion techniques to ensure the patient feels safe to travel; and - involve family members, carers, neighbours etc. who may be able to influence the patient's decisions.

[69] AOABH – Assault occasioning actual bodily harm

HIGH RISK – Police assistance WILL BE required		
Significant history of any of the medium risk indicators. ***MEDIUM RISK patients*** who have disengaged from treatment and where there are HIGH RISK threats when disengaged.	Person currently presenting ***significant*** behavioural indicators (including substance use) which could cause serious physical harm to self or others **OR** recent criminal / medical indicators that the individual may be violent OR is a threat to anyone's safety.	Prior to escalation to red, assistance provided for low and medium may be provided if appropriate by both HSC Trusts and NIAS.

Requesting police assistance

3.93 The ASW will consult appropriately with staff from Trusts, NIAS and police to support effective decision making based on all the relevant information available. Each agency will complete and document a risk assessment detailing their opinion on the likelihood of the patient behaving in a violent or dangerous manner and share their risk assessment with the other agencies involved.

3.94 The ASW and NIAS should request the assistance of the police when the outcome of their risk assessment indicates it is at the level for police involvement as reflected in the Risk Matrix above.

3.95 Police assistance should be requested from the police control room by phoning 101 and the call will be directed to the relevant force's control room.

3.96 The ASW should quote 'Operation ASW' to the call handler, together with the desired level of police support. This will then trigger the police action plan in place for such requests. Police will assess the information in line with normal call taking policy and consider deployment and categorisation of the call. Any disagreement on deployment should be raised through the regionally agreed escalation processes.

3.97 In the event of urgent and immediate assistance being required, the ASW and NIAS should use the 999 system, giving as much information about the situation as is practicable in the circumstances. The police incident

number will be used by the ASW and NIAS staff for all communications with the police call handler.

3.98 Where the police have been urgently requested, due to an escalation of risk it would also be advisable to contact NIAS and update regarding the change in circumstances where NIAS will gather information and reassess appropriate response.

4 PROCESS TO FOLLOW WHEN AN APPLICATION FOR ASSESSMENT HAS BEEN COMPLETED (FORMS 1 OR 2 AND 3 SIGNED) AND PATIENT IS PRESENTED AT A PSYCHIATRIC HOSPITAL

Medical examination on arrival

4.1 A patient must be medically examined immediately on arrival at the hospital by the RMO, another Part II medical practitioner, or any other medical practitioner on the staff of the hospital (Article 9). The examining medical practitioner should preferably have discussed the patient beforehand with the medical practitioner who made the recommendation for admission and completed **Form 3**.

4.2 On occasion, the hospital-based medical practitioner, who is undertaking the medical assessment following admission to the ward, will not have been the medical practitioner who communicated with the community medical practitioner who completed **Form 3.** In these circumstances, the hospital-based examining medical practitioner should seek all relevant information from the hospital-based medical practitioner who communicated directly with the medical practitioner who completed **Form 3**. Communication between the medical practitioners involved has resulted in a high level of agreement on the need for admission of patients who have a **Form 3** in place. This continued communication supports shared understanding and agreement on the need to admit the patient for assessment.

4.3 The examining medical practitioner must report the result of their examination immediately to the Trust on **Form 7**, whether their opinion be that the patient should be detained in hospital for assessment, should remain in hospital on a voluntary basis or should not remain in hospital. The patient may be detained for up to 7 days on the opinion of the RMO or another Part II medical practitioner.

4.4 Where the medical practitioner completing **Form 7**[70] is not the RMO or Part II doctor, the patient may be detained for a period of up to 48 hours during which they must be examined by the RMO or other Part II medical practitioner who must report to the Trust on **Form 8**. If the RMO forms the opinion that detention should continue, the patient may be detained for up to 7 days from the date of the first examination. Either way, the assessment period cannot exceed 7 days without a further examination.

4.5 If within the 7-day period the RMO examines the patient and reports to the Trust on **Form 9** (Article 9(9)), the assessment period may be extended for a further 7 days after the expiration of the first 7-day period. Where it

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is not practicable for the RMO to undertake the **Form 9** assessments, a Part II doctor may do so (Article 9(9).

4.6 In no circumstances can a patient be detained more than 14 days for assessment.[71]

4.7 The Trust has an obligation under Article 8(2)(b) to send a copy of the application for assessment, and the medical recommendation on which it is founded, to RQIA as soon as the patient is admitted to hospital. Copies of the medical reports completed following admission and for extension of the assessment period (**Forms 7, 8 and 9**) must also be sent to RQIA as soon as they are received by the Trust (Article 9(10)).

4.8 Where a patient has been admitted for assessment on the application of their nearest relative, the Trust must arrange for a social worker to interview the patient and report on the patient's social circumstances to the RMO (Article 5(6)). The RMO should take the social worker's report into account when making their assessment. It is imperative, therefore, that the report should be available to the RMO as soon as possible within the assessment period.

4.9 The purpose of the application for admission is to permit a comprehensive assessment of the patient to be made in hospital, and a decision as to the need for further detention for treatment to be taken on the strength of that assessment. There are obvious objections to anticipating the outcome of the assessment process. A decision to reject the application on examination of the patient on arrival should not, therefore, be taken lightly. Such a decision should only be taken on the judgement of a Part II medical practitioner, normally after consultation with, and, if possible, the agreement of, the medical practitioner who made the recommendation for admission. An examining medical practitioner who is not a Part II medical practitioner should, therefore, before taking such a decision, consult a Part II medical practitioner.

4.10 The examining medical practitioner should arrange for the medical practitioner who made the recommendation for admission and the applicant to be informed by letter where the patient is to be detained for assessment or to remain in hospital as a voluntary patient. Where the decision is that the patient should not be admitted, the examining medical practitioner should immediately inform the medical practitioner who made the medical recommendation (**Form 3**) and the latter should, with the other professionals concerned, decide what action is needed to meet the patient's needs, including the possible provision of other health and social services, and decide how to implement that action.

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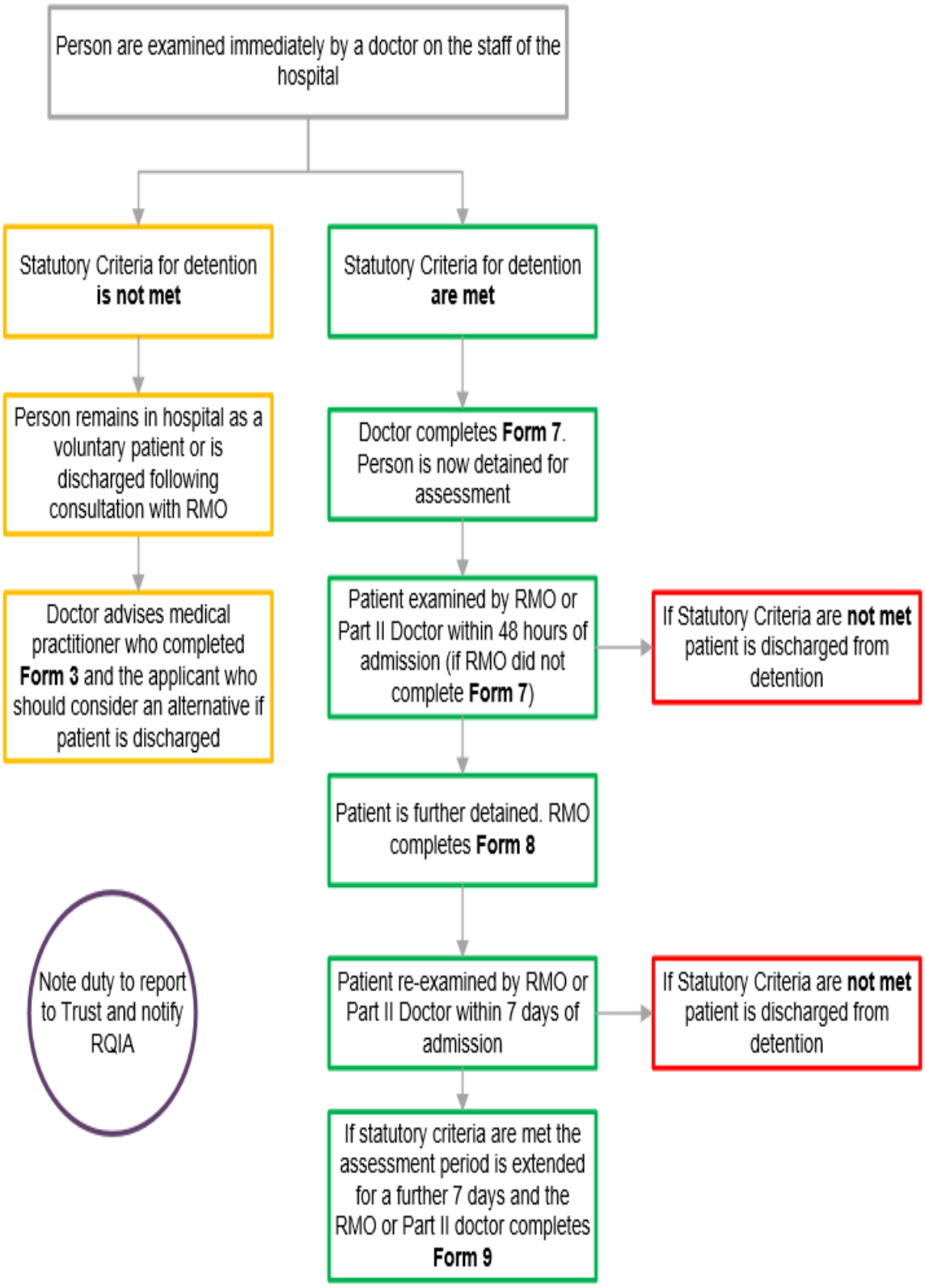
[71] The medical reports contained in **Forms 7, 8 and 9** constitute the authority to detain the patient and if they are not provided to the Trust at the appropriate times the patient will not be liable to be detained.

Flowchart 11: Mental health inpatients / learning disability facilities



Admission procedures

4.11 A valid application for assessment constitutes authority for the patient not only to be conveyed to hospital, but also to be detained there for the purposes of the medical examination in relation to **Form 7** – Report of medical examination immediately after admission for assessment (**Form 7** should be sent to the responsible authority which is the receiving Trust). The essential procedures to be followed on the patient's arrival at hospital are:

- receipt and scrutiny of the application and medical recommendation **(Form 1 or 2 and 3)**[72];
- acceptance and medical examination of the patient;
- notification of the application and detention for assessment to the Trust and notification by medical records to RQIA.

4.12 Proper procedures should be applied for the care of patients' property on admission to hospital. This includes securing the patient's home and making arrangements for livestock and pets. Consideration must also be given to the care of children, young people and vulnerable others who are in the care and responsibility of the patient.

4.13 Trusts should have arrangements in place to support the procedures as outlined above when the patient is admitted to a medical ward.

Receipt and scrutiny of documents

4.14 Senior managers, responsible for the care and treatment of patients in hospital, are responsible for establishing the validity of a duly completed application for assessment as authority to detain a patient for medical examination and assessment. They should formally delegate this responsibility to the nurse who will receive the patient. Normally this duty will fall to the nurse in charge of the ward or unit. The nurse in charge will be responsible for providing the patient with information on their admission, including their rights.

4.15 Responsibility for receiving the patient and checking the application should be assumed by a senior nurse who is a first level nurse registered in the Register of Nurses, Midwives and Health Visitors in accordance with Regulation 3 of the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 (that is, a first level nurse trained in the nursing of persons suffering from mental illness or patients with a learning disability).

4.16 The nurse in charge of receiving the patient should have delegated authority to ensure that the documents are in order. The nurse in charge should be familiar with the requirements of the Order and be able to refer

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to an authorised administrative staff member in any case where there is doubt about the validity of the documents. Both the nurse in charge and the administrative staff member should understand what errors can properly be corrected in accordance with Article 11. Detention based on a procedurally defective form may be deemed unlawful under Article 5(1) of the ECHR and may give rise to liability.

Errors which may be amended under Article 11

4.17 Article 11(1) allows an application, medical recommendation or medical report which is found in any respect to be incorrect or defective to be amended by the person who signed it, with the consent of the responsible Trust, within 14 days from the date of the patient's admission. Faults which may be capable of amendment under this Article include the leaving of blank spaces on the form which should have been filled in (other than the signature), or failure to delete one or more alternatives in places where only one can be correct. The patient's forenames and surname should agree in all places where they appear in the application, the supporting medical recommendation and medical reports.[73]

4.18 If the nurse in charge or administrative support staff scrutinising any document finds any errors of this sort, they should return the document to the person who signed it for amendment. When the amended document is returned to the Trust, it should again be scrutinised to check that it is now in the proper form. If this is all done within a period of 14 days, starting with the date on which the patient was admitted (or the date when the application was received by the responsible Trust if the patient was already in hospital when it was made), the documents are deemed to have had effect as though originally made as amended.

4.19 An error or a defect in an application for assessment, the medical recommendation on which it is based, or a medical report given under Article 9, may mean that the authority for the detention of the patient is open to challenge and could be found to be invalid. Article 11, as outlined above, contains certain provisions under which documents which are found to be incorrect, defective or insufficient may be rectified after they have been acted on, and under which patients may continue to be detained for a limited period while an error capable of being rectified is corrected.

4.20 Those who sign applications, medical recommendations or reports should take care to see that they comply with the requirements of the Order and are in the proper form. Arrangements should be in place to have the admission documents carefully scrutinised as soon as the patient has been admitted, or, if they are already in hospital, as soon as the documents are received.

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[73]RQIA MHO Prescribed Forms (Forms 1-12) Guide

4.21 Medical recommendations should be examined at the same time as the application. They must be scrutinised to ensure that they show sufficient legal grounds for detention. The clinical description of the patient's mental condition should include a description of their symptoms and of their behaviour, not merely a diagnostic classification.

4.22 The receiving staff should have ready access to a hospital medical practitioner with delegated responsibility who is familiar with the requirements of the Order, and be able to refer to the medical practitioner in any case where there is uncertainty about the medical recommendation accompanying the application for assessment.

4.23 The medical practitioner making the recommendation will have been in touch with a hospital medical practitioner to arrange for the patient's reception, and that hospital medical practitioner should have advised the receiving nurse that the patient is to be admitted and explained the medical grounds for the recommendation. Ideally, it should be the hospital medical practitioner to whom the nurse can refer queries about the medical recommendation. If not that medical practitioner, they should brief colleagues to whom such reference may be made, in anticipation of the arrival at hospital of the patient and the documents. It would be advantageous, when contacting the hospital, for the medical practitioner recommending admission to speak to the medical practitioner who will examine the patient on arrival.

4.24 When the person is being admitted on the application of an ASW, the person receiving the admission documents should check their accuracy with the ASW.

RQIA responsibility – receipt and scrutiny of documents

4.25 A valid application is authority for the Trust to detain the patient in hospital up until they have been assessed by a medical practitioner in relation to **Form 7**.

4.26 Once the hospital has admitted a patient for examination, a copy of the application for assessment (**Form 1** or **Form 2**) and the medical recommendation (**Form 3**) should be forwarded to the Trust and immediately copied to RQIA and no later than 14 days. The examining medical practitioner's report (**Form 7**) should also, whatever the outcome of their examination, be forwarded to the Trust on completion and copied immediately by the Trust to RQIA (Article 8(2)(b)). Any subsequent reports relating to detention for assessment (**Forms 8 or 9**) should be forwarded

on completion to the Trust and immediately copied by the Trust to RQIA, as should a report on **Form 10** relating to detention for treatment.[74]

4.27 RQIA have a statutory duty to ensure patients are not improperly detained. RQIA will draw attention to the relevant HSC Trust any errors or concerns that may indicate an improper detention and will require appropriate action to be taken. The Trust is required to notify RQIA immediately of any amendments made to admission documents or medical reports and immediately forward to it copies of any fresh medical recommendations or reports which may have been provided. The faults which should be looked for fall into three categories:

i. those which invalidate the application completely and cannot be rectified;
ii. those which may be capable of amendment under Article 11(1); and
iii. those which make a medical recommendation or report insufficient to detain the patient, but which may be capable of rectification by the substitution of a fresh medical recommendation or report under Article 11(2).

4.28 Rectification can only be done where the issue of itself does not make the detention invalid and therefore unlawful.

4.29 Documents cannot be rectified under Article 11 unless they can be properly regarded as applications or medical recommendations or reports within the meaning of the Order. A document purporting to be an application, medical recommendation or medical report cannot be regarded as such if it is signed by a person who is not empowered under the Order to do so, or if it is not signed at all. The first check to be made, therefore, is that each document is signed; that the application appears to be signed by the patient's nearest relative or the acting nearest relative or by an ASW; that the medical recommendation is signed by a practitioner who is not excluded under Article 6(d); and that medical reports under Article 9(3), (6) or (8) are signed by medical practitioners empowered to do so.

4.30 Unless there is any reason to believe that they are inaccurate, the scrutinising members of staff may accept at their face value the statements made on the documents; for example, they need not check that a medical practitioner who has stated that they are a registered medical practitioner is so registered, nor that a person who states that they are the patient's nearest relative, is in fact the nearest relative within the meaning of the Order.

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[74] It is a requirement of the legislation that prescribed forms and other reports are immediately submitted to RQIA by HSC Trusts. These may be sent electronically.

4.31 If a fault of this kind is discovered in the documents, there is no proper authority for the patient's detention unless steps are taken for a new application to be made based on a medical recommendation which complies with Article 6. If the patient is already in hospital, they may be detained while a new application is being made, but only if a medical practitioner on the staff of the hospital issues a report under Article 7(2). The patient should be informed by nursing staff immediately when an error of this nature is identified, and the actions taken to rectify the error, in addition to being informed of their rights.

Time limits

4.32 Another point which should be checked by the receiving nurse as soon as the documents are first received is whether the time limits mentioned in Article 5(2), 6(a), 8(1), 9(1), 9(5) and 9(8) have been complied with. The time limits should also be checked by authorised administrative staff and RQIA. These limits are:

a) the date on which the applicant last saw the patient must not be more than two days before the date on which the application is made - Article 5(2);
b) the date of the medical examination of the patient by the medical practitioner giving the medical recommendation must not be more than two days before the date on which they sign the recommendation - Article 6(a);
c) the patient's admission to hospital must take place within 48 hours beginning with the date on which the medical recommendation was signed. Where **Form 4** has been completed, extending the period for admission (which can be up to 14 days), the admission must take place within the number of days specified in that form, beginning with the date on which the medical recommendation was signed - Article 8(1);
d) the patient must be medically examined immediately after they are admitted to hospital (the report of this examination is made on **Form 7**). As the examination may run over a period of time, the patient may arrive on the ward and the medical examination commence before midnight but not be complete for several hours, therefore the date and time on the Form will be the day after the arrival.
e) the medical examination by the RMO or a Part II medical practitioner to extend the assessment period from 48 hours to seven days, the report of which is provided to the Trust on **Form 8**, must be carried out no later than 48 hours from the time at which the report of the medical examination immediately after the patient's admission to hospital (**Form 7**) is signed - Article 9(5);
f) the date of the medical report for the extension of the assessment period for a further 7 days (**Form 9**) must not be later than seven days

inclusive after the patient's date of admission (i.e. the date on which **Form 7** is signed) - Article 9(8).[75]

4.33 If the dates entered on the application, medical recommendation or medical report do not conform with these time limits, the persons who signed them should be asked whether the dates or times entered are correct. If they are not correct, and the correct dates and times do conform with the limits, the entry on the forms may be amended under Article 11(1). If the time limits have, in fact, not been complied with, the application is invalid.

Faulty medical recommendations and reports

4.34 In addition to scrutiny for errors or defects of a technical nature described in the previous paragraphs, medical recommendations and reports should be scrutinised by a medical practitioner at the hospital appointed for this purpose by the Trust. They will make sure that the clinical details entered on these forms, including statements and reasons given to support opinions expressed, meet the requirements of the Order and are sufficient to warrant the patient's detention for assessment. To do so they will probably wish to consult the medical practitioner who made the recommendation or report before coming to a decision that they are insufficient.

4.35 Where they are found to be defective, the Trust must notify the applicant (nearest relative or ASW) of this fact in writing. It would be advisable at the same time to inform the medical practitioner who gave the recommendation or report. The applicant should be advised that if a fresh recommendation or report is provided to the Trust within 14 days from the patient's admission, the application for assessment will be regarded as in order. In some cases, it may be suitable for the fresh medical recommendation to be given by a medical practitioner on the staff of the hospital provided they did not also give the medical report immediately after the patient’s admission.

Responsibility to inform patient’s own GP

4.36 The authorised administrative officer should ensure the patient’s own GP has been informed of the patient’s admission.

Detention for treatment

4.37 It is best practice for the RMO, or another Part II medical practitioner in the absence of the RMO, to examine the patient before the end of the initial 7-day assessment period. It may be that during the assessment

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period the patient's condition has improved to the extent that they are now prepared to remain in hospital as a voluntary patient or to receive treatment as an out-patient. However, as a result of the examination, the Part II doctor may be satisfied the patient should be further detained on the following grounds as set out in Article 12(1):

(a) that, in their opinion, the patient is suffering from mental illness or severe mental impairment of a nature or degree which warrants his detention in hospital for medical treatment; and
(b) that, in their opinion, failure to so detain the patient would create a substantial likelihood of serious physical harm to himself or to other persons; and
(c) such particulars as may be prescribed of the grounds for his opinion so far as it relates to the matters set out in sub-paragraph (a); and
*(d) they must furnish a report to that effect to the Trust using **Form 10**.*

4.38 The patient may then be detained for up to six months, beginning with the date of admission, so that they can receive the treatment they need. That period will commence after the expiry of the first period (Article 9(8)). It is best practice that the patient must be re-examined before the end of the second period.

4.39 The grounds for detention to be stated on **Form 10** are the same as for admission, except that the general diagnosis of mental disorder is no longer sufficient and it must be clearly stated that the patient suffers from either mental illness or severe mental impairment or, exceptionally, from both.

4.40 The grounds for detention for treatment (**Form 10**)[76] must include evidence of a mental health/serious mental impairment diagnosis, evidence of symptoms, and evidence that other options, other than detention, have been considered in the management of the patient, discounted and the reason for same.

4.41 The medical practitioner who decides whether the patient should be detained for treatment must not be the one who gave the medical recommendation on which the application for assessment was founded, nor any of the persons listed in Schedule 1 to the Order. This excludes certain relatives, business associates and others closely involved with the patient who might have ulterior motives for having them detained.

4.42 The Trust should scrutinise the medical report on **Form 10** to ensure that it constitutes proper authority to detain the patient and will then arrange to send a copy to RQIA immediately for review. RQIA will alert the HSC Trust where it identifies an improper detention and will request that the Trust

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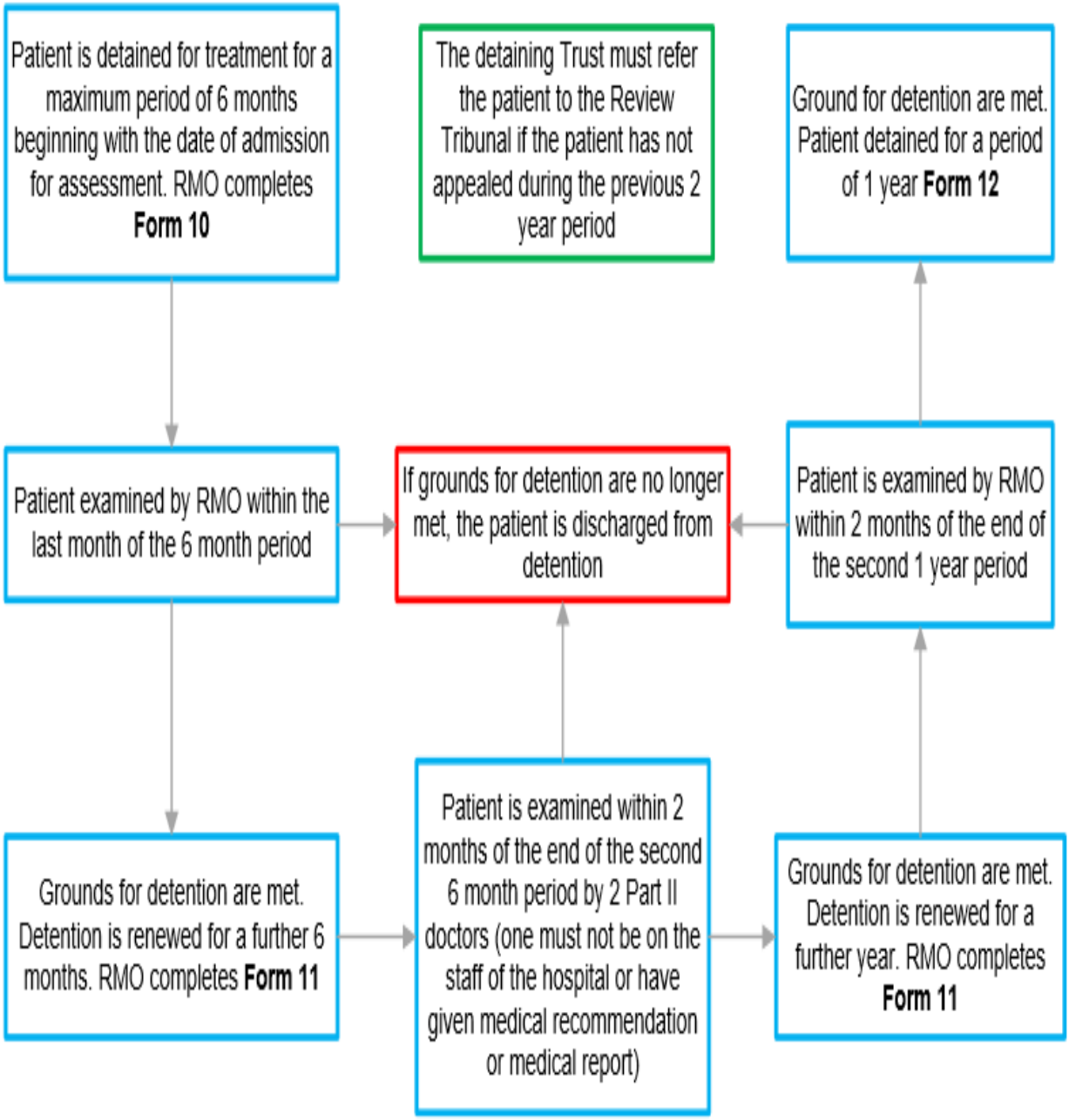
takes immediate action. The patient should be informed of their right to apply to the Review Tribunal within the first six months period.

Flowchart 12: Detention for treatment in hospital



Renewal of authority for detention

4.43 Under the Order, the periods for which detention for treatment can be renewed after the initial six-month period are for six months in the first instance, and, thereafter, one year at a time. If, within a month of the end of the initial six-month period of detention, the RMO examines the patient and provides a report on **Form 11** to the Trust confirming that, in their opinion, the criteria for detention continue to be met and giving the necessary particulars and evidence to support their opinion as set out in Article 12(1), then the patient can be detained for a further six months. It is not necessary that the form of mental disorder the patient is assessed as having at this stage is the same as that stated on **Form 10** when they were first detained for treatment.

4.44 Within two months of the end of the second six-month period of detention, the authority to detain can be renewed again but this time for a full year. This is seen as a very important stage in the detention and treatment of a patient, and extra safeguards are built into the system to ensure that their interests are fully protected. The patient and their nearest relative must be informed at least 14 days before the patient is to be medically examined and the examination itself must be carried out by two Part II medical practitioners, one of whom must not be on the staff of the hospital where the patient is detained and must not previously have been involved in giving a medical recommendation or report on the patient. A completely fresh medical opinion will therefore be brought to bear at this stage. The medical report which will have the effect of detaining the patient for up to a year must be jointly completed and signed by the two medical practitioners concerned and made on **Form 12**.[77]

4.45 If, at the end of this year, which in practice will be two years from the date on which the patient was admitted to hospital, the patient is to be further detained, they will be examined by the RMO who will complete Form 11 stating that the conditions for detention as set out in Article 12(1) are still satisfied. Thereafter detention can be renewed in the same way for a year at a time, with the medical examination in each case taking place within two months of the end of the previous period of detention. Each time the authority is renewed, the patient and the nearest relative must be informed and copies of the medical reports which have been accepted by the Trust as a basis for continued detention must be sent to RQIA.

Transporting patients between hospitals or between hospital and court, and returning patients who abscond during this type of transfer

4.46 When a patient requires transport between hospitals, or between hospital and court, it is for the managers of the hospitals concerned to ensure that

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appropriate arrangements are put in place. The managers of the hospital from which the patient is being transferred remain responsible for the patient until the patient is admitted to the new hospital. The hospital should ensure they have sufficiently qualified and appropriately trained staff to manage the transfer of patients.

4.47 In the infrequent circumstances where the level of potential violence or risk is so high that it cannot be managed solely by HSC staff, police assistance should be requested. The Risk Matrix should inform these decisions, especially when moving from and to hospital and court. Specific details of why police assistance is required should be clear. Hospital managers should ensure there is clear guidance for their staff to inform this decision-making process. Should a patient abscond during transfer between one hospital and another, HSC agencies have a responsibility to attempt to locate and secure the patient and complete their transfer to the agreed hospital setting.

Discharge of patient from detention

4.48 Article 14 sets out who may discharge a patient from compulsory detention in hospital and the circumstances in which this must be done. Discharge in accordance with the provisions of this Article means discharge from detention and it is in this technical sense that it is used in this Code. It does not mean that the patient must leave hospital and, indeed, Article 127(1) makes it plain that nothing in the Order is to prevent a patient remaining in hospital for treatment on a voluntary basis after they have ceased to be subject to detention there.

4.49 Patients in hospital for assessment or detained for treatment may be discharged at any time by the RMO, the Trust or the nearest relative. Furthermore, the RMO has a duty to discharge a patient if they are satisfied that the criteria for detention are no longer satisfied, that is:

(a) that the patient is no longer suffering from mental illness or severe mental impairment of a nature or degree which warrants their detention in hospital for medical treatment; or
(b) that, having regard to the care which would be available for the patient if they were discharged, the discharge would not create a substantial likelihood of serious physical harm to themself or other person.

4.50 A patient cannot be discharged unless the person empowered to discharge them makes an order in writing for this purpose. There is no prescribed form of notice; however, standardised discharge recording formats should be used.

4.51 The RMO, as the person in clinical charge of the patient, will normally be responsible for any action required by a change in their condition and will therefore usually be the one who exercises the power to discharge. The Trust will rarely exercise its power to discharge since the medical opinion

to enable it to do so would normally come from the RMO who themself has this power. Nonetheless, the Trust Executive Director of Medicine has the authority to do so, and this should enable the Trust to act quickly if, for example, it has reason to believe that the RMO is not acting in the patient's best interests.

4.52 The nearest relative's power to order discharge is subject to the restrictions set out in Article 14(4). If they wish to exercise this power, the nearest relative must give 72 hours' notice in writing to the Trust concerned. The recording format should be completed by the nearest relative and given to the nurse in charge of the ward who can send it through to the hospital's medical records department. Ward staff will provide a blank copy to the nearest relative on request. The 72 hours runs from the time the notice is received by the Trust and arrangements should therefore be made to record the time of receipt of the notice. Where any part of the 72-hour period falls on a Sunday, the period of notice is automatically extended to 96 hours. It is essential that the receipt of such a notice is brought to the attention of the RMO as soon as possible, since they have power to bar discharge by the nearest relative in certain circumstances. Therefore, Trusts should ensure that suitable arrangements are in place in each hospital for this purpose, particularly at weekends or during holidays.

4.53 If the RMO makes a report to the responsible authority (which is the receiving Trust) within the 72 hour period mentioned above, to the effect that the criteria for detention still apply or that they are not satisfied that the patient, if discharged, would receive proper care, the discharge by the nearest relative will not be approved and the nearest relative may normally not make another order for discharge for a period of six months beginning with the date of the report. Where possible, the RMO should endeavour to see the nearest relative to explain the circumstances in which the report was made. In any event, the Trust must inform the nearest relative and forward a copy of the report to RQIA. The nearest relative then has a right to apply to the Review Tribunal, within 28 days from the date on which they are so informed, for the patient's discharge.

4.54 If the patient is discharged under Article 14 by the RMO, the nearest relative or the responsible authority (which is the receiving Trust), the Trust must immediately notify RQIA.

4.55 The nearest relative may authorise a medical practitioner of their choice to visit and examine the patient in private for the purpose of advising them as to the exercise of their power to discharge the patient. The medical practitioner so authorised also has a right to require the production of and inspect any records relating to the detention or treatment of the patient.

Discharge planning for patient to leave hospital

4.56 The multidisciplinary team responsible for the patient's care should be satisfied that there are appropriate arrangements in place to meet the patient's identified care needs prior to discharge from hospital, or arrangements are in place for appropriate follow up and review where this is deemed necessary. This will involve discussion with community based mental health teams and community services, as appropriate. Discharge plans should include the management of risks identified and safeguarding concerns. Family, carers and those with parental responsibility should, as far as possible, be involved in the discharge planning process whilst working within a framework that reflects the patient's rights.

Leave of absence from hospital

4.57 Article 15(1) allows the RMO to grant a patient leave to be absent from the hospital in which they are liable to be detained. The RMO may impose any conditions on the leave they think necessary in the interests of the patient or for the protection of other people; for example, they may require the patient to live in a specified place or under the care of a specified person, or may require the patient to accept visits from medical practitioners, nurses or social workers or attend a day hospital or out-patient clinic. Leave of absence can be given either for a temporary absence or on a specific occasion, after which the patient is expected to return to hospital, or as a period of trial of the patient's suitability for discharge. Leave can be extended in the absence of the patient (Article 15(2)).

4.58 Article 15(3) states explicitly that the RMO may direct that the patient must remain in custody during their leave if it is necessary in the interests of the patient or for the protection of other persons. The patient may be kept in the custody of an officer of the Trust or of any other person authorised in writing by the Trust. These kinds of arrangements would allow detained patients to have escorted leave for outings, to attend other hospitals for treatment, or to have home visits on compassionate grounds. So long as a patient is still liable to be detained in hospital, the RMO remains responsible for their care and treatment and must see that appropriate arrangements are made for their supervision while absent on leave.

4.59 It is particularly important when the patient is sent on leave as a trial for discharge that such matters as somewhere for them to live, and a job or day centre placement, are arranged before they leave hospital. These arrangements will normally be made by the appropriate social work department and after discussion with the nearest relative where practicable. Where appropriate, support from the community mental health team should be arranged.

Recall from leave of absence

4.60 If leave of absence is granted for a specified period the patient should understand that, unless the period of leave is extended, they will be expected to return to the hospital at the end of the period without notice of recall. For longer periods of absence, Trusts may wish to make arrangements to remind the patient when they are due to return. If the patient does not return at the appointed time, the RMO should make arrangements with the hospital management for HSC staff to support the patient's return. When the identified risks are at such a level that they require police intervention, they may be taken into custody and returned to hospital under the provisions of Article 29.

4.61 Under Article 15(5) the RMO may recall a patient before the end of the period for which they were originally granted leave. This would arise where the RMO considered it to be necessary in the interests of the patient's health or safety, or for the protection of other persons, or because the patient was not receiving proper care. Where a patient is to be recalled, notice in writing revoking the leave of absence must be given to the patient or to the person in charge of them. A patient may not be recalled from leave after they have ceased to be liable to be detained under Part II of the Order.

Notification of RQIA

4.62 The Trust is required under Article 15(4) to notify RQIA if the RMO grants a patient a period of leave of absence – or extension of leave of absence – which in total exceeds 28 days. The notification must advise RQIA of the address at which the patient will reside while on leave. RQIA must also be informed of the return of the patient to hospital following recall from leave or the expiry of a period of leave. Sample forms of notification have been prepared for these purposes by the Department. The Order requires RQIA to be notified at the latest within 14 days of the granting of the leave or extension of leave, or the return of the patient, as the case may be. The purpose of these arrangements is to enable RQIA to carry out its statutory duty to visit detained patients. It is not necessary for RQIA to be informed if the patient's absence is for less than 28 days.

Nurses' holding power

4.63 Voluntary patients have consented to be in hospital for the care and treatment recommended by their RMO. However, they may during the period of their treatment decide they no longer wish to stay in hospital, and they have the right to leave and continue treatment in the community, where appropriate.

4.64 On occasions, however, concerns may be identified when a voluntary patient decides to leave during their period of treatment, particularly if their mental state has deteriorated and the risk to themself and others is

significant, and they cannot be persuaded to stay. When this happens, a medical practitioner may not always be immediately available. In such circumstances, an appropriately qualified nurse may exercise a holding power (provision for which is made in Article 7(3) of the Order) to detain the patient where the nurse is of the opinion that:

- an application for assessment ought to be made in respect of the patient; and
- it is not practicable to secure the immediate attendance of a medical practitioner.

4.65 In these circumstances, Article 7(3) permits a registered nurse of the prescribed class with a live and appropriate registration with the Nursing & Midwifery Council to exercise a "holding power" that can detain a patient in hospital for a maximum of six hours.

4.66 A suitably qualified nurse should be on all wards where there is a possibility of the nurse's holding power being used. This is most likely to occur on acute admission wards and wards where there are severely disturbed patients. Hospital management should assess the potential for its use elsewhere in the hospital and ensure that appropriate arrangements are in place for a suitably qualified nurse to be available. Trust operational procedural guidelines should be available to all staff in these settings.

4.67 The decision to exercise the holding power is at the personal discretion of the nurse. They cannot be instructed to exercise this power by anyone else. Before using the power, the nurse should assess:

(a) the likely arrival time of the medical practitioner as against the likely intention of the patient to leave. Most patients who express a wish to leave hospital can be persuaded to wait until a medical practitioner arrives, to discuss the matter further. Where this is not possible the nurse should try to predict the impact of any delay upon the patient; and

(b) the consequences of a patient leaving hospital immediately including the harm that might occur to the patient or others taking into account:

- what the patient is saying they will do and their known history;
- the likelihood of the patient completing suicide or making a significant attempt;
- the patient's current behaviour and in particular any changes from usual behaviour;
- the likelihood of the patient behaving in a violent manner;
- the availability of appropriate accommodation and support in the home;
- any recently received messages from relatives or friends;
- any recent disturbance on the ward (which may or may not have involved the patient);

- any relevant involvement of other patients;
- any relevant information from other members of the multi-disciplinary team.

4.68 The nurse must record, on **Form 6,** their opinion that an application for assessment ought to be made. The reasons for invoking the holding power should be entered in the patient's notes. The nurse's holding power starts once they have signed **Form 6** and ends six hours later or on the earlier arrival of a hospital medical practitioner empowered to report that an application for assessment should be made. Where the medical practitioner is in attendance pursuant to the exercise of the nurse's holding power but is of the opinion that an application for assessment should not be made the patient cannot be held further, and **Form 5** should not be completed.[78]

Detention of a voluntary patient already in hospital

4.69 Article 7(1) of the Order provides that an application for assessment may be made in respect of a hospital in-patient who is not liable to be detained under the Order. Where an application is made in relation to a voluntary patient, the patient shall be treated as if they had been admitted to the hospital at the time the application was made.

4.70 Where a medical practitioner is of the opinion that an application for assessment ought to be made in respect of a patient already in hospital, including a general hospital (but not an out-patient or someone attending an ED), the medical practitioner should, when appropriate, complete Form 5 recording their reasons. A Form 5 process can commence in parallel to the admission to ward process and should do so, if risks to the patient or others is indicated.

4.71 Use should only be made of this provision, and Form 5 should only be completed, where there is a possibility that the patient could seek to leave hospital before an application can be made. The form should not be completed unless at that time there is a genuine intention on the part of the medical practitioner that an application for assessment should be made.

4.72 Once **Form 5** has been completed the patient can be held in the hospital for up to 48 hours to permit that to be completed (Article 7(2)). An application for assessment in respect of a voluntary patient should be made in the normal way without resort to Article 7 of the Order and completion of **Form 5**.[79]

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[78] It is a requirement of the legislation that prescribed forms and other reports are immediately submitted to RQIA by HSC Trusts. These may be sent electronically.

[79] As above.

Application for assessment in respect of a patient already in hospital

4.73 As far as possible, the application procedures described in paragraphs 2.4 to 2.41 of the Code should be followed. The procedure will be the same as if the patient were being admitted for assessment from outside hospital and the patient may be detained on a **Form 5** as described above to enable the application for assessment process to be completed. This will ensure that, where possible, the nearest relative, a social worker and a medical practitioner not involved in delivering care within the hospital will be involved in all cases where compulsory detention is being considered. Where practicable, the patient's own GP should attend the hospital to give the medical recommendation on which the application would be founded.

4.74 It is recognised that due to other clinical pressures and priorities, GP response times can vary. If the medical recommendation is to be significantly delayed (for example, due to GP competing demands), a risk assessment should be completed by the RMO to inform next steps.

4.75 In cases of urgent necessity, another medical practitioner trained to act under Part II of the Order can undertake this medical assessment. Urgent necessity in such cases refers to the measure of risk to the patient or others due to any delay in assessment.

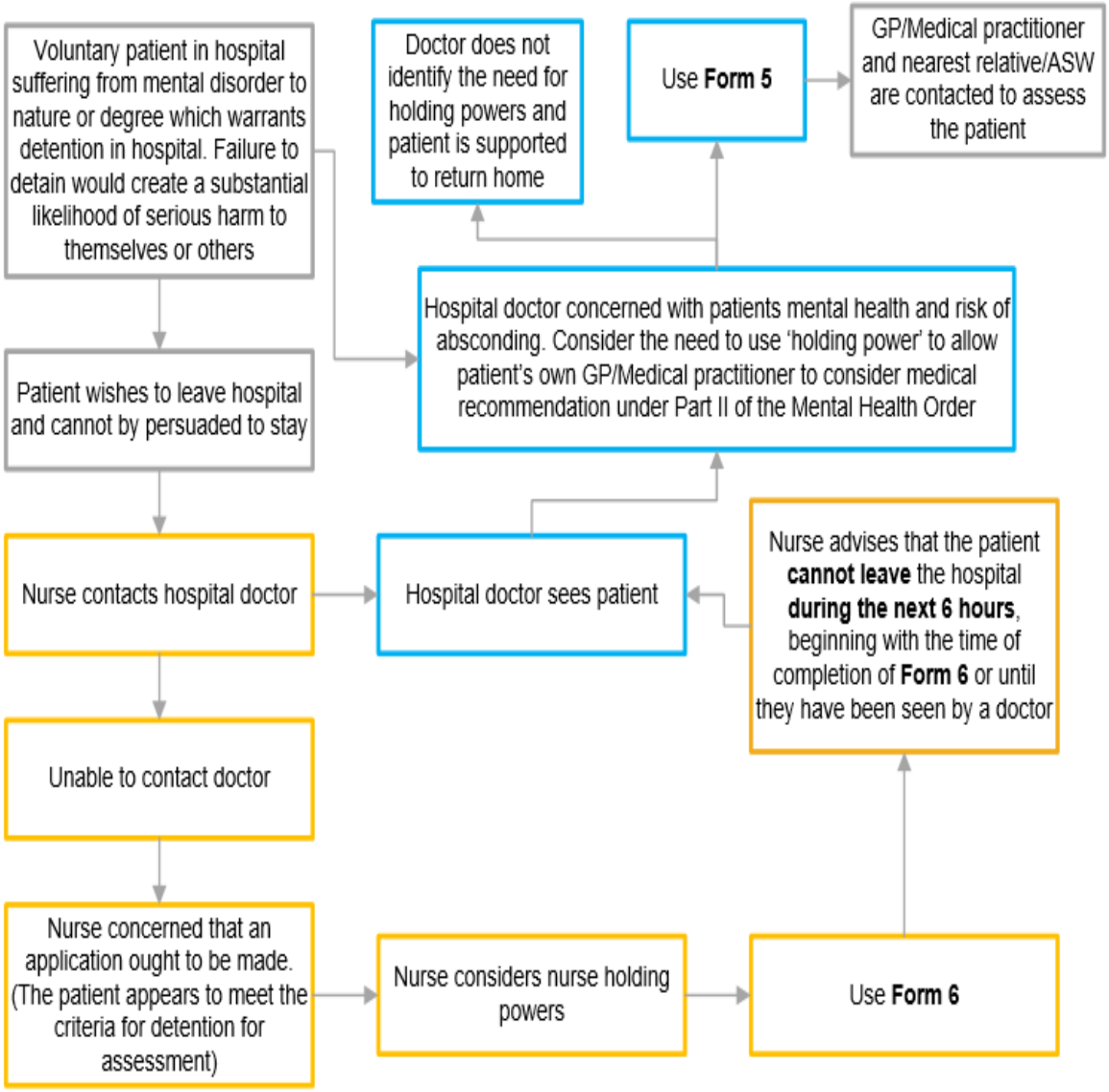
4.76 The outcome of the risk assessment should guide decision-making, specifically regarding the decision to wait for a GP or arrange an assessment with another medical practitioner.

4.77 A medical practitioner on the staff of the hospital in which it is intended the assessment should be carried out cannot give the recommendation except in a case of urgent necessity (Article 6(c)). The Order does not prohibit a medical practitioner on the staff of another hospital from making the medical recommendation, but it is preferable for this to be done by the patient's own GP, or by another practitioner who has previous knowledge of the patient (Article 6(b)).

4.78 The reason the medical practitioner on the staff of the hospital should not provide the medical recommendation, except in cases of urgent necessity, is to preserve independence in the assessment process and this is therefore an important patient safeguard. Close relatives, business partners and others (see Schedule I to the Order) are NOT permitted to give the medical recommendation.

Flowchart 13: Presentation in a psychiatric or learning disability hospital where the patient does NOT present a risk to self or to others

Flowchart 14: Presentation in a psychiatric or learning disability hospital where the patient does present a risk to self or to others



Absent Without Leave (AWOL) patients

4.79 When a patient leaves a HSC facility and staff have concerns about their wellbeing, staff should follow regional guidance. Detained patients are often reported to police as AWOL. The fact that a patient is AWOL does not in itself equate to a critical concern with a real and immediate risk to life or significant harm. Staff should satisfy themselves that they have completed all relevant due diligence actions before reporting an AWOL patient to the police as a missing person unless there is a critical concern.

4.80 Those due diligence actions include:

- searching the ward and hospital grounds;
- contacting the patient by phone;
- contacting the appropriate nearest relative/carer; and
- checking CCTV for possible sightings or to see how they left the HSC facility.

4.81 HSC organisations should identify specific staff who are able to co-ordinate the HSC response to their AWOL patient with police.

4.82 A patient is considered to be AWOL if they are detained and either abscond from a hospital or fail to return from a period of authorised leave. In these circumstances, police powers exist to detain and return the individual to the hospital facility under Article 29 of the Order if located. However, these powers do not include a power of entry to a private dwelling, and an Article 129 (2) warrant would be required under these circumstances if entry was refused. The HSC facility which has primary care for the patient should be presented with the required information that allows them to apply for the warrant if required. The power is conditional and can only be used if the person is found within 28 days of absconding/going AWOL, or the period for which they were liable to be detained has not lapsed. Therefore, when reported absent, the details of the date on which the power to retake the person ceases must be recorded.

4.83 The Order (Article 132(3)) further states: "*A person who escapes while being taken to or detained in a place of safety under Article 129 or Article 130 shall not be retaken under this Article after the expiration of the period of 48 hours beginning with the time when the patient escapes or the period during which the patient is liable to be so detained [i.e. after arrival to the place of safety], whichever expires first".*

4.84 All staff authorised by the HSC setting to return a patient back to the hospital have the same powers as the police under Article 29 (return and re-admission of patients absent without leave) or Article 132 (re-taking of patients escaping from custody).

Duty of Trust to give information to patients and nearest relatives

4.85 When the RMO, nurse or social worker is giving information to the patient they should be as helpful as possible and try to explain to the patient any points they do not appear to understand. Some patients will not be able to comprehend what they are told, but the law requires that the attempt should be made, and in the case of the short-term powers there may be little time to wait and see if a patient's powers of understanding improve.

4.86 Article 27(1) requires the Trust to take such steps as are practicable to ensure that the patient detained in hospital or subject to guardianship understands under which of the provisions of the Order they are detained or subject to guardianship, the effect of that provision and what rights of applying to the Tribunal are available to them in respect of their detention or guardianship. It is recommended that staff visit this issue with the patient more than once.

4.87 Article 27(2) places a further duty on the Trust to take such steps as are practicable to ensure that a patient detained in hospital or subject to guardianship understands the effect, so far as they apply to them, of Articles 14, 24 and 71(4) of the Order which deal with the power of the RMO officer, an authorised social worker, the Trust and the nearest relative to discharge them; and that they understand that they may make representations to RQIA.

4.88 The Trust must also take steps to ensure that a detained patient understands the effects, so far as they apply to them, of Articles 16 and 17 which deal with patients' correspondence, Article 111 which deals with the Code, and Part IV which deals with consent to treatment; and that the patient's nearest relative is provided with a written statement of their rights and powers under the Order. Trust guidance should include the management of emails, text messages, phone calls, media communication and packages delivered by alternative routes to the post office.

Patients' correspondence

4.89 Article 16 provides powers for the incoming and outgoing mail of detained patients to be inspected and withheld in certain circumstances. The term "postal packet" is used in Articles 16 and 17 and has the same meaning as in the Post Office Act 1953, that is: *"a letter, postcard, reply to postcard, newspaper, printed packet or parcel and every packet or article transmissible by post (which) includes a telegram".*

Correspondence of patients in ordinary psychiatric or learning disability hospitals or units

4.90 The Order places no restrictions whatsoever on the correspondence of voluntary patients. Furthermore, there are no restrictions on the incoming

correspondence of patients detained in ordinary psychiatric or learning disability hospitals or units. The only restriction on outgoing mail in such hospitals or units is the power to withhold from the post office a postal packet addressed by a detained patient if the person to whom it is addressed has requested that they receive no correspondence from that patient (Article 16(1)(a)). Such a request must be in writing and can be made to either the Trust responsible or the RMO. Trusts should provide guidance to staff on the restrictions on similar correspondence of patients through more modern forms of communication.

4.91 Where such a request has been made, the ability of staff to intercept correspondence will depend on the circumstances of the patient's detention. For example, if the patient has been granted leave to be absent from the hospital for any period each day or week, then the patient may use public postal facilities. Only when the patient is under constant supervision and is obliged to deliver their mail to staff for dispatch will it be possible to ensure that such a request is complied with. The Order gives the Trust the power to comply with a request that communications be withheld, but it does not place the Trust under duty to exercise any particular degree of vigilance to ensure that the patient does not succeed in any attempt to communicate with the person concerned.

4.92 Generally, where it is possible to monitor a patient's outgoing mail, and a request under Article 16(1)(a) has been made, it will be sufficient to look at the address to which the patient's letters are being sent, and to withhold any addressed to the person who has made the request. It is not likely that these powers will have to be used often; and where they do have to be used, interception at ward level is likely to be most appropriate.

4.93 Where a postal packet is withheld from the Post Office as described above, the Trust responsible has to record that fact in writing. It is suggested that this record should include the name of the patient concerned, the nature of the postal packet, the date on which it was withheld and the reason for withholding it (that is, that the addressee has requested that communications addressed to them by the patient should be withheld). This record, together with the postal packet, should be kept with the patient's records. An explanation should be given to the patient, and the postal packet should be returned to the patient if they so request; this also should be noted on the record.

4.94 Article 27(3) places a duty on the Trust to provide the information to be given to the patient under Article 27(1), (2) (a) and (b) both orally and in writing, and the information to be given to the nearest relative under Article 27(2)(c) must be in writing. In addition, the information must be given as soon as practicable after the patient's detention or guardianship begins as required under Article 27(4).

4.95 It should be noted that Article 27(5) requires that the patient's nearest relative should also be given a copy of any written information given to the patient, but this requirement is subject to the patient's wishes; in other words, if the patient expressly requests that such information should not be given to the nearest relative then the Trust should not do so.

Transfer between hospitals

4.96 However the suggestion for the transfer of a patient to another hospital originates, it will normally be for the RMO in the original hospital to ensure that a suitable vacancy exists in the receiving hospital, and that the medical practitioner who will be acting as RMO of the patient once they reach that hospital, has full information about the patient's condition and the statutory provisions to which they are subject. Once these preliminary arrangements have been satisfactorily completed, the Trust responsible must, if practicable, inform the nearest relative of the proposed transfer before it takes place (Article 28(9)).

4.97 If the transfer is to a hospital in another Trust's area, the written agreement of the receiving Trust should be obtained quickly. Where the transfer is from one hospital to another in the same Trust’s area, it is essential that the names and designations of those who arranged the transfer be recorded in writing and kept with other documents relating to the patient's detention. Otherwise, there may be no correspondence or papers to indicate that the appropriate persons arranged and agreed to the transfer.

4.98 The transfer should then go ahead with the minimum of delay making sure that the patient's records precede or accompany them to their new destination. In addition, the Trust responsible should notify RQIA of the transfer, immediately it takes place. Transferring to a different hospital will not affect the patient's legal status or position in any way. They will be treated in all respects, including the documentation completed in relation to their admission to, and detention in, hospital, as if they had always been in the new hospital. The authority to detain and the power of discharge are of course transferred to the RMO at the new hospital and to the new Trust (if applicable) from the time the patient is admitted to the receiving hospital.

5 RECEPTION INTO GUARDIANSHIP

Introduction

5.1 The purpose of guardianship is primarily to ensure the welfare (rather than the medical treatment) of a patient in a community setting where this cannot be achieved without the use of some or all of the powers vested by guardianship. It provides a less restrictive means of offering assistance to a person than, and should be considered as an alternative to, detention in hospital. It enables the establishment of an authoritative framework for working with a patient with a minimum of constraint to help them to achieve as independent a life as possible within the community. Arrangements for giving effect to guardianship should not be unnecessarily complicated. The objective should be simply to ensure that guardianship is used properly and in a positive and flexible manner.

5.2 Part II of the Order sets out the circumstances in which, and the procedures through which, certain persons with a mental disorder, aged 16 or over may be received into guardianship. Part II does not, however, deal with guardianship orders made by the Courts which are covered in Part III.

Components of effective guardianship

5.3 Where guardianship is used, it should be part of an agreed comprehensive care plan drawn up by the professionals who are or who could be involved in the patient's care, and, where appropriate, the patient's nearest relative or other informal carer. The plan should identify the services needed by the patient, including as necessary their care arrangements, appropriate accommodation, their treatment and personal support requirements, and those who have responsibilities under the care plan. It should indicate which of the powers given by guardianship are necessary to achieve the plan. If none of the powers given by guardianship are considered necessary for achieving the patient's welfare, guardianship is inappropriate.

5.4 The following components are necessary for guardianship to be effective:

- a willingness by the guardian to "advocate" on behalf of the patient in relation to those agencies whose services are needed to carry out the care plan;
- readily available support from the Trust for the guardian;
- an appropriate place of residence taking into account the patient's needs for support, care, treatment and protection;
- access to necessary day care, education and training facilities as appropriate; and
- effective co-operation and communication between all persons concerned in implementing the care plan.

5.5 Where the patient is capable of understanding, it is also necessary that there should be a recognition by the patient of the "authority" of the guardian. There must be a willingness on the part of both parties to work together within the terms of the authority which is vested in the guardian by the Order.

5.6 Where an adult is assessed as requiring residential care or supported living but, due to mental incapacity, is unable to make a decision as to whether they wish to be placed there, those who are responsible for their care should consider the applicability and appropriateness of guardianship for providing a framework within which decisions about their current and future care can be planned. Guardianship does not, however, confer powers to compel the admission of an unwilling person into any place of residency and physical interventions cannot be used to convey them there. Although the patient can be encouraged to return to a place of residence they may have removed themself from, significant persuasion and/or physical intervention cannot be used to return the patient. Consideration should also be given to the statutory criteria for a Deprivation of Liberty application under the MCA.

Grounds for guardianship

5.7 There are two grounds for guardianship: the medical ground and the welfare ground. A guardianship application may be made on the grounds that a person:

- *is suffering from mental illness or severe mental handicap of a nature of degree which warrants their reception into guardianship (the medical ground); and*
- *it is necessary in the interests of the welfare of the patient that they should be so received (the welfare ground).*

5.8 An application must be accompanied by two medical recommendations stating that the medical ground is met and a recommendation by an ASW stating that the welfare ground is met.

Powers of a guardian

5.9 Article 22 of the Order gives the guardian three specific powers:

"To require the patient to reside at a place specified by the Trust or person named as guardian".

The patient may be taken to the specified place if they willingly comply or offer no resistance. However, this power does not provide the legal authority to detain a patient physically in such a place, nor does it authorise the removal of a patient against their will. If the patient is absent without leave from the specified place, they may be returned to it within 28 days by those authorised to do so under Article 29(2) and (3) of the

Order. This may be used to discourage the patient from living with people who may exploit or mistreat them, or to ensure that they reside in a particular facility.

"To require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training".

If the patient refuses to attend, the guardian is not authorised to use force to secure such attendance, nor does the Order enable medical treatment to be administered in the absence of the patient's consent.

"To require access to the patient to be given at any place where the patient is residing to any medical practitioner, ASW or other person so specified".

A refusal without reasonable cause to permit an authorised person to have access to the patient is an offence under Article 125 of the Order. Neither the guardian nor any authorised person can use force to secure entry.

5.10 If the patient consistently resists the exercise of the guardian's powers, it can be concluded that guardianship should be discharged.

5.11 Guardianship does not restrict the patient's access to hospital services on a voluntary basis. Furthermore, guardianship can remain in force if the patient is admitted to hospital for assessment under Article 4 of the Order As the grounds for detention in hospital are so different from those required for guardianship, there is no provision in the Order for the transfer of patients in guardianship to detention in hospital. Consequently, the normal procedure for admission for assessment must be followed in this situation.

5.12 Guardianship can remain in force during the assessment period but does not do so if the patient is detained for treatment (Article 12(3)). If guardianship is considered to be appropriate when the patient is discharged following detention for treatment, a fresh application for guardianship is required.

5.13 It is possible for a person subject to guardianship under Part II of the Order to be transferred into the guardianship of another Trust or person approved by such Trust (Article 28).

Choice of applicant

5.14 Application for reception into guardianship may be made by:

- the patient's nearest relative (Article 19(1)(a));
- an ASW (Article 19(1)(b)); or
- a person appointed by a County Court to act as the nearest relative (Article 36).

The nearest relative

5.15 The nearest relative is defined in Article 32 of the Order by reference to a list of relationships in paragraph (1) of that Article, a caring relative taking priority over a non-caring relative (whatever their position on the list). They have an important part to play in the guardianship application even if they are not the applicant or the person named as the prospective guardian. They are normally the person who is closest to the patient and will usually be aware of the circumstances surrounding the possible need for guardianship. The patient may be required to live with the nearest relative whilst under guardianship.

5.16 Professionals involved in a case should offer to the nearest relative any advice or assistance required where they are proposing to act as the applicant and/or guardian. As applicant they should be made aware of the relevant form (**Form 13**)[80] and how it should be completed. As prospective guardian, they should be advised about the effect of guardianship, and the extent and limitations of a guardian's powers. Trusts should provide the nearest relative with written information that will support their role as applicant and provide information on the powers and process of guardianship.

5.17 The nearest relative will continue to play a significant part in the reception of patients into guardianship, even where the ASW acts as applicant, except where this is clearly not desirable; for example, where the patient has been neglected or abused by the nearest relative. In no circumstances should pressure be brought to bear on the nearest relative to make a guardianship application, act as guardian or participate in the continuing care of the patient whilst the patient is subject to guardianship.

5.18 Where the nearest relative unreasonably objects to the making of a guardianship application, the ASW should pursue the application. Alternatively, they may apply to the County Court to have an acting nearest relative appointed.

Application for reception into guardianship

5.19 The application, founded on two medical recommendations and a recommendation by an ASW, is central to the reception into guardianship procedure. The procedure is laid down in Articles 18 to 21 of the Order. Applications and recommendations must be made on the appropriate prescribed forms, and care should be taken to ensure that these are completed correctly.

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[80] It is a requirement of the legislation that prescribed forms and other reports are immediately submitted to RQIA by HSC Trusts. These may be sent electronically.

5.20 An application for guardianship may be made by the nearest relative or by an ASW, and the applicant must have seen the patient within 14 days prior to the making of the application. The application must be made on a prescribed form: **Form 13** is for use by the nearest relative and **Form 14** for use by the ASW. Part II of these forms provides for a statement by the person chosen as guardian (other than the Trust) that they are willing to act in this capacity.

5.21 In the majority of cases, Trust staff act as guardian and, in these situations, the Trust is named as the guardian rather than the individual staff member. The applicant is allowed to name themself as guardian (Article 18(5)), but they may instead name another person such as a relative or family friend. The completed application form and accompanying medical and social work recommendations must be forwarded to and be accepted by the Trust, otherwise the application will have no effect. It follows therefore that the Trust must accept the nominee as a suitable person to act as guardian. A guardianship application cannot be made by the same ASW who gave the social work recommendation on which it is founded.

5.22 Before making an application, the ASW must consult the nearest relative unless this is not reasonably practicable or would involve unreasonable delay. If the nearest relative objects to the application, the ASW, if they wish to proceed, must consult a second ASW. The person consulted must not be the same ASW who gave the social work recommendation on which the application is founded. This means that, in this case, three different ASWs are involved in the application. If, following the consultation with the second ASW, the applicant is satisfied that the application should be made, they can proceed with it provided they record the nearest relative's objection on the application form. Thus, this information will be available to the Trust when it comes to consider whether or not the application should be accepted. If the ASW is unable to consult the nearest relative before the patient is received into guardianship, they must inform the nearest relative as soon as practicable afterwards.

ASW responsibilities

5.23 ASWs have two distinct roles in the application process, and these must be carried out by two different ASWs.

5.24 Article 40 of the Order places a duty on the ASW to make a guardianship application where they are satisfied that an application ought to be made and that it is necessary or proper for the application to be made by them. The ASW must also be satisfied it is the most appropriate way of providing the care and medical treatment (Article 40(2)). The practical guidance in paragraphs 2.23 to 2.41 of the Code is equally applicable where the ASW is considering making a guardianship application pursuant to their duty under Article 40 and is also generally applicable where they are considering an application at the request of the nearest relative.

5.25 A guardianship application must be founded on a recommendation by an ASW other than the ASW applicant and on two medical recommendations, one of which must be made by a Part II medical practitioner. In making a recommendation, the ASW must be satisfied that reception into guardianship is in the interests of the welfare of the patient. In making their determination, ASWs should consider whether appropriate facilities are available to give effect to the powers of guardianship, such as a suitable place of residence or adequate arrangements for occupation, education or training.

5.26 The recommendation must be given on a prescribed form (**Form 17**)[81] and should include:

i. a statement that in the opinion of the ASW it is necessary in the interests of the welfare of the patient that they should be received into guardianship;
ii. a statement of the reasons for the opinion that the patient cannot be appropriately cared for without powers of guardianship; and
iii. a statement as to whether the ASW is related to the patient or has any pecuniary interest in their reception into guardianship. Although the Order does not specify when the ASW's recommendation should be signed, it is essential that this is done before the date of the application, and within, at most, two weeks prior to that date.

Medical recommendations

5.27 Two medical recommendations are required and may be made jointly or separately. The medical recommendations must be in the prescribed form and may be given either separately or jointly using **Form 15** or **Form 16.** Each medical practitioner must examine the patient within two days prior to signing the recommendation and, where the medical practitioners examine the patient separately, the two examinations must not be more than seven days apart. This means that the earlier of the two examinations can never take place more than 14 days before the application is sent to the Trust. One of the medical practitioners must be a Part II medical practitioner who will in practice be a consultant psychiatrist and will have special knowledge of the patient's condition, and the other should, if practicable, be the patient's own GP or a medical practitioner who has previous experience of the patient. This could be a hospital medical practitioner who has previously been involved in treating the patient or another GP. The aim is to ensure that the decision to place the patient in guardianship is taken in the light of full and recent evidence as to their mental condition, given, as far as possible, by medical practitioners who have been clinically responsible for them in the past, and may be in the future.

[81] It is a requirement of the legislation that prescribed forms and other reports are immediately submitted to RQIA by HSC Trusts. These may be sent electronically.

5.28 The statements as to the form of mental disorder which constitute the medical ground for reception into guardianship are statements of opinion. The details on which these opinions are based should be given and should include a full description of the patient's clinical condition. Both medical recommendations must specify at least one common form of mental disorder, either mental illness or severe learning disability, otherwise a guardianship application will be of no effect.

5.29 If the medical practitioners examine the patient separately, each must sign their recommendation within two days of carrying out the examination.

5.30 The criteria for guardianship application and medical recommendation are set out in Article 18(2) and (3)(a) of the Order. The medical criteria differ from those for application for admission to hospital for assessment in that the patient must be suffering from "mental illness or severe mental handicap".

The Application

5.31 A guardianship application is made to the responsible authority which is the receiving Trust. The application may name the Trust or any other willing person, Including the applicant, as prospective guardian (Article 18(5) and (6)). The application is made on **Form 13** by the nearest relative, or on **Form 14** by the ASW. The ASW' s recommendation is given on **Form 17**. As the application must be founded on these recommendations, **Form 15** (or two separate **Forms 16**) and **Form 17** must be completed before **Form 13** or **Form 14**. It follows that the completed recommendation forms should be given to the applicant. The correct forms should be used and should be properly completed if the Trust is to be able to grant the application.

5.32 A guardianship application must be forwarded to the Trust Director of Mental Health or equivalent, not more than seven days after the patient's last medical examination for the purposes of the application (Article 22(2)). Once the application has been accepted by the Trust, the powers of guardianship take effect immediately. Any previous application for guardianship, or liability to be detained, ceases to have effect when the patient is placed under guardianship. The Trust is required to send a copy of the application form, and the recommendations on which it is founded, to RQIA immediately when the patient is received into guardianship.[82] Details of the processes to be followed should be set out in the Trust's operational policy and this should be made available to both patients and nearest relatives when guardianship is being considered.

5.33 A patient received into guardianship may be supported through guardianship for a period not exceeding six months, beginning with the day on which the guardianship application was accepted.

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[82] It is a requirement of the legislation that prescribed forms and other reports are immediately submitted to RQIA by HSC Trusts. These may be sent electronically.

5.34 Where a patient is received into guardianship on the application of an ASW who has not consulted the patient's nearest relative, the ASW must inform the nearest relative as soon as is practicable (Article 19(6)).

Renewal of authority for guardianship

5.35 The authority for guardianship may be renewed at the end of the initial six months period for a further six months and subsequently for consecutive periods of one year. The medical and welfare grounds for renewal are the same as those required for making an application. The procedure for renewal remains the same, regardless of the duration of the authority sought. The RMO must, within the period of two months before the expiry of the authority for guardianship, either examine the patient themself or obtain a report on the condition of the patient from another doctor (this should be the patient's own GP). If the RMO is satisfied that the medical ground for guardianship continues to be satisfied, they must give to an ASW named by the Trust a report on the prescribed form **(Form 18)** to that effect, together with the other doctor's report if they have obtained one. The ASW must then consider whether the welfare ground for guardianship continues to apply. If they are satisfied that it does, they must send to the Trust a report on the prescribed form **(Form 19)** to that effect, along with the RMO's report and any second medical report that they may have obtained. When these reports have been received by the Trust, the authority for guardianship is renewed for the appropriate period. Each time the authority is renewed, the Trust must inform the patient, the nearest relative and the guardian, and must send copies of the reports on which the renewal is founded to RQIA.

Notifications to RQIA

5.36 Where a patient is received into guardianship the Trust should immediately forward a copy of the application and the recommendations on which it is founded to RQIA for review (Article 22(5)). Forms should be forwarded to RQIA immediately on completion, with a copy emailed to RQIA within 24 hours of completion so they can be scrutinised and confirmation provided that the process has been followed.

Rectification of guardianship applications and recommendations

5.37 Article 21 of the Order provides that a guardianship application or any recommendation on which it is founded, discovered within 14 days of acceptance by the Trust to be incorrect or defective, may be corrected within the 14 days. Where a recommendation is deemed insufficient to warrant reception into guardianship, the applicant should be informed. Article 21 provides that in such circumstances the recommendation shall be disregarded but that the application shall be deemed to be sufficient if a fresh recommendation complying with the provisions of the Order is provided to the Trust. RQIA must be informed of any alterations made and sent a copy of any substitution provided.

Role of the Trust

5.38 The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 govern the exercise by guardians of their powers under the Order and impose duties on guardians and on the Trusts in the interests of patients. It is recommended that each Trust should prepare and publish its operational guidance in relation to guardianship. The guidance should also include reference to regulation 4(a) of the 1986 Regulations which imposes a duty on private guardians to comply with any direction given by the Trust.

Duty of the Trust to give information to patients and nearest relatives

5.39 Article 27 places a duty on the Trust to provide certain information to patients subject to guardianship and to their nearest relatives. Article 27(1) requires the Trust to take such steps as are practicable to ensure that the patient understands:

(a) under which provision of the Order, they are subject to guardianship and the effect of that provision; and
(b) their right to apply to the Review Tribunal (if applicable).

5.40 This information must be given, as soon as practicable, after the commencement of the patient's reception into guardianship, or after any renewal of the authority for guardianship and must be given both orally and in writing. This information should be provided within five working days. It is important that the patient is made aware of the legal aid scheme when they are being told about their right to apply to the Tribunal.

5.41 When the RMO, nurse or social worker is giving information to the patient, they should be as helpful as possible and try to explain to the patient any points they do not appear to understand. Some patients will not be able to comprehend what they are told, but the law requires that the attempt should be made, and in the case of the short-term powers there may be little time to wait and see if a patient's powers of understanding improve.

5.42 Article 27(2) places a further duty on the Trust to take such steps as are practicable to ensure that a patient subject to guardianship understands the effect, so far as they apply to them, of Articles 14, 24 and 71(4) of the Order which deal with the power of the RMO, an authorised social worker, the Trust and the nearest relative to discharge them; and that they understand that they may make representations to RQIA. The Trust must also take steps to ensure that the patient understands the effects, so far as they apply to them, of Articles 15 and 17 which deal with patients' correspondence, Article 11 which deals with the Code of Practice, and Part IV which deals with consent to treatment; and that the patient's nearest relative is provided with a written statement of their rights and powers under the Order.

5.43 The information to be given to the patient under Article 27(2)(a) and (b) must be given both orally and in writing, and the information to be given to the nearest relative under Article 27(2)(c) must be given in writing. In addition, the information must be given as soon as practicable after the patient's guardianship begins. It should be noted that Article 27(5) requires that the patient's nearest relative should also be given a copy of any written information given to the patient, but this requirement is subject to the patient's wishes; in other words, if the patient expressly requests that such information should not be given to the nearest relative then the Trust should not do so. Patients and nearest relative information leaflets are available for this purpose.

5.44 An oral explanation is required because this will often be the best way of helping the patient to understand their position. The person who explains the patient's rights to them should answer all reasonable questions and should take account of the patient's intelligence as well as any physical disability which inhibits the patient's ability to communicate. It may be necessary to call upon the services of persons trained in working with patients with a sensory impairment, if the patient has a sensory impairment. In the case of the longer term powers, a period of time may be allowed to lapse before the patient is given this information if, at the start of detention, their condition is so poor that it is felt they will not understand it, but it is important that this delay is not prolonged to the extent that it conflicts with the requirements of the Order to inform "as soon as practicable".

Discharge from guardianship

5.45 A patient may be discharged from guardianship under Article 27 by the RMO, an ASW authorised for this purpose by the Trust or by the nearest relative. The RMO must discharge the patient if they are satisfied that the medical ground for guardianship is no longer satisfied and the authorised social worker must discharge the patient if the welfare ground no longer applies. To be valid, an order for discharge must be in writing and the recording format should be used.

5.46 If the nearest relative wishes to exercise their right to discharge the patient, they must give at least 72 hours' notice to the responsible Trust. Where any part of the 72-hour period falls on a Sunday, the period of notice is automatically extended to 96 hours. If, during this period of notice, the RMO makes a written report to the Trust stating that the medical ground for guardianship continues to apply AND an authorised social worker reports to the Trust in writing that the welfare ground still applies, the discharge will not occur. In these circumstances, the Trust must forward a copy of each report to RQIA and also must inform the nearest relative that the discharge has been barred and that they will not be able to make another order for discharge for six months from the date of the later of the two reports by the RMO and the authorised social worker. The nearest relative then has a right of appeal to the Review Tribunal to seek the patient's discharge, and such

applications may be made within 28 days of being so informed by the Trust that reports have been provided under Article 24(4).

5.47 If the patient is discharged by the RMO, an authorised social worker or the nearest relative, the Trust must immediately inform RQIA and the patient's guardian, if other than the Trust.

5.48 A doctor authorised by or on behalf of the nearest relative may at any reasonable time visit the patient and examine him in private, for the purpose of advising the nearest relative as to the exercise of their powers to discharge the patient, or providing information as to the condition of a patient for the purposes of such an application (Article 81).

Transfer of guardianship

5.49 Articles 25 and 28(5)(a) provide for the transfer of a patient from the guardianship of one person to another without a break in the authority for guardianship and without the need for a fresh application. This may arise in a variety of circumstances; for example, if the guardian dies, becomes incapacitated, wishes to relinquish their functions or is found to be performing their functions negligently.

5.50 Where a guardian dies or gives notice in writing to the Trust that they are no longer willing to act as guardian, the guardianship of the patient will immediately be vested in the Trust. The Trust then has the option of acting as guardian itself or of transferring the patient into the guardianship of another person under Article 28(5). The Trust should take the necessary steps to ensure that any new guardian is a suitable person for the purpose and that they are willing to act in that capacity. Their consent should be obtained in writing. Before arranging a transfer under Article 28(5), the Trust must, if practicable, inform the patient's nearest relative and the guardian, if other than the Trust, who is being replaced.

5.51 Where the guardian is temporarily incapable of acting, because of illness or for any other reason, the Trust itself may temporarily act as guardian or approve another person for the purpose. This makes it unnecessary to operate the full procedure for transfer of guardianship where the guardian's incapacity is clearly not going to be permanent.

Transfer of patients

5.52 Article 28 permits the Trust to arrange for the transfer of a detained patient into guardianship; and for the transfer of a patient subject to guardianship from the guardianship of one person into that of another. A patient subject to guardianship cannot be transferred to detention in hospital. A transfer may be arranged for a variety of reasons; for example, the RMO may consider that another hospital could provide treatment more suitable to the patient's needs, or the nearest relative or other relatives of the patient may request it to facilitate visiting.

Transfer from hospital to guardianship

5.53 The question of transferring a patient from detention in hospital to guardianship is most likely to arise after a patient has already been on leave of absence from hospital with a view to discharge from hospital. In such cases, if, after a suitable period on trial in the community, it is still not clear that a patient has recovered to the extent that would justify complete discharge from all compulsory powers, but it is not likely to be necessary to recall them to hospital, the patient may be transferred to guardianship to provide the necessary statutory basis for long-term care under powers in the community.

5.54 As with transfers between hospitals, the initiative for transfer from hospital to guardianship will usually originate with the RMO. They should involve an ASW at a very early stage who should give advice on the patient's suitability for guardianship from a welfare point of view. The nearest relative may also be consulted at an early stage but in any case, the Trust is required to notify them before any transfer takes place (Article 28(9)). If the guardian is to be a person other than the Trust, the guardian's consent should be obtained in writing. The Trust's agreement to the transfer should also be recorded in writing. If the transfer is to another Trust's area, the agreement of that Trust should also be obtained in writing. These records will ensure that the authority of the guardian over the patient and the powers and duties of the Trust may not subsequently be questioned.

5.55 The removal of the patient to the place where the guardian wishes them to live should be arranged as soon as possible after the above records have been made. The authority of the guardian will date from the day on which the patient reaches their new residence (or, if the patient is already there on leave, from the date on which the procedure for authorising the transfer is completed).

5.56 Where a patient is transferred from detention in hospital to guardianship, the provisions of Part II of the Order apply to them as if the application for assessment, by virtue of which they were admitted to hospital, were a guardianship application. The date of the application is the date the guardianship is accepted as running from. This may mean that the guardianship will need renewed soon after it has been authorised. The transfer does not affect the duration of the patient's detention, which will expire at the same time as it would have expired if the patient had remained in hospital. Both the medical and welfare grounds for guardianship will, of course, have to continue to be met if the patient is to remain in guardianship or if the authority for guardianship is to be renewed. As with transfers between hospitals, the Trust is required under Article 28(10) to notify RQIA of the transfer of a patient from hospital to guardianship or from one guardian to another, immediately when the transfer takes place.

Alternatives to guardianship application

5.57 Before making a recommendation or guardianship application, the professionals involved should consider all reasonable alternatives for providing for the patient's care and protection. The Trust's operational guidance is equally applicable when guardianship is being contemplated.

6 NOTIFICATIONS TO THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (RQIA)

6.1 Following the transfer of its functions from the former Mental Health Commission, under Article 25(1) of the Health and Social Care Reform Act (Northern Ireland) 2009,[83] RQIA has a range of statutory duties as specified in the Order. RQIA's overarching duty under the Order is set out in Article 86.

RQIA's primary functions

6.2 RQIA's primary functions are to keep under review the care and treatment of those with a mental disorder, including the exercise of the powers and the discharge of the duties conferred or imposed by the Order. The function is twofold: a protective role in relation to all people with a mental disorder; and a monitoring role in relation to the operation of the Order. RQIA has been given a wide range of duties and powers in the Order to enable it to carry out this role. Among these duties is to bring any matters concerning the welfare of people with a mental disorder to the attention of the appropriate authority (the DoH, the DoJ) where it considers that this is appropriate, and a duty to give advice to any statutory body on matters arising out of the Order, if it is asked to do so.

6.3 RQIA's role is not confined to patients detained in hospital; on the contrary, its jurisdiction extends to voluntary patients, people subject to guardianship, patients in nursing homes or residential care accommodation, and anyone with, or even appearing to have a mental disorder.

Formal inquiry

6.4 RQIA has a specific duty to investigate any case where there appears to be ill-treatment, or deficiency in care and treatment of any patient, improper detention in hospital, or reception into guardianship, or actual or potential loss or damage of a patient's property. If need be, RQIA has the power to conduct a formal inquiry to establish the facts of a case.[84] Where, following full investigation, RQIA is satisfied that remedial action needs to be taken, it must bring the facts to the appropriate authority. This might be the DoH, the DoJ, a Trust, a guardian or any other person having care of the person with a mental disorder. Although RQIA does not have the power to enforce compliance with its recommendations or advice, it can require the relevant authority or person to make a formal response within a specified period, explaining what action has been taken to remedy the situation or why no action has been taken. This power is discretionary because a formal reply would not be necessary or even desirable in every case.

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[83] Health and Social Care Reform Act (Northern Ireland) 2009

[84] Formal Inquiry by RQIA is not an Inquiry under the Inquiries Act 2005. It is a term used to reflect the formal process undertaken by RQIA to determine the fact of a situation where ill treatment or deficiency in care or treatment etc. has been reported or suspected.

6.5 It should be noted that RQIA has regulatory powers as set out in The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003,[85] which may also be used when appropriate.

Visiting and interviewing patients

6.6 RQIA has a statutory duty to visit, and interview in private, patients liable to be detained under the Order. This includes patients on a leave of absence or conditionally discharged patients. The timing and frequency of such visits is not specified and is entirely at the discretion of RQIA. However, hospitals can expect to be visited at least once per year. In practice, some short-term patients may not receive a visit during their stay in hospital. RQIA may give notice of its intention to visit a hospital, but it does not have to and visits may be unannounced.

6.7 RQIA has the power to visit, interview and medically examine in private any patient with a mental disorder whether they are in hospital, subject to guardianship, in a nursing home or any form of residential accommodation. Only medically qualified doctors employed by RQIA can medically examine patients. The doctor can require the production of and inspect medical records relating to the detention or treatment of the patient. Equally, RQIA can require the production of, and inspect records of, a multidisciplinary nature or any other records which relate to a patient's detention or treatment. This extends to patients who have been discharged, whose complaints can also be investigated.

6.8 RQIA must be offered all facilities necessary to enable them to carry out their tasks. Hospital and Trust staff must therefore co-operate fully with RQIA, as must any person responsible for caring for a person with a mental disorder, subject to guardianship, in a nursing home or residential facility. To refuse access to patients or records, or to obstruct RQIA from carrying out its functions under the Order, is an offence under Article 125.

Other RQIA functions

6.9 RQIA, when requested to do so, may review a decision to withhold a postal packet and compel the production of items withheld for this purpose (Article 17).

6.10 In relation to patients' property, RQIA has a duty to notify the Office of Care and Protection of any person who is incapable of managing their affairs (Article 107(3)). It can also allow Trusts to hold money or valuables for a patient in excess of the amount allowed by the DoH.[86]

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[85] The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

[86] The DoH amount in September 2025 is £20,000

Matters which RQIA must be notified of through the submission of prescribed forms

6.11 The Order sets out a number of matters about which RQIA must be notified, including matters relating to reception of patients into guardianship; detention; electroconvulsive therapy treatment; and in cases where prescribed medications are prescribed for a period exceeding three months. Prescribed forms are to be completed and submitted to RQIA to notify of such matters. These prescribed forms are set out in The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986.[87]

6.12 It is a requirement of the legislation that prescribed forms and other reports are immediately submitted to RQIA by HSC Trusts. These may be sent electronically.

6.13 Article 11 of the Order allows certain amendments of prescribed forms associated with applications, recommendations and reports by the person who signed the form, providing they are received within 14 days from the date of the patient's admission to hospital.

Errors and/or omissions

6.14 Where RQIA identifies errors and/or omissions noted outside of the 14-day timeframe, as these cannot be rectified and may render the entire application invalid and the detention improper, if the patient still requires to be detained in hospital, RQIA will direct the entire detention process to be recommenced.

6.15 Forms should be legible, complete and accurate.

Compulsory admission to hospital

6.16 When a patient has been admitted to hospital for assessment, a copy of **Form 1** (Application by Nearest Relative) or a copy of **Form 2** (Application by an ASW) and **Form 3** (Medical Recommendation) must be submitted to RQIA.

6.17 If a **Form 5** (Medical Practitioner's Report) or **Form 6** (Nurse's Record) for a patient not liable to be detained have been completed, a copy must be submitted to RQIA.

6.18 When the time limit for conveying a patient to hospital requires to be extended due to exceptional circumstances, a copy of **Form 4** (Medical Certificate to Extend the Time Limit for conveying a Patient to Hospital) must be submitted to RQIA.

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[87] The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986

The assessment period

6.19 A copy of **Form 7** (A Report of Medical Examination Immediately After Admission for Assessment)) must, regardless of the outcome of the examination, be submitted to RQIA.

6.20 If applicable, a copy of **Form 8** (Medical Report to Extend Assessment Period from 48 hours to 7 days) or **Form 9** (Medical Report to Extend Assessment Period for A Further 7 Days) must be submitted to RQIA.

Detention for treatment

6.21 Following a period of assessment, if it is necessary to detain a patient for treatment for a period not exceeding six months beginning with the date of admission, a copy of **Form 10** (Medical Report for Detention for Treatment) must be submitted to RQIA.

6.22 If applicable, when the detention for treatment extends beyond six months, **Form 11** (Report by RMO for Renewal of Authority for Detention for 6 Months or One Year) must be submitted to RQIA.

6.23 If applicable, when the detention for treatment extends beyond one year, **Form 12** (A Joint Medical Report for First Renewal of Authority for Detention for One Year) must be submitted to RQIA.

6.24 Where the detention for treatment extends beyond this time period (24 months or two years) a copy of **Form 11** (Report by RMO for Renewal of Authority for Detention for 6 Months or One Year) must be submitted to RQIA.

Guardianship

6.25 RQIA monitor and review all patients who have been received into guardianship.

6.26 A guardianship application may be made by the nearest relative (**Form 13**) or an ASW (**Form 14**).

6.27 A guardianship application shall be founded on and accompanied by two medical recommendations and a recommendation by an ASW for Reception into Guardianship (**Form 17**). The Medical Recommendation for Reception into Guardianship is sufficient if the medical recommendations on which it is founded are given either as separate recommendations (**Form 16**), each signed by a medical practitioner, or as a joint recommendation signed by two medical practitioners (**Form 15**). A copy of the reports (**Forms 15, 16, 17**) must be submitted to RQIA.

6.28 A patient received into guardianship may be supported through guardianship for a period not exceeding six months, beginning with the day on which the guardianship application was accepted.

6.29 Authority for the guardianship of a patient may be renewed, provided the grounds in Article 18(2)(a) continue to be met, for a period of six months, then a further six months (one year) and so on for periods of one year at a time. A report by a RMO for Renewal of Authority for Guardianship (**Form 18**) and report by an ASW for Renewal of Authority for Guardianship (**Form 19**) must be submitted to RQIA.

6.30 It is recommended that all supporting evidence, including medical and social work reports that justify the use of guardianship, should be submitted to RQIA

Discharge of patient from detention and guardianship

6.31 Articles 14 and 24 of the Order require HSC Trusts to notify RQIA of the discharge of a patient from detention or guardianship.

RQIA appointed medical practitioners

6.32 The power to appoint medical practitioners was vested in RQIA following the transfer of functions from the former Mental Health Commission, under Article 25(1) of the Health and Social Care (Reform) Act (Northern Ireland) 2009. The suitability of each applicant is considered by an Appointment Panel, which takes account of the relevant experience, training and professional standing of the medical practitioner. RQIA's Medical Appointments Panel has delegated authority to make appropriate appointments for medical practitioners under Part II and Part IV of the Order.

6.33 Medical practitioners under Part II of the Order are normally consultant psychiatrists who provide the medical reports required for the purposes for compulsory detention in hospital or reception into guardianship.

6.34 Medical practitioners under Part IV of the Order are those doctors who, in cases where it is proposed to administer drugs and urgent treatment without consent, can provide a second opinion for the purposes of Part IV of the Order.

Treatment requiring consent and a second opinion

6.35 Article 63 of the Order outlines RQIA's statutory duties with respect to specific forms of medical treatment for mental disorder. Some forms of treatment are considered so severe and have such side effects that it is not sufficient for one RMO to authorise their use.

6.36 The treatments are surgical operations for destroying brain tissue, or for destroying the functioning of brain tissue, and the surgical implementation of hormones for the purpose of reducing male sexual drive. The patient must consent to having this treatment. A copy of a Certificate of Consent to Treatment and Second Opinion (**Form 21**) must be submitted to RQIA.

Treatment requiring consent or a second opinion

6.37 Article 64 of the Order outlines RQIA's statutory duties with respect to specific forms of medical treatment for mental disorder. The treatments are:

i) the administration of medicine as may be prescribed during a period of detention if three months or more have lapsed since the first occasion in that period when medicine was administered to the patient by any means for their mental disorder; or
ii) electro-convulsive therapy.

6.38 When a patient has been assessed as having capacity to consent to the treatment, the RMO or a Second Opinion Appointed Doctor (SOAD) (Part IV medical practitioner) must complete the Certificate of Consent to Treatment (**Form 22**) and a copy must be submitted to RQIA.

6.39 When a patient has been assessed as not having capacity to consent to the treatment, a SOAD must complete the Certificate of Second Opinion (Treatment Requiring Consent or a Second Opinion) (**Form 23**) and a copy must be submitted to RQIA.

Transfers to Northern Ireland

6.40 When a patient is moved to Northern Ireland from another jurisdiction, a copy of the Medical Report on Patient Removed to Northern Ireland (**Form 24**) must be submitted to RQIA together with A Medical Report for Detention for Treatment (**Form 10**).

7 REVIEW TRIBUNAL

7.1 The Tribunal is an independent judicial body established under Article 70 of the Schedule to the Order. Its role is to review the cases of patients who are detained in hospital, subject to guardianship under the Order, or subject to authorisations of deprivation of liberty, as well as applications relating to the appointment or removal of nominated persons under the MCA.

7.2 The Tribunal's functions under the MCA are set out in the MCA Code of Practice. This section deals specifically with the Tribunal's functions under the Order.

7.3 The Tribunal provides patients with an important safeguard against unjustified detention in hospital or control under guardianship by reviewing cases from both medical and non-medical perspectives. There are two ways in which a patient's case may be considered by the Tribunal:

- by application, usually made by the patient, but in certain circumstances by the nearest relative; or
- by referral, which may be discretionary or mandatory.

7.4 The Tribunal is made up of legally qualified members, medically qualified members, and experienced lay members. At a hearing, the Tribunal will be composed of either two or three members, one of whom must be legally qualified.

Right to apply – patient

7.5 Patients detained in hospital or subject to guardianship have a right to apply to the Tribunal on the following occasions:

Non-offender patients
a) Once during the first six months of detention or guardianship. The application may be made at any time from the date of admission to hospital for assessment or acceptance into guardianship.
b) Once during the six-month period beginning with the date of the first renewal of the authority for detention or guardianship.
c) Once during each subsequent twelve-month period for which detention or guardianship is renewed.

Unrestricted offender patients
The same rights apply as for non-offender patients, with the date of the hospital order or transfer direction treated as the date of admission to hospital or acceptance into guardianship.

Restricted patients

a) Once during the six-month period beginning with the date of the hospital order or transfer direction.
b) Once during the six-month period following that initial period.
c) Once during each subsequent twelve-month period of detention in hospital.

Conditionally discharged patients

Where not recalled to hospital, once during the first twelve-month period following conditional discharge and annually thereafter. Where recalled to hospital, the DoJ must refer the case to the Tribunal within one month of the patient's return to hospital.

7.6 Applications to the Tribunal must be made in writing using the appropriate form, depending on the patient's circumstances.

Right to apply – nearest relative

7.7 The nearest relative of a patient detained in hospital or subject to guardianship may apply to the Tribunal in the following circumstances:

Non-offender patients

a) Once within the first 28 days from the date on which the nearest relative is informed that their order for the patient's discharge has been barred by the RMO under Article 14(4), or by the RMO and an authorised social worker under Article 14(4).
b) Where the nearest relative has been barred from acting by an order of the County Court under Article 36, once during the first twelve months following the date of the court order and once during each subsequent twelve-month period for the duration of that order.

Unrestricted offender patients

To reflect the absence of a right to order discharge, the nearest relative may apply once during the first twelve-month period of detention in hospital or reception into guardianship, and annually thereafter.

Discretionary referrals

7.8 The case of a patient liable to be detained in hospital or subject to guardianship under the Order may be referred to the Tribunal as follows:

Non-offender and unrestricted offender patients*:* at any time by the Attorney General, the DoH, or the Master (Care and Protection), acting on the direction of the Court.

Restricted patients: at any time by the Secretary of State.

All detained patients or persons subject to guardianship: RQIA may refer a case at any time under Article 86(3)(a).

7.9 Any case referred under these provisions must be considered at a properly constituted hearing of the Tribunal.

Mandatory referrals

7.10 Patients subject to detention or guardianship must be referred to the Tribunal in the following circumstances:

Non-offender and unrestricted offender patients*:* by the responsible Trust, where the case has not been considered by the Tribunal within two years (or one year for patients under 16). Referral is normally made at the next renewal of detention or guardianship.

Restricted patients*:* by the DoJ, where the case has not been considered within two years.

Conditionally discharged patients: where recalled to hospital, the DoJ must refer the case within one month.

7.11 References by the DoJ must be considered at a properly constituted hearing. Hearings following Trust referrals are held at the discretion of the Tribunal.

Powers of the Tribunal

7.12 The Tribunal's powers vary depending on the legal status of the patient whose case is under consideration.

Non-offender and unrestricted offender patients (Article 77)

The Tribunal:

i) May discharge the patient at its discretion.
ii) Must discharge the patient if satisfied that one or more of the statutory criteria for detention or guardianship no longer apply. Where discharge by the nearest relative was barred under Article 14(4), the Tribunal must also be satisfied that the patient would receive proper care if discharged.
iii) May direct a delayed discharge, where time is required to make appropriate arrangements.
iv) May recommend leave of absence, transfer to another hospital, or transfer into guardianship. If recommendations are not complied with, the Tribunal may reconsider the case.

Patients subject to restriction orders (Article 78)

The Tribunal has no discretionary power to discharge patients subject to restriction orders, except in cases of conditional discharge, and cannot

recommend leave of absence or transfer. The DoJ retains its discretionary powers in relation to discharge and termination of restrictions.

The Tribunal must:

i) Direct absolute discharge where the criteria for continued detention are no longer met and recall liability is not appropriate.
ii) Direct conditional discharge where recall liability remains appropriate.
iii) Defer conditional discharge until satisfied that suitable arrangements are in place.

Conditionally discharged patients may be recalled by the DoJ at any time and must comply with imposed conditions, which may be varied. Where restrictions expire or are removed, the patient is treated as absolutely discharged.

Patients subject to restriction directions (Article 79)

Patients subject to restriction directions may be returned to prison or brought before a Court if they no longer require hospital treatment. The Tribunal cannot authorise discharge but must notify the DoJ where discharge would otherwise be appropriate. It may recommend continued hospital detention where discharge is not possible.

Sentenced patients

In the case of a sentenced patient, it may be that the DoJ is able to agree to the discharge. The DoJ has 90 days from the date of notification of the Tribunal's finding in which to give notice that the patient may be discharged if they do not do so, the patient must be returned to prison unless the Tribunal has recommended that in these circumstances they should remain in hospital.

In the case of a patient who was originally a remand prisoner or other prisoner transferred to hospital under Article 54(2) (civil prisoners and persons detained under the Immigration Act 1971, etc.), the DoJ has no discretion. Unless the Tribunal has recommended that the patient be detained in hospital they must return the patient to prison.

How to apply to the Tribunal

7.13 Applications to the Tribunal must be made in writing, signed by the applicant or any person authorised by them to do so on their behalf and addressed to the Tribunal. Although there is no prescribed form of application, a suitable form can be supplied to the applicant on request by either the Secretary to the Tribunal or by the responsible Trust, which should arrange for hospitals in which patients are detained, and local social services offices, to hold stocks of these forms. Trust staff should give patients and their relatives any help required to fill in the forms.

7.14 In each case only one application can be made in the period specified. This application can be made at any time during the period. An application which is withdrawn before it can be determined does not count for this purpose. However, the agreement of the Tribunal is required if an application is to be withdrawn. This is to ensure that withdrawal is not the result of improper influence or has not been decided on without due consideration.

Tribunal rules

7.15 The Review Tribunal Rules (Article 83), are governed by The Review Tribunal (Amendment) Rules (Northern Ireland) 2019.[88] These impose certain duties on the responsible Trust: for example, the Tribunal will send a copy of each application to the Trust and ask it to submit a statement giving certain information including a medical report by the RMO. The Trust should inform the Tribunal immediately if the patient has no right to apply; for example, if the patient is not subject to detention under the Order and is free to leave hospital. In all other cases the Trust should forward its statement as soon as possible, and in any case within three weeks, and the Tribunal will then arrange a hearing in accordance with the Rules. Where the applicant is a restricted patient detained in hospital, the DoJ will also provide a statement. Where the applicant is a conditionally discharged patient, the DoJ will provide the whole statement. The responsible Trust or the DoJ may ask, giving supporting reasons, that part of the statement is withheld from the patient (see Rules 6(4) and 12).

7.16 The Tribunal has power under the Rules to obtain any information it deems necessary, including the power to subpoena witnesses. The medical member of the Tribunal will, in all cases, be required to examine the patient or take such steps as they consider necessary to form an opinion of the patient's mental condition. It should be noted that the patient or the applicant has also got a right to have a doctor of their choice carry out an independent medical examination of the patient. This examination may be carried out in private and the doctor involved may require any records relating to the patient's detention or treatment in hospital to be produced for their inspection. Such an independent medical examination may be carried out either for the purpose of advising whether an application to the Tribunal should be made in the first instance or, in the case of a reference to the Tribunal, for the purposes of furnishing information for the purpose of the reference. However, restricted patients do not have a right to independent medical advice for the purposes of a reference by the Secretary of State.

7.17 Legal aid may be available and the patient must undergo a simple assessment of resources carried out by their solicitor to ensure that they qualify on financial grounds. The solicitor must also apply to the Legal Aid Department for approval to assist by way of representation in the

[88] The Review Tribunal (Amendment) Rules (Northern Ireland) 2019

proceedings. Trusts are usually represented by the RMO, with hearings normally held at the hospital.

7.18 Legal aid application forms may be obtained from any solicitor undertaking legal aid work. The Legal Aid Solicitors List and leaflets on eligibility for legal aid are available from the Legal Aid Department. In addition, HSC Trusts, and any member of hospital staff, including social workers, may obtain advice on legal aid and the availability of solicitors from that Department to assist those patients who have no access to solicitors or other legal advice.

7.19 The responsible Trust may be represented at a Tribunal hearing by any officer they authorise for this purpose. This will normally be the RMO who should be ready to answer any questions the Tribunal may have about the patient's suitability for discharge and his home circumstances. Other people, in particular social workers, may be brought as witnesses when necessary. It is not usually necessary for the responsible Trust to be legally represented.

7.20 Tribunal hearings are usually held at the hospital in which the patient is detained. Trusts are asked to ensure that suitable rooms are made available for the Tribunal and anyone attending as a witness.

7.21 Further information for patients is provided by the DoJ.

7.22 Tribunal hearings can feel daunting. Patients are entitled to support before, during, and after the hearing, including advocacy services and reasonable adjustments.

Outcome of hearings

7.23 Patients and Trusts are normally notified of determinations on the day of the hearing, with full written decisions issued within 14 days.

8 PATIENTS CONCERNED IN CRIMINAL PROCEEDINGS OR UNDER SENTENCE

8.1 The DoJ Public Protection Branch can be contacted for further information and assistance to staff who will use this document and/or work at an operational level. Email: DOJMentallyDisordered.Offenders@justice-ni.gov.uk

Introduction

8.2 Part III of the Order provides for the admission to hospital or placement under guardianship of persons concerned in criminal proceedings or under sentence. The DoH's role and responsibilities under the provisions of Part III have been transferred to Trusts by the Health and Social Care Act (Northern Ireland) 2022.[89]

8.3 People who have a mental disorder are particularly vulnerable when in custody. All professional staff should take this into account in dealing with accused or convicted prisoners, not forgetting the possibility of self-injury or suicide.

8.4 Those subject to criminal proceedings are entitled to any necessary psychiatric assessment and treatment. Although psychiatric treatment is available to persons in prison custody, there are limitations to the treatment which can be provided in prison, and a prison hospital or a prison psychiatric unit is not a hospital as defined in the Order.

8.5 Part III of the Order provides that in certain circumstances an accused person may, by order of a Court, be admitted to hospital on grounds of mental illness or severe mental impairment or placed under guardianship on grounds of mental illness or severe mental handicap. Part III also provides that, in certain circumstances, a person convicted of an offence, or on remand, may by direction of the DoJ be admitted, by way of transfer from prison to hospital on grounds of mental illness or severe mental impairment.

Hospital admissions ordered by a Court

8.6 A Court may order a person's admission to hospital under the following Articles of the Order:

i. Article 42 – Remand for report on accused's mental condition

The Crown Court or a Magistrates' Court may remand to hospital a person, who has been accused of an offence, for a report on their mental condition. Before exercising the powers in Article 42 the Court must be satisfied that

[89] Health and Social Care Act (Northern Ireland) 2022

there is reason to suspect mental illness or severe mental impairment. The Court must also be of the opinion that it would be impracticable for a report on the accused's mental condition to be made if they were remanded on bail (Article 43(2)(b)). Oral evidence by a Part II medical practitioner is required. The remanded person must be admitted to hospital within seven days of the date of the remand. They may be detained in hospital for up to 28 days and thereafter may be further remanded by the Court for similar periods up to a maximum of 12 weeks.

ii. Article 43 – Remand for treatment

The Crown Court may remand an accused person to hospital for treatment. Before exercising the powers in Article 43 the Court must be satisfied that the accused person is suffering from mental illness or severe mental impairment. Oral evidence by a Part II medical practitioner, and oral or written evidence by one other medical practitioner, is required. The remanded person must be admitted to hospital within 7 days of the date of the remand. They may be detained in hospital for up to 28 days and thereafter may be further remanded by the Court for similar periods up to a maximum of 12 weeks.

iii. Articles 44 and 47 – Hospital order and restriction order

The Crown Court or a Magistrates' Court may (by a hospital order) order the hospital admission of a person convicted of an imprisonable offence (Article 44(1)). A Magistrates' Court may also make a hospital order in respect of an accused person without conviction if it is satisfied that they committed the act of which they are accused (Article 44(4)). Either Court may, in addition, make an order restricting discharge from hospital (Article 47), either for a specified period or without limit of time. Before exercising the powers in Articles 44 and 47, the Court must be satisfied that the convicted or accused person is suffering from mental illness or severe mental impairment. Oral evidence by a Part II medical practitioner, and written or oral evidence by another medical practitioner, are required. The subject of a hospital order should be admitted to hospital within 28 days of the date of the order (Article 46(2)(a) and(b)).

An unrestricted patient *"shall be treated for the purposes of the provisions of Part II mentioned in Part I of Schedule 2 as if he were detained for treatment and his date of admission were the date of the order, but subject to any modifications of those provisions specified in that Part of Schedule 2"* (Article 46(6)(a)).

If there is a restriction order, the DoJ will exercise authority over the patient's discharge or leave of absence from hospital and will require periodic reports on the patient from the RMO. In relation to a restricted patient, Article 46(6)(a) "*shall have effect as if it referred to Part II of Schedule 2 instead of Part 1 of that Schedule".*

iv. Article 45 – Interim hospital order

The Crown Court or a Magistrates' Court may (by an interim hospital order) order the hospital admission of a person convicted of an imprisonable offence, if it has reason to suppose, but is not certain at the time, that a hospital order under Article 44 is justified. Before exercising the power in Article 45, the Court must be satisfied that the convicted person is suffering from mental illness or severe mental impairment. Oral evidence by a Part II medical practitioner, and oral or written evidence by another medical practitioner, is required. The subject of an interim order must be admitted to hospital within 28 days of the date of the order (Article 46 (3)(b) and (c)). The effect of an interim order is similar to that of a hospital order, except that the Court specifies its duration, which must not exceed 12 weeks. The Court may renew an interim order on expiry for periods of up to 28 days, but the maximum period of an interim hospital order (with renewals) must not exceed six months. It may be superseded by a hospital order made under Article 44.

v. Article 49 – Unfitness to be tried

Article 49 sets out the procedure to be followed in cases where a question arises as to a person's fitness to plead. The question of fitness to be tried shall be determined by court without a jury (Article 49(4)) and the *"The court shall not make a determination under paragraph (4) except on the oral evidence of a medical practitioner appointed for the purposes of Part II by RQIA and on the written or oral evidence of one other medical practitioner."* (Article 49(4A)).

vi. Article 50 – Procedure in relation to finding of insanity

The Criminal Justice (Northern Ireland) Order 1996[90] inserted Article 50A into the Order which sets out how the Court may deal with patients found unfit to be tried but guilty of the act, or not guilty by reason of insanity.

Article 50(1): *"Where upon the trial on indictment of any person charged with the commission of an offence—*

(a) oral evidence of a medical practitioner appointed for the purposes of Part II by RQIA and on the written or oral evidence of one other medical practitioner is given that the person charged was an insane person at the time the offence was committed; and

(b) the jury finds that although the person charged did the act or made the omission charged, they were an insane person at that time, the court shall direct a finding to be recorded to the effect that the person is not guilty of the offence charged on the ground of insanity."

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[90] The Criminal Justice (Northern Ireland) Order 1996

(Paras. (2), (3) rep by 1996 NI 24)

(4) In this Article "insane person" and "insanity" have the meanings assigned by section 1 of the [1966 c. 20 (N.I.)] Criminal Justice Act (Northern Ireland) 1966.

Under Article 50A (2), the Court shall either direct a hospital order, a guardianship order, a supervision and treatment order (Part II of Schedule 2A) or an absolute discharge.

Article 50A (3): *"a person admitted to a hospital in pursuance of an order under paragraph (2)(a) shall be treated for the purposes of this Order—*

(a) as if they had been so admitted in pursuance of a hospital order made on the date on which the order under paragraph (2)(a) was made; and

(b) if the court so directs, as if a restriction order had been made, either without limit of time or during such period as may be specified in the direction.

The Court shall not make any order listed above unless an opportunity has been given to the authorised HSC Trust in which the hospital to which the patient is to be admitted is vested, has had the opportunity to make representations to the Court concerning the making of such an order. The patient should be admitted to hospital within 28 days of the date of the Court decision.

Equally, the Court should be assured that the identified guardian is willing to receive the patient into guardianship before issuing an order.

Where the DoJ is notified by the RMO that a person detained in hospital in pursuance of an order made by virtue of Article 50(1)(b) no longer requires treatment for mental disorder, the DoJ may remit that person for trial—

(a) to the Crown Court at the place where, but for the order, the patient would have been tried; or
(b) to a prison; or
(c) to a remand centre; or
(d) to a juvenile justice centre.

and on his arrival at the Crown Court, prison, remand centre or juvenile justice centre the order shall cease to have effect.

Role of the Trust

8.7 In all cases, the decision as to whether the person in Court should be admitted to hospital lies solely with the Court. However, a Court cannot remand a person to hospital for assessment or treatment, nor make a

hospital order or interim hospital order, unless the Trust which will be responsible for implementing the order has been given an opportunity to make representations to the Court in accordance with Articles 42(4), 43(3), 44(5) and 45(3) of the Order. The DoH's statutory role in making representations has been transferred to the Trusts, as explained in paragraph 8.2 of the Code. No similar opportunity is provided by the Order in respect of orders made under Articles 49 and 50, though the Court may invite the Trust to make representations and Trusts should, therefore, always be prepared for this eventuality.

8.8 Trusts are responsible for securing admission when this is ordered by a Court. By availing itself of the opportunity to make representations to the Court, the Trust should be able to keep itself informed of what is happening and to satisfy the Court that proper arrangements can and will be made for the accused person's admission and care. Each Trust should establish standard arrangements and procedures for making representations to a Court.

Trusts' Designated Officers

8.9 Each Trust should designate an officer (referred to hereafter as the Designated Officer) to take responsibility for making the Trust's representations in Court and advance arrangements for admission and, if admission is ordered, for ensuring that the admission is properly effected within the time available. In performing these duties, the Designated Officer should co-operate with SPPG identified lead, professional staff including consultant psychiatrists and the Director of Public Health, all of whom should be notified of the identity of the Designated Officer and be prepared to co-operate with them in any case where admission by order of a Court is a possibility. The Designated Officer's identity should also be given to the Northern Ireland Courts and Tribunal Service for notification to the Courts as their point of contact with the Trust, to the DoJ and to the DoH.

Duties of the medical practitioner giving medical evidence to the Court

8.10 The medical practitioner is required, without prejudging the case, to give impartial professional evidence about the accused patient's mental condition and what arrangements would be appropriate for the accused patient's further care. They could also be asked for advice as to how those arrangements could be put into practice.

8.11 In order to carry out these duties it is recommended that the medical practitioner is familiar with the provisions of Part III of the Order. They should be able to make an adequate assessment of the accused person's mental state. To do this they should have access to relevant reports, including details of the accused patient's previous psychiatric history and treatment, documents relating to the alleged offence and any relevant reports by other professionals such as social workers. They should have

access to and examine the accused patient and form an opinion on the most suitable provision for their future management.

Arrangements for the accused patient's hospital care

8.12 If the medical practitioner concludes that hospital admission would be a proper and suitable provision for the accused person, the examining medical practitioner, before giving their evidence to the Court, should ascertain whether admission can be arranged and the accused person given the care they need. To that end the examining medical practitioner should identify the hospital to which the accused person should be admitted and the consultant who will be in charge of their treatment. If the examining medical practitioner is to be that consultant, they should consult their professional and administrative colleagues, including the Designated Officer, to ensure that they agree that admission would be feasible. If another consultant is to be responsible for the accused person's hospital care, the examining medical practitioner should confirm that the consultant concerned is in a position to admit the patient and arrange for their proper management. Before giving this confirmation, that consultant should consult their professional and administrative colleagues, including the Designated Officer, to ensure that they agree that admission would be feasible.

8.13 Patients who are accused should have the same right of access to care and treatment for their mental health needs as non-accused patients and therefore should not be subjected to multiple reassessments.

8.14 It is particularly important that nursing staff understand what is proposed so that they can make adequate preparation for the admission. If the examining medical practitioner is to be the consultant in charge of the accused person's treatment, it would normally be good practice for them to arrange for a nursing colleague also to assess the accused person's suitability for care in the hospital identified. If another consultant is to be responsible for the accused person's hospital care, that consultant should consult their nursing colleagues before advising the examining medical practitioner on the feasibility of managing the accused person in their unit. The Designated Officer should be kept fully informed of the professionals' decisions and their agreement obtained to the recommendations being made.

8.15 If the accused person appears to need facilities that are not available in Northern Ireland, the examining medical practitioner should confirm that other satisfactory arrangements can be made. This applies where psychiatric care is needed in conditions of security which can only be provided in HSHs in Scotland or England (paragraph 8.31).

8.16 It is particularly important, where there is a possibility that the Court may find the accused person unfit to be tried or not guilty on the grounds of insanity, that any medical practitioner giving evidence should ensure that

the consultant likely to be responsible for the accused person's care and the Trust's Designated Officer are notified at the earliest possible stage.

Trusts' representations in Court

8.17 In those cases where Trusts must be given an opportunity to make representations, the Court will notify the Trust's Designated Officer of the circumstances of the case and the date of the hearing. There should be prior understanding about which Trust to notify. Usually this will be the Trust for the area in which the accused person resides and will be clear from their home address. Where there is any uncertainty, the accused person should be asked where they usually live in order to obtain a decision. The principle is that the accused person's perception of where they are resident (either currently or, failing that, most recently) is the criterion.

8.18 Where an accused person cannot identify a current or recent address, the Trust for the area in which the alleged crime was committed should accept responsibility. If the Court notifies the wrong Trust, that Trust should promptly refer the matter back to the Court for redirection and at the same time inform the appropriate Trust that this is being done. Exceptionally, where admission to a hospital which is administered by another Trust is proposed, the latter Trust should make the representations to the Court. In such circumstances the Designated Officer of each Trust should agree the way forward and explain the position to the Court.

8.19 Any notification of a case by a Court to a Trust should be referred to the Trust's Designated Officer. The Trust's standard procedures for making representations to the Court should be put into effect by the Designated Officer and followed in any case where there is a possibility that the Court may order admission to hospital.

8.20 The Trust's representative should be able to advise the Court what arrangements would be made for the accused person's admission to hospital and subsequent care should the Court decide to order admission. They may be either the Designated Officer or another officer so authorised by the Designated Officer. Where a consultant psychiatrist employed by the Trust is giving evidence, that consultant may be the authorised officer. This would, however, probably not be a suitable arrangement where they were giving evidence to the effect that hospital admission would not be appropriate. In such circumstances, the Designated Officer should attend in person or send an authorised deputy. In any event the Designated Officer should, before the date of the hearing, give the name of the Trust's representative to the Clerk of the Court.

8.21 If a consultant psychiatrist acts as the Trust's representative, they should obtain the Designated Officer's assurance that the Trust endorses their proposals. Likewise, if the Designated Officer or another officer acts in this capacity, they should ensure that they have the agreement of the

professional staff concerned to any arrangements in regard to which they may express the Trust's acceptance. They should consult with the psychiatrist giving evidence to ensure that the representations made on the Trust's behalf are compatible with the medical proposals for the accused person's further management.

Arrangements for admission

8.22 An order by a Court for admission must be implemented within a fixed time: seven days for admission under Article 42 or 43; 28 days under Article 44, 45, or 50A (2).

8.23 A Court has no power to designate the hospital to which the patient is to be admitted. That is a matter for the Trust after an order is made, though normally it will have been determined before the order is made. The Designated Officer in each Trust will be responsible for ensuring that arrangements for the patient's reception are made by the appropriate professional and administrative staff. It is essential that these are made in advance so that if admission is ordered the patient can be admitted within the appropriate fixed time.

Admissions directed by the Department of Justice

8.24 The DoJ may direct that a person in custody be admitted to hospital under Articles 53 and 54 (transfer directions) of the Order.

8.25 The DoJ may direct the hospital admission of a person serving a sentence of imprisonment (Article 53) or of certain other persons who are in custody, most commonly those on remand (Article 54). The DoJ may also, and in some cases must, direct that the person removed to hospital should be subject to restrictions (Article 55). Written reports by a Part II medical practitioner and by one other medical practitioner are required. These must specify that the person to be transferred is suffering from mental illness or severe mental impairment and that the nature or degree of the disorder is such to warrant their detention in hospital for medical treatment. In practice these reports are commonly made by a consultant psychiatrist in attendance at the prison and by a prison medical officer.

8.26 The subject of a transfer direction must be admitted to hospital within 14 days of the date of the direction. Any situation where this has not been possible should be escalated to the DoH using the email address: mentalhealthunit@health-ni.gov.uk. A transfer direction has the same effect as a hospital order, and a restriction direction made by the DoJ has the same effect as a restriction order made by a Court under Article 47 (paragraph 8.6 of the Code).

8.27 The Order makes no provision for Trust representation where the DoJ is considering hospital admission. In practice the DoJ will ensure that the appropriate Trust is adequately consulted, and that professional staff of

the Trust are given an opportunity to assess the patient. The guidance in paragraphs 8.12 to 8.16 of the Code on examining the patient, agreeing a course of action and making representations, should be applied as appropriate.

Admission

8.28 Once a Part III admission has been ordered, the Trust should receive immediate formal notification. Court orders are given by the Court to the person directed to convey the patient to the hospital, and a copy will be sent to the Trust's Chief Executive. A transfer direction is sent by the DoJ to the governor of the prison where the person to whom the direction applies is being held. The DoJ will at the same time send a copy of the direction to the Trust's Chief Executive. If received by any other Trust employee, the orders and transfer directions should immediately be brought to the attention of the Chief Executive. The latter should ensure that arrangements for admission are finalised promptly so that the patient can be conveyed to hospital within the specified time.

Conveyance to hospital

8.29 A Court order or transfer direction is sufficient authority for the patient to be conveyed to hospital. Most Part III admissions are of persons in custody. In these circumstances, the Trust's Designated Officer should ensure that consultations take place between staff in the prison and the receiving hospital at an early date on the timing of the move, and on any other practical details. In the unlikely event of an ASW being directed by the Court to convey the patient to hospital, the ASW should refer to the guidance in paragraphs 2.114 to 2.115.

8.30 A Court order or transfer direction is also the authority to detain the patient. Trusts should ensure that the original order or direction is received. This should be delivered with the patient to the receiving hospital.

Admissions to High Secure Hospitals

8.31 A patient ordered by a Court or ordered by the DoJ to be detained in hospital may require treatment in conditions of security which are not available in Northern Ireland. In these circumstances, the DoH may provide special accommodation (Article 110) for these patients. High Secure Hospitals (HSHs) in England and Scotland provide psychiatric care in conditions of extra security, and patients from Northern Ireland may be admitted to these hospitals, provided the relevant authority or Trust agrees to their admission.

8.32 There are four HSHs in the UK: three in England and one in Scotland. The function of a HSH is to provide hospital care for certain mentally disordered patients who, because of extremely violent, disruptive or dangerous behaviour, require treatment in conditions of high security which are not available in other psychiatric or learning disability facilities.

Many of these patients will have been the subject of criminal proceedings. Patients who are challenging to manage are present in all psychiatric and learning disability hospitals. Every effort should be made to look after these patients within NI local facilities before considering a transfer to an HSH in England or Scotland.

8.33 Once the condition of a transferred patient in an HSH in England or Scotland improves to the point where they can be managed in less secure accommodation, their transfer to appropriate accommodation in NI should be arranged, subject to the agreement of the Scottish or English appropriate authority; and the DoJ in NI if they are restricted patients, or the DoH in NI in all other cases. Confirmation from the relevant HSC Trust that the person's reception into the NI hospital can be accommodated is also required.

8.34 A Northern Ireland Court can only order admission to a hospital within its jurisdiction. If admission to an HSH is necessary, the Court will order the appropriate Trust to admit the patient to hospital, and that Trust must seek authority, from the DoH or the DoJ, for their transfer to an HSH. The necessary arrangements for the move must, therefore, be put in hand before representations are made to the Court. It is of vital importance in such cases that the Court should be advised that the patient cannot be accommodated in an NI hospital, that transfer to an HSH will be required, and the prospects and likely timing of such an admission.

8.35 The arrangements for the removal of a patient to an HSH in England or Scotland are complex as several different agencies are involved. Before the Authority/Trust responsible for the HSH agrees to the admission of a patient from Northern Ireland, it is usual for a consultant from the HSH to visit and assess the patient. The DoJ formal authorisation must be obtained for the removal of any patient to an HSH in England or Scotland where a restriction order is in place. The original Court order or transfer direction and the original authorisation for removal (which will be sent to the Trust's Designated Officer by the DoH or the DoJ) must accompany the patient, when they are transferred. Specific guidance has been issued to psychiatrists on the transfer of patients to HSHs.

Admissions from High Secure Hospitals

8.36 The HSHs in England and Scotland accept patients from NI on the understanding that these patients will return to NI when they no longer require to be managed in conditions of high security. Normally such a patient will return to the hospital from which they were originally transferred, or to which they were originally committed. Section 81 of the Mental Health Act 1983 governs removal of patients to NI from England and Wales. Article 4 of The Mental Health (Care and Treatment) (Scotland) Act 2003 (Consequential Provisions) Order 2005 provides for removal to NI of hospital patients from Scotland. Before it is given, the relevant authority in England or Scotland will seek formal confirmation from the

DoH or the DoJ, that arrangements have been made for the patient's admission to an NI hospital.

8.37 The first approach is usually made by the responsible consultant in the HSH to the NI consultant who will be the RMO on the patient's return. The latter in turn has responsibility for ensuring that the patient can be suitably managed under their care, for advising their Trust that this is so, and for agreeing the timing and details of the transfer. That requires, firstly, an assessment of the patient's condition and of the requirements for their management in hospital. It is common practice, though not an absolute requirement, for an assessment visit to be made to the HSH by the NI consultant concerned, and, when this is done, a nursing colleague should accompany the visiting consultant.

8.38 On return the consultant should confirm their assessment in writing to the HSH consultant and inform the Trust of their conclusions. Trusts should send a copy of their report to RQIA and the Mental Health Unit at the DoH by email: mentalhealthunit@health-ni.gov.uk. If the consultant is reporting to the Trust that the patient can be properly managed under their care, they should confirm that their nursing colleagues agree with that view. Further information to support practice can be found in the **DoH guidance on the Transfer of Patients Detained under Mental Health Legislation between Hospitals in NI and GB**.[91]

8.39 When a detained patient is transferred to NI, the receiving hospital must ensure that the original Court order or transfer direction and the original authorisation for removal to NI are received.

Guardianship ordered by a Court

8.40 As a potentially useful alternative to hospital orders, Courts are empowered (Article 44) to make guardianship orders where the prescribed criteria, which are similar to those applying to a hospital order, are met; and the Court, having regard to all the circumstances, considers reception into the guardianship of the Trust, or of any other person, appropriate. Guardianship orders may be particularly suitable in helping to meet the needs of some offenders who could benefit from occupation, training and education in the community. The Court's decision will be based on oral evidence by a Part II medical practitioner, written or oral evidence from another medical practitioner, and written or oral evidence from an ASW.

8.41 Before making such an order, the Court has to be satisfied that the Trust or other person is willing to act as guardian. The Trust should be satisfied with the arrangements, and, in considering the appropriateness of guardianship, it should be guided by the same principles as apply under Part II of the Order. Similarly, the powers and duties conferred on the Trust

[91] DoH Guidance on the Transfer of Patients Detained under Mental Health Legislation between Hospitals in NI and GB

or private guardian and the provisions as to duration, renewal and discharge are those which apply to Part II guardianship applications, except that the power to discharge is not available to the nearest relative.

Supervision and Treatment Orders

8.42 Supervision and Treatment Orders (STOs) were introduced into the criminal justice system of Northern Ireland by The Criminal Justice (Northern Ireland) Order 1996. Articles 49A to 50A and Schedule 2A are of particular importance. STOs operate in a similar manner to probation orders with a condition of psychiatric treatment. The role of Supervising Officer may be allocated to either a Social Worker or a Probation Officer, according to the assessed needs of the individual.

8.43 The purpose of an STO is to provide supervision and assistance in the community, including medical treatment, for such persons. Supervision is the mechanism under which is determined the frequency and nature of contact to ensure that all conditions of the STO are adequately supported and monitored according to the needs of the individual. Treatment is intervention, the purpose of which is to maintain and improve the mental wellbeing of the individual and, where appropriate, reduce the risk of harm to the individual and others.

Conditions necessary for the making of a Supervision and Treatment Order

8.44 The Court may not make the STO unless it is satisfied:

- that the order is the most suitable means of dealing with the person;
- that the mental condition of the person requires and may be susceptible to treatment, but does not require a hospital committal order or guardianship order;
- that the supervising officer intended to be specified in the STO is willing to undertake the supervision; and
- that arrangements have been made for the treatment intended to be specified in the order.[92]

8.45 In relation to the second bullet point above, the Court must receive evidence from two medical practitioners: the first, orally, from a practitioner appointed by the RQIA for the purposes of Part II of the Order (a Part II practitioner); the second, either orally or in writing, from another medical practitioner.

Process for Supervision and Treatment Order

8.46 The STO will require the supervised person to be under the supervision of a "supervising officer", who will be an ASW from a specified HSC Trust for

[92]Paragraph 2 of Schedule 2A to The Mental Health (Northern Ireland) Order 1986

the area in which the supervised person resides (or a probation officer in a specified petty session district).

8.47 Before making an STO, the Court must explain, in ordinary language, to the person to whom the order relates ("the supervised person") the effect of the STO, the requirements proposed to be included in the STO, and that the Magistrate's Court has the power to review the STO on the application of the supervised person, or the supervising officer.[93]

8.48 An STO may be made for a period of not more than three years.

8.49 For the duration of the STO, or such part of it as may be specified, the supervised person must submit to treatment by, or under the direction of, a medical practitioner with a view to the improvement of his mental condition.[94]

Social work assessment pre-Supervision and Treatment Order

8.50 Responsibility for the social work assessment of an appropriate disposal by the Court will be held by an ASW. That assessment must consider the options available to the Court, i.e. a Hospital Order, Guardianship Order, STO or an absolute discharge. Specifically in relation to an STO, the assessment of the proposed supervised person's suitability by the ASW should include consideration of:

- the risk which the supervised person may pose to self or others (taking into consideration the medical assessment);
- whether the supervised person is likely to comply with the conditions of the STO;
- the satisfactoriness of the home surroundings and environment to meet the supervised person's needs, and manage any risks identified; and
- whether a condition of residence (including residence in a hospital) may be necessary.

8.51 The above assessment should be multi-agency and multi-professional according to the risk assessment and care plan. Specific reference may need to be made, as appropriate, to:

- The Children (Northern Ireland) Order 1995
- Adult protection policies and related legislation
- Public protection arrangements Northern Ireland (PPANI)

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[93] Paragraph 3(2) of Schedule 2A to The Mental Health (Northern Ireland) Order 1986

[94] Paragraphs 1 and 4 of Schedule 2A to The Mental Health (Northern Ireland) Order 1986

- Sexual offences prevention order (SOPO)
- the needs of the local community – awareness and sensitivity to the responses of the local community may require ongoing consultation in order to attend to their expressed concerns

8.52 It is the responsibility of the ASW intending to be the supervising officer, in consultation with, and with support from, Trust senior management, to ensure that the above assessment is complete and they are familiar with it before indicating a willingness to undertake the supervision. It is the responsibility also of senior management within the Trust to ensure that necessary provisions are in place to monitor and review all aspects of the STO, including the circumstances in which the supervising officer can bring the case back to Court where risks are not manageable within the parameters of the STO. It is vital to recognise that the implementation of an STO is entirely dependent upon the compliance of the supervised person to the conditions given in the care plan. In the event of non-compliance in relation to health and social care matters, the supervising officer should refer back to Court for consideration of appropriate action.

The Supervising Officer's role and responsibility following imposition of a Supervision and Treatment Order

8.53 The role and responsibility of the supervising officer may be described as follows:

- Co-ordination of a multi-agency case discussion to assist with the comprehensive assessment of the supervised person's needs and associated risks to themself and others. It may be expected that the supervised person and main carer would actively participate in this process.

- The co-ordination of a comprehensive care plan which would identify clearly:
  - potential risks and the management of these;
  - indicators of increased risk and deteriorating mental state with agreed actions;
  - monitoring and review arrangements and lines of accountability;
  - any contingency plans to deal with situations where the supervised person presents a significant level of risk to others; and
  - a point of contact for all agencies at times of crisis.

8.54 In association with this, the care plan should take account of relevant guidance in respect of assessment and care planning, the promotion of quality care, and risk assessment and management.

8.55 While the medical practitioner will be primarily responsible for medical treatment, the supervising officer and medical practitioner would be expected to work closely together in monitoring the supervised person's mental state.

The need for regular joint reviews of progress would need to be put in place as an integral part of the care plan.

Maintaining the Supervision and Treatment Order

8.56 The supervising officer is responsible to the Court for maintaining the STO and is the person who can apply to the Court to seek to amend the STO. In practice, an application should normally be supported by a joint report from the medical practitioner and the supervising officer. The supervised person may also make such applications directly to the Court. The supervising officer must remain in 'regular' contact with the supervised person and also seek to ensure that the supervision plan is implemented. Frequency of contact should be determined by the supervising officer in consultation with his/her line manager, taking account of the degree of risk and other associated factors. It is for the supervising officer in consultation with the medical practitioner to alert the Court if problems arise and to apply to the Court formally to amend or revoke the STO.

Amendment or revocation of Supervision and Treatment Orders – general

8.57 Taking account of the need for close co-operation with the medical practitioner, the supervising officer or the supervised person may, at any time, apply to the Court to amend or revoke the STO. This may include:

- cancelling any of the requirements of the STO (including the requirement for treatment);
- inserting or replacing of any requirement which could have been made at the time of making the original STO; or
- revoking the STO, which the Court may do if it is of the view that it would be in the interests of the health or welfare of the supervised person to do so.

8.58 It may be that the supervised person is admitted to hospital either voluntarily or compulsorily whilst an STO is still in force. In such cases it will be for the medical practitioner to assess and report to the supervising officer about whether any change in the mental condition of the supervised person, since the date of the STO was made, is such that the STO is no longer appropriate. Similarly, at the point of discharge it will be for the medical practitioner to assess and report to the supervising officer whether an STO or another type of STO is now appropriate, taking account of any change in the supervised person's mental condition whilst in hospital.

Amendment in relation to residence requirements

8.59 The STO must specify the Trust area or Petty Sessions district where the supervised person resides and may specify the supervised person's residence, or a requirement to reside in hospital. The Court should agree the supervised person's move to another area only if it is satisfied that the requirements of the STO regarding medical treatment will continue to be

complied with, and that the new local Trust area is willing to undertake supervision.

8.60 Where a move to an address in another Trust area is proposed, the supervising officer must contact the appropriate Executive Director of Social Work in the new area immediately and request that:

- the proposed new residence is investigated to assess its suitability;
- the new Trust indicates whether the requirements of the STO, including medical treatment, can be met;
- the new Trust nominates a new supervising officer to be named in the amended STO, who is willing to undertake the supervision; and
- the Executive Director of Social Work (in the area stipulated in the STO) should facilitate the passing of appropriate information and records to the new supervising officer.

8.61 The initial supervising officer should then apply to the Court for the STO to be amended by substituting the new Trust and new supervising officer. If enquiries show that any of the requirements of the STO cannot be complied with, the Court shall not amend the STO without either cancelling these requirements or substituting ones which can be complied with.

8.62 It is not possible for STOs to be transferred to areas outside Northern Ireland. If the supervised person intends to move, or has already moved, away from Northern Ireland, then the supervising officer through the Executive Director of Social Work should contact the appropriate Executive Director of Social Work in the area where the supervised person intends to live and ask them to investigate the circumstances, and to indicate whether the supervised person's health and social care needs can be met on a voluntary basis.

8.63 If the Trust considers that these requirements cannot be met, the supervising officer should consult the medical practitioner about what to do, both in the interests of the supervised person and where the supervised person may pose a risk to others. This may involve applying to the Court under the relevant provisions of the Order.

Amendment and revocation of Supervision and Treatment Orders – medical treatment

8.64 If the medical practitioner responsible for directing the treatment of the supervised person is of the opinion that:

- treatment needs to be continued beyond the period specified in the STO; or
- the supervised person requires a different form of treatment of a kind which he or she could be required to submit to under an STO; or
- the supervised person has failed without reasonable excuse to comply with any of the requirements of treatment; or

- the supervised person is not susceptible to or requires no further treatment; or
- the supervised person does not require further treatment; or
- he or she is for any reason unwilling to continue to treat or direct the treatment of the supervised person

he or she must report the matter in writing to the supervising officer who must in turn apply to the local Court to amend or revoke the STO.

8.65 In cases where the medical practitioner is of the opinion that part of the treatment could be better provided at a location other than that specified in the STO, then, provided that the treatment remains under the direction of the same medical practitioner and the supervised person consents, this may be done without formal amendment of the STO. This kind of agreement should be notified in writing to the supervising officer and must specify the place where treatment is to be carried out.

8.66 Particularly close consultation between the medical practitioner and the supervising officer is necessary in cases where the medical practitioner considers that no further treatment is necessary or that the supervised person is no longer susceptible to treatment. In the first instance, the supervising officer should be fully apprised of the reason; in the second, the supervising officer must know what the implications are and the extent to which the supervised person may pose a risk because of his or her lack of susceptibility to treatment. Where such a risk is identified, the supervising officer and the medical practitioner should decide what steps can be taken to safeguard the public and request the Trust Designated Officer to co-ordinate a multi-agency case discussion to consider any risks.

8.67 If the supervising officer becomes aware, for instance through contact with the supervised person, that medical treatment is not taking place, he or she should contact the medical practitioner at once to clarify the situation. It is the responsibility of the medical practitioner to inform the supervising officer if the required medical treatment is not taking place and to discuss with the supervising officer what the next steps should be. Depending on what information the supervising officer is able to obtain, he or she may apply to the Court to vary the STO. The Court should be notified at once if the supervising officer is concerned that arrangements for treatment have broken down or have not been implemented.

Court action following amendment or revocation

8.68 Where the Court has amended or revoked an STO a copy of the amending or revoking STO must be given to the supervising officer forthwith, and where the amendment involves a change in residence to another Trust, copies of the amended STO and other documents should be forwarded by the Court Service to the relevant Petty Sessions District.

8.69 On receiving an amending or revoking STO, the supervising officer must give a copy to:

- the supervised person;
- in the case of STOs containing a residence requirement, any person in charge of the “old” or “new” address; and
- the person in charge of any hospital in which the supervised person is or was required by the STO to reside and the named medical practitioner.

Non-compliance

8.70 An STO is a disposal in respect of a person who has not been convicted. The Court may vary or revoke the STO but has no power to enforce it or to otherwise intervene in cases of non-compliance, and penal sanctions are not appropriate. It will be for the supervising officer and medical practitioner to decide on the appropriate action. If they believe that compulsory medical treatment is necessary, the patient will be required to meet the criteria for detention under the STO. In cases where the supervising officer or medical practitioner believe that the supervised person poses a danger to others but does not meet the requirements for detention under the civil powers, they should act jointly in the same way as they would in respect of any other person in this position. This would require close liaison with the police to ensure that they are aware of any concern about the possible danger to others.

The expiry of a Supervision and Treatment Order

8.71 The supervising officer should ensure a multi-disciplinary/multi-agency meeting is arranged not less than two months before the expiry of an STO. This meeting must have the medical practitioner and supervising officer present and should be chaired by the Executive Director of Social Work (or nominee).

9 TREATMENT AND CARE

Introduction

9.1 The guidance in this chapter builds on Part IV of the Order and deals with the treatment and care, under medical supervision, of all patients with a mental disorder. Specific guidance is given on particular aspects of treatment and care for patients in hospital. Where the guidance applies only to patients detained under the provisions of the Order, that is made clear in the text. Part IV doctors are referred to in this section as SOADs. Part IV SOADs are used to refer to a doctor, normally a consultant psychiatrist, appointed by RQIA for the purpose of Part IV (consent to treatment) of the Order.

9.2 As defined in Article 2(2) of the Order, medical treatment "*includes nursing and also includes care and training under medical supervision*". This acknowledges that modern psychiatric care requires a multi-disciplinary approach, including psychiatry, clinical psychology, nursing, occupational therapy and social work. The team approach need not undermine the professional independence of the various team members who will have their own professional codes of practice. However, it is necessary to reconcile the need for team involvement in patient care with continuing medical responsibility for the patient's medical management. That responsibility is recognised in the term RMO, the medical practitioner who is in charge of the assessment or treatment of the patient.

Principles of treatment

9.3 All treatment should be underpinned by the following principles:

- **Patient benefit** – Where possible the patient's willing participation should be obtained. The main aims should be, so far as is possible, to improve health and reduce the impact of a mental disorder. Compulsory admission and treatment are only justified when there are demonstrable real and appropriate therapeutic measures available.[95]
- **Reciprocity** – In practice this means suitable treatment must be provided in return for depriving a patient of their liberty.
- **Non-discrimination**
- **Least restrictive option**
- **Respect for diversity**
- **Patient participation**
- **Respect for personal autonomy**
- **Consensual care where possible**
- **Informal care where possible**
- **Respect for carers**

9.4 Involuntary treatment should enshrine the concepts of:

[95] Rooman v Belgium 18052/11 [2019] ECHR 105

- **Choice and autonomy** – ensuring service users' views and choices are respected. This relates to situations where there might be a range of choices and options open to the patient and that those choices should be respected as far as possible.
- **Least restriction** – compulsory powers should only be used when necessary and for as short a time as necessary.
- **Therapeutic benefit** – ensuring patients are supported to get better, so they can be discharged from involuntary treatment.
- **The Person as an individual** – ensuring patients are viewed and treated as individuals.

9.5 These principles apply to the treatment of all patients with a mental disorder whether they are in hospital or in the community. In hospital practice they apply to both voluntary and detained patients, including those admitted under Part III of the Order.

9.6 All patients have the right to be involved in decisions about their treatment and care and be supported to make informed decisions if they are able. Decision making is an ongoing process focused on meaningful dialogue: the exchange of relevant information specific to the individual patient.

9.7 All patients have the right to be listened to, and to be given the information they need to make a decision and the time and support they need to understand it.

9.8 Medical professionals must try to find out what matters to patients so they can share relevant information about the benefits and harms of proposed options and reasonable alternatives, including the option to take no action.

9.9 Patients whose right to consent is affected by law should be supported to be involved in the decision-making process, and to exercise choice if possible.[96]

Definition of consent

9.10 Consent is the voluntary and continuing permission of the patient for a particular form of treatment to be given, based on sufficient knowledge of its nature, purpose, and likely effects, including risks. It is time and decision specific, and support should be provided, when necessary, to maximise decision making by the patient. Patients need relevant information to be shared in a way they can understand and retain, so they can use it to make a decision. The information should be shared in a place and at a time when the patient is most likely to understand and retain it.

[96] The seven principles of decision making and consent - professional standards - GMC

9.11 Patients need relevant information to be shared in a way they can understand and retain, so they can use it to make a decision. To help patients understand and retain relevant information, professionals should:

- share it in a place and at a time when they are most likely to understand and retain it;
- anticipate whether they are likely to find any of it distressing and, if so, be considerate when sharing it;
- accommodate a patient's wishes if they would like to record the discussion;
- accommodate a patient's wishes if they would like anyone else, a relative, partner, friend, carer or advocate, to be involved in discussions and/or help them make decisions;
- use an interpreter or translation service if they have difficulty understanding spoken English;
- share it in a format they prefer - written, audio, translated, pictures or other media or methods;
- give time and opportunity to consider it before and after making a decision;
- be alert to signs that patients may need support to understand and retain the relevant information, use it to make a decision, or communicate that decision;
- make sure that reasonable adjustments are made so that patients with additional needs have enough time and support to understand relevant information and make a decision; and
- check whether patients have understood the information they have been given, and if they would like more information before making a decision.[97]

9.12 The assessment of the patient's ability to make a decision about their own treatment and the nature and extent of the information to be given in seeking consent are matters for clinical judgement, guided by current professional practice and subject to legal requirements. Permission given under duress is not "consent". Having a mental disorder does not preclude the ability to give consent. The treatment proposed should be explained to the patient as fully as possible, in terms appropriate to their ability to understand. An explanation should be given of the desired effect and outcome of the treatment as well as of the risk of developing significant and disabling side-effects. The explanation may also include an account of the likely progress of the illness if the treatment is not given. It should be explained to the patient that they have a right to withdraw consent at any time.

[97] The dialogue leading to a decision part one of four - professional standards - GMC

Treatment requiring consent AND a second opinion

9.13 Only one treatment – psychosurgery (any surgical operation for destroying the functioning of brain tissue) - is specified on the face of the Order as a form of treatment requiring consent and a second opinion (Article 63 (1)(a)). Article 63 also provides that other forms of treatment can be prescribed in regulations and, accordingly, under regulation 6(1) of The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986,[98] surgical implantation of hormones for the purposes of reducing male sexual drive also requires consent and a second opinion. There is also provision in Article 111(2) which enables the DoH to specify additional forms of treatment in the Code.

9.14 Psychosurgery can only be given if the patient has given their consent. This means the patient needs to have understood, "*the nature, purpose and likely effects"* of the treatment (Article 63(2)(a)), and three independent people appointed by RQIA, one of whom must be a medical practitioner, have certified that the patient understands the treatment and has consented to it.

Process to determine if the patient is providing valid consent

9.15 Where it is proposed to give any of these most serious forms of treatment, the RMO should in the first instance seek the patient's consent in the normal way. They should explain to the patient in simple terms the nature, purpose and likely effects of the treatment. If the patient is not considered to be capable of giving valid consent or if they do not give their consent, the treatment cannot be given. If the patient consents to the treatment and appears to have understood the explanation given to them, the RMO should contact RQIA. RQIA will appoint a SOAD (who is not the patient's RMO) and two other appointed persons, who are not medical practitioners, to consider the validity of the consent.

9.16 The SOAD must be allowed to interview or, in the case of the medical practitioner, examine, the patient, in private if they wish, and the medical practitioner may also require the production of, and inspect, any records relating to the treatment of the patient.

Obtaining a second opinion

9.17 If the SOAD and the two appointed persons agree that the consent is valid, they will jointly issue a Certificate of Consent to Treatment and Second Opinion **(Part 1 of Form 21**) to the effect that the patient is capable of understanding the nature, purpose and likely effects of the treatment in question and has consented to it. This certificate is not a substitute for a

[98] The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986

standard consent form, which should be obtained. The SOAD must have "regard to the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition" and only after can they sign **Part 2 of Form 21** (Article 63(1)(b)). When a patient requires these treatments, a copy of **Form 21** must be submitted immediately to RQIA.

Need to consult others concerned in the patient's treatment

9.18 Before they issue this certificate, the SOAD is required to consult such person or persons as appear to them to be principally concerned with the patient's treatment. This will include the RMO and should invariably include the senior nurse in charge of the patient's ward, or other nurse who has been caring for the patient. It should also include any other professional (psychologist, social worker, occupational therapist etc.) involved in the patient's treatment who may reasonably be expected to have an informed view on the suitability of the proposed treatment. The RMO should provide the SOAD with the relevant documents and the names of other professionals involved in the case. Arrangements should then be made for the SOAD to see the professionals they wish to see. The original **Form 21**, the two parts of which constitute the authority for proceeding with the treatment, should be retained with the patient's records and a copy of **Form 21** must be submitted immediately to RQIA.[99]

Treatment requiring consent <u>OR</u> a second opinion

9.19 Article 64(1)(a) allows for certain other treatments that require consent or a second opinion to be prescribed by regulations.

9.20 Under Article 64(1)(b), the administration of medicine, three months or more after its first administration during any continuing period of liability for detention, requires consent or a second opinion. Regulation 6 of The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 prescribes electro-convulsive therapy as such a treatment that requires consent or a second opinion. In the case of detained patients to whom Article 64 does not apply, consent must be obtained.

9.21 It should be noted that during each period of detention that:

i) a course of medication for each mental disorder can be given to a patient for up to three months without consent and without the need to consult or obtain validation from a SOAD; and
ii) the three-month period will run from the day after medicine was first administered as a form of treatment for mental disorder regardless of whether there was an interval during which no medicine was given.

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[99] It is a requirement of the legislation that prescribed forms and other reports are immediately submitted to RQIA by HSC Trusts. These may be sent electronically.

9.22 Two forms of treatment have been specified for the purposes of Article 64. These treatments can be given where the patient has consented, or a SOAD has certified that either the patient is not capable of giving their consent, or that the patient should receive the treatment even though they have not consented to it. Article 64 itself specifies the administration of medicine for mental disorder if three months or more have elapsed since medicine was first given during that particular period of detention, and Regulation 6(2) specifies electroconvulsive therapy.

Process to determine if the patient is providing valid consent for the treatment or securing a second opinion

9.23 If a patient is considered to be capable of giving valid consent to a form of treatment which comes under Article 64, and which the RMO has proposed and explained to the patient, the RMO or a SOAD must certify in writing that the patient is capable of understanding the nature, purpose, and likely effect of the treatment and has consented to it. **Form 22** must be used for this purpose, whether or not a standard consent form has also been completed. The original **Form 22** should be retained with the patient's records and a copy sent immediately to RQIA.[100]

9.24 If the patient does not consent to a treatment to which Article 64 applies or is considered to be incapable of giving valid consent, and the RMO, having considered the alternatives, continues in the opinion that the patient needs that particular form of treatment, they should contact RQIA. RQIA will arrange for a SOAD to examine the patient, to consult with those who appear to be principally concerned with the patient's medical treatment and to give a second opinion.

9.25 The SOAD must use **Form 23** for this purpose, and when certifying that, having regard to the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition, the treatment should be given, will also certify either that the patient is not capable of understanding the nature, purpose and likely effect of the treatment or that the patient has not consented to that treatment. **Form 23** should be retained with the patient's records and a copy sent immediately to RQIA.

Process to determine valid consent for the administration of medication

9.26 In the case of the administration of medicine, RQIA should appoint a SOAD to provide all external second opinions on all treatment plans where consent is not given. **Form 22** is used for this purpose. Where a valid consent is not or cannot be given for electro-convulsive therapy, a second

[100] It is a requirement of the legislation that prescribed forms and other reports are immediately submitted to RQIA by HSC Trusts. These may be sent electronically.

opinion certificate must be obtained from a SOAD. This is recorded on **Form 23**. The completed forms must be sent to RQIA.[101]

Treatment without consent and no second opinion is required

9.27 Article 69 of the Order applies to detained patients other than those excepted by Article 62. Under Article 69, consent is not required for medical treatment (other than treatment falling within Article 63 or 64) given to those patients with a mental disorder provided the treatment is given by or under the direction of the RMO. The exclusion of patients remanded under Article 42 should be noted. If a Court remands an accused person to hospital for assessment under that Article, no power to treat without consent is thereby conferred, and this will be relevant if a therapeutic trial of drugs is contemplated as part of the assessment process. In that case, unless the patient is willing to accept treatment, remand for treatment under Article 43 would be required.

9.28 For patients to whom Article 69 does not apply, including all patients not subject to detention, the legal position concerning treatment without consent derives from common law. Consent is a legal pre-requisite of treatment, except when the patient is incapable of giving consent because they are:

- A child, 16 years or under, with insufficient understanding and intelligence, in which case a person having parental responsibility may consent. Unless statute specifically overrides, young people should be regarded as having the right to make their own decisions (and in particular treatment decisions) when they have sufficient "understanding and intelligence". It is considered best practice that reference should be made to the Gillick competence test[102] in determining these decisions (refer to paragraph 2.80 for further guidance).[103]

- An adult with a learning disability of a degree that renders them incapable of understanding.

- Unconscious and in urgent need of treatment to preserve life, health or well-being (unless there is unequivocal and reliable evidence that the patient did not want that treatment) provided that the treatment has to be administered while the patient is still unconscious.

- A patient with a mental disorder leading to behaviour which is an immediate and serious danger to themself or others, and the

[101] See list of prescribed forms at Annex 1
[102] Gillick v West Norfolk AHA
[103] Consent to treatment - Children and young people - NHS

treatment is the minimum necessary to avert that danger, but the provisions of the Order cannot be immediately invoked.

- Otherwise incapable and in need of medical care in circumstances in which they have not declared their unwillingness to be treated prior to the onset of the incapacitating condition.

9.29 The standard of care required of the medical practitioner concerned in all cases is that laid down in Bolam v Friern Hospital Management Committee ([1957] 1 WLR 582)[104]; namely, that they must act in accordance with a responsible and competent body of relevant professional opinion. The agreement of the nearest relative is desirable but not essential. Informed consent related case law may also be helpful in informing practice.[105]

9.30 In F v West Berkshire Health Authority and another (Mental Health Act Commissioner intervening) ([1989] 2 ALL ER 545) [106], the House of Lords held that, in all cases involving the treatment of a person incapable of giving consent, the treatment must be "*in the patient's best interest*". It must be:

- necessary to save life or prevent a deterioration or ensure an improvement in the patient's physical or mental health; and
- in accordance with a practice accepted at the time by a responsible body of medical opinion skilled in the particular form of treatment in question.

9.31 If repeated emergency drug treatment for mental disorder needs to be given to a patient, without their consent, the RMO should determine if the criteria for detention are met so the treatment can be provided and the patient is afforded the necessary safeguards.

9.32 In the above noted case, F v West Berkshire Health Authority and another (Mental Health Act Commission intervening), the House of Lords held that, as a matter of practice, sterilisation should not be performed on an adult who lacks the capacity to give consent without first obtaining the opinion of the High Court that the operation is, in the circumstances, in the best

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[104] Bolam v Friern Hospital Management Committee

[105] Montgomery (Appellant) v Lanarkshire Health Board (Respondent) (Scotland) - UK Supreme Court

[106] F v West Berkshire Health Authority and another (Mental Health Act Commission intervening)

Court of Appeal later recognised in Re S (Adult: Sterilisation) - vLex United Kingdom [2001] Fam 15: *The duty to act in accordance with responsible and competent professional opinion may give the doctor more than one option since there may well be more than one acceptable medical opinion. When the doctor moves on to consider the best interests of the patient, he/she has to choose the best option, often from a range of options. As Mr Munby has pointed out, the best interests test ought, logically, to give only one answer".*

interests of the person concerned. The Courts in Northern Ireland may apply that decision.

Consent to treatment in relation to children and young persons under the age of 18 years

9.33 The guidance in relation to consent to admission to hospital of children and young persons under the age of 18 years applies also to their treatment (see paragraphs 2.76 to 2.95 of the Code). However, consent for treatment cannot be assumed to be the same as consent to admission.

9.34 When treatment is being planned the following questions (in addition to those listed in paragraph 2.83 which explains parental responsibility) need to be asked:

- Has the child or young person been given the relevant information in an appropriate manner (such as age-appropriate language)?

- Is the child Gillick competent / does the young person have capacity, in relation to their treatment? The rights of parents to determine such matters end when a child achieves sufficient intelligence and understanding to make their own decision.

- Who is legally responsible for decisions affecting the child, and who has the authority to make such decisions? Those assuming professional responsibility for the care of a child or young person should always request copies of any statutory orders (care order, guardianship order, contact arrangements, etc) for reference on the ward.

- Who has parental responsibility? More than one person can have responsibility at any one time, including situations where the child is Looked After.

- A child is defined as Looked After by an authority when they are:

  - in the care of the authority; or
  - provided with accommodation by the authority (Article 25 of the Children (NI) Order 1995).

- Where a parent refuses consent to treatment, how sound are the reasons and on what grounds are they made?

- Is the treatment medically necessary and justified under the Order?

Informal treatment of children under 16 who are Gillick competent

9.35 Where a child who is Gillick competent to decide about the treatment of their mental disorder consents to the treatment, treatment should commence.

9.36 Where there is a dispute between the competent child and the person(s) with parental responsibility, the views of the person(s) with parental responsibility should be accorded serious consideration and given due weight. Support should be provided to assist the child to discuss treatment options with the person(s) with parental responsibilities. The RMO may wish to involve other team members in these considerations but ultimately it is the RMO's responsibility to make the decision.

9.37 Unlike adults, the refusal by a competent child or young person with capacity under the age of 18 may in certain circumstances, be overridden by a Court. In the case Re W,[107] the Court decided that it has jurisdiction to override the refusal of a child or young person of treatment in circumstances that will, in all probability, lead to the death of the child or young person or to severe permanent injury; or where there is a serious and imminent risk that the child or young person will suffer grave and irreversible mental or physical harm.

9.38 However, the Court also emphasised that the child or young person's refusal is a very important consideration when deciding whether treatment should be given, despite the child or young person's refusal, noting that its importance increases with their age and maturity.

Informal treatment of children under 16 who are not Gillick competent

9.39 Where a child is not Gillick competent then it may be possible for the person(s) with parental responsibility to consent, on their behalf, if they are acting in the best interests of the child, as long as all other persons with "Parental Responsibility" have agreed – see paragraph 34[108] of Re

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[107] Re W (A Minor) (Medical Treatment: Court's Jurisdiction) - vLex United Kingdom - (note UK Supreme Court judgment on 2 June 2026 - A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998

[108] *Para 34: "I have set out the case law in some detail above as it is clearly material to the issue that I must determine in relation to RN. There is an established line of authority that supports the proposition that parents, in the exercise of their parental responsibility, may consent to care arrangements which would otherwise amount to a deprivation of liberty of child under the age of 16, provided that they are acting in the best interests of the child. If I am satisfied that this is the position for RN, is there any reason for me to depart from that approach?"* Re RN (Deprivation of Liberty and Parental Consent) [2022] EWHC 2576 (Fam) - (note UK Supreme Court judgment on 2 June 2026 - A Reference by the Attorney General for Northern Ireland of a devolution issue under paragraph 34 of Schedule 10 to the Northern Ireland Act 1998)

RN (Deprivation of Liberty and Parental Consent) [2022] EWHC 2576 (Fam). Professional staff should ensure the consent is valid and in the child's best interests.

9.40 If parental consent can be relied upon and consent is given by the person(s) with parental responsibility, then the child may be treated as an informal patient. If there is disagreement between persons who have parental consent in relation to the child's treatment, best interest decisions should be made.

9.41 The "Court will only become involved if there is a dispute between the parent and the responsible authority or between the parents themselves, as to what is in the child's best interests", per HHJ Burrows (sitting as a High Court Judge) in paragraph 56 of Lancashire CC v PX [2022] EWHC 2379 (Fam).[109]

9.42 Where the statutory criteria for detention are met, the child should be formally detained in order for the treatment to commence.

9.43 Where there is dispute between those with parental responsibility and the statutory criteria for detention are not met, an application for authorisation of the treatment should be made to Court.

Informal treatment of 16 and 17 year olds with capacity to consent

9.44 Article 127(2) sets out how a young people aged 16 or 17 can consent to their medical treatment and to any ancillary procedures involved in that treatment, such as an anaesthetic. Accordingly, treatment can be given if the young person, who has capacity, gives valid consent.

9.45 A young person must have the capacity to make the decision in relation to treatment. They must have sufficient information and not be subject to any undue influence when doing so. Unlike adults, the refusal by a competent young person with capacity under the age of 18 may, in certain circumstances, be overridden by a Court.

9.46 In the case of Re W (a minor) (medical treatment: Court's jurisdiction), the Court decided that it has jurisdiction to override the refusal of a child or young person of treatment in circumstances that will, in all probability, lead to the death of the child or young person or to severe permanent injury; or

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[109] *Para 56: "This means that the Court will only become involved if there is a dispute between the parents and the local authority or other State body, such as the NHS, or between the parents themselves, as to what is in the child's best interests. As I understand it, Article 5 is not engaged unless and until the matter is referred to a Court. At that stage if, and only if the Court then concludes that it has to override the parent's decision because it is not in the child's best interests, is Article 5 engaged. That is because it is the Court that is authorising the State detention of the child rather than the parents, and the subjective limb in Article 5 is present".* Lancashire CC v PX [2022] EWHC 2379 (Fam)

where there is a serious and imminent risk that the child or young person will suffer grave and irreversible mental or physical harm. However, the Court also emphasised that the young person's refusal is a very important consideration when deciding whether treatment should be given, despite the young person's refusal, noting that its importance increases with their age and maturity.

Informal treatment of 16 and 17 year olds who lack capacity to consent

9.47 Different considerations apply to a decision to treat a young person aged 16 or 17 informally where the young person lacks capacity to make decisions about their care and treatment or is otherwise not able to decide whether or not to consent to the proposed treatment.

9.48 Where the young person lacks capacity, based on an assessment informed by the MCA, the person(s) with parental responsibility may consent on behalf of the young person who lacks capacity to make decisions about their treatment.

9.49 The DoH would advise practitioners to seek legal guidance before relying on parental consent to treat in instances where the young person has capacity and has refused treatment.

Figure 6: Overview of consent for children and young people

	Can give consent	**Others can give consent on their behalf**	**Can they refuse treatment?**
Over 16 and under 18			
Has capacity	**Yes** – without the need for consent from a person with parental responsibility	Court	**No** – minors with capacity who withhold consent can be over-ruled by Court in situations described as grave and with serious consequences
Does not have capacity	**No** – if no capacity cannot give valid consent	Persons with parental responsibility or Court	**No** – if lacks capacity cannot withhold consent
Under 16 yrs			
Competent	**Yes** – but, if possible, also with consent of person with parental responsibility	Court	**No** – competent minors who withhold consent can be over-ruled by Court in situations described as grave and with serious consequences
Not competent	**No** – if not competent cannot give valid consent	Persons with parental responsibility or Court	**No** – if not competent cannot withhold consent

Establishing what is in the patient's best interests

9.50 When determining what is in the best interests of a patient who lacks capacity, Article 7 of the MCA should be referred to for guidance.

"Best interests
(1) This section applies where for any purpose of this Act it falls to a person to determine what would be in the best interests of another person who is 16 or over ("P").
(2) The person making the determination must not make it merely on the basis of—
(a) P's age or appearance; or
(b) any other characteristic of P's, including any condition that P has, which might lead others to make unjustified assumptions about what might be in P's best interests.
(3) That person—
(a) must consider all the relevant circumstances (that is, all the circumstances of which that person is aware which it is reasonable to regard as relevant); and
(b) must in particular take the following steps.
(4) That person must consider—
(a) whether it is likely that P will at some time have capacity in relation to the matter in question; and
(b) if it appears likely that P will, when that is likely to be.
(5) That person must, so far as practicable, encourage and help P to participate as fully as possible in the determination of what would be in P's best interests.
(6) That person must have special regard to (so far as they are reasonably ascertainable)—
(a) P's past and present wishes and feelings (and, in particular, any relevant written statement made by P when P had capacity);
(b) the beliefs and values that would be likely to influence P's decision if P had capacity; and
(c) the other factors that P would be likely to consider if able to do so.
(7) That person must—
(a) so far as it is practicable and appropriate to do so, consult the relevant people about what would be in P's best interests and in particular about the matters mentioned in subsection (6); and
(b) consider the views of those people (so far as ascertained from that consultation or otherwise) about what would be in P's best interests and in particular about those matters."

Withdrawal of consent

9.51 Article 66 of the Order provides that a patient may withdraw consent given by them in respect of treatment specifically requiring their consent under Article 63 or 64 of the Order before completion of the treatment. In such circumstances treatment must cease immediately:

- unless the RMO considers that its discontinuance would cause serious suffering to the patient (Article 68(2)); or
- until a second medical opinion is obtained in the case of a detained patient to whom Article 64 applies.

9.52 The patient should be kept informed of the intended course of action.

9.53 Where a patient withdraws his consent to an Article 63 treatment it must not be given or, if a plan of treatment is in progress, the treatment must cease immediately unless one of the criteria for urgent treatment described above is met. If a patient withdraws consent to a treatment or plan of treatment specified for the purposes of Article 64, the RMO must stop the treatment, unless the circumstances are such that it can be given as urgent treatment, until the requirements of that Article relating to a non-consenting patient can be complied with.

Urgent treatment without consent

9.54 Urgent treatment that would fall within Articles 63 and 64 may be given without the patient's consent if the circumstances make it impractical to obtain their consent and it is immediately necessary to give treatment.

9.55 Article 68 describes the circumstances in which treatments specified for the purposes of Articles 63 and 64 may be given without the patient's consent, or without a certificate, to a patient who is not capable of giving valid consent. Any treatment may be given which is immediately necessary to save the patient's life (Article 68(1)(a)). Treatments for mental disorder will of course seldom come into this category. Treatment for physical disorder is not covered by the Order, and medical practitioners should follow their usual policy; for example, if a brain tumour is incidentally causing mental disorder, surgery to remove it would not come under Article 63, since it would not be primarily a form of treatment for the incidental mental disorder.

9.56 Other urgent treatments which may be given are set out in Article 68 (1) (b), (c) and (d):

- a treatment which is not irreversible and is immediately necessary to prevent a serious deterioration in the patient's condition (a treatment is considered to be irreversible if it has unfavourable irreversible physical or psychological consequences (Article 68(3));
- a treatment which is not irreversible or hazardous and is immediately necessary to alleviate serious suffering by the patient (a treatment is considered to be hazardous if it entails significant physical hazard, (Article 68(3)); or
- a treatment which is not irreversible or hazardous, is immediately necessary, and represents the minimum interference necessary to prevent the patient behaving violently or being a danger to themself or others.

9.57 Urgent treatment within the meaning of Article 68 must cease as soon as the crisis which led to it being given has been successfully resolved.

9.58 A course of treatment or a plan of treatment may be continued where the patient has withdrawn their consent, if the RMO considers that discontinuing the treatment abruptly would cause serious suffering to the patient. In all such cases, treatment may be continued only until the provision of Article 63 or 64, as in the case may be, can be complied with. Treatment must ease as soon as its cessation will no longer cause serious suffering.

9.59 Where a patient is given urgent treatment, or treatment is continued in the circumstances described in the previous paragraphs (Article 68), the RMO is required to notify RQIA immediately (Article 68(4)) as to:

- the nature of the treatment given to the patient; and
- to confirm that the treatment is not irreversible or hazardous and is immediately necessary to alleviate serious suffering by the patient (a treatment is considered to be hazardous if it entails significant physical hazard); or
- which of paragraphs (a) to (d) of Article 68(1) applied in relation to the patient – in other words, the circumstances which made it necessary to give the treatment.

9.60 A second Part II doctor completing a **Form 23** whilst awaiting the Part IV opinion would provide the required evidence as set out above.

Consent by relatives

9.61 Except for consent by a person with parental responsibility of a child, consent by a patient's relative is not an acceptable legal alternative to consent by the patient. The fact that a relative may agree to treatment being given to the patient does not alter the requirements of the common law or of the Order.

Treatment for physical illness

9.62 It should be noted that the principles of common law on consent apply not only to treatment for mental disorder, but to medical or surgical treatment which may be required for a patient with a mental disorder.

Review of treatment: reporting to RQIA

9.63 Where a patient is given treatment under Article 63 or 64, for which a SOAD has provided a certificate, the RMO must report, in accordance with Article 67, to RQIA on the treatment and on the patient's condition:

(a) when the authority to detain the patient is renewed under Article 13 of the Order; and
(b) at any other time, RQIA requires them to do so.

9.64 In the case of a patient subject to a restriction order or direction, the report must be made:

(a) six months after the date of the restriction order or direction if the treatment was given in that period;
(b) if the treatment is given more than six months after the date of the restriction order or direction, the next time the RMO makes a report to the DOJ under Article 47(5); or
(c) at any time RQIA requires them to do so.

9.65 RQIA may at any time direct that a form of treatment should cease by giving notice to the RMO that the certificate authorising the treatment shall not apply to the patient after a specified date. If the RMO wishes to continue treatment after that date, they will again have to go through the procedure set out above under the section "treatment requiring consent or a second opinion" unless the grounds for urgent treatment described above are met. Treatment may be continued only if the provisions of the appropriate Article have been complied with once again or, pending such compliance, if the RMO considers that the abrupt discontinuance of the treatment would cause serious suffering to the patient (Article 68(2)).

Use of restrictive practices, including restraint and seclusion

9.66 The use of restrictive practices, including restraint and seclusion in any setting where health or social care is provided, must adhere to the standards and guidance detailed in the Regional Policy on the use of Restrictive Practices in Health and Social Care Settings and regional operational procedure for the use of Seclusion.[110]

Personal searches

9.67 PHA regional policy and procedural guidelines relating to searching both detained and voluntary patients and their belongings, and the recording of searches[111], should be kept under review and updates disseminated to the Trusts. This policy and procedure should be made known to all staff who may be involved in personal searches of patients. Patients should be informed of the policy on admission. Relatives and patients' visitors should also be informed. The list of prohibited and restricted items should be shared with the patient and relatives. Searches should only be carried out

[110] Regional Policy on the use of Restrictive Practices in Health and Social Care Settings and regional operational procedure for the use of Seclusion
[111] Regional guidelines for the search of patients, their belongings and the environment of care within adult mental health/learning disability settings

where they are necessary to manage the identified risk to the patient and/or others. The patient's consent should be obtained if possible. Two members of staff should be present during personal searches. All staff involved in the personal searches of patients should have received up to date accredited and certified training delivered by an appropriately trained instructor. All staff should be assessed as competent by their line manager.

9.68 The manner in which a search is conducted should ensure the greatest possible privacy and respect for the dignity of the patient. Searches of a patient's body should only be done by a staff member of a gender acceptable, as far as possible, to the patient, unless urgent necessity dictates otherwise, and may include situations where there is reason to believe the patient may have concealed an object which may result in immediate harm to themself or others. If items belonging to the patient are removed, a full explanation should be provided to the patient and the patient told who has custody and responsibility for these items.

Special accommodation of dangerous patients

9.69 The DoH may provide special accommodation as appears to it to be necessary for detained patients who, in the opinion of the DoH, require treatment under conditions of special security on account of their dangerous, violent or criminal propensities (Article 110). Some, but not all, will be detained by order of a Court or the DoJ under Part III of the Order. Conditions of increased security for such patients are provided in the HSHs in England and Scotland, as detailed in paragraph 8.31.

9.70 The regional medium secure unit provides a lower level of safe accommodation and specialist care for dangerous patients than that provided in England and Scotland high secure units but higher than that which can be provided within the Psychiatric Intensive Care Units (PICUs) in the psychiatric and learning disability hospitals in Northern Ireland.

9.71 For patients presenting similar problems but to a lesser degree, their needs may be accommodated within the Northern Ireland psychiatric and learning disability hospitals' PICUs.

ANNEX 1 – PRESCRIBED FORMS

All 24 prescribed forms under the Order can be found at:
The Mental Health Northern Ireland Order 1986 | prescribed forms

Form 1 – Application by **Nearest Relative** for assessment
Form 2 – Application by **ASW** for assessment
Form 3 – **Medical recommendation** for assessment
Form 4 – **Extension** of 48-hour conveyance/admission window (up to 14 days)
Form 5/6 – **Hospital holding powers** (doctor/nurse) for voluntary inpatients
Form 7/8/9 – **Assessment period** reports (arrival; to 7 days; to 14 days)
Form 10/11/12 – **Detention for treatment** and renewals
Form 13–19 – **Guardianship** applications/recommendations/renewals
Form 20 – **Assignment** of NR functions to another person
Form 21–23 – **Consent/Second Opinion** certifications

Use the links below for the current templates.

Form 1	(Form 1) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 2	(Form 2) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 3	(Form 3) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 4	(Form 4) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 5	(Form 5) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 6	(Form 6) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 7	(Form 7) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 8	(Form 8) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 9	(Form 9) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 10	(Form 10) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 11	(Form 11) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 12	(Form 12) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 13	(Form 13) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 14	(Form 14) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 15	(Form 15) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 16	(Form 16) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 17	(Form 17) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx

Form 18	(Form 18) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 19	(Form 19) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 20	(Form 20) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 21	(Form 21) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 22	(Form 22) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 23	(Form 23) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx
Form 24	(Form 24) the-mental-health-northern-ireland-order-1986-prescribed-forms.docx

ANNEX 2 – LIST OF WEBLINKS REFERRED TO IN THE FOOTNOTES

Para	Foot note	Title of Document	URL
Intro	1	SHARE Guidelines	https://www.health-ni.gov.uk/publications/share-guidelines-northern-ireland
1.12	2	Children (Northern Ireland) Order 1995	https://www.legislation.gov.uk/nisi/1995/755/contents
1.15	3	Mental Health NI Order 1986 Prescribed Forms	https://www.health-ni.gov.uk/publications/mental-health-ni-order-1986-prescribed-forms
1.18	4	UN Convention on the Rights of Persons with Disabilities (UNCRPD)	https://social.desa.un.org/issues/disability/crpd/convention-on-the-rights-of-persons-with-disabilities-crpd
1.20	5	RCSLT Good Communication Standards	https://www.rcslt.org/wp-content/uploads/media/Project/RCSLT/good-comm-standards.pdf
1.20	6	BSO Information for HSC Staff and Practitioners	https://bso.hscni.net/directorates/operations/regional-interpreting-service/information-for-hsc-staff-and-practitioners/
1.40	7	European Convention on Human Rights	https://www.echr.coe.int/documents/d/echr/convention_ENG
1.48	8	Winterwerp v Netherlands [1979] ECHR 4	https://www.mentalhealthlaw.co.uk/Winterwerp_v_Netherlands_6301/73_(1979)_ECHR_4
1.51	9	A guide to individual rights ICO	https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/individual-rights/individual-rights/
1.53	10	Review Tribunal Department of Justice	https://www.justice-ni.gov.uk/articles/review-tribunal
1.53	11	The Bournewood case	https://www.mentalhealthlaw.co.uk/HL_v_UK_45508/99_(2004)_ECHR_471
1.53	12	Stanev v Bulgaria [2012]	https://www.mentalhealthlaw.co.uk/Stanev_v_Bulgaria_36760/06_(2012)_ECHR_46,_(2012)_MHLO_1
1.54	13	The Law Centre Northern Ireland	https://www.lawcentreni.org/
1.54	14	Children's Law Centre	https://childrenslawcentre.org.uk/
1.59	15	Regional Policy on the use of Restrictive Practices in HSC Settings	https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-regional-policy-restrictive-practices-hsc-nov-2023.pdf

1.59	16	Black v Forsey 1998	https://www.investigativepsychiatry.com/wp-content/uploads/2025/03/black_v_forsey_ukhl_1988.pdf https://www.investigativepsychiatry.com/2025/03/21/case-study-sessay-v-south-london-maudsley-nhs-foundation-trust-2011/
1.59	17	Syed v Director of Public Prosecutions	https://www.casemine.com/judgement/uk/5a8ff72360d03e7f57ea85fa
1.59	18	The Fire and Rescue Services (Northern Ireland) Order 2006	https://www.legislation.gov.uk/nisi/2006/1254/contents
1.59	19	The Fire Safety Regulations (Northern Ireland) 2010	https://www.legislation.gov.uk/nisr/2010/325/contents/made
1.72	20	The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003	https://www.legislation.gov.uk/nisi/2003/431/contents/made
1.75	21	RCRP Governance Arrangements	https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health-ni.gov.uk%2Fsites%2Fdefault%2Ffiles%2F2026-03%2FRCRP%2520Governance%2520Arrangements.DOCX&wdOrigin=BROWSELINK
2.4	22	No URL	
2.12	23	The Marriage (Same-sex Couples) and Civil Partnership (Opposite-sex Couples) (Northern Ireland) Regulations 2019	https://www.legislation.gov.uk/uksi/2019/1514/contents
2.16	24	No URL	
2.20	25	No URL	
2.31	26	HM's Application [2014] NIQB 43	https://www.judiciaryni.uk/files/judiciaryni/decisions/HM%E2%80%99s%20Application.pdf
2.33	27	TW v Enfield Borough Council Court of Appeal	https://www.mentalhealthlaw.co.uk/TW_v_Enfield_Borough_Council_(2014)_EWCA_Civ_362,_(2014)_MHLO_26
2.35	28	Mental Health Act 1983	https://www.legislation.gov.uk/ukpga/1983/20/contents
2.37	29	Second ASW report	https://www.health-ni.gov.uk/sites/default/files/2025-01/MHO%20C%20-%20Second%20Approved%20Social%20Worker%20Report.pdf

2.43	30	MHO(a) MHO(b) Guidance for MHO(b)	https://www.health-ni.gov.uk/sites/default/files/2025-01/MHO%20A%20-%20Approved%20Social%20Worker%20Information%20Report.pdf https://www.health-ni.gov.uk/sites/default/files/2025-01/MHO%20B%20-%20Approved%20Social%20Worker%20Report.pdf https://www.health-ni.gov.uk/sites/default/files/2025-01/Guidance%20%20ASW%20Report%20%28MHO%20B%29%20%28Article%204%20MHO%29.pdf
2.44	31	Social Circumstances Report	https://www.health-ni.gov.uk/sites/default/files/2025-01/Social%20Circumstances%20Report.pdf
2.48	32	Promoting Quality Care	https://www.health-ni.gov.uk/publications/promoting-quality-care-good-practice-guidance-assessment-and-management-risk-mental-health-and-learning-disability
2.49	33	Regional Mental Health Care Pathway	https://online.hscni.net/wpfd_file/regional_mental_health_care_pathway/
2.52	34	No URL	
2.61	35	No URL	
2.68	36	HL v UK 45508/99 [2004] ECHR 471	https://www.mentalhealthlaw.co.uk/HL_v_UK_45508/99_(2004)_ECHR_471
2.72	37	Alternative Care Plan	https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health-ni.gov.uk%2Fsites%2Fdefault%2Ffiles%2F2026-03%2FAlternative%2520Care%2520Plan%2520-%2520ASW%2520Assessment%2520under%2520the%2520Mental%2520Health%2520Order%25201986.docx&wdOrigin=BROWSELINK
2.80	38	Gillick v West Norfolk AHA	https://www.lawteacher.net/cases/gillick-v-west-norfolk.php
2.80	39	Consent to treatment - Children and young people - NHS	https://www.nhs.uk/tests-and-treatments/consent-to-treatment/children/
2.86	40	Health and Social Care Act (Northern Ireland) 2022	https://www.legislation.gov.uk/nia/2022/3/contents/enacted
2.93	41	Re RN (Deprivation of Liberty and Parental Consent) [2022] EWHC 2576 (Fam)	https://www.mentalhealthlaw.co.uk/Re_RN_(Deprivation_of_Liberty_and_Parental_Consent)_(2022)_EWHC_2576_(Fam)

2.94	42	Lancashire CC v PX [2022] EWHC 2327 (Fam)	https://caselaw.nationalarchives.gov.uk/ewhc/fam/2022/2379?query=Lancashire+County+Council+PX+%282022%29
2.96	43	Police (Northern Ireland) Act 2000	https://www.legislation.gov.uk/ukpga/2000/32/contents
2.108	44	No URL	
2.134	45	Additional Guidance for Healthcare Professionals requesting an Ambulance	https://www.health-ni.gov.uk/sites/default/files/2026-03/Additional%20Guidance%20for%20Healthcare%20Professionals%20requesting%20an%20Ambulance.pdf
3.3	46	No URL	
3.3	47	Record of Decision Making for Staff by HSC Advice Line Best Practice Recording Format	https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health-ni.gov.uk%2Fsites%2Fdefault%2Ffiles%2F2026-03%2FRecord%2520of%2520Decision%2520Making%2520for%2520Staff%2520by%2520HSC%2520Advice%2520Line%2520-.docx&wdOrigin=BROWSELINK
3.5	48	HSC Trust Designated Places of Safety	https://www.health-ni.gov.uk/publications/hsc-trust-designated-places-safety
3.18	49	Regionally Agreed Place of Safety Recording Format	https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health-ni.gov.uk%2Fsites%2Fdefault%2Ffiles%2F2026-03%2FRegionally%2520Agreed%2520Place%2520of%2520Safety%2520Recording%2520Format.docx&wdOrigin=BROWSELINK
3.21	50	Patient Information Leaflet	https://www.health-ni.gov.uk/sites/default/files/2025-02/Information%20leaflet%20to%20be%20given%20to%20persons%20detained%20under%20Article%20129%20or%20130.PDF
3.21	51	Right to be informed - ICO	https://ico.org.uk/for-organisations/uk-gdpr-guidance-and-resources/individual-rights/individual-rights/right-to-be-informed/
3.26	52	RCRP Governance Arrangements	https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health-ni.gov.uk%2Fsites%2Fdefault%2Ffiles%2F2026-03%2FRCRP%2520Governance%2520Arrangements.DOCX&wdOrigin=BROWSELINK
3.28	53	GPs carrying out medical recommendations for seriously mentally ill patients (Form 3)	https://primarycare.hscni.net/download/DocLibrary/GMS/Enhanced%20services/NILES/Care-of-seriously-mentally-ill-patients/Form-3.pdf
3.33	54	National Decision-Making Model	https://www.college.police.uk/app/national-decision-model/national-decision-model
3.41	55	Regional Policy on the use of Restrictive	https://www.health-ni.gov.uk/sites/default/files/publications/health

		Practices in HSC Settings	/doh-regional-policy-restrictive-practices-hsc-nov-2023.pdf
3.44	56	No URL	
3.57	57	Alternative Care Plan	https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health-ni.gov.uk%2Fsites%2Fdefault%2Ffiles%2F2026-03%2FAlternative%2520Care%2520Plan%2520-%2520ASW%2520Assessment%2520under%2520the%2520Mental%2520Health%2520Order%25201986.docx&wdOrigin=BROWSELINK
3.68	58	Warrant Article 129 Information Template	https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health-ni.gov.uk%2Fsites%2Fdefault%2Ffiles%2F2026-03%2FWarrant%2520Article%2520129%2520Information%2520Template%2520Recording%2520Format.docx&wdOrigin=BROWSELINK
3.73	59	Regionally Agreed Place of Safety Recording Format	https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health-ni.gov.uk%2Fsites%2Fdefault%2Ffiles%2F2026-03%2FRegionally%2520Agreed%2520Place%2520of%2520Safety%2520Recording%2520Format.docx&wdOrigin=BROWSELINK
3.79	60	Risk Assessment for HSC Staff in Emergency Departments	https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health-ni.gov.uk%2Fsites%2Fdefault%2Ffiles%2F2026-03%2FVoluntary%2520Attendees%2520-%2520Risk%2520Assessment%2520for%2520HSC%2520staff%2520in%2520EDs.docx&wdOrigin=BROWSELINK
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		Document relating to Article 129(2) Warrant of Search and Entry	%2520PLACE%2520OF%2520SAFETY.doc&wdOrigin=BROWSELINK https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Fwww.health-ni.gov.uk%2Fsites%2Fdefault%2Ffiles%2F2024-12%2FARTICLE%2520129%25282%2529%2520warrant%2520of%2520search%2520and%2520entry.doc&wdOrigin=BROWSELINK
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8.6	89	The Criminal Justice (Northern Ireland) Order 1996	https://www.legislation.gov.uk/nisi/1996/3160/contents

8.15	90	DoH Guidance on the Transfer of Patients Detained under Mental Health Legislation between Hospitals in Northern Ireland and Great Britain	https://www.health-ni.gov.uk/sites/default/files/publications/health/Addendum-on-DOH-Guidance-on-Transfers_0.pdf
8.44	91	Paragraph 2 of Schedule 2A to The Mental Health (Northern Ireland) Order 1986	https://www.legislation.gov.uk/nisi/1986/595/schedule/2A
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9.9	95	The seven principles of decision making and consent - professional standards - GMC	https://www.gmc-uk.org/professional-standards/the-professional-standards/decision-making-and-consent/the-seven-principles-of-decision-making-and-consent
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9.37	106	Re W (A Minor) (Medical Treatment: Court's Jurisdiction)	https://vlex.co.uk/vid/re-w-minor-medical-804572145
9.39	107	Re RN (Deprivation of Liberty and Parental Consent) [2022] EWHC 2576 (Fam)	https://www.mentalhealthlaw.co.uk/Re_RN_(Deprivation_of_Liberty_and_Parental_Consent)_(2022)_EWHC_2576_(Fam)
9.41	108	Lancashire CC v PX [2022] EWHC 2379 (Fam)	https://www.bailii.org/ew/cases/EWHC/Fam/2022/2379.html
9.66	109	Regional Policy on the Use of Restrictive Practices in HSC Settings and Regional Operational Procedure for the Use of Seclusion	https://www.health-ni.gov.uk/sites/default/files/publications/health/doh-regional-policy-restrictive-practices-hsc-nov-2023.pdf
9.67	110	Regional guidelines for the search of patients, their belongings and the environment of care within adult mental health/learning disability settings	https://www.publichealth.hscni.net/sites/default/files/201402_Regional%20Guidelines%20for%20Search_FINAL_0.pdf

EMAIL CONTACT LINKS

Purpose	Email link
DoH - Requests for documents in alternative formats	mcaimplementation@health-ni.gov.uk
DoH – MCA implementation queries	mcaimplementation@health-ni.gov.uk
DoH – Escalation to DoH in circumstances described in Chapter 8 of the Code	mentalhealthunit@health-ni.gov.uk
DOJ – Mentally Disordered Offenders queries	DOJMentallyDisordered.Offenders@justice-ni.gov.uk

GLOSSARY

ABWOR	Assistance by Way of Representation (legal aid mechanism sometimes referenced in Tribunal/legal contexts).
Admission (compulsory)	Hospital admission for assessment under the Order, initiated by an application (Form 1 or 2) and a medical recommendation (Form 3), when statutory criteria are met (mental disorder + substantial likelihood of serious physical harm). See Articles 4–8.
Alternative Care Plan	A documented plan for needs/support when detention criteria are not met or after discharge; agreed with the person (and carers where appropriate).
Applicant, the	The patient's nearest relative or an ASW, or a person appointed by the County Court to act as the nearest relative.
Approved Social Worker (ASW)	A social worker specially trained in dealing with persons suffering from mental disorder and appointed by a Trust to act as an ASW for the purposes of the Order.
Article 11 (Rectification)	Allows certain errors/omissions in prescribed forms/reports to be amended within 14 days of admission by the original signatory with Trust consent; some defects cannot be cured and make detention invalid.
Article 129 (Warrants & detention at a "place of safety")	Police/Trust-led warrant routes to enter premises and remove a person and (via 129(5)) detain there for up to 48 hours for assessment/arrangements. Sub-routes: • 129(1): Suspected ill-treatment/neglect/not under proper control, or living alone and unable to care for self. • 129(2): Access refused/anticipated refusal *after* admission documents are duly completed (e.g. absconded patient).

	• 129(3): Access to persons detained under England/Wales/Scotland legislation who are now in NI. • 129(4): Applicant (often NR) cannot practically convey the person; Trust has failed to do so.
Article 130 (Public place power / place of safety)	Police power to remove a person from a public place to a place of safety and detain up to 48 hours for medical exam + ASW interview + care planning, where the person appears to have a mental disorder and needs immediate care and control for their own protection or protection of others. No warrant is required.
Assessment period (in hospital)	Structured time limits managed via Forms 7–9: immediate exam on arrival (Form 7), extension to 7 days (Form 8), and a further extension to 14 days (Form 9).
Authorised Administrative Officer	Trust's administrative staff who have been identified to support the processing of statutory forms both internally and between the Trust and RQIA.
Best interests (children)	For under-16s, decisions must prioritise best interests (considering age/characteristics) and be recorded; advocacy availability and suitable environment duties apply. See Children (NI) Order 1995 and updated Articles 3A–3D interface.
Care Order (child)	Where a child/young person is in Trust care by virtue of a care order, the Trust is deemed the Nearest Relative (ahead of most others).
Children (NI) Order 1995	Core child law framework (parental responsibility, care orders, looked-after status) that interacts with the Order for under-18s.
Consent (to treatment)	Valid consent is voluntary, informed, and ongoing, and time/decision-specific. Certain treatments require consent AND second opinion; others consent OR second opinion; urgent treatment may proceed without consent under strict limits (see Articles 63–68; Forms 21–23).
Conveyance Agency	Trusts may have made arrangements through conveyance agencies to increase the options to transport patients to hospital and other facilities. When commissioning conveyance agencies to transport patients under the order, conveyance services should be clear about their role and responsibilities
Data protection / UK General Data Protection Regulation (GDPR)	Trusts and partners are data controllers; share necessary, relevant, proportionate data under a data sharing agreement; ensure security and uphold patients' information rights.
Department, the / DoH	Department of Health
Detention for treatment	After assessment, a Part II doctor may detain the patient for treatment up to 6 months, then renew for 6 months, then for 1 year (annual thereafter), using Forms 10–12, if criteria continue to be met.
DoJ	Department of Justice

Equality (s.75 NI Act 1998)	Public bodies must promote equality of opportunity and have regard to good relations; services must be person-centred and address diverse needs.
European Convention on Human Rights (ECHR) / Human Rights Act (HRA) 1998	Human rights framework (Articles 2–14). Articles 3 (absolute), 5 & 8 (qualified) are especially relevant to detention/restraint.
Forms (prescribed)	The forms which are required to be prescribed under the Order. They are prescribed under the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 (SR 1986 No 174) as amended.
Gillick competence	A child under 16 who has sufficient understanding and intelligence can consent to treatment/admission. A non-Gillick-competent child requires parental consent (or formal powers if objecting).
Guardianship	A community-based long-term power for welfare/supervision where criteria are met; applied for by ASW or Nearest Relative (Forms 13–17), renewed as per the Order (Forms 18–19). Distinct from detention for treatment.
HRA	The Human Rights Act 1998
HSC Trust	Health and Social Care Trust; responsible for service provision, quality/governance, designated places of safety, ASW capacity, inter-agency procedures, and notifying RQIA.
Human rights (in practice)	Decisions must have legal basis, be necessary for a legitimate aim, proportionate, and the least restrictive option; reasoning should be documented.
Intellectual/Learning Disability (modern term)	Preferred terminology replacing the legal term “mental handicap” in professional communications (except where legal wording is strictly required).
Looked After Child (LAC)	A child in the care of a Trust (by Care Order or accommodation). Admission and treatment decisions must engage children’s services.
MCA (Mental Capacity Act (NI) 2016)	Provides capacity and deprivation-of-liberty framework (phased commencement). If detention criteria under the Order are met, the Order takes precedence; otherwise use the MCA with its principles: presumption of capacity, support to decide, unwise decisions, best interests, least restrictive.
Medical Practitioner	Medical practitioners appointed by the RQIA for the purposes of Part II of the Order and Part IV of the Order are commonly known as Part II and Part IV medical practitioners respectively and are referred to as such throughout the Code. Doctors are the only profession that can meet this requirement.
Medical treatment	Medical treatment is broadly defined to include nursing and also care and training under medical supervision.
Mental disorder	This is defined in Article 3 of the Order: “Mental illness, mental handicap, and any other disorder or disability of mind.” Exclusions (by Article 3(2)) include personality disorder by reason only, promiscuity, immoral conduct,

	sexual deviancy, or dependence on alcohol/drugs (though treatment may proceed voluntarily).
Nearest Relative (NR)	This is defined in Article 32 of the Order by reference to a list of relationships, a caring relative taking priority over a non-caring relative, whatever their position on the list. The list is also reproduced in the notes to the relevant prescribed forms. Functions: apply for admission/guardianship, object to admission, assign functions (Form 20), seek discharge, apply to Tribunal. Replacement via court is possible.
NIAS	Northern Ireland Ambulance Service
Order, the	The Mental Health (Northern Ireland) Order 1986.
Part II/Part IV Medical practitioner	A medical practitioner appointed by the RQIA for the purposes of these Parts of the Order.
Patient	The term "patient" is used throughout the code to describe a person experiencing or appearing to be experiencing a mental disorder and includes patients in the community as well as in hospital. (NB. A different meaning applies for the purposes of Part VIII of the Order).
Patient information & rights	People must be told their rights on detention and given accessible information (including place of safety leaflets), legal advice routes, and advocacy options.
Place of safety	A hospital willing to receive the patient, a police station (used exceptionally), or another suitable place where the occupier is willing (e.g. home, residential/nursing home) and risks can be safely managed. Max detention is 48 hours, and time starts on arrival at the place of safety.
Promoting Quality Care (PQC)	Regional risk assessment/management approach to inform decisions across multi-disciplinary teams and organisations.
Regional Mental Health Care Pathway	NI pathway emphasising personalised, recovery-oriented and co-produced care, with consistency across regions.
Regulations	A number of regulations (also known as Statutory Rules) have been made under powers given in the Order. The most important, for the purposes of this Code, are the Mental Health (Nurses, Guardianship, Con- sent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986, as amended.
Responsible Trust	For a hospital patient, the Trust administering the hospital. For guardianship, the Trust for the area in which the patient resides.
Responsible Medical Officer (RMO)	Each patient has a responsible medical practitioner, the medical person in charge of their assessment and treatment whilst in hospital. This medical practitioner may or may not be a Part II doctor. This is often the case with Locum Consultants. Where the RMO is not a Part II doctor, a Part II doctor is required to undertake the functions of that role.
Restrictive practices / restraint	Must be minimised, lawful, necessary, proportionate, and time-limited; apply the regional policy and record rationale.

Review Tribunal (NI)	Appeal tribunal, constituted in accordance with Article 70 of the Order, where patients/NRs can challenge detention/guardianship/treatment decisions; has powers including discharge and recommendations.
Right Care, Right Person (RCRP)	RCRP is a policy framework designed to make sure that people in mental-health or welfare-related crisis are attended by the most appropriate agency, rather than defaulting to police attendance. It aims to reduce situations where the police attend incidents that are actually unmet health or social-care needs, not policing matters.
RQIA (Regulation and Quality Improvement Authority)	The RQIA for Northern Ireland established under Article 85 of the Order to perform specified statutory functions. Duties include: to receive/scrutinise prescribed forms, check lawfulness of detention, and query improper detentions with Trusts.
Second Opinion Appointed Doctor (SOAD)	A doctor appointed by RQIA to provide a second opinion for Part IV patients.
Social Circumstances Report (SCR)	Report by a social worker (not necessarily an ASW) when application is by NR; covers history, social factors, wishes of person/relatives, and options
Supervision and Treatment Order (STO)	Court-ordered supervision/treatment framework in criminal proceedings; includes roles for supervising officer and ASW; amendable/revocable by court.
Urgent necessity	A risk-based justification for deviating from usual safeguards (e.g., a hospital doctor providing Form 3 where waiting would heighten risk). Must be recorded and not dictated by service pressures alone.
Voluntary attendee	Person not detained who accepts transport/support to hospital; police may assist, then handover to HSC.
Voluntary patient	A person consenting to admission/treatment. If they seek to leave and risk is high, nurse's holding power (Form 6) can detain up to 6 hours until a doctor attends (Form 5 relates to doctor's route for voluntary inpatients).
Winterwerp test	ECHR standard for psychiatric detention: a true mental disorder evidenced by objective medical expertise, of kind/degree justifying confinement, and continuing to justify ongoing confinement.

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