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CONSENT TO TREATMENT (PART IV)

INTRODUCTION AND PRINCIPLES

Introduction

Part IV of the Order is concerned with the treatment of people who experience a mental disorder, both with and without their consent. It describes the procedures and safeguards in relation to specific treatments for mental disorder.

Under existing common law within this jurisdiction, all mentally competent adults have an absolute right to give or withhold consent to any medical treatment. Consent to a particular form of treatment allows that treatment to be given lawfully. To give treatment without informed and continuing consent may constitute assault and trespass against the person.

The common law allows treatment to be given without consent if a person is considered to lack the capacity to consent to it. In these circumstances, treatment can be given if it is deemed to be in the person's best interests.

The common law, as it relates to consent to treatment, applies to all patients whether voluntary or detained, except where statute (e.g. Part IV of the Order) specifically overrides it. There may, however, be occasions when voluntary patients can be given treatment under the common law until the provisions of the Order are adhered to.

In certain circumstances patients are unable to provide consent for treatment of their mental illness or are unwilling to do so. For those patients who meet the criteria and are detained in hospital, the Mental Health (Northern Ireland) Order 1986 allows for treatment without consent with specific safeguards.

Being mentally disordered, as defined by the Order, does not automatically infer a lack of capacity to consent to or refuse treatment. However, the Order authorises certain treatments for mental disorder to detained patients, without consent and regardless of capacity, as long as the appropriate criteria and safeguards are met.



It should always be remembered that even when dealing with detained patients, good practice requires that the doctor and other professionals involved in the patient's care should always:

- Assess whether the person has the capacity to understand the nature of their illness and the potential effects of treatment;
- Where capacity exists, seek the patient's informed consent taking account of the patient's preferences;
- Review the treatment plan and consider alternative options if the patient refuses or withdraws consent;
- Seek the patient's consent where changes in treatment are proposed;
- Keep the patient's capacity and consent under review.

What principles should guide good practice?

The 1992 Code of Practice contains a list of specific principles in relation to treatment. It states that all treatment should:

- **Be primarily for the benefit of the patient.** 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 handicap, including social handicap;
- **Protect the safety of the patient and other people.** In the course of treatment or in the interests of safety, restriction of liberty may be necessary but should never be used as a punishment and should only be used as a last resort to the minimum extent necessary;
- **Respect the patient's dignity and rights.** No treatment should deprive a patient of food, shelter, water, warmth, a comfortable environment or confidentiality;
- **Respect the patient's rights to privacy and freedom of choice.** Forms of treatment, such as psychological treatment techniques, group therapy and behaviour modification programmes, which may intrude on the patient's normal right to privacy and freedom of action, should be carefully planned and conducted by experienced and appropriately trained staff and should be kept under review;

- **Respect the patient's rights to information.** Patients are entitled to information and an explanation about their condition, any treatment which is proposed, and their rights. This information should be conveyed at a suitable time and in a form which takes account of the patient's capacity to understand.

These principles apply to the treatment of mentally disordered patients whether or not they are in hospital. In hospital practice they apply to both voluntary and detained patients including those admitted under Part III of the Order.

GOOD PRACTICE AND CONSENT

What does 'consent to treatment' mean?

Consent to treatment is a patient's agreement for a health professional to provide a particular form of treatment. For consent to be valid, the patient must:

- Have received sufficient information to make that decision;
- Have the mental capacity to make it;
- Not be acting under duress.

What does 'mental capacity' mean?

Mental capacity relates to an individual's ability to make a particular decision. In England and Wales there is a statutory Mental Capacity Law that does not apply in Northern Ireland, but is guiding good practice.



Is there good practice guidance on consent to treatment?

Good practice guidance is available for Northern Ireland.

Guide to Consent for Examination, Treatment or Care (2003). Department of Health, Social Services and Public Safety. **LINK TO Guide to Consent for Examination, Treatment or Care (2003)**

Further information can be found in the **Consent to Treatment Appendix**. **LINK TO CONSENT TO TREATMENT APPENDIX**

DEFINITIONS OF TREATMENT AND MEDICAL RESPONSIBILITIES

What constitutes medical treatment for a mental disorder under the Order?

The definition of medical treatment for mental disorder is very broad. It includes nursing care and physical treatments such as the administration of medication, all under the supervision of the responsible medical officer. It also embraces the range of activities aimed at alleviating or preventing a deterioration of a patient's mental disorder. This could include the use of specialised services provided by professional staff, including nurses, psychologists, occupational therapists and social workers. These services may aim to equip a patient with skills and abilities he has never had or help him to recover skills and abilities he has lost.

Does the Order cover treatment for physical illness?

In most cases the provisions apply only to the medical treatment of a mental disorder. They do not apply to treatment for a physical disorder except in situations where the treatment is directly related to the mental disorder, e.g. the compulsory feeding of a detained patient with severe anorexia nervosa, whose health is seriously threatened by food refusal, to allow treatment for the underlying mental disorder following steady weight gain.

Treatment for a physical disorder is covered by the common law. According to common law, consent (informed and free from the pressure of undue influence) must be obtained for all patients unless it can be shown that the patient lacks the capacity to consent. In these cases, a decision about treatment must be made in the person's best interests.

What is a responsible medical officer (RMO)?

In relation to a patient detained in hospital under the Order, the responsible medical officer (RMO) is a medical practitioner, appointed for the purposes of Part II by RQIA, who is responsible for the assessment and treatment of the patient. The RMO is usually a consultant psychiatrist.

What is a Part II doctor?

A Part II doctor is a medical practitioner, usually a consultant psychiatrist, appointed by the RQIA for the purposes of Part II of the Order. He may fulfill the role of responsible medical officer or give a second opinion on a patient under the care of another RMO.

What is a Part IV doctor?

A Part IV doctor is an experienced consultant psychiatrist, appointed by the RQIA for the purposes of Part IV of the Order. Part IV doctors provide an independent medical opinion on whether it is appropriate for certain treatments to be given to individual patients.



TREATMENTS AND SAFEGUARDS UNDER PART IV OF THE ORDER

Can medical treatment be given to a detained patient without his consent?

Yes, in most cases, treatment can be given to a detained patient without his consent although the Order provides certain procedural safeguards for the following treatments as set out in **Article 64**:

1. The continued administration of medication past an initial period of 3 months;
2. Electroconvulsive therapy (ECT).

These treatments require either the consent of the patient or a second opinion from a Part II doctor for medication (or a Part IV doctor for ECT) if the patient is unable or unwilling to consent to treatment.

Psychosurgery and the surgical implantation of hormones for the purpose of reducing male sexual drive is seldom performed nowadays. The procedural safeguards relating to such treatments apply to all patients, voluntary and detained, and are outlined in the Order (**Article 63**), the 1992 Code of Practice and the 1986 Guide. These safeguards will not be discussed in any further detail in this Guideline.

Can other forms of treatment be given to a detained patient without his consent?

Yes, all other forms of treatment for mental disorder not involving those listed above (i.e. treatment falling within **Article 63** or **64**) can be given to the majority of detained patients without their consent or a second opinion (**Article 69**). This includes patients admitted for assessment under the Order but excludes those detained patients to whom the consent to treatment provisions do not apply (**see question below**). The treatment must be given by the responsible medical officer or under his direction.

The Order does not give any statutory authority to impose these treatments upon any other people, for example, voluntary patients or people subject to guardianship. If such treatments are necessary, the common law has to be relied upon for the authority to do so.

Can treatment be given to a detained patient without his consent during the assessment period?

Yes, once a **Form 7** has been completed, treatment for mental disorder (excluding treatments falling within **Article 63** or **64**) can be given to the majority of detained patients without consent or a second opinion (**Article 69**). This includes the administration of medication. Detained patients to whom the consent to treatment provisions do not apply are excluded (**see question below**). The treatment must be given by the responsible medical officer or under his direction.

Do the consent to treatment provisions apply to all detained patients?

No, the following patients are specifically excluded from the consent to treatment provisions:

1. Inpatients detained for up to 48 hours on a doctor's report (**Form 5**) or for up to 6 hours under the nurses' holding power (**Form 6**);
2. Accused patients remanded to hospital for a report on their mental condition (**Article 42**);
3. Offenders admitted to hospital as a place of safety under a direction made by the court for up to 28 days following the making of a hospital order (**Article 46 (4)**);
4. People suffering from or believed to be suffering from a mental disorder and removed to a place of safety by a warrant made under **Article 129** or found in a public place and removed to a place of safety under **Article 130** for up to 48 hours
5. A restricted patient who has been conditionally discharged under **Article 48 (2)**, **78** or **79** and has not been recalled to hospital.



These patients are in the same position as voluntary patients with regards to treatment. They can only be treated without their consent under common law provisions. However, provisions relating to treatments requiring consent and a second opinion apply to detained patients, voluntary patients and people who are subject to guardianship.

TREATMENT WITH MEDICATION

When can medication be administered to a detained patient without his consent?

Starting with completion of a **Form 7**, a patient admitted involuntarily may be administered medicine with or without his consent, for the purposes of ameliorating his mental disorder. Once a **Form 10** has been completed, medication can be administered for up to a period of 3 months until further safeguards are introduced. This includes patients admitted for assessment under the Order but excludes those detained patients to whom the consent to treatment provisions do not apply **as described in the section above**.

This is to enable a treatment regime to be established so that both the doctor and patient can find out if a course of medication is having a beneficial effect. No formal documentation is required, however, an appropriate record should be entered into the clinical notes.

When does the 3 month period begin?

The 3 month period does not run from the date of the start of the patient's detention, but begins from the first administration of any medication for his mental disorder after his detention. Safeguards apply whether that medication was given with the patient's consent, or by using the powers in the Order to give treatment without consent.

What safeguards are in place if the administration of medication is to continue beyond 3 months?

There are special protections in place for all detained patients, particularly those who are unwilling or unable to give consent to treatment, if the administration of medication is to continue beyond 3 months.

For detained patients capable of giving consent to treatment:

The responsible medical officer (or a Part IV doctor) must validate the consent. The outcome of his assessment must be documented on a **Form 22** and the Treatment Plan specified. A copy of the completed **Form 22** must be sent immediately to RQIA while the original should be retained within the patient's records. **LINK TO FORM 22**

For detained patients unwilling or unable to give consent to treatment:

If the patient is either unable or unwilling to give such consent, the administration of that medicine may only be continued where the responsible medical officer approves the administration and refers the matter to another consultant psychiatrist for a second opinion. The proposed Treatment Plan should be recorded in the patient's records.

The responsible medical officer may obtain a second opinion from either a Part II doctor (or a Part IV doctor). The Part II doctor can be a doctor on the staff of the hospital in which the patient is detained but obviously cannot be the responsible medical officer for the patient.

The Part II doctor will examine the patient, discuss his case with relevant staff and consider the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition. If he is satisfied that it will, then a **Form 23** must be completed authorising the Treatment Plan specified. The doctor will also certify that the patient is either not capable of giving valid consent to the treatment or that he is unwilling to



consent to the treatment. A copy of the completed **Form 23** must be sent immediately to RQIA while the original should be retained within the patient's records. **LINK TO FORM 23**

Consent to treatment should be reassessed every time the detention is renewed and a **Form 22** or **Form 23** completed accordingly.

TREATMENT WITH ECT

What conditions must be fulfilled before Electroconvulsive Therapy (ECT) can be administered?

Electroconvulsive therapy (ECT) is a psychiatric treatment that is still clinically indicated in specific circumstances and for particular patients, though used less often than in the past. It is considered after a careful assessment and is administered following Good Practice Guidance from the Royal College of Psychiatrists.

The ECT Handbook, The Royal College of Psychiatrists 2005. **LINK TO The ECT Handbook, The Royal College of Psychiatrists 2005**

In the case of a voluntary patient for whom a course of ECT is being considered, the consultant psychiatrist should seek valid consent to the procedure in the usual way. If the patient refuses to give his consent, then the treatment cannot be administered.

The Order provides safeguards for detained patients for whom this treatment is being considered.

For detained patients capable of giving consent to treatment:

The responsible medical officer (or a Part IV doctor) must validate the consent. The outcome of his assessment must be documented on a **Form 22** and the Treatment Plan specified. A copy of the completed **Form 22** must be sent immediately to RQIA while the original should be retained within the patient's records.

This is not a substitute for documenting the essential elements of discussion with the patient in the process of gaining valid consent or for completing a standard consent form. The full Treatment Plan should also be documented in the patient's records.

For detained patients unwilling or unable to give consent to treatment:

If the patient is either unable or unwilling to give such consent, then the responsible medical officer should consider the appropriateness of treatment and the alternatives to it. If the responsible medical officer continues to believe that the patient requires a course of electroconvulsive therapy, he should contact RQIA to request a second opinion from a Part IV doctor. The responsible medical officer should document the proposed Treatment Plan in the patient's records.

RQIA will arrange for a Part IV doctor to examine the patient, discuss his case with relevant staff and consider the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition. If he is satisfied that it will, then a **Form 23** must be completed authorising the Treatment Plan specified. The Part IV doctor will also certify that the patient is either not capable of giving valid consent to the treatment or that he is unwilling to consent to the treatment. A copy of the completed **Form 23** must be sent immediately to RQIA while the original should be retained within the patient's records.

URGENT TREATMENTS

Under what circumstances can treatment be administered to a patient in advance of the safeguards being fulfilled?

Treatment requiring consent *and/or* a second opinion (i.e. treatments falling under **Article 63** and **64**) may be administered without the patient's consent, in the absence of a **Form 23**, to a patient unable or unwilling to give consent in certain circumstances:



Criteria for urgent treatment (Article 68)

Any treatment may be given which is:

- i. Immediately necessary to save the patient's life (it must be noted that treatments for mental disorder will seldom come into this category); **or**
- ii. 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); **or**
- iii. Not irreversible or hazardous and is immediately necessary to prevent serious suffering by the patient (a treatment is considered to be hazardous if it entails significant physical hazard); **or**
- iv. Not irreversible or hazardous, is immediately necessary and represents the minimum interference necessary to prevent the patient behaving violently or being a danger to himself or others.

Urgent treatment must cease as soon as the crisis that led to its being given has been successfully resolved. The responsible medical officer should notify RQIA immediately, explaining the circumstances and nature of the treatment provided. Further treatment can only continue if the safeguards can be complied with.

Can ECT ever be administered under the 'Urgent Treatment' provisions?

Yes, in exceptional circumstances, one treatment with ECT can be administered to a detained patient who is unwilling or unable to consent to treatment, while awaiting a second opinion by a Part IV doctor.

These exceptional circumstances include the situation where a Part IV doctor cannot attend in time for the next ECT session or for some reason RQIA cannot be contacted, e.g. a weekend or bank holiday, and a patient requires urgent treatment to prevent further deterioration or as a life-saving measure.

The responsible medical officer should immediately notify RQIA, explaining which indication(s) for urgent treatment applied and why treatment was administered prior to a second opinion being provided.

A Part IV doctor appointed by RQIA will attend as soon as possible to provide the second opinion.

The Order does not state that ECT is to be regarded as either irreversible or hazardous. The potential hazard of treatment will vary substantially among patients and must be estimated by the clinical assessment of the potential risks in the context of the patient's general health and balanced against the risk of not receiving ECT.

WITHDRAWAL OF CONSENT TO TREATMENT

Can a detained patient withdraw his consent to treatment?

Yes, a detained patient is entitled to change his mind and withdraw his consent to treatment at any time. This means that for any course of treatment extending over time, steps must be taken by professionals to assure themselves that a patient continues to consent.

Those treatments not falling within **Article 63** or **64** may continue without the patient's consent, as long as this is given by the responsible medical officer or under his direction.

If a patient withdraws consent to Electroconvulsive therapy (ECT) or the continued administration of medication past an initial period of 3 months, the responsible medical officer must stop the treatment, unless the circumstances are such that it can be given as urgent treatment. The remainder of the treatment must then be considered as a separate treatment.

If the patient continues to refuse treatment or is unable to give valid consent, then the responsible medical officer should consider the appropriateness of further treatment and the alternatives to it.



If further Electroconvulsive therapy is deemed necessary, then the responsible medical officer should contact RQIA to request a second opinion from a Part IV doctor.

If the continued administration of medication past an initial period of 3 months is deemed necessary, then the responsible medical officer may obtain a second opinion from either a Part II doctor or a Part IV doctor.

Can a course or plan of treatment be continued if the patient has withdrawn his consent or if RQIA has given notice invalidating a certificate of consent?

Yes, if the responsible medical officer considers that discontinuing the treatment abruptly would cause serious suffering to the patient, then a course or plan of treatment may continue in these circumstances. In all such cases treatment may be continued only until the provisions of **Articles 63** or **64** (as the case may be) can be complied with. Treatment must cease as soon as its cessation will no longer cause serious suffering.

Where urgent treatment is administered or treatment is continued under the circumstances outlined above, the responsible medical officer should notify RQIA immediately, explaining the circumstances and nature of the treatment provided.

PERSONS WITH MENTAL DISORDERS CONCERNED IN CRIMINAL PROCEEDINGS OR UNDER SENTENCE (PART III)

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PERSONS WITH MENTAL DISORDERS CONCERNED IN CRIMINAL PROCEEDINGS OR UNDER SENTENCE (PART III)

What is the purpose of Part III?

The purpose of Part III of the Mental Health (Northern Ireland) 1986 Order is to ensure that those people with a mental disorder who come into contact with the criminal justice system are dealt with in an appropriate way that meets their mental health needs and also provides protection for society.

Part III sets out provisions available to the courts and the Department of Justice in relation to those individuals with a mental disorder who are concerned in criminal proceedings or under sentence.

The Police Service of Northern Ireland (PSNI) also has powers in relation to patients subject to Part III. **See Role of PSNI and Warrants in the APPENDIX Section.** In addition the PSNI must take account of the guidance contained in the Codes of Practice for the Police and Criminal Evidence (Northern Ireland) Order 1989 in relation to the detention, treatment and questioning of persons who have or thought to have a mental disorder.

The powers contained in Part III can be usefully be divided into 2 categories:

- The powers of the **Courts** and
- The Powers of the **Department of Justice**. These are powers previously held by the Secretary of State for Northern Ireland and now devolved as part of a number of policing and justice functions to the Northern Ireland Department Of Justice under the Northern Ireland Act 1998 (Devolution of Policing and Justice Functions) Order 2010. **LINK TO Northern Ireland Act 1998 (Devolution of Policing and Justice Functions) Order 2010**

In addition Part III sets out the processes that must be followed in relation to these matters.



The Code of Practice gives more detailed guidance, particularly on aspects of good practice.

How does this framework differ from that in Part II?

The main difference is that the person is subject to admission and detention in hospital or to a community based compulsory arrangement by order of the Court or has been transferred to hospital from prison on the order of the Department of Justice.

While medical practitioners may recommend to the court or Department of Justice that a person be detained in hospital rather than prison or transferred from prison to hospital, approved social workers and nearest relatives are **not** involved in making an application for the person's detention in hospital nor does the nearest relative have rights of consultation in these matters, a right to object or a right to order the person's discharge from hospital, guardianship or supervision and treatment order.

What Powers are available to the Court under the Mental Health (Northern Ireland) Order 1986?

Courts have the following powers in relation to persons who have or are suspected of having a mental disorder:

1. Powers to remand an accused person to hospital for a report on their mental condition. **Article 42**
2. Powers to remand an accused person to hospital for treatment. **Article 43**
3. Powers to order the admission to hospital or guardianship of a person who has been convicted of an offence – i.e. hospital or guardianship orders. **Article 44**
4. Power to impose an interim hospital order. **Article 45**

5. Powers to restrict discharge from hospital. **Article 47** and
6. In relation to a person who has been found not guilty by reason of insanity or is unfit to plead, the court may impose, under **Article 50A**:
 - A hospital order
 - A guardianship order
 - A supervision and treatment order or
 - An order for absolute discharge

Does the Court have to consult with the Department of Health, Social Services and Personal Safety?

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 Department of Health, Social Services and Personal Safety 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.

No similar opportunity is provided by the Order under Article 49 (procedure in relation to unfitness to be tried) and **Article 50** (procedure in relation to finding of insanity) though the Court may invite the Trust to make representations.

In the case of guardianship the Court must be satisfied that the potential guardian is willing to receive the accused into guardianship.

In the case of Supervision and Treatment Orders under Schedule 2A to the Order the Court must be satisfied that the supervising officer intended to be specified in the order is willing to undertake the supervision.



REMAND TO HOSPITAL FOR REPORT OR FOR TREATMENT

What powers do the Courts have in relation to remand to hospital for report on an accused person's mental condition?

Both the Crown Court and a Magistrates Court can, under **Article 42**, remand an accused person into the care of the Department of Health, Social Services and Public Safety for admission to hospital for a report on that person's mental condition.

The Crown Court can remand any person who:

1. Is awaiting trial before the court for an offence punishable with imprisonment or
2. Has been arraigned (brought before the court to plead guilty or not guilty) for such an offence and has not been sentenced or otherwise dealt with for the offence on which he has been arraigned.

A Magistrates' Court can remand a person who has:

1. Been convicted by the court of an offence punishable on summary conviction with imprisonment and
2. Been charged with an offence if the court is satisfied that he did the act or made the omission charged or he has consented to the exercise of the power to remand.

What are the criteria that must be met?

The court must be satisfied that, on the oral evidence of a Part II doctor, there is reason to suspect that the accused person is suffering from mental illness or severe mental impairment and it would be impracticable for a report on his mental condition to be made if he were remanded on bail.

How long can the person be remanded in hospital?

The remanded person must be admitted to hospital within 7 days of the date of the remand and can be remanded in hospital for an initial period of 28 days and can be remanded for additional periods of 28 days to a maximum period not exceeding 12 weeks.

Can the person appeal against detention under Article 42?

Yes. The accused person is entitled to obtain an independent report from a medical practitioner on their mental condition and to apply to the court on the basis of this report for the remand to be terminated.

The accused person has no right to apply to the Mental Health Review Tribunal while subject to **Article 42**.

What powers do courts have in relation to remanding an accused person to hospital for treatment?

Article 43 permits the Crown Court only, to remand an accused person to hospital for treatment. The person cannot be remanded unless the Department has been given the opportunity to make representations to the Court concerning the proposed remand.



What criteria must be met before a person can be remanded to hospital for treatment under Article 43?

The Court must be satisfied, on the oral evidence by a Part II doctor and oral, or written evidence by one other medical practitioner that the accused person is suffering from mental illness or severe mental impairment of a nature or degree which warrants his detention in hospital for medical treatment. The person must also be awaiting trial before the court for an offence punishable with imprisonment (other than murder) or be in custody at any stage of such a trial prior to sentence.

How long can an accused person be remanded in hospital for treatment?

The remanded person must be admitted to hospital within 7 days of the date of the remand and can be remanded in hospital for treatment for an initial period of 4 weeks and if necessary further remand for periods of up to 28 days to a maximum total period not exceeding 12 weeks.

Can the person remanded to and detained in hospital under Articles 43 appeal against their detention?

Yes. The accused person is entitled to obtain an independent report from a medical practitioner on their mental condition and to apply to the Crown Court on the basis of this report for the remand to be terminated.

Persons detained under **Article 43** have no right to apply to the Mental Health Review Tribunal.

HOSPITAL ORDERS

What is a Hospital Order under Article 44?

A hospital order can be made by the Crown Court or a Magistrates Court. The order can direct that a person is admitted to and detained in a hospital rather than prison in order that the person receives care and treatment for their mental disorder.

There are two Hospital Orders that can be imposed by the court:

- A hospital order without restriction and
- A hospital order accompanied by restrictions (Restriction Order – **Article 47**)

Courts are empowered to make a hospital order under **Article 44 (1)** in respect of any person convicted before that court for an imprisonable offence punishable with imprisonment (other than murder).

A Magistrates' Court may also make a hospital order and a restriction order in respect of an accused person without conviction if it is satisfied that the person committed the act of which he/she stands accused (**Article 44 (4)**).

What are the criteria for a Hospital Order (Article 44)?

Criteria include:

- On the oral evidence of a Part II doctor and on the oral or written evidence of one other medical practitioner that the offender is suffering from mental illness or severe mental impairment.
- The offender's mental disorder is of a nature or degree which warrants his detention in a hospital for medical treatment.
- The court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to other available methods of dealing with him/her, that a hospital order is the most suitable method of dealing with the case.



What is the effect of a Hospital Order without Restriction?

The subject of the hospital order must be admitted to hospital within 28 days of the date of the order. The person will then have the same status as a person detained under Part II of the Order. When the person no longer meets the criteria for detention in hospital for treatment they must be discharged from detention. The patient's nearest relative, however, has no power to discharge him from hospital.

Has a person detained in hospital under Article 44 a right of appeal to the Court of Appeal or the County Court?

All patients admitted to hospital on a hospital order have certain rights of appeal either to the Court of Appeal or the County Court.

Has the person a right to apply to a Mental Health Review Tribunal?

Yes. The person has the same right to apply as a person detained under Part II of the Order with the date of the hospital order counting as the date of admission.

RESTRICTION ORDERS

What is a Restriction Order? – Article 47

Article 47 empowers the courts to make an order restricting the person's movements while in hospital and from discharge from hospital. A restriction order can only be made if a hospital order is also made.

In what circumstances can a Restriction Order be imposed by a court?

In addition to the criteria as set out in relation to a hospital order without restriction the Court can impose a restriction order if it appears to the court, having regard to the nature of the offence, the person's history of offending and, the risk of further offending if released from detention, that the order is necessary for the protection of the public from serious harm.

What is the effect of a Restriction Order?

As in the case of a hospital order without restrictions, the person must be admitted to hospital within 28 days of the date of the order. The restrictions may be imposed without limit of time or during a period of time specified in the order. The main restrictions are that the patient **cannot** be discharged from hospital, given leave of absence or transferred to another hospital or to guardianship without the approval of the Department of Justice.

Has a person detained under a Hospital Order with restriction a right of appeal to the Court of Appeal or the County Court?

Yes. All patients admitted to hospital on a hospital order have certain rights of appeal either to the Court of Appeal or the County Court. However if the court requires that the person attend their appeal the Department of Justice must be notified immediately so that a direction under **Article 48 (5)** can be issued authorizing that attendance.



May a person detained in hospital under a Restriction Order make an application to the Mental Health Review Tribunal?

Yes. However the Mental Health Review Tribunal has no discretionary powers to discharge patients subject to a restriction order from hospital, nor to direct delayed discharge, recommend leave of absence, transfer to another hospital or into guardianship and although the Tribunal may discharge restriction. The Department of Justice retains the discretionary power to discharge restricted patients or terminate restrictions. Discharge may be absolute or subject to conditions. When a restriction Order has been terminated the patient is treated as though he had been admitted to hospital under a hospital order without restriction made on the date on which the restriction order ceased to have effect (**Article 47 (40)**).

The Tribunal must direct a conditional discharge if it is satisfied that it is appropriate for the patient to remain liable to be recalled to hospital for further treatment. The patient must comply with any conditions imposed. A conditional discharge can be deferred by the Tribunal until it is satisfied that suitable arrangements have been made for the patient's conditional discharge.

Conditionally discharged patients can appeal to the Mental Health Review Tribunal. (**Article 80 (2)**). The Tribunal can vary any condition or impose another condition or direct that the restriction order ceases to have effect – with the result that the restriction order ceases to have effect. The Department of Justice can recall a conditionally discharged patient to hospital (**Article 48 (2)**) or vary the conditions of discharge (**Article 78 (5)**).

The Department of Justice must always be advised of applications to the Mental Health Review Tribunal.

What is an Interim Hospital Order?

An interim hospital order is a provision under Article 45 which can assist the court in their decision making regarding the making of a hospital order.

What are the criteria for an Interim Hospital Order under Article 45?

Criteria include:

- The person has been convicted by a Magistrates Court or the Crown Court of an offence punishable with imprisonment (other than murder)
- The court is satisfied on oral evidence by a Part II doctor, and oral or written advice by another medical practitioner that the convicted person is suffering from mental illness or severe mental impairment and
- There is reason to suppose that the mental disorder is such that it may warrant a hospital order being made in his case.

What is the effect of an Interim Hospital Order?

The subject of the interim order must be admitted to hospital within 28 days of the date of the order. The duration of the initial order can be specified by the court and must not exceed 12 weeks. However the court can renew the order on expiry for up to 28 days although the total period including renewals must not exceed 6 months.

Can a person appeal against an Interim Hospital Order?

As an interim hospital order is a form of sentence the patient can appeal from the Crown Court to the Court of Appeal and from a Magistrates' Court to the County Court.



GUARDIANSHIP ORDERS

What is a Guardianship Order?

Article 44 also empowers courts to make a guardianship order in respect of certain categories of offender. The effect of such an order is to confer on the Health and Social Care Trust or person named on the order the same powers as a guardian under Part II of the Order.

What are the criteria for a Guardianship Order?

Criteria include:

- On the oral evidence of a Part II doctor and on the oral or written evidence of one other medical practitioner that the offender is suffering from mental illness or severe mental handicap of a nature or degree which warrants his/her reception into guardianship; and
- The court is satisfied, on the written or oral evidence of an approved social worker, that it is in the interests of the welfare of the offender that he should be received into guardianship; and
- The offender has attained the age of 16 years; and
- The court is of the opinion, having regard to all the circumstances including the nature of the offence and the character and antecedents of the offender, and to other available methods of dealing with him/her, that a guardianship order is the most suitable method of dealing with the case; and
- The Court is satisfied that the guardian is willing to receive the person into guardianship.

Can a person subject to a Guardianship Order apply to the Mental Health Review Tribunal?

Yes. Persons subject to a guardianship order are treated essentially the same as a patient placed under guardianship under Part II.

How does a Guardianship Order differ from being received into guardianship under Part II?

Firstly the guardianship order is made by the court and although an ASW is required to provide evidence to the court an application or recommendation by an ASW or a nearest relative is not required. The powers and duties conferred on the Health and Social Care Trust or private guardian, approved by a Health and Social Care Trust, 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.



PERSONS UNFIT TO BE TRIED OR FOUND NOT GUILTY ON GROUNDS OF INSANITY

What powers does the Court have under Part III of the Order in relation to individuals who are unfit to be tried or who are found by the court to be not guilty on grounds of insanity?

Under **Article 50 A** of the Mental Health (Northern Ireland) Order 1986, where a court has found that an accused person is either -

- a) Not guilty by reason of insanity; or
- b) Unfit to stand trial but the court has found that the person committed the acts or omissions that form the offence;

the court is obliged to make one of the following orders -

- a) An order admitting the person to hospital **Article 50 A (2) (a)**;
- b) A guardianship order **Article 50 A (2) (b)**;
- c) A supervision and treatment order **Article 50 A (2) (b) (ii)** and **Schedule 2 A**; or
- d) An order for the person's absolute discharge. **Article 50 A (2) (b) (iii)**.

An order under **Article 50 A (2) (a)** is treated as if it were a hospital order and may be made with or without restrictions.

What are the criteria for a Hospital Order under Article 50 A (2) (a)?

A hospital order can be made where findings have been made that:

- The person is not guilty by reason of insanity; or
- The person is unfit to be tried and that he did the act or made the omission charged against him.

What are the criteria for a Guardianship Order under Article 50 A (2) (b) (i)?

The criteria are the same as for Hospital Orders under **Article 50 (2) (a) (A)**.

However, a Guardianship Order cannot be made if the act or omission they have been charged with relates to an offence for which the penalty is fixed by law. In that circumstance the court must make a hospital order with restriction without limit of time.



SUPERVISION AND TREATMENT ORDERS

What is a Supervision and Treatment Order under Article 50 A (2) (b) (ii) and Schedule 2 A?

The Court can make a Supervision and Treatment Order (STO) where findings have been recorded that:

- A person is not guilty by reason of insanity or
- A person is unfit to be tried and that he did the act or made the omission charged against him.

As in the case of a guardianship order under this Article the court cannot impose this Order if the act or omission they have been charged with relate to an offence for which the penalty is fixed by law.

What is the purpose of a Supervision and Treatment Order?

The purpose of an STO is to provide supervision and assistance in the community including medical treatment, for the purpose of improving the individuals mental well being and where appropriate, reduce the risk of harm to that individual and others.

What are the criteria for a Supervision and Treatment Order?

The Court must be satisfied that:

- The order is the most suitable means of dealing with the person.
- The mental condition of the person is such as requires and may be susceptible to treatment, but does not require a hospital order or guardianship order.
- The supervising officer intended to be specified in the order is willing to undertake the supervision, and
- Arrangements have been made for the treatment intended to be specified in the order.

What is the effect of a Supervision and Treatment Order?

Under this order the person is placed under the supervision of a social worker or probation officer ("the supervising officer") and must submit, during the whole or such part as may be specified in the order, to treatment (either as an in-patient or out-patient) by or under the direction of a medical practitioner. The supervising officer has the power to direct where that person should reside.

The supervised person must also submit to treatment by, or under the direction of, a medical practitioner with a view to the improvement of his mental condition for the duration of the order, or such part as may be specified.

How long can the person be made subject to the Supervision and Treatment Order?

An **STO** may be made for a period of not more than 3 years.

Can the person appeal to the court against the court's decision to impose an order made under Article 50 A i.e. Hospital Order, Guardianship Order or Supervision and Treatment Order?

Yes. The person can appeal against sentence from the Crown Court to the Court of Appeal and from a Magistrates' Court to the County Court.



Can the supervised person and the professionals involved in a Supervision and Treatment Order apply to the court to amend or revoke the Order?

Yes. 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 order.

This may include:

- Cancelling any of the requirements of the order (including the requirement for treatment) (paragraph 8 (1) (a));
- Inserting or replacing any requirement which could have been made at the time of making the original order (paragraph 8 (1) (b));
- Revoking the order, 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 (paragraph 6).

Can persons subject to the orders contained in Article 50 A apply to the Mental Health Review Tribunal?

Persons subject to a Supervision and Treatment Order have no right to apply to the Mental Health Review Tribunal.

Persons detained in hospital under **Article 50 A** or subject to a guardianship order have a right to apply to the Mental Health Review Tribunal. In addition to powers of discharge the Tribunal can direct that an unrestricted patient, be granted leave of absence, transfer to another hospital or received into Guardianship.

The Mental Health Review Tribunal can direct the absolute or conditional discharge or defer the discharge of patients detained under an **Article 50 A** hospital order with a restriction order.

The Department of Justice must be advised of these applications. In addition the Department of Justice can discharge restricted patients absolutely or conditionally, recall conditionally discharged patients, vary the conditions of discharge or direct that the restriction order cease to have effect.

Is any additional Guidance available in relation to Supervision and Treatment Orders?

Yes. The Department has published guidance for Health and Social Care Staff.

LINK TO Management of Supervision and Treatment Order – Guidance for Health and Social Care Staff. DHSSPS May 2011 pdf

What legal provisions exist for the transfer of a patient, subject to Part III of the Order, to hospitals in the UK?

The Mental Health (Northern Ireland) Order 1986 permits the transfer of a patient subject to Part III of the Order to other hospitals in the UK in situations where:

- The patient requires treatment in conditions of high security which are not available in Northern Ireland and
- The patient requires specific services which are not available in Northern Ireland.

Do provisions exist for the return of patients who have been transferred in these situations?

Yes. Transfers between Northern Ireland hospitals and Scottish hospitals, including The State Hospital, Carstairs, are carried out under **Article 6** of the Mental Health (Care and Treatment) (Scotland) Act 2003 (Consequential Provisions) Order 2005. Transfers between Northern Ireland hospitals and hospitals in England are carried out under **sections 81** and **82** of the Mental Health Act 1983.



What Guidance is available in relation to the transfer of patients between these jurisdictions?

The Department has revised and updated the guidance in relation to these matters.

LINK TO Guidance on the transfer of mentally disordered patients detained under the Mental Health (NI) Order 1986 to and from Hospitals in Great Britain August 2011

POWERS IN RELATION TO PRISONERS

Part III of the Order also sets out the powers, duties and responsibilities of the Department of Justice and others in relation to the assessment, care and treatment of those persons in custody who have or are suspected of having a mental disorder.

What powers does the Department of Justice have in relation to persons detained in prison either on remand awaiting trial, detained under Immigration laws or serving prison sentences (Transfer Directions)?

The Department of Justice has a number of powers under Part III in relation to the admission to hospital of sentenced and other persons detained in a prison or other institutions, who have , or are suspected of having a mental disorder.

What powers are available in relation to sentenced prisoners?

The power to transfer sentenced prisoners to hospital applies to any person serving a sentence of imprisonment or other form of detention. The Department of Justice can issue a transfer direction if the transfer is recommended and the Department of Justice is satisfied that the criteria are met. The transfer is a warrant directing the prisoner's patient's transfer to hospital.

What are the criteria for the transfer of these prisoners?

The Department of Justice must be satisfied by written reports from at least 2 medical practitioners, one of whom must be a Part II doctor that:

1. The person is suffering from mental illness or severe mental impairment and
2. The mental disorder is of a nature or degree which warrants the prisoner's detention in hospital for medical treatment and
3. The Department is of the opinion, having regard to the public interest and all the circumstances, that it is expedient to direct the prisoner's transfer.



What is the effect of the Transfer Direction?

A transfer direction under **Article 53** has the same effect as a hospital order made by a court. The direction is valid for 14 days after which a fresh direction will be necessary if the patient has not been admitted to hospital.

The Department has the discretion to give a restriction direction under **Article 55**. This direction has the same effect as a restriction order made by a court.

When does a Restriction Direction cease to have effect?

A restriction direction ceases to have effect on the date when the prisoner's sentence would have ended if he had remained in prison **Article 56 (2)**.

Can the person be returned to prison?

Yes. When a transfer direction and restriction direction are in force, the Department of Justice may direct the person's return to prison. The Department of Justice must first be notified by the responsible medical officer, Mental Health Review Tribunal or any Part II doctor that the patient no longer requires treatment in hospital for mental disorder or that no effective treatment for his disorder can be given in the hospital in which he/she has been transferred. The transfer and restriction directions cease to have effect on the person's arrival in prison.

What powers are available in relation to other prisoners?

The Department of Justice can also direct the transfer of:

Detained or remand prisoners	Article 54 (2) (a)
Persons remanded by a Magistrates' Court	Article 54 (2) (b)
Civil prisoners	Article 54 (2) (c)

Persons detained under the Immigration Act 1971 or under section 62 of the Nationality, Immigration and Asylum Act 2002. Article 54 (2) (d)

What criteria must be met before a person can be transferred to hospital under these provisions?

The Department of Justice must be satisfied by reports similar to those required by **Article 53** that the person is suffering from mental illness or severe mental impairment and the mental disorder from which the person is suffering is of a nature or degree which warrants detention in hospital for medical treatment and the person is in urgent need of such treatment. The Department of Justice has a discretion to also make a restriction direction and must do so in respect of persons under **Article 54 (2) (a) or (b)**.

Do these persons have a right to apply to the Mental Health Review Tribunal?

Prisoners transferred to hospital under **Article 53** with a Restriction Direction under **Article 55** have a right to apply to the Mental Health Review Tribunal.

If the Tribunal considers that the criteria for detention no longer exist the Tribunal must notify the Department of Justice that the patient would, if subject to a Hospital Order, be entitled to be absolutely or conditionally discharged.

If the Tribunal notifies the Department of Justice that the patient would be entitled to be conditionally discharged it may recommend that, if he is not so discharged, he should continue to be detained in hospital (**Article 79 (1) (b)**).

If, within 90 days, the Department of Justice notifies the patient that he may be discharged the Tribunal must direct his absolute or conditional discharge, as the case may be. Otherwise, as the patient is still considered a prisoner remains subject to the sentence passed by the court and must be returned to prison unless the Tribunal has made a recommendation under **Article 79 (1) (b)**.



In the case of a prisoner detained under **Article 54 (2)**, unless the Tribunal has made a recommendation under **Article 79 (1) (b)** that, in the event of the patient not being discharged he should continue to be detained in hospital, the Department of Justice must return the prisoner to prison or other institution if the Mental Health Review Tribunal rule that the criteria for detention no longer exist.

RELATED PROVISIONS IN OTHER LEGISLATION- PROBATION ORDER WITH A REQUIREMENT FOR TREATMENT FOR MENTAL DISORDER

When can a Probation Order with a Treatment Requirement be made?

Under **(Article 11 (3) of and paragraph 4 of Schedule 1 to Criminal Justice (Northern Ireland) Order 1996)** a Court can impose a Probation Order with a requirement for treatment for mental disorder.

Where a Court proposes to make a probation order it may include a requirement for treatment if it is satisfied that the mental condition of the offender is such as requires and may be susceptible to treatment; but is not such as to warrant detention under a hospital order under Part III of the Mental Health (NI) Order 1986

Do these persons have a right to apply to the Mental Health Review Tribunal?

There is no right to apply to a Mental Health Review Tribunal. A probation order can be revoked by a court under **Part 3** of Schedule 2 to the Criminal Justice (Northern Ireland) Order **1996** or amended under **Part 4** of that Schedule. The person can appeal against sentence to the Crown Court or the County Court.



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GUARDIANSHIP PART II

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GUARDIANSHIP (PART II)

INTRODUCTION

Guardianship was introduced by the Mental Health (Northern Ireland) Order 1986 with the aim of providing a framework in which people with a mental disorder could live safely and as independently as possible in the community and as a less restrictive alternative to detention in hospital.

This Chapter provides an overview of Guardianship under Part II of the Order.

For more detailed guidance, Health and Social Care staff are recommended to use the comprehensive guidance produced by members of the Regional ASW Forum: **“Guardianship under the Mental Health (Northern Ireland) Order 1986 – A Model for Operation 2008”**.

This guidance has been adopted and customised by individual Health and Social Care Trusts and should be available to practitioners in each Trust. An electronic version of this, customised by the NHSCT can be accessed through the following link: **LINK TO Guardianship under the Mental Health (Northern Ireland) Order 1986 – A Model for Operation 2008**

The guidelines in this Chapter are set out in a question and answer format under the following headings:

1. The purpose and powers of Guardianship
2. Reception into Guardianship and Renewal
3. Patients in hospital – Transfer into Guardianship
4. Putting Guardianship into effect
5. Discharge from Guardianship



THE PURPOSE AND POWERS OF GUARDIANSHIP

What is Guardianship?

Guardianship refers to 2 separate community-based legal provisions contained in Part II and Part III of the Mental Health (Northern Ireland) Order 1986:

- Part II contains provision for a person to be “received into guardianship”.
- Part III contains provision for a court to make a “Guardianship Order”. This can only be used for persons with a mental disorder who are concerned in criminal proceedings.

Article 44

Further reference to this provision is contained in the Chapter - Persons concerned in criminal proceedings or under sentence.

What is the purpose of Guardianship?

The purpose of guardianship is to ensure that people with a mental disorder, who meet certain criteria, receive the care and protection they require where this cannot be provided without the use of compulsory powers. It is primarily concerned with the welfare of the individual rather than their medical treatment.

Guardianship provides a less restrictive means of offering assistance to a person than detention in hospital and should be considered as an alternative to such an admission. It also enables a relative or social worker to help a mentally disordered person to manage in his own home or in other accommodation in the community, where the alternative would be detention in hospital. **Code 3.1 and Guide para.69**

In what circumstances can a person be received into guardianship?

A person can only be received into guardianship under Part II if they are:

- Aged 16 or over.
- Suffering from mental illness or severe mental handicap of a nature or degree which warrants reception into guardianship and
- It is considered necessary in the interests of the welfare of the patient that the person should be so received.

Article 18

What is the definition of mental illness and severe mental handicap?

Mental illness is defined as 'a state of mind which affects a person's thinking, perceiving, emotion or judgement to the extent that he requires care or medical treatment in his own interests or the interests of other persons. Severe mental handicap is defined as 'a state of arrested or incomplete development of mind which includes severe impairment of intelligence and social functioning.

Who can act as the Guardian?

The Guardian may be:

- The Responsible Authority, i.e. the Health and Social Care Trust in whose area the person who is to be received into guardianship resides. While the Trust will be named as the guardian, a professional officer must be nominated to carry out its duties as guardian. This role will be usually delegated to a social worker employed by the Trust, but may be delegated to another Health and Social Care Professional whom the Trust deems suitable.
- Or
- Any other person, including the applicant (i.e. the approved social worker or nearest relative). However this person must provide a written statement that he/she is willing to act as guardian and must be accepted as suitable by the Health and Social Care Trust to which the application is made.

Article 18 (5) & (6)



What are the powers of the Guardian?

The Order gives the guardian power to require the person who has been received into guardianship to:

- Reside at a place specified by the Health and Social Care Trust or person named as guardian;
- Attend at places and times specified for the purpose of medical treatment, occupation, education or training;
- Allow access to any medical practitioner, approved social worker or other person so specified to any place where the person is residing.

Article 22

The Code advises that guardianship should be used in a positive and flexible manner and as part of a comprehensive care plan agreed by the professionals who are or could be involved in the person's care, and where appropriate, the patient's nearest relative or other informal carers. **Code 3.1**

In order to ensure that practice reflects the principles contained in the code, all attempts must be made by the professionals and others involved to enable the person, received into guardianship, to be involved in the care planning process.

The care plan should identify the services needed by the person including all necessary care arrangements, appropriate accommodation, treatment and personal support requirements and should identify those who have responsibilities under the care plan. It should indicate which of the powers given by guardianship are considered necessary to achieve the plan.

If none of the powers of the Guardian are considered necessary for achieving the person's welfare, guardianship is inappropriate. Code 3.3

RECEPTION INTO GUARDIANSHIP AND RENEWAL

What must happen before a person can be received into Guardianship?

Part II of the Order sets out the process that must be followed before a person can be received into Guardianship. An application founded on two medical recommendations and a recommendation by an approved social worker must be made to the Health and Social Care Trust in which the person resides. This can be made by the person's nearest relative as set out in **Article 32** or an approved social worker or a person appointed by a county court to act as the nearest relative.

LINK TO ROLE OF NEAREST RELATIVE AND ROLE OF ASW

Who can make the medical recommendations?

Two medical recommendations are required and can be made jointly (**LINK TO FORM 15**) or separately (**LINK TO FORM 16**) on the prescribed form/s by:

1. A Part II doctor
2. The person's General Practitioner (GP), if possible or a medical practitioner who already knows the patient.

What must happen before the medical practitioners make their recommendations?

Both medical practitioners must examine the person whose reception into guardianship is being considered jointly or separately within 7 days of each other. Their recommendation/s must be completed and signed within 2 days of carrying out the examination. **Article 20**



Who can make the approved social worker recommendation?

This must be made by any approved social worker appointed for the purposes of carrying out statutory responsibilities within the Health and Social Care Trust in which the person resides (**LINK TO FORM 17**). It cannot be made by the same approved social worker who is considering making the application for guardianship.

Code 3.13

What must happen before the approved social worker makes their recommendation?

The Order is not specific about the timing of the approved social worker's recommendation. However the Guide refers to the need for the decision to make the recommendation in the "light of full and recent knowledge" of the person's circumstances and the Code states that the approved social worker has to be reasonably satisfied that reception into guardianship is in the interests of the welfare of the person. This clearly indicates that a comprehensive assessment of the person's circumstances is required to ensure that 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". **Code 3.13. Guide para. 74**

Who can make the application?

The application can be made on the appropriate prescribed form by:

- The nearest relative as set out in **Article 32** of the Order; or
- A person appointed by the county court to act as a nearest relative (who must complete **Form 13 LINK TO FORM 13**); or
- An approved social worker (who must complete **Form 14 LINK TO FORM 14**). This cannot be the same approved social worker who has made the recommendation that the person be received into guardianship.

Article 19

In most situations an approved social worker rather than the nearest relative will make the application. The Code states that “in no circumstances should pressure be brought to bear on the nearest relative to make a guardianship application”.

Code 3.9

Can a nearest relative request an ASW to make an application for guardianship?

Yes. **Article 40** requires an approved social worker, appointed by the Health and Social Care Trust to respond to a request by a nearest relative to make an application for guardianship in respect of a person who resides in that Trust area.

The approved social worker is required to consider the matter as soon as practicable. If however, after due consideration he decides not to proceed with the application he must inform the nearest relative of the reasons for doing so in writing.

Article 40 (4)

What must the applicant (approved social worker) do before making the application that a person is received into guardianship?

The approved social worker must carry out a comprehensive assessment of the need for reception into guardianship. This assessment must include;

- An interview with the person whose reception into guardianship is being considered. This must take place within 14 days of the application being made,
- An interview and consultation with the person considered to be the nearest relative and
- Identification and consideration of any other relevant circumstances.

The approved social worker must also;

- Identify a guardian,
- Ensure that person is advised about the effect of guardianship and the extent and limitations of a guardian’s powers,



- Ensure that the person is willing to act as guardian, and
- Following assessment and before making the application, the approved social worker must consult the nearest relative unless this is not reasonably practicable or would involve unreasonable delay.

Can the nearest relative object to the application being made by the approved social worker?

Yes, the nearest relative has the right to object to the application being made. This objection **must** be recorded on the application form.

The ASW has a duty to consult with the patient's nearest relative prior to making the application and, if this not possible as soon as is practicable following application. The ASW should record details of this consultation.

The ASW must make repeated attempts to consult with the nearest relative. These efforts must be recorded.

Can the approved social worker proceed with the application if the nearest relative objects?

Yes but **only** following consultation with another ASW (not the ASW who has made the recommendation).

If the decision following this consultation is to proceed with the application then the ASW must record the nearest relative's objection on the application form. **Articles 19 (5) & 40**

If the approved social worker is concerned that the nearest relative is objecting unreasonably to the guardianship application that approved social worker can also apply to the County Court to have an acting nearest relative appointed to carry out the functions of the nearest relative. **Article 36**

What must happen if the approved social worker is unable to consult with the nearest relative prior to making the application for reception into guardianship?

The Order directs that it shall be the duty of the approved social worker to inform the nearest relative “as soon as may be practicable”. **Article 19 (6)**

What should happen if the nearest relative chooses to make an application for a person to be received into Guardianship?

The nearest relative can ask for and should be offered the assistance of the health and social care professionals involved in the care of the person whose reception into guardianship is sought. Those professionals should offer any advice or assistance required. This will include making the nearest relative aware of the process to be followed and advice and guidance regarding the completion of the relevant prescribed form, in this case **Form 13**. As applicant, the nearest relative must have seen the person whose reception into guardianship is being considered within 14 days prior to the making of the application. **Article 3.8**

When should the application for guardianship be forwarded to the relevant Health and Social Care Trust?

The guardianship application must be forwarded to the Trust not more than 7 days after the last medical examination. **Article 22 (2)**

What must the Health and Social Care Trust do once the Guardianship Application has been made?

The Health and Social Care Trust must ensure that:

- Any proposed private guardian i.e. a guardian other than the Health and Social Care Trust is suitable to be appointed in this role;
- Private guardians understand and carry out their statutory powers and duties;



- The person is notified that they have been received into Guardianship and that they have been advised of the provisions and the effects of this provision;
- The person is advised of their right to apply to the Mental Health Review Tribunal;
- The person must also be advised that a named officer of the Trust will give any necessary assistance to make such an application;
- The person has been advised of the effects of the Order relating to discharge from guardianship and their rights to make representation to RQIA.

Article 27

The Trust must also;

1. Ensure that the nearest relative is furnished with a statement of their rights and powers under the Order and,
2. Subject to the patient's wishes, the nearest relative should be given a copy of any written information given to the person who has been received into guardianship.

Article 27

3. Forward the relevant documentation to RQIA.

Code 3.18

What should happen once the application has been accepted by the Health and Social Care Trust?

The powers of the guardianship take effect immediately once the application has been accepted by the Trust. **Article 22 (3)**

The Trust must:

- Monitor the progress of the guardianship;
- Maintain detailed records relating to persons received into guardianship;
- Review guardianship towards the end of each period;
- Ensure that a person is formally discharged from guardianship when it is no longer appropriate, rather than letting the arrangement lapse;

- Transfer guardianship from one Health and Social Care Trust to another or from one person to another in accordance with the Order;
- Notify RQIA of events prescribed in the DHSSPS Regulations;
- In situations where the Health and Social Care Trust nominate a professional officer in the Trust to carry out its duties as guardian.

How long can a person be subject to guardianship?

A person can be subject to the provisions of guardianship for an initial period not exceeding **6 months** from the day on which the guardianship application was accepted by the Health and Social Care Trust. **Article 22 (3)**

Can the guardianship be renewed?

Yes, the authority for guardianship can be renewed at the end of the initial **6 month** period for a further **6 months** and subsequently annually. **Article 23**

LINK TO FORM 18 and **LINK TO FORM 19**

PATIENTS IN HOSPITAL - TRANSFER INTO GUARDIANSHIP

Can a person be transferred from detention in hospital to guardianship?

Yes. A person who is detained for treatment in hospital may be transferred directly into guardianship. **Article 28 (5) Guide paras. 102 and 103**

How can a patient be transferred from detention in hospital to Guardianship?

The person's reception into guardianship will usually be initiated by the RMO, who the Guide advises, is likely to involve an approved social worker at a very early stage. The approved social worker will give advice on the person's suitability for guardianship from a welfare point of view. The decision will usually follow a multi-disciplinary discussion and consultation with the patient and his carers.



Although the person will be subject to the same provisions as a person who was received into guardianship following an application, there are no prescribed forms to facilitate this process. The RMO is however required to obtain the written agreement of the appropriate Health and Social Care Trust for the person's reception into guardianship and the written consent of the guardian. The Guide further advises that "these records will ensure that the authority of the guardian over the patient and the powers and duties of the responsible Health and Social Care Trust may not be subsequently questioned". **Guide para 103**

The Trust must ensure that the person and their nearest relative are advised that they have been received into guardianship and of their rights. The Trust must also notify RQIA.

Can a person continue to be subject to guardianship if they are subsequently admitted to hospital?

Yes. Guardianship does not restrict the person's access to hospital services on a voluntary basis. However if the person is subsequently admitted to and detained in hospital, guardianship can only remain in place for the duration of the assessment period and will cease to have effect if the person is subsequently detained for treatment. **Code 3.22**

PUTTING GUARDIANSHIP INTO EFFECT

Can the person object to the application and reception into guardianship?

No, there is no provision for the person to object to the application being made. However the person can apply once they have been received into guardianship to **the Mental Health Review Tribunal** to have their control under guardianship reviewed. This is limited to one review every 6 months beginning with the date of the acceptance of the application for guardianship.

The Code states that “Where the person is capable of understanding” it is also necessary that there should be “recognition of the authority of the guardian and a willingness on the part of both parties to work together”. **Code 3.4 LINK TO PROTECTIONS, Mental Health Review Tribunal**

Can a person be received into guardianship if, due to incapacity, they are unable to agree or disagree with the requirements of their guardianship provisions?

The Order does not specifically address issues of capacity in relation to reception into guardianship and, at this time, there is no statutory framework in relation to the welfare needs of those who lack the capacity to make such decisions. However the Code states “Where an adult is assessed as requiring residential care, but due to mental incapacity is unable to make a decision as to whether he wishes to be placed in residential care, those who are responsible for his care should consider the applicability and appropriateness of guardianship for providing a framework within which decisions about his current and future care can be planned”. **Code 3.24**

Those professionals involved in the planning and implementation of care arrangements for a person who lacks capacity to make a decision in relation to these matters should be guided by the interim guidance provided by DHSSPSNI in relation to these matters. **LINK TO DHSSPS Deprivation of Liberty Safeguards**

Can a person be forced to go to the place of residence named by the Guardian?

The Code states that the person can be taken to the specified place **only** if he willingly complies or offers no resistance. It does not confer powers to compel the admission of an unwilling person into residential care and does not provide the legal authority to detain a person physically in such a place, nor authorise the removal of a person against their will. **Code 3.21**



In the case of a person who lacks the mental capacity to make a decision as to whether or not they should be placed in residential care, the Code states that those who are responsible for the person's care should consider the applicability and appropriateness of guardianship for providing a framework within which decisions about current and future care can be planned.

Can a person be forced to return to the place of residence specified by the Guardian?

If the person is absent without leave from the specified place they can be taken into custody and removed to that place by a constable or an approved social worker or any other person authorised by the guardian or responsible Health and Social Care Trust. **Article 29**

Can access to the place of residence of the person who has been received into guardianship be denied to a medical practitioner, approved social worker or any other person so specified?

No. Such a denial, without reasonable cause, is deemed an offence under Article 125 of the Order. However neither the guardian nor any authorised person can use force to gain entry. In this event the use of a Warrant under Article 129 may need to be considered. **Article 125 & Article 129**

Can a person who has been received into guardianship be forced to attend places for the purpose of medical treatment, occupation, education or training and at times specified?

No. The Code states that if the person refuses to attend, the guardian is not authorised to use force to secure such attendance nor can medical treatment be administered to the person without their consent.

The Code states "If the patient consistently resists the exercise of the guardian's powers, it can be concluded that guardianship is not the most appropriate form of care for that person and guardianship should be discharged".

DISCHARGE FROM GUARDIANSHIP

When should guardianship be discharged?

Guardianship must be discharged as soon as the person no longer meets the criteria for reception into guardianship, i.e. the patient is no longer suffering from mental illness or severe mental handicap of a nature or degree which warrants reception into guardianship and /or it is no longer considered necessary in the interests of the welfare of the patient that the person should be subject to guardianship. **Article 24**

Who can discharge the person from guardianship?

The person can be discharged from guardianship by:

- **The Responsible Medical Officer Article 23 (2)**
- **An authorised Social Worker Article 23 (3)** *In this Article "authorised social worker" means an approved social worker authorised for the purposes of this article by the responsible authority.*
- **The Nearest Relative (Article 24 (4) and (5))**

In this event the nearest relative must give at least 72 hours notice (or 96 hours if a weekend) to the responsible Health and Social Care Trust. However if necessary this can be overturned by the responsible medical officer and an approved social worker. The nearest relative will not be able to make another order for discharge for 6 months but can make an appeal to the Mental Health Review Tribunal within 28 days of being informed that their relative will continue to be subject to guardianship.

The Health and Social Care Trust must immediately inform RQIA and the patient's guardian, if other than the Trust, that the person is being discharged from guardianship. **Article 24 (8)**

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PROTECTIONS FOR THE PATIENT

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THE ROLE OF THE REGULATION AND QUALITY IMPROVEMENT AUTHORITY (PART VI)

THE ROLE AND FUNCTION OF RQIA

What is RQIA?

The Regulation and Quality Improvement Authority (RQIA) is Northern Ireland's independent health and social care regulator.

RQIA is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and for encouraging improvements in the quality of those services.

Why was RQIA established?

RQIA was established in April 2005 under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003. This created the legal framework for raising the quality of health and social care services in Northern Ireland, and extended regulation and quality improvement to a wider range of services.

Since April 2009, under The Health and Social Care (Reform) Act (Northern Ireland) 2009, RQIA has undertaken the functions under the Mental Health Order (NI) 1986 which were previously carried out by the Mental Health Commission.



What are the primary functions of RQIA?

RQIA's main functions are:

- To inspect the quality of services provided by health and social care (HSC) bodies in Northern Ireland through reviews of clinical and social care governance arrangements within these bodies
- To regulate (register and inspect) a wide range of services delivered by HSC bodies and by the independent sector. The regulation of services is based on legislative requirements and minimum care standards to ensure that service users know what quality of services they can expect to receive, and service providers have a benchmark against which to measure their quality
- Since 2009, to have specific responsibilities for people with a mental illness and those with a learning disability. These include; preventing ill treatment, remedying any deficiency in care or treatment, terminating improper detention in a hospital or guardianship and preventing or redressing loss or damage to a patient's property.

What services does RQIA inspect?

RQIA inspects a wide range of statutory, voluntary and private health and social care facilities.

These include:

- Nursing and residential care homes
- Children's homes
- Day care settings
- Independent hospitals and clinics
- Domiciliary care agencies

RQIA also has a programme of inspection to examine infection prevention and control in health and social care facilities, including hospitals, and a programme of inspection at mental health and learning disability services across Northern Ireland.

How are inspections carried out?

RQIA's inspections are carried out by professionally qualified inspection staff including nurses, social workers and allied health professionals. Inspections are based on service specific regulations and minimum standards.

During inspection RQIA examines the:

- Quality of care
- Quality of life of the residents
- Quality of management
- Quality of the environment

These focus on encouraging improvement in the quality of services to ensure they are safe, accessible, well managed and meet the required standards. Good practice is highlighted and shared. All inspections use a human rights based framework.

How does RQIA encourage improvement across services?

Where areas of improvement are identified, RQIA will inform the Registered Person/ Manager of its views, and agree with them what remedial action is required to improve the service and to ensure the safety of service users.

Following an inspection RQIA asks the service provider to make any changes considered necessary through a quality improvement plan (QIP) and this information is published in a report, available on the RQIA website.

Enforcement action is an essential element of the responsibilities of RQIA under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, and is central to the aim of RQIA to protect service users and bring about sustained improvements in the safety and quality of service provision. RQIA ensure that all enforcement activity is targeted, proportionate and consistent.



This includes the issue of notices of failure to comply with regulations, placing conditions of registration, imposing fines, or closing a service.

RQIA - MENTAL HEALTH AND LEARNING DISABILITY

How does this include people with mental illness or learning disability?

RQIA has both general inspectorial and specific statutory functions that protect people with mental illness and learning disability:

Inspection of services

Under The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, RQIA has a specific function of reviewing mental health and learning disability services across Northern Ireland.

This includes:

- Conducting reviews into the monitoring and improvement arrangements
- Carrying out investigations and inspections
- Recommending actions for improvement
- Reporting unacceptably poor quality or significant failings to the DHSSPS

The visiting programme includes annual announced and unannounced reviews and inspections of mental health and learning disability hospitals, community care and treatment facilities.

Statutory functions

In 2009, RQIA established a multi-professional Mental Health and Learning Disability Team to take specific responsibility for the statutory requirements in Part VI of the 1986 Order.

The Mental Health and Learning Disability Team works closely with the other teams in RQIA as some aspects of the general care and treatment of persons with mental illness or a learning disability are included in their inspection and monitoring functions.

What are RQIA's responsibilities under the Mental Health (Northern Ireland) Order 1986?

Under the Mental Health (NI) Order 1986 and following the transfer of responsibilities of the Mental Health Commission under The Health and Social Care (Reform) Act (Northern Ireland) 2009, RQIA now has specific responsibility for keeping under review the care and treatment of patients with a mental disorder.

In taking on this responsibility RQIA takes an approach that is independent, multidisciplinary, and protective, with investigative, inspectorial and advisory functions. In particular, RQIA will:

- Inquire into cases where there may have been ill-treatment or deficiency in care and treatment; improper detention in hospital; improper reception into guardianship of a patient; or where the property of a patient may have been exposed to loss or damage
- Visit and interview detained patients in private
- Advise the relevant authorities of steps to be taken to secure the welfare of a patient; or any matter concerning the welfare of a patient
- Inspect a patient's records and their movements within mental health and learning disability services

How does RQIA carry out these responsibilities?

RQIA established a dedicated mental health and learning disability (MHL) team responsible for inspecting and reviewing mental health and learning disability services across Northern Ireland.



The MHL D team includes:

- Mental Health Officers from a range of professional health and social care backgrounds.
- Administrative staff with responsibility for scrutinising documents, including: forms in relation to application for admission; detention for assessment and treatment; and guardianship.

Are there protections for all patients with a mental disorder?

Yes, for all persons with a mental disorder: (Article 86 (1))

- The **Inspection programme** across inpatient and community settings uses specially developed human rights based principles and “Expectation standards”
This process enables providers to produce a Quality Improvement Plan and allows issues of concern to be raised and dealt with at the appropriate level in the health and social care system. These reports will be published on the RQIA website
- **Specific Reviews** of Mental Health and Learning Disability Services and Issues are undertaken either as part of the RQIA commissioned Reviews or as part of the RQIA 3 year programme of Reviews
This allows a focussed review of relevant ongoing and emerging areas of concern, e.g. children in adult services.

Are there specific protections for persons with a mental disorder?

Yes, for persons detained or under guardianship under Part II of the Order

- To visit and interview detained patients in private **Article 86 (2) (b)**

The MHL D Team have developed a programme called the Patient Experience Review which was informed by consultation with service users and advocates and is based on Human Rights principles. Annual visits are made by Mental Health Officers and

all detained patients are offered the opportunity to engage. Their views regarding care are incorporated into the inspection process and improvements recommended where necessary.

- To appoint doctors to carry out specific functions in relation to detention in hospital for assessment and treatment and guardianship (Part II) and safeguards for treatment under the Order (Part IV)

How does RQIA review the exercise of the powers and the discharge of duties conferred or imposed by the Order?

- The Mental Health and Learning Disability team scrutinize all detention and guardianship forms to ensure that they comply with the Order.

See **Scrutiny and Rectification of Documents Appendix** for full details.

- A Guardianship Panel meets to review and scrutinize the information relating to the welfare grounds required and to ensure that the process meets all the requirements of the order. The MHLDD team works closely with other regulatory teams to enhance the scrutiny of care and treatment of persons under guardianship in community facilities that are inspected by RQIA.
- RQIA holds a register of all Part II and Part IV doctors and Approved Social Workers to ensure that those professionals involved in restrictive measures under the Order are approved to do so.
- "To bring to the attention of the relevant authorities the facts of any case to secure the welfare of a patient". **Article 86 (2) (c,d & e)**

This includes a wide range of issues of care, treatment, management of finance etc which are most likely to be identified through the review and inspection programmes but may come to attention in a number of ways including through concerns raised by staff or families.

In addition, a Multidisciplinary panel reviews all Serious Adverse Incidents and ensures that appropriate action has been taken.

- RQIA may refer to the MHRT the case of any person who is liable to be detained or under guardianship, **Article (3) (a)**, if it considers that there are legal issues that require examination.

What is RQIA's role in relation to prisons?

On 1 April 2009 the responsibility for the provision of healthcare was transferred from the Northern Ireland Prison Service to Health and Social Care Services. Services are now commissioned by the HSC Board and provided by the South Eastern Health and Social Care Trust. This transfer of responsibility brought health services for people detained in prison under the remit of RQIA.

RQIA has commenced a programme of inspection of prison healthcare which has been carried out in partnership with Criminal Justice Inspectorate Northern Ireland (CJINI), Her Majesty's Inspectorate of Prisons (HMIP), and the Education and Training Inspectorate Northern Ireland. RQIA inspections will include consideration of services for people with a mental illness and learning disability.

RQIA has a separate role in relation to the Optional Protocol to the Convention against Torture (OPCAT) as one of a number of organisations who have been given responsibility as a National Preventive Mechanism (NPM) for people in detention.

Can any member of the public, including people with a mental disorder and their carers contact RQIA regarding care and treatment?

- The Mental Health and Learning Disability Team is accessible for all service users and their carers to contact by telephone for advice or to discuss aspects of their care. This information is documented and informs the overall process of monitoring the quality of care provided. Unannounced inspection may be arranged to investigate serious concerns.

- Training and information sessions are provided to the public, Health and Social Care Trusts and professional and voluntary bodies as a means of promoting shared learning and best practice.

How does RQIA include and support service users?

- Service users and advocates were consulted and shaped the development of the Patient Experience Reviews.
- The Mental Health and Learning Disability Team works closely with independent advocacy services to assess the level of provision for service users and to ensure inclusion in planning and delivery of the service RQIA provides.

To learn more or to obtain contact details please go to the RQIA website-
www.rqia.org.uk



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THE MENTAL HEALTH REVIEW TRIBUNAL FOR NORTHERN IRELAND (PART V)

INTRODUCTION

The Mental Health Review Tribunal is an independent judicial body, set up under the Mental Health (Northern Ireland) Order 1986 (the Order), to review the cases of patients who are compulsorily detained in hospital or are subject to guardianship under the Order. **Article 70**

What is the purpose of the Mental Health Review Tribunal?

The Tribunal was established to provide a safeguard against unjustified detention in hospital or control under guardianship by means of an independent review of a patient's case including both the medical and non-medical aspects.

The Tribunal provides the vehicle by which patients who have been detained or made subject to guardianship have access to an appeal regarding their detention or control under guardianship. The Order also makes provision for an additional safeguard for the patient by way of the automatic referral to the Tribunal of those patients who have not exercised their right to appeal or are incapable of doing so, within the previous 2 years.

What are the powers of the Mental Health Review Tribunal?

The Tribunal has powers to direct the discharge of patients whom the Tribunal considers do not meet the criteria for detention in hospital and guardianship under Part II of the Order.

The Tribunal has the same powers in relation to patients subject to a Hospital Order (without restriction) or a patient subject to a Guardianship Order under Part III.

Similar powers are available in relation to patients subject to a Hospital Order (with restrictions) and patients who have been conditionally discharged.



Articles 77 and **78** of the 1986 Order set out the procedure to follow, and the test which must be used by the Tribunal when deciding whether to discharge patients from detention.

However in 2001 a court ruled¹ that similar provisions in the Mental Health Act 1983 were held to be incompatible with **Articles 5 (1) and 5 (4) of the European Convention of Human Rights**.

In order to remove the incompatibility with the Convention right, new legislation, to amend these Articles was introduced. www.legislation.gov.uk/nisi/2004/1272/contents/made

In effect the 2004 Order now places the burden of proof justifying the detention on the responsible authority, i.e. the Health and Social Care Trust. Originally the 1986 Order placed this burden on the patient to show why he should be discharged.

Article 3 of the Mental Health (Amendment) (Northern Ireland) Order 2004 amended **Article 77** of the Mental Health (Northern Ireland) Order 1986 to provide that a Mental Health Review Tribunal shall direct the discharge of a patient if it is not satisfied that the criteria justifying detention in hospital for treatment continue to be met. **Article 4** of the Order also made a similar amendment to **Article 78** of the 1986 Order.

¹ *H v Mental Health Review Tribunal North & East London Region (Secretary of State for Health Intervening)* (4 April 2001)

Who are the members of the Tribunal?

The Tribunal has 26 part-time members at present, appointed by the Lord Chancellor of whom;

- 11 are medical members (psychiatrists),
- 8 are legal members (having legal experience as the Lord Chancellor considers suitable), and
- 7 are lay members (persons having such experience in administration, such knowledge of social services or such other qualifications or experience as the Lord Chancellor considers suitable. **Schedule 3 (1)**)

A panel comprising a legal member as President, a consultant psychiatrist and a lay member sit to consider each case. A panel may, on occasions, comprise more than 3 members.

Three of the legal members are specifically approved to serve as president of Mental Health Review Tribunals considering applications relating to restricted patients subject to Part III of the Order.

Are the rules of procedure for the Mental Health Review Tribunal contained in the Order?

No. The rules of procedure for the Tribunal are contained in the Mental Health Review Tribunal Rules 1986. **LINK TO Statutory Rules of Northern Ireland: Mental Health Review Tribunal (Northern Ireland) Rules 1986 (SR 1986/193)**



APPLICATION TO THE MENTAL HEALTH REVIEW TRIBUNAL

How may a patient's continued detention in hospital or guardianship be considered by the Tribunal?

A patient's detention in hospital or guardianship may be considered following an **application** or a **referral** to the Mental Health Review Tribunal.

Who can make an application?

An application can be made by:

- The person who is subject to detention in hospital or reception into guardianship.
Or
- The person's nearest relative **SEE Role of the Nearest Relative Appendix section**

Can a child or young person subject to detention in hospital or reception into guardianship apply?

A child or young person, (under 18) subject to detention in hospital has the same rights of application as any other person. However only those aged 16 or over can be received into guardianship therefore those aged 16 and under 18 can apply.

Can a person who is subject to detention in hospital or guardianship under sentence by a court under Part III of the Order apply to the Mental Health Review Tribunal?

Yes. Persons detained under Part III have the same rights of application as persons detained under Part II of the Order.

Can a conditionally discharged patient apply?

Yes, if not already recalled to hospital.

Can a person subject to restriction directions under Part III of the Order apply to the Mental Health Review Tribunal?

Yes, however the Tribunal cannot authorise discharge in the usual way.

How may an application be made?

An application may be made in writing to the Mental Health Review Tribunal or by sending a completed application form to the Mental Health Review Tribunal Office:

The Secretary
Mental Health Review Tribunal for Northern Ireland
3rd Floor
Bedford House
16 – 22 Bedford Street
Belfast
BT2 7FD

LINK TO Mental Health Review Tribunal, Patient Subject to Detention in Hospital Application and LINK TO Mental Health Review Tribunal, Patient Subject to Guardianship Application

Copies of the application forms including guidance on the information required for the application should be available within the hospital. Health and Social Care staff should ensure that the patient and those subject to guardianship should be advised throughout their period of detention or guardianship of their right to appeal to the Tribunal and must ensure that support is available to assist the patient/person in the exercise of this right. In doing so staff should take account of each individual's needs in relation to communication and understanding.



APPLICATION TO THE MENTAL HEALTH REVIEW TRIBUNAL

When may a person apply?

An application may be made by a person subject to detention in hospital or received into guardianship in writing to the Tribunal once during the first six months dating from the date of their admission or from the date of their reception into guardianship. They can also apply in writing **once** during each renewal period i.e. once during the second six months and once in each yearly period thereafter if this is renewed. These rules also apply to a person detained in hospital under Part III of the Order.

When can a person, previously detained in hospital under Part III and who has been conditionally discharged appeal?

A conditionally discharged patient can apply to the Mental Health Review Tribunal once in the first 12 months period after their conditional discharge commenced and every 12 months thereafter.

Can a patient subject to a transfer direction from prison with restrictions apply?

Yes.

When can the nearest relative apply?

The nearest relative of a person detained in hospital or subject to guardianship may apply to the Tribunal for a review of the patient's detention in hospital or reception in guardianship on the occasions set out below:

- (a) Once within the first 28 days from the date on which the nearest relative is informed that his order² for the patient's discharge from detention or

2 The nearest relative has a restricted power of discharge from detention in hospital or guardianship under Article 14(4). Guide paragraphs 55 – 58. Notice (72hrs) must be provided in writing to the HSCT concerned. However discharge can be barred by the RMO under Article 14(4)(a)(b) or, in the case of a patient subject to guardianship by the RMO or authorised social worker under Article 24(4).

guardianship has been barred by the RMO (**Article 14 (4)**) or by the RMO and an authorised social worker under **Article 24 (4)**.

- (b) Where the nearest relative is barred from acting as such by county court order under **Article 36**, he may apply to the Tribunal once in the first 12 months following the date of the court order and once in each 12 month period for the duration of that order.

If the Tribunal uphold the decision to continue to detain the person or that the patient remains subject to guardianship, the nearest relative may apply to the Tribunal again within the following 12 months and in any subsequent 12 months during which the order remains in force. **LINK TO Mental Health Review Tribunal, Nearest Relative Application**

Can the nearest relative of a person subject to detention under a hospital order apply to the Tribunal?

Yes, the nearest relative of an unrestricted offender patient can apply to the Tribunal once during the first 12 month period of detention in hospital or reception into guardianship and every 12 months thereafter. **However the nearest relative of a person who is subject to a hospital order with restriction has no right to apply.**

REFERRAL TO THE MENTAL HEALTH REVIEW TRIBUNAL

Is there any requirement to refer the case of a person who is subject to detention or guardianship?

Yes, on 2 grounds:

- The Responsible Trust must refer a person whose case has not been considered by the Tribunal within the previous 2 years (**1 year if the patient is under 16**)



- The Department of Justice³ must refer restricted patients if the Tribunal has not considered the case for 2 years and the case of any person who has been recalled to hospital following their conditional discharge. In this case the referral must be made within 1 month of recall.

May any other body/individual refer the case of a person who is subject to detention or guardianship?

Yes. The following may do so:

- The Attorney General, the DHSS and Master of the Office of Care and Protection (on direction from the High Court) - may refer at any time (non – offender and unrestricted offender patients)
- RQIA – has power under **Article 86 (3) (a)** to refer any case of a person detained or under guardianship at any time where there are concerns regarding a patient's continued detention in hospital or reception in Guardianship.

ARRANGEMENTS FOR A MENTAL HEALTH REVIEW TRIBUNAL HEARING

What happens when the Tribunal office receive the application or referral?

The Tribunal office will write to acknowledge receipt of the application and will then contact the Trust responsible for the person's care to ask for reports and documents including medical and social circumstances reports, to be returned within a defined period of time.

In the case of a restricted or conditionally discharged patient, the Department of Justice will also be contacted.

3 The functions of the Secretary of State have been devolved to the Department of Justice under the Northern Ireland Act 1998 (Devolution of Policy and Justice Functions) Order 2010. All references to the Secretary of State in the Order, Guide and Code should now read Department of Justice.

What must the Trust do when informed that the patient/person has applied to the Tribunal?

The Trust, as the responsible authority, must prepare a statement for the Tribunal to include information specified in Part A of the Schedule to the Mental Health Review Tribunal Rules and Part B namely, an up-to date medical report and up-to-date social circumstances report and any other information or observation on the application which the Trust, as the responsible authority, wishes to make.

The Trust must ensure that the appropriate professional staff are contacted and directed to prepare a medical report, a social circumstances report and any other relevant information. The Trust's statement should be sent to the Tribunal and, in the case of a restricted patient, the Department of Justice, **within 3 weeks** of its receipt of the notice of application.

The Trust should ensure that the preparation of the reports is not delayed. Failure to provide these reports in the timescale required leaves Trusts and hospitals vulnerable to challenge under **Article 5** of the Human Rights Act 1998, particularly where the hearing is delayed or adjourned for late or non-receipt of these reports.

It should be noted that the professionals involved are, in effect, representing the detaining authority. Their reports and presentation in the Tribunal should reflect this responsibility. If either party is concerned that the patient no longer meets the criteria for detention in hospital or guardianship this matter should be discussed and resolved as a matter of urgency prior to the Tribunal hearing. If necessary, legal advice should be sought prior to the hearing from the Trust solicitors.

What is the role of the Department of Justice in the case of patient subject to restrictions or conditionally discharged under Part III?

The Department of Justice shall send to the Tribunal, as soon as practicable and in any case within 3 weeks of notification of the statement by the relevant Trust, a statement of such further information relevant to the application that may be



available. In relation to a conditionally discharged patient the Department must send a statement to the Tribunal within 6 weeks of notification that the conditionally discharged patient has appealed their conditional discharge to include information specified in Part C and D of the schedule to the Rules. **LINK TO Statutory Rules of Northern Ireland: Mental Health Review Tribunal (Northern Ireland) Rules 1986 (SR 1986/193)**

Who should prepare the Medical Report?

This will usually be prepared by the Responsible Medical Officer (RMO) with responsibility for the patient's care and treatment.

Who should prepare the social circumstances report?

In most situations this will be prepared by the social worker who has been involved in the patient's care and treatment as a member of the multi-disciplinary team.

What must be included in the medical report?

The Rules state that the medical report should include the relevant medical history of the patient and a full report on the patient's medical condition. **LINK TO Guidance for Medical Report**

What must be included in the social circumstances report?

The Rules state that the social circumstances report should include reports on the following:

- (a) The patient's home and family circumstances, including the attitude of the patient's nearest relative or the person so acting;
- (b) The opportunities for employment or occupation and the housing facilities which would be available to the patient if discharged;

- (c) The availability of community support and relevant medical facilities;
- (d) The financial circumstances of the patient.

LINK TO Guidance for MHRT Social Circumstances Report concerning patients subject to detention in hospital

LINK TO Guidance for MHRT Social Circumstances Report Guardianship

What if the Trust or Department do not wish to disclose certain information to the applicant?

The Trust or Department of Justice may request that certain information is withheld from the patient under **Rule 6** of the Mental Health Review Tribunal Rules. The RMO and Social Worker, or the Department of Justice should ensure this information is contained in a separate document. The need for this request must be carefully considered and set out by the professionals involved and must be on the grounds that its disclosure would adversely affect the health or welfare of the patient or others.

This is a request which will be carefully considered by the members of the Tribunal and may or may not be granted. Where the Tribunal is minded not to disclose the information submitted under **Rule 6** this will be disclosed as soon as practicable to that patient's representative if he is;

- (a) A barrister or solicitor.
- (b) A registered medical practitioner;
- (c) In the opinion of the Tribunal a suitable person by virtue of experience or professional qualification.

In addition an undertaking must be given that the information is not disclosed either directly or indirectly to the applicant or (where he is not the applicant) the patient or to any other person without the authority of the Tribunal or used otherwise in connection with the application.



When will the Tribunal take place?

The MHRT hearing will take place approximately 6 weeks after the application is received.

Where will the Tribunal hearing take place?

The hearing will take place somewhere that is convenient for the patient, most often on the hospital site if the person is subject to detention in hospital and at a suitable place in the community if the person is subject to guardianship.

Will there always be a hearing?

In exceptional circumstances the Tribunal may decide not to proceed with a formal hearing, if a hearing is not requested by the applicant or where it appears to the Tribunal that such a hearing would be detrimental to the health of the patient.

What if the patient changes his mind about having a hearing?

If the patient is the applicant and changes his mind about having a hearing, he should write to the Tribunal stating his reasons for the change of mind. The President of the Tribunal will consider the reasons and take account of the circumstances of the case before deciding whether or not to accept their request.

What must the Tribunal do when the statement of the responsible authority and or the Department of Justice is received?

The Tribunal will arrange the date and venue of the hearing. When these arrangements have been made, the Tribunal will write to the person again to give notification of the date, time and venue for the hearing. At least 14 days notice will be given. They will also be informed of when and where the meeting with the Tribunal doctor will take place. This is most often on the morning of the hearing.

The person's nearest relative (within the meaning of the Order) will be also be notified in writing of the date, time and venue for the hearing.

Approximately 2-3 weeks before the hearing date the person who has applied or has been referred to the Tribunal and/or their representative will be given copies of reports so that the case can be prepared.

Who else will be informed?

On receipt of the responsible authority's statement or, in the case of a restricted or a conditionally discharged patient, the Department of Justice's statement, the Tribunal shall give notice of the proceedings to:

- (a) The guardian, if the person is subject to the guardianship of a private guardian;
- (b) The Master, if the patient's financial affairs are under the control of the Office of Care and Protection;
- (c) Any person exercising the function of the nearest relative who is not the applicant;
- (d) Any other person who, in the opinion of the Tribunal, should have the opportunity of being heard.

How will the members of the Tribunal be selected?

The members of the Tribunal who are to hear the application are appointed by the Chairman. No one who is a member or officer of the responsible authority (the detaining Health and Social Care Trust) or has a personal connection with the patient or who has recently treated the patient in a professional capacity will serve as a member of the Tribunal.

Only those legal members who have been approved to do so will act as president of a Tribunal considering an application or reference to a restricted patient.



Who can represent the person at the hearing?

The person can be represented by a solicitor or barrister or can represent him or herself. He can also choose to be represented by a patient advocate. Most patients choose to be represented by a lawyer. The patient must be provided with information to allow him to arrange his legal or other appropriate representation.

Will the patient have to pay for this representation?

No, from December 2010 there has been a change in the financial eligibility criteria and all applicants are now entitled to free legal aid for Mental Health Review Tribunal advice, assistance and representation. A copy of this authorisation, Circular 02/11 has been published on the Legal Services Commission website. **LINK TO Legal Services Commission Circular 02/11**

Who cannot represent the person at the hearing?

The person **may not** be represented by another patient, that is a person liable to be compulsorily detained or subject to guardianship or a person receiving treatment for mental disorder at the same hospital as the patient.

What happens if the person does not or refuses to appoint a representative or there are concerns about his capacity to do so?

In this circumstance the MHRT may direct that a representative be appointed on the person's behalf.

Can the person seeking the Tribunal hearing ask for the opinion of another doctor?

Yes. Any doctor authorised by or on behalf of the patient or any other person who has made the application may, at any reasonable time, visit and examine the patient in private and may inspect any records relating to the detention or treatment of the patient in hospital.

THE MENTAL HEALTH REVIEW TRIBUNAL HEARING

What happens on the day of the Tribunal hearing?

In the days prior to the hearing the panel (a legal member of the Mental Health Review Tribunal and a medical and lay member) will read the written reports submitted as evidence by the responsible authority or Department of Justice.

Prior to the hearing the medical member of the Tribunal will visit and interview the person whose case is to be considered by the Tribunal, in private. Any records relating to that person will be reviewed. The medical member will also speak to ward staff and other steps considered necessary will be taken to form an opinion of the patient's mental condition. The doctor's findings will subsequently be reported to the other members of the MHRT panel.

Prior to the hearing the RMO, social worker and any other Trust witnesses will usually have the opportunity to consult with the Trust's legal representatives.

How is the Hearing conducted?

The MHRT President will make every effort to ensure the hearing is conducted as informally as possible and will conduct the hearing in such a manner as is suitable given the health and interests of the person who has made application for the Tribunal or has been referred.

Will the hearing be in private?

Yes, unless the person has requested a hearing in public and the Tribunal is satisfied that this would not be detrimental to the person.

Can the person choose to be accompanied to the hearing?

Yes. The person can choose someone e.g. family, staff or an advocate to accompany them. This will be in addition to their authorised representative. However the Tribunal have the right to admit or exclude any person it considers appropriate.



What happens at the hearing?

Prior to the hearing, the legal representatives may be asked, or may request, to appear before the panel in the absence of all the witnesses in order to deal with any legal issues that may have arisen. The medical member's preliminary findings from the examination of the patient will be shared with them and there will be an opportunity to deal with the withholding of information under rule 6 and any points of law arising.

The Tribunal may even, on rare occasions, hear evidence or require witnesses to attend regarding any preliminary issues such as deficiencies in the relevant detention forms.

At the substantive hearing, the Health and Social Care Trust case is presented through their legal representative. The panel will then hear the evidence of witnesses present on behalf of the Trust, usually the Consultant Psychiatrist (RMO) and Social Worker, followed by any evidence from the person or his representative. Both parties will be given the opportunity to ask questions and make submissions. After all the evidence has been given, the applicant, and where he is not the applicant the person who has been referred, is given the opportunity to address the Tribunal.

Will the information shared at the Tribunal be made public?

No, unless otherwise directed by the Tribunal.

Can the hearing be adjourned?

The hearing may be adjourned for the purpose of obtaining additional information or other purposes it deems appropriate. If adjourned all parties shall be given notice within 14 days or earlier of the date and time of the resumed hearing.

THE DECISION

How is the decision made?

A decision will be made after careful consideration of the evidence presented. The Tribunal's decision is the decision of the majority of the panel members. In the event of a tie of votes, the legal chairman (President) will have the casting vote. The decision will be recorded in writing, along with the reasons for the decision and signed by the president.

What are the possible outcomes from a MHRT hearing?

After hearing all the evidence at the hearing the Tribunal will decide whether or not the patient should continue to be detained or subject to guardianship under the Order.

The possible outcomes in relation to a patient subject to detention in hospital are:

1. The Tribunal is satisfied that the patient does meet the criteria for detention in hospital or guardianship and does not direct discharge.
2. The Tribunal may direct that the patient be discharged if:
 - The Tribunal is not satisfied that the patient is suffering from mental illness or severe mental impairment or from either of those forms of mental disorder of a nature or degree which warrants his detention in hospital for medical treatment;
or that his discharge would create a substantial likelihood of serious physical harm to himself or others.
 - The Tribunal is not satisfied, where the patient is subject to guardianship, that he is not suffering from mental illness of severe mental handicap or from either of those forms of mental disorder of a nature or degree which warrants his remaining under guardianship;
or that it is not necessary in the interests of the welfare of the patient that he should remain under guardianship.



3. In exceptional circumstances the Tribunal may, with a view to facilitating his discharge on a future date, recommend that he be granted leave of absence or transferred to another hospital or into guardianship, with the intention of considering the patient's case again to ensure that these recommendations are complied with.
4. The Tribunal may adjourn the hearing.

What powers are available to the Tribunal when considering the appeal or referral of a restricted patient who is subject to a restriction order under Part III of the Order?

The Tribunal may direct the conditional discharge of the patient. In this event the patient can be recalled by the Department of Justice and must comply with conditions imposed by the Tribunal at the time of discharge and any subsequent time by the Department of Justice. The Tribunal may defer the discharge of the patient until necessary arrangements are in place.

The Tribunal **must** direct the absolute discharge of the patient if the Tribunal is not satisfied that the patient meets the criteria for detention in hospital and the Tribunal is satisfied that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.

What powers are available to the Tribunal in the case of an appeal by a patient who has been conditionally discharged?

The Tribunal may direct that the restrictions/conditions be amended or the patient be absolutely discharged.

What powers are available to the Tribunal when considering the appeal or referral of a patient detained under Article 53 with a transfer direction under Article 55?

If the Tribunal considers that the criteria for detention no longer exists, the Tribunal must notify the Department of Justice that the patient could, if subject to a Hospital

Order, be absolutely or conditionally discharged. The Department of Justice has 90 days to agree to these terms, if not the patient must be returned to prison.

In the case of a prisoner detained under **Article 54 (2)** the Department of Justice must return the prisoner to prison or remand centre if the Mental Health Review Tribunal rule that the criteria for detention no longer exists.

BEING TOLD THE OUTCOME

The decision of the Tribunal may be announced immediately after the hearing of the case and if not, all parties will be notified as soon as possible. A copy of the written decision will be forwarded within 14 days.

Will the patient always be informed of all the reasons for a MHRT decision?

In most cases the patient is informed. However in some exceptional cases the Tribunal may be of the opinion that it would not be in the best interests of the patient to be informed of all the reasons for a decision. for example, if the Tribunal was concerned that it may adversely affect the health or welfare of the patient. The Tribunal would then communicate the decision to the patient in a way it thought was appropriate and may then fully disclose its reasons for a decision to the patient's representative.

What will happen if the recommendations of the MHRT are not adhered to?

Where the Tribunal makes a decision with recommendations the decision will specify the time period during which the recommendations should be complied with. If at the end of this period it is clear to the Tribunal that the recommendations have not been complied with, then the Tribunal may reconvene proceedings. The Tribunal will give at least 10 days notice to all parties of the time, date and venue of the hearing.



Can the Tribunal's decision be appealed?

There is no automatic right to an appeal of the MHRT decision; however it is liable to be subject to judicial review by the High Court. **LINK TO CASE LAW APPENDIX**

Does the MHRT provide easily accessible information to patients and the public?

Yes, the MHRT has a website which provides this information.

LINK TO Tribunals Mental Health Review Guide for Patients

MANAGEMENT OF PROPERTY AND AFFAIRS OF PATIENTS (PART VIII)

INTRODUCTION

Most people who suffer from mental disorder are quite capable of looking after their property and affairs. The law recognises this fact and assumes that a person is capable until the contrary is proved.

However when a person is deemed incapable of managing his financial affairs because of mental disorder, the law, in particular, the Mental Health (Northern Ireland) Order 1986, permits the appointment of another person to take charge of these.

Part VIII of the Order places the responsibility for managing the financial affairs of patients, i.e. those with insufficient mental capacity to manage their own affairs, on the High Court in Northern Ireland. Within the High Court system, it is the Office of Care and Protection which deals with the appointment of controllers and the management of patients' financial affairs.

What is the Office of Care and Protection?

The Office of Care and Protection is a section of the Family Division of the High Court. **The Master of the Office of Care and Protection** is the judicial officer of the court who is authorised to exercise any discretion, power or other function of the court.

If the Court is satisfied that there is a need for a Controller to be appointed and has received medical evidence confirming the Patient's incapacity, it will make an order appointing a Controller. This order gives details of the specific powers conferred on the Controller, which are usually quite limited. Additional orders or authorities may be issued by the Court from time to time, varying or extending the Controller's power. It is usual for the person applying to be Controller to have to attend the Court.



What are the powers of the Office of Care and Protection?

The Master of the Office of Care and Protection can take and delegate responsibility for the management of a person's property and affairs. This includes everything a person could do if he was well enough to administer his property and affairs for the benefit himself, his family or dependents.

What powers does Office of Care and Protection not have?

The Office of Care and Protection does not have any power to decide where a patient should live or any decisions relating to medical care.

How does the Office of Care and Protection perform its duties?

The Office of Care and Protection will generally appoint a 'Controller' to deal with the day-to-day management of the Patient's financial affairs. This can be a relative, a friend, or perhaps a professional advisor.

What happens if there is no one suitable or willing to act as Controller?

If no relative or friend is willing to act or if there is a disagreement between them as to whom should act, the Master may appoint an officer of the Court, or the Official Solicitor as a the last resort, as the Controller. If there are limited assets, instead of appointing a Controller, the Master may authorise someone to manage the property and affairs of the patient under a 'Short Procedure Order'.

What powers will the Controller have?

A controller can do all the things in relation to the property and affairs of the patient as the court orders, directs or authorises him to do. If the court is later satisfied that the patient has become capable of managing his property and affairs the controller will be discharged by the court.

Who can refer to the Office of Care and Protection?

Anyone who believes that the property or affairs of an individual with a mental disorder may require protection can contact the Office of Care and Protection themselves or through a solicitor. The Court will require satisfactory medical evidence that the patient is suffering from a mental disorder and is incapable of managing their finances and property (the court can act in the interim if the patient's property or affairs need to be protected as a matter of urgency).

Who **MUST** refer?

The Regional Health and Social Care Board, Health and Social Care Trusts, the Regulation and Quality Improvement Authority (RQIA) and any person running a nursing home, a home for persons in need or a private hospital are under a legal duty to notify the Office of Care and Protection if they are satisfied that:

- A person for whom they have responsibility (or, in the case of RQIA, of whom they have knowledge) is incapable of managing his property or affairs;
- The involvement of the court in managing that person's affairs is appropriate; and
- No one else has taken steps to notify the Office of Care and Protection.

How should the referral be made to the Office of Care and Protection?

In most situations referral will be made by a social worker or care manager in the Health and Social Care Trust in which the patient currently resides or is hospitalised.

The social worker/care manager is required to complete the **Article 107** referral form (**the Office of Care and Protection's Form 1**). This must be accompanied by a medical certificate (A5). All sections of this certificate must be completed by the medical practitioner in full. **LINK TO Article 107 referral form (the Office of Care and Protection's Form 1)** and **LINK TO Medical Certificate (A5)**



In addition the social worker/care manager should also prepare a short but comprehensive report outlining the patient's current social and financial circumstances. **LINK TO OCP Article 107 Checklist**

A statement should also be included to reflect the fact that the Office can only consider the case if there are sufficient assets which would merit the appointment of a Controller.

These documents should then be sent to the Office of Care and Protection.

When should the referral be made to the Office of Care and Protection?

The referral should be made within fourteen days of the body or person becoming aware that the person is incapable of managing his financial affairs because of the mental disorder.

As stated above a statement should be included to reflect the fact that the Office can only consider the case if there is sufficient assets which would merit the appointment of a Controller.

When may a referral to the Office of Care and Protection NOT be required?

If the patient relies on social security benefits only, it may not be necessary to refer to the Office of Care and Protection.

Regulation 33 of the Social Security (Claims and Payments) (NI) Regulations 1987 provides that the DHSSPS can authorise an appointee to act on behalf of a person who cannot claim for himself because of mental incapacity, for example if he is mentally ill or suffering from dementia.

What happens once the Referral has been received by the Office of Care and Protection?

On receipt of a referral, and provided it contains all the information / details as laid out in the **Article 107** referral form, the Office will write to the relevant next-of-kin with a view to their appointment as Controller.

If sufficient information has not been provided within the referral the Office of Care and Protection will revert back to the person who lodged same for further clarification.

Can the family of a person, considered incapable of managing financial and property affairs lodge an independent application for controllership?

Yes. If a Health and Social Care Trusts is not involved the family can lodge an independent application for controllership.

The relevant forms can be requested directly from the Office of Care and Protection. Where there is no one suitable to make the application, the Office can direct an officer of the court or the official solicitor to make the application. In urgent cases, the requirement to apply in writing can be waived.

What other protections for the patient's property and finances are available within the provisions of the Mental Health (Northern Ireland) Order 1986?

The court may arrange a visit by a 'Lord Chief Justice Visitor' who may be a medical, legal or lay visitor, to investigate any particular matter relating to the capacity of the patient to manage his property or affairs and then report to the court.

Article 104



In addition Health and Social Care Trusts have some powers in relation to the property of a person in accommodation for which he is responsible. Under **Article 116 (1)** of the Order, these powers apply to a person incapable by reason of mental disorder of managing and administering his property and affairs who resides in accommodation for which the Regional Board is responsible. The power does not apply where a controller has already been appointed.

Where is the Office of Care and Protection located?

Office of Care and Protection
Patients' Office
Royal Courts of Justice
Chichester Street
Belfast
BT1 3JF

For further information on this please follow the link below.

LINK TO Dealing with the Financial Affairs of the Mentally Ill

What other protections are available for a person who is or may become mentally disordered and unable to manage their financial affairs and property?

In addition to the protections contained in the Mental Health (Northern Ireland) Order 1986 the law provides the additional protections:

- **The Enduring Powers of Attorney (Northern Ireland) Order 1987**

An Enduring Power of Attorney (EPA) is where one person (the donor) gives another person (the attorney) the authority to act on his behalf in relation to the donor's property and affairs. There is no authority to act in welfare or health decisions. This power can only be granted by the donor whilst s/he is capable of understanding the nature and effect of creating such a power.

The EPA will become active immediately unless it specifically states it is not to come into effect until the person is mentally incapable. The attorney has a duty to register the EPA with the Office of Care and Protection when he believes that the Donor is becoming incapable or is incapable.

LINK TO The Enduring Powers of Attorney (Northern Ireland) Order 1987

- **Article 38 of Health and Personal Social Services Order 1972**

This Order imposes a specific duty on social services to protect or deal with the property of any person in respect of whom arrangements have been made for admission to hospital or removal to suitable premises under **Article 37** (persons in need of care and attention).

- **Regulation 33 of the Social Security (Claims and Payments) (NI) Regulations 1987 (referred to above)**

This regulation provides that the DHSSPS can authorise an appointee to act on behalf of a person who cannot claim social security benefits for himself because of mental incapacity/mental disorder,



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OFFENCES, INCLUDING THOSE AGAINST PEOPLE WITH A MENTAL DISORDER (PART X)

INTRODUCTION

The Mental Health (Northern Ireland) Order 1986 recognises that those with a mental disorder may be particularly vulnerable to abuse and exploitation from others. The Order therefore contains a number of provisions designed to protect the rights of those with a mental disorder.

These provisions, as contained in **Part X** of the Order, will be described in this Chapter.

The Provisions can usefully be divided into the following categories:

- **Offences in relation to the abuse of the legal process**
- **Offences in relation to obstructing those tasked to carry out functions under the Order**
- **Offences in relation to the ill-treatment and neglect of people with a mental disorder**
- **Sexual Offences against people with a mental disorder.**

OFFENCES IN RELATION TO THE ABUSE OF THE LEGAL PROCESS

It is unlawful for **any person** to knowingly receive or detain a person with a mental disorder except through the processes and procedures set out in the Order.

What are the specific offences and penalties in relation to the improper operation of the Order?

Part X of the Order sets out a list of offences and penalties in relation to:

- Possession by a person without lawful authority or excuse of any document in relation to this Order which that person knows or believes to be, false within the meaning of Part I of the Forgery and Counterfeiting Act 1981.
- Making or possession of any document which closely resembles a document purporting to be:
 - An application under Part II
 - Any recommendation or report and
 - Any other document required or authorised to be made for any of the purposes of the Order.
- Wilful making of a false entry or statement in any application, recommendation, report, record or other document required or authorised to be made for the purposes of the Order.
- Making use of any entry or statement in any application, recommendation, report, record or other document required or authorised to be made for the purposes of the Order with intent to deceive.

Article 119

What penalties are available to the Courts for those who commit these offences?

Penalties can range from a term of up to 6 months imprisonment or fine, or both. This will depend on the seriousness of the offence.

OFFENCES IN RELATION TO UNLAWFUL DETENTION

What is the law in relation to the unlawful detention of a person with a mental disorder and who do these offences apply to?

The Order states that it is unlawful for any person who knowingly receives or detains a person with a mental disorder except through the processes and procedures set out in the Order.

In addition the Order makes it an offence for any person to knowingly exercise any powers of detention or any other powers conferred by or under the Order, after that the power has expired. **Article 120**

What penalties are available to the Courts for those who commit these offences?

Penalties can range from a term of imprisonment for a period of up to 6 months or a fine up to a term of imprisonment for a period up to 2 years or fine, or both. This will depend on the seriousness of the offence.

OFFENCES IN RELATION TO OBSTRUCTING THOSE TASKED TO CARRY OUT FUNCTIONS UNDER THE ORDER

The provisions in relation to detention and guardianship contained in the Order are legal provisions enacted to ensure protections for a person with a mental disorder who may be a risk, as a consequence of that disorder to themselves and/or others. Persons who obstruct those tasked to carry out functions under the Order may be placing both the person who is subject to detention or guardianship and potentially others at risk.



The Order sets out specific offences in relation to these matters in **Articles 124 and 125 as set out below:**

When can a person be deemed to have committed an offence under Article 124 of the Order?

Article 124 makes it an offence for anyone to induce or knowingly assist a person who is liable to be detained or who is subject to guardianship, to go absent without leave, or to induce or knowingly assist a person who has been legally detained to escape from the hospital or any other place they are required to be/reside.

It is also an offence to knowingly harbour a person who is subject to detention or guardianship and who is absent without leave or who has escaped from detention or place where they are legally required to be, or to give that person any assistance with intent to prevent, hinder or interfere with their being taken into custody or returned to the hospital or other place where they ought to be.

What penalties are available to the Courts for those who commit these offences?

Penalties can range from a term of imprisonment for a period of up to 6 months or 2 years or a fine. This will depend on the seriousness of the offence.

In what circumstances can a person be deemed to have committed an offence under Article 125?

Article 125 states that it is an offence to:

- Refuse to allow the inspection of any premises by a person authorised in that behalf by or under the Order;
- Refuse to allow visiting, interviewing or examination of any person by a person so authorised;
- Refuse to produce for inspection of any person so authorised any document or record the production of which is duly required or
- Otherwise obstruct any person in the exercise of his functions.

- Refuse to leave when asked to do so by a person who is authorized to interview a person believed to have a mental disorder in private.

What penalties are available to the Courts for those who commit these offences?

Any person guilty of an offence under this Article shall be liable on summary conviction to imprisonment for a term not exceeding 3 months or to a fine or to both.

OFFENCES IN RELATION TO THE ILL-TREATMENT AND NEGLECT OF PEOPLE WITH A MENTAL DISORDER

The Order makes it an offence for any person to ill-treat or wilfully neglect a person with a mental disorder. **(Article 121)** and specifies penalties for those found guilty of doing so.

What is the law in relation to ill-treatment and neglect of persons with a mental disorder?

The Order makes it an offence for any person who is:

- An officer on the staff of or otherwise employed in a hospital, private hospital or nursing home or
- A member of the Board or director of the Health and Social Care Trust managing a hospital or
- A person carrying on a private hospital or nursing home

to ill treat or wilfully neglect a person who is receiving treatment for a mental disorder as an in-patient or an out-patient in that hospital or nursing home or on premises of which the hospital or nursing home forms part of where a person is receiving treatment as an out-patient. **Article 121 (1)**



Does this offence only relate to those persons listed above?

No, the Order also makes it an offence for any individual who is:

- A guardian to a person received into or subject to guardianship under the Order
- Has custody of a person with a mental disorder
- Has care of a person with a mental disorder regardless of whether that person is subject to legal provisions within the Order

to ill-treat or wilfully neglect a person with a mental disorder. **Article 121 (2)**

What penalties are available to the Courts for those who commit these offences?

Penalties can range from a term of imprisonment for a period of up to 6 months or 2 years and or a fine. This will depend on the seriousness of the offence.

What is the process for instituting proceedings against a person under Article 120 (Unlawful detention of patients) and Article 121 (Ill-treatment of patients)?

Consent must be sought by or with the consent of the Director of Public Prosecution Service for Northern Ireland before instituting legal proceedings.

SEXUAL OFFENCES AGAINST PEOPLE WITH A MENTAL DISORDER.

Article 122 and 123 of the Mental Health (Northern Ireland) Order 1986 previously outlined the law in relation to sexual offences.

These provisions have now been repealed and replaced by more comprehensive legislation in **Part IV of the Sexual Offences (Northern Ireland) Order 2008** which came into force in February 2009. **LINK TO Part IV of the Sexual Offences (Northern Ireland) Order 2008**

Explanatory Guidance on the Sexual Offences Order 2008 is available on the NIO website. **LINK TO Explanatory Guidance to the Sexual Offences (NI) Order 2008**

A leaflet is also available LINK TO “Working Within The Sexual Offences Order”

This Order introduced important new legislation to protect people with a mental disorder:

- **Articles 43 to 46** of the 2008 Order relate to offences against people who cannot legally consent to sexual activity because of a mental disorder.
- **Articles 47 to 50** relate to offences against people who may or may not legally be able to consent to sexual activity but who are vulnerable to inducements, threats or deceptions because of a mental disorder.

None of these measures are intended to interfere with the right of people with a mental disorder, who have capacity to consent, to a full and active life, including a sexual life.

However those caring or providing treatment for people with a mental disorder have particular responsibilities towards patients in all settings.

- **Articles 51-54** relate to particular offences carried out by those in a “relationship of care”. These provisions prohibit all sexual activity between a care worker and a person with a mental disorder, whilst a relationship of care continues.
- **Article 55** provides a definition of “relationship of care”.
- **Articles 56 and 57** set those who are exempted from the **Articles 51 to 55**.

Is it always unlawful to engage in sexual activity with a person who has a mental disorder?

No. If the person with a mental disorder has the capacity to consent freely to the sexual activity a crime will not be considered to have taken place. In most situations a person with a mental disorder will be able to consent freely to sexual activity and therefore has the same rights to engage in consensual sexual activity as anyone else.



In what circumstances then can a person who engages in sexual activity with a person with a mental disorder be considered to have committed a crime?

An offence will be considered to have been committed if:

- The person with a mental disorder is a victim of unlawful inducements, threat or deception or
- The person with a mental disorder is an individual who lacks capacity to make decisions and or who is unable to communicate his decisions.

What specific sexual offences exist against people with a mental disorder under the Sexual Offences (Northern Ireland) Order 2008?

That law states that a person will be guilty of an offence if he:

- Engages in sexual activity (touching) with a person he knows or should reasonably be expected to know has a mental disorder and who lacks the capacity to agree to such activity or is unable to communicate such a choice. **(Article 43)**
- Causes or incites a person to engage in sexual activity, who he knows or should reasonably be expected to know has a mental disorder and lacks the capacity to choose whether to agree in engaging in the activity or is unable to communicate such a choice. **(Article 44)**
- Intentionally engage in sexual activity in the presence of a person who they know or should reasonably be expected to know has a mental disorder and who lacks the capacity to choose whether to agree to be present or is unable to communicate such a choice. **(Article 45)**
- For his own sexual gratification intentionally cause a person who he know or should reasonably be expected to know has a mental disorder and who lacks the capacity to choose whether to agree to be present or is unable to communicate such a choice, to watch or look at an image of a third party engage in a sexual act. **(Article 46)**

- Procure sexual activity by means of inducement offered or given, a threat made or deception practised with a person they know or should reasonably be expected to know has a mental disorder. **(Article 47)**
- Causes a person he knows or should reasonably be expected to know has a mental disorder by means of an inducement offered or given, a threat made or a deception practised to, engage in or agree to sexual activity. **(Article 48)**
- Procures, for personal gratification, a person he knows or should reasonably be expected to know has a mental disorder to be present while engaging in sexual activity. **(Article 49)**
- Intentionally causes, for personal gratification, a person with a mental disorder, to watch a third party engaging in a sexual activity or look at an image of a person engaging in such activity. **(Article 50)**

What penalties are available to the courts for those persons found guilty of these offences?

Any person found guilty of an offence under

- **Article 43, 44, 47 and 48** is liable –
 - a) On summary conviction, to imprisonment for a term not exceeding 6 months or a fine not exceeding the statutory maximum or both;
 - b) On conviction on indictment, to imprisonment for a term not exceeding 14 years.
- **Articles 45, 46, 49 and 50** is liable -
 - a) On summary conviction, to imprisonment for a term not exceeding 6 months or a fine not exceeding the statutory maximum or both;
 - b) On conviction on indictment, to imprisonment for a term not exceeding 10 years.

Do these provisions also relate to care workers?

Similar but separate provisions relating to care workers are contained in **Articles 51 to 54** of the Sexual Offences (Northern Ireland) Order 2008.



These provisions prohibit all sexual activity between a care worker and a person with a mental disorder whilst that ***“relationship of care”*** continues.

What if the person with a mental disorder is able to communicate and give consent?

The laws relating to care workers of people with a mental disorder apply whether or not the victim appears to consent, and whether or not he has the legal capacity to consent. The apparent consent of the victim is only relevant in so far as it may mean that the care worker is not guilty of a non-consensual offence, such as rape or sexual assault. These particular provisions can apply to anyone, including family or friends, if they provide care, assistance or services in relation to the person’s mental disorder.

What is a “relationship of care”?

A relationship of care is defined as where one person has a mental disorder and another is regularly involved or is likely to be involved, face to face in their care, where that care arises from a mental disorder. It applies to any person working on both a paid and voluntary basis such as:

- Doctors, nurses, social workers, medical receptionists, cleaning staff, advocates and voluntary helpers.
- Workers in a care home, community home, voluntary home or children’s home.
- Workers who provide services through the Health and Social Care Board or Trusts or a private medical agency or independent clinic or hospital.
- Workers who provide services in the home or for a body or agency which brings them into or could bring them into, regular face-to-face contact with people with mental disorders.
- Workers with regular face-to-face contact with people with mental disorders who provide any services where care or assistance are given. This could include paid or unpaid staff who take people with mental disorders on outings every week, or visit them at home to provide complementary therapy.

Also included is anyone (including a friend or family member) if they provide care, assistance or services in connection with the person's mental disorder.

What specific sexual offences can a care worker be charged with?

Care workers can be charged with:

- Sexual Activity with a person with a mental disorder including where the care worker knew or could reasonably be expected to know that the person had a mental disorder. **(Article 51)**
- Causing or inciting sexual activity. **(Article 52)**
- Sexual activity in the presence of a person with a mental disorder. **(Article 53)**
- Causing a person with a mental disorder to watch a sexual act. **(Article 54)**

What are the penalties available to the courts for those care workers found guilty of these offences?

A person found guilty of an offence under

- **Article 51 and 52** is liable –
- On summary conviction, to imprisonment for a term not exceeding 6 months or a fine not exceeding the statutory maximum or both;
- On conviction on indictment, to either imprisonment for a term not exceeding 10 years. However where the person is found guilty of the more offences set out in **Article 51 (3)** that person may be liable to imprisonment for a term not exceeding 14 years.

A person found guilty of an offence under

- **Articles 53 and 54** is liable -
- On summary conviction, to imprisonment for a term not exceeding 6 months or a fine not exceeding the statutory maximum or both;
- On conviction on indictment, to imprisonment for a term not exceeding 7 years.



Are there any exceptions?

Yes, there are certain situations in which Articles 51 to 53 do not apply. These include:

- Where the care worker is legally married to, or is a civil partner of, the person with a mental disorder, or
- Where it can be proved that the sexual relationship pre-dated the start of the relationship of care, as long as that sexual relationship was lawful. This would apply, for instance, where someone who looks after his or her partner following the onset of a mental disorder continues to have a consensual sexual relationship with them.

APPENDICES

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THE ROLE OF THE APPROVED SOCIAL WORKER

What is an Approved Social Worker?

Approved Social Workers (ASWs) are qualified and experienced social workers who have participated in additional training and have been assessed as competent to carry out the specific duties and responsibilities set out in the **Mental Health (Northern Ireland) Order 1986**.

ASWs have an integral and significant role in the care and protection of people who have a mental disorder and have specific duties and responsibilities under the **Mental Health (Northern Ireland) Order 1986**.

The five Health and Social Care Trusts in Northern Ireland have a duty under **Article 115** of the Order to appoint a sufficient number of ASWs to carry out functions under the Order and to ensure that they are and continue to be competent in this role. **[LINK TO ASW Contacts List](#)**

WHAT ARE THE SPECIFIC DUTIES OF THE ASW UNDER PART II OF THE ORDER?

The specific duties of the ASW under Part II of the Order relate to the assessment and if necessary application, for a person to be:

- Compulsorily admitted to hospital for assessment or
- Received into Guardianship.

Although appointed by their employing Trust, ASWs are required under **Article 40** of the Order to make independent decisions regarding these actions and must be satisfied, having regard to the wishes expressed by relatives, all other relevant circumstances and the criteria set out in the Order that an application ought to be made and it is necessary or proper to do so.



What are the duties and responsibilities of the ASW in relation to Compulsory Admission to hospital for Assessment?

The ASW is required by law to make an independent professional judgement in relation to whether an application for detention in hospital should be made. In order to do so the ASW is required to:

- Interview the person whose detention in hospital is being considered.
- Identify and consult with the person who appears to be the Nearest Relative*. **See Role of Nearest Relative**
- The ASW must also consult with a second ASW, prior to making the application, if the nearest relative objects. **LINK TO MHO C**
- Gather relevant information as part of the assessment process.
- Consult with the medical practitioner who has made the medical recommendation.
- Consult with relevant others, including other health and social care professionals with prior knowledge of the person.
- Advise the person and nearest relative of the outcome of the assessment and their rights under the Order.

* The nearest relative will not necessarily be the person identified by the patient as their next of kin and indeed the patient has little control over who will be seen as the nearest relative. However, recent judicial decisions have considered the patient's **Article 8 Rights under the ECHR** in this context, and determined that, in certain circumstances, a patient's wishes in refusing to accept the nomination of a nearest relative as defined in the legislation may be respected.

In England, Wales and Scotland mental health legislation has been revised as a result of these rulings. It is hoped new legislation in Northern Ireland will address this issue. As a result of this case law, the ASW is allowed, in some exceptional circumstances, a degree of flexibility in who can be considered as the nearest relative¹.

¹ Case Law - Following a judgment, *R (E) v Bristol City Council* (2005) EWHC 74 (Admin) in which the Judge involved, Bennet J., considered the duty of the ASW to consult with the nearest relative and the rights of a patient under Section 3(1) of the Human Rights Act 1998, ASWs can interpret the words "practicable" and "reasonable delay" in a way that takes into account the person/patient's "wishes, health and well being".

When satisfied that admission to hospital is the most appropriate way of providing the care and treatment needed by the person, the ASW has a duty to make the application, founded on a medical recommendation, for their admission to hospital for assessment.

In circumstances where a decision is made that admission to hospital is necessary the ASW, as applicant, has a duty to ensure that the person is conveyed to and admitted to hospital in a lawful and humane manner.

The ASW must work closely with the medical practitioner, nearest relative and others in this task. In most situations the ASW will seek assistance from the Northern Ireland Ambulance Service.

In exceptional circumstances, where there is a risk of physical harm to the person and/or others in the conveyance of the person to hospital, the ASW is required to advise and seek assistance from the police and liaise with and co-ordinate these services.

In situations where a decision is made that an application should **not** be made the ASW has responsibility with the medical practitioner to consider and if necessary agree alternatives to admission as part of a care plan in conjunction with the person and nearest relative.

The ASW must also produce a comprehensive report which sets out the circumstances of the case, the information gathered and the assessment, decision making and management process involved. This must include consideration of the human rights implications of their action. This report contributes to the process of assessment during the detention in hospital for assessment period and to the multi disciplinary comprehensive risk assessment. **LINK TO Guidance ASW Report MHO B**
LINK TO Pro-Forma MHO B

The ASW may have already completed an MHO A at the point of admission. **LINK TO MHO A**



Although this is a statutory social worker rather than an ASW role, ASWs may be also are involved in the preparation of social circumstances reports under **Article 5 (6)**. This report must be prepared in circumstances where a nearest relative has acted as applicant. Again the information gathered contributes to the process of assessment during the detention in hospital for assessment period and to the multi disciplinary comprehensive risk assessment. **LINK TO Guidance Article 5 Social Circumstances Report LINK TO Pro-Forma MHO D**

LINK TO Guidance for ASW Assessment for Admission

What are the ASW's duties and responsibilities in relation to Guardianship?

ASWs have 2 distinct roles in the guardianship application process and these must be carried out by 2 different ASWs.

- **Article 40** of the Order places a duty on the ASW to make a guardianship **application** where, after taking into account the views of the relatives and any other relevant circumstances, he is satisfied that an application ought to be made by him and that it is necessary and proper for the application to be made by him. The ASW's duties and responsibilities include:
 - Interviewing the person whose reception into guardianship is being considered.
 - Identifying and consulting with the person who appears to be the Nearest Relative. If the nearest relative objects to the application the ASW must consult with another ASW before proceeding (3rd ASW).
 - Gathering relevant information as part of the assessment.
 - Consulting with the medical practitioners who has made the medical recommendations
 - Consulting with relevant others including other health and social care professionals with prior knowledge of the person.
 - Advising the person and nearest relative of the outcome of the assessment and their rights under the Order.
- Another ASW is required to make the **recommendation** in relation to guardianship.

What is the role of the social worker in relation to the Mental Health Review Tribunal?

The social worker is required to carry out a number of tasks in relation to the Tribunal. Again the Order and Rules do not stipulate that an ASW rather than a social worker must prepare and present the Mental Health Review Tribunal social circumstances report, in relation to a patient detained in hospital or received into guardianship under the Order.

The tasks of the social worker include:

- To advise the patient or person under guardianship of their right to appeal to the MHRT.
- To advise the patient re legal representation.
- Prepare social circumstances report for the Tribunal
- Give evidence at the MHRT hearing.

The social worker is acting in a professional capacity but also as a representative of the Health and Social Care Trust, as the detaining authority or authority who has received the patient into guardianship. One of the most challenging aspects of this work is to maintain a supportive and empowering relationship with the patient while ensuring that the patient receives the appropriate care and treatment.

[LINK TO Guidance MHRT Guardianship Social Circumstances Report](#)

[LINK TO Pro-Forma MHRT Guardianship Social Circumstances Report](#)

[LINK TO Guidance MHRT Detained Patient Social Circumstances Report](#)

[LINK TO Pro-Forma MHRT Detained Patient Social Circumstances Report](#)

What is the role of the ASW in relation to Part III of the Order?

ASWs also have responsibilities in relation to Part III of the Order in relation to Guardianship and Supervision and Treatment Orders for persons who are involved in criminal proceedings.



These include:

- Preparation of Mental Health Review Tribunal Social Circumstances Reports for persons subject to Part III
- Duties in relation to those subject to Guardianship Orders under Part III
- Duties in relation to Supervision and Treatment Orders:

Approved Social Workers are clearly identified as having the specific role in relation to Supervision and Treatment Orders as provided for under Part II of Schedule 2A within the Mental Health (NI) Order 1986 (revised 1996). The role involves co-ordinating and compiling a comprehensive assessment detailing the needs of an individual and assisting the decision if the responsible trust can safely meet these needs prior to the implementation of the order. The Approved Social Worker is pivotal in co-ordinating and working in partnership with a range of key agencies.

The ASW is responsible for ensuring the order is maintained and liaising with the courts as required and, as supervising officer, is responsible for maintaining regular contact with the supervised person and working to develop a productive relationship with the service user despite the coercive context. This often necessitates the approved social worker dealing with a high level of both risk and uncontrolled variables. In preparation for the expiry of a Supervision and Treatment Order, the ASW has the leading role in co-ordinating assessments and planning how to continue delivering services to the patient who is often associated with a high level of risk and stigmatisation.

ASW ROLE IN RISK MANAGEMENT

As a professionals with a comprehensive knowledge of the legislation, Code and Guide, ASWs also have a role in providing advice and consultation to the multi disciplinary team as part of the risk assessment process.

Promoting Quality Care states that "Healthcare staff need to be aware of the powers available to them under Mental Health (Northern Ireland) Order 1986 that can, if necessary, be used. Detention should always be used as a last measure where a service user is considered a significant risk to him/herself or others".

**LINK TO Promoting Quality Care Good Practice Guidance and Risk Assessment
September 2009**



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THE NEAREST RELATIVE

What does the term “Nearest relative” mean?

Nearest relative is a specific legal term defined in **Article 32** of the **Mental Health (Northern Ireland) Order 1986** and the role is one of the major safeguards for the rights of someone who is or may be subject to compulsion under the Order.

The Order gives a patient’s nearest relative a number of important rights in relation to detention, discharge and being informed or consulted when certain actions have been taken under the Order or when these are being proposed. The role of a nearest relative is limited to these rights and powers under the Order.

What is the difference between nearest relative and ‘next of kin’?

Many people confuse the term nearest relative with ‘next of kin’. It is important to note that the nearest relative and the ‘next of kin’ **may be two different people**. The next of kin is usually a relative or close friend chosen by someone soon after they have been admitted to any hospital while a nearest relative is the person identified with reference to **Article 32** of the Order.

The nearest relative will not necessarily be the person identified by the patient as their next of kin and indeed the patient has little control over who will be seen as the nearest relative. However, recent judicial decisions have considered the patient’s **Article 8 Rights under the ECHR** in this context, and determined that, in certain circumstances, a patient’s wishes in refusing to accept the nomination of a nearest relative as defined in the legislation may be respected.

In England, Wales and Scotland mental health legislation has been revised as a result of these rulings. It is hoped new legislation in Northern Ireland will address this issue. As a result of this case law, the ASW is allowed, in some circumstances a degree of flexibility in who can be considered as the nearest relative¹.

¹ Case Law - Following a judgment, *R (E) v Bristol City Council* (2005) EWHC 74 (Admin) in which the Judge involved, Bennet J., considered the duty of the ASW to consult with the nearest relative and the rights of a patient under Section 3(1) of the Human Rights Act 1998, ASWs can interpret the words “practicable” and “reasonable delay” in a way that takes into account the person/patient’s “wishes, health and well being”.

What rights does the nearest relative have?

The nearest relative has a number of rights under the Order. These include:

- The right to make an application for admission for assessment **Article 5**.
- The right to assistance in making the application and in conveying the patient to hospital if necessary.
- The right to request an ASW assessment (**Article 40**) and to reasons, set out in writing, if the ASW declines to make such an application.
- The right to consultation with the ASW as soon as is practicable before and following the application. The nearest relative also has the right to information regarding why an application is being considered and the effects of making the application. **LINK TO Nearest Relative Information Leaflet** (customised for Belfast Health and Social Care Trust)
- The right to object to the application. In this circumstance the ASW must consult with a second ASW.
- The right to request that the detained patient be discharged from detention or guardianship. If the nearest relative disagrees with his relative's detention in hospital or guardianship he can:
 - Authorise a doctor of his choice to visit and examine his relative in private for the purpose of advising about discharge. That doctor must examine the documents relating to their detention and treatment.
 - Request that the patient be discharged from detention. This request must be made in writing to the detaining Health and Social Care Trust, giving 72 hours notice or 96 hours at weekends. However the RMO with responsibility for the care and treatment of the patient can overrule the request. In this event the nearest relative must be officially informed of this decision. (**Article 14**)

Internal forms

- The Nearest relative can also appeal to The Mental Health Review Tribunal for their relative to be discharged from detention. This can be done within the first 28 days from the date on which he has been informed that his request for the discharge (see above) has been overruled. The Mental Health Review Tribunal, Bedford House, 16-22 Bedford Street, Belfast. BT2 7FD Tel: 028 9072 4843. e mail: **mhrt@courtsni.gov.uk**
- The right, subject to the patient's permission, to copies of any written information given to the patient. **Article 27 (5)**
- The right to 14 days prior notice of an examination of the patient by two medical practitioners with a view to renewal of detention for treatment. **Article 13 (4)**.
- The right, if practicable, and *with the patient's agreement*, to be informed of the discharge of the patient from detention at least 7 days prior to the date of discharge. **Article 117 (1)**

Can the nearest relative intervene in the detained patient's treatment?

No. A patient who is detained under the MHO may be treated without consent. There is no power under the MHO for the nearest relative to intervene in a patient's treatment whilst the patient is detained in hospital. If the nearest relative is unhappy about the treatment being given to their relative, they should initially discuss this with the RMO. If they are still unhappy, they can make a formal complaint using the relevant Trust's complaint procedure. If this action fails to produce a satisfactory outcome, then it is possible to contact the RQIA.

How is the nearest relative identified?

The nearest relative is strictly defined with reference to a list set out in **Article 32** of the Order. Certain relations are treated as relatives under the Order and these are listed in groups or pairs, as follows:

- a) Spouse* (Husband or wife). If the marriage is broken up and the spouse is no longer living with the patient – that person is disregarded
- b) Child (son or daughter)
- c) Parent (father or mother)



- d) Brother or sister;
- e) Grandparent;
- f) grandchild;
- g) uncle or aunt;
- h) nephew or niece.

“The nearest relative” is the **first person listed** who is providing care to the person with a mental disorder.

For example, if the patient lives with an uncle or aunt, that person will be the nearest relative even if the patient has a mother or father. Similarly, if the patient lives with a younger brother or sister, that person will be the nearest relative even if the patient has an older brother or sister, or a parent.

* The term “spouse” includes a person who is living with the patient as if he or she were the spouse of the patient or has been or had been so living for a period of not less than 6 months. Persons living in a same sex relationship can also be included in this category². However civil partnerships are not treated as marriage for this purpose.

If the patient has lived with any person not on the list (maybe a friend or a more distant relation, such as a cousin) for five years or more and that person has been caring for the patient, then that person is the nearest relative.

What if no one in the list above was/is caring for the patient?

If no one on the list is caring for the person then the nearest relative is identified by starting at the top of the list and working down. If there is a husband or wife, that person will be the nearest relative. If there is no one in this first group, it is necessary to look in the second group. If there is no one in the second, then the third group should be used, and so on.

² Case Law - (R (SSG) v Liverpool County Council 22 October 2002)

If there is more than one person in each group or pair who could be the patient's nearest relative, the eldest takes priority as nearest relative. For example, if the rules in **Article 32** indicate that a parent is the patient's nearest relative and both parents are still alive, then it is the elder of the two who is the nearest relative. If **Article 32** indicates that the nearest relative should be a brother or sister, it is the oldest brother or sister who is the nearest relative.

The nearest relative must be over 18, unless they are the spouse or parent of the patient. For a child, a mother will always be the parent under the Order but the father will only be considered as the nearest relative if he has parental responsibility.

A person listed above will not be considered as the nearest relative if they are living outside of the UK, unless the patient also ordinarily lives abroad. For example, if the rules in **Article 32** indicate that the eldest brother should be nearest relative but that brother lives abroad, the eldest brother or sister still living in the United Kingdom, Channel Islands, Isle of Man or Republic of Ireland will be the nearest relative.

How is the nearest relative of a child or young person identified?

In the case of children and young people the nearest relative will be:

- The older parent, if both are caring and share parental responsibility.
- The Health and Social Care Trust", if the patient is a child or young person subject to a care order (**Article 50**), with parental responsibility, within the meaning of the **Children (Northern Ireland) Order 1995**
- The person named in the Residence Order
- The Guardian in relation to minors under guardianship



In the case of a Ward of Court, no action is allowed without permission of the Court.

The detaining Health and Social Care Trust has a duty under the Order to advise DHSSPS when a child or young person has been admitted to and detained in hospital.

What can a person/patient do if he or she objects to who is considered as their nearest relative?

At this time a person/patient has no right to object to who is considered as their nearest relative.

What happens if the patient does not have a nearest relative?

In this situation the ASW can proceed without consultation. The ASW may also apply to County Court to be appointed as the nearest relative.

Can a County Court appoint a nearest relative for a person/patient?

Yes, in some circumstances the County Court has the power under **Article 36** to make an order appointing a nearest relative to carry out functions under the Order following an application to the Court by:

- a) Any relative of the patient:
- b) Any other person with whom the patient is residing (or if the patient is an in-patient in hospital, was last residing before he was admitted): or
- c) An approved social worker (the responsible authority).

On what grounds can the nearest relative be appointed?

The Court can appoint the “applicant” on any one of the following grounds:

1. There is no nearest relative within the meaning of the Order or it is not reasonably practicable to ascertain if the patient has a nearest relative or;
2. The nearest relative of the patient is incapable of acting as such by reason of mental disorder or other illness or;
3. The nearest relative of the patient unreasonably objects to the making of an application for assessment or guardianship application in respect of the patient; or
4. The Nearest relative of the patient has exercised without due regard to the welfare of the patient or the interests of the public his power to discharge the patient from hospital or guardianship under Part II or is likely to do so.

What if the nearest relative does not want to exercise their rights?

Under **Article 35** the nearest relative of a patient who is liable to be detained or subject to guardianship may assign their functions under Part II to any person who indicates in writing his willingness to exercise those functions **Form 20. LINK TO FORM 20**

Can a nearest relative be prevented from acting in this role?

Yes. Under **Article 36** of the Order a county court, on application, can order that the functions of the nearest relative be assigned to the applicant or a person specified in the application if the court believes that:

- The nearest relative is incapable of acting as such by reason of mental disorder or other illness or
- The nearest relative unreasonably objects to the making of an application for assessment or guardianship application or
- The nearest relative of the patient has exercised without due regard to the welfare of the patient or the interests of the public his power to discharge the patient from hospital or guardianship under this Part, or is likely to do so.



What if the person has no nearest relative within the meaning of Article 32 of the Order?

In this event the approved social worker can proceed with his assessment and make an application if necessary. An application can also be made to a county court under **Article 36** by any relative of the patient, any other person with whom the patient is residing or an approved social worker to have that person appointed as the nearest relative on the grounds that the person has no nearest relative within the meaning of the Order or that it is not reasonably practicable to ascertain whether the person has such a relative or who that relative is.

ROLE OF THE GENERAL PRACTITIONER/MEDICAL PRACTITIONER

At the time of these Gain Guidelines going to press (October 2011), issues of contract concerning the role of the GP in carrying out responsibilities under the Mental Health (NI) Order 1986 have been challenged and await legal clarification.

Until then, the Role of the General Practitioner in these Gain Guidelines closely follows what is outlined in the Mental Health (NI) Order 1986, Guide to the Order and in the Code of Practice.

The GP role is well described in the WHO Guide to Mental and Neurological Health in Primary Care 2004

LINK TO WHO Guide to Mental and Neurological Health in Primary Care 2004

(See page 11 onwards of above document)

http://www.whoguidemhpcuk.org/page_view.asp?c=16&fc=006003&did=2230

This site provides a very useful overview and guidance on the role of the General Practitioner in relation to the Mental Health (Northern Ireland) Order 2011.



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THE ROLES AND RESPONSIBILITIES OF MENTAL HEALTH NURSES IN RELATION TO THE APPLICATION OF THE MENTAL HEALTH (NORTHERN IRELAND) ORDER 1986

The roles and responsibilities of 1st level Registered Mental Health Nurses (RMN) and Learning disability nurses (LDN) in relation to the application of the Mental Health Order (1986) Northern Ireland are clearly outlined within the Code of Practice issued by the DHSSPSNI. These roles are specific to both the application, validation and monitoring of the MHO 1986. RMNs and LDN's are responsible for the following procedures:

- Receipt and scrutiny of the application upon admission of a patient.
- Ensuring the documents are in order by familiarity with the MH Order, including recognising possible errors and being able to refer to an authorised administrative officer for clarity.
- Ensuring access to a hospital doctor for validation of the medical recommendation
- Checking admission documents with the ASW.
- Ensuring that copies of all appropriate admission documents are forwarded to the correct authority.
- Ensuring through the authorised administrative officer the rectification of applications within the 14 day period stipulated by the Order and that any such alterations/corrections are forwarded to RQIA.
- Ensuring that subsequent dates for assessment and/or detention are adhered to as directed under the Order. This includes **Forms 7, 8, 9 & 10** as well as **22/23**.
- Ensuring **Forms 1, 2, 3, & 5** are completed as per the Order with regards to a voluntary patient detained within a hospital setting under the terms of the Mental Health Order.
- In the event of a medical officer not being available in time, RMNs and LDN's have the responsibility of exercising the **Form 6** Nurse's Holding Power in an appropriate manner, based on risk assessment of the factors laid out in the Order and in the Code of Practice. This should then be followed up by the appropriate process for further assessment for detention as outlined in the Order and it is the responsibility of the Nurse in charge to ensure that this is completed.



- RMN and LDN should ensure that all information leaflets specified in the Order are made available to patients and their carers/NOK as appropriate and in the manner specified in that Article of the Order.
- The community mental health nurse is responsible for liaising with the GP the ASW coordinator and the ward regarding the impending admission and often plays a significant continuity role with both the service user/carer.

THE ROLE OF THE PSYCHIATRIST

What is a Psychiatrist?

A Psychiatrist is a qualified medical doctor who has specialised and taken further training in the care and treatment of people who have a mental disorder. Psychiatrists work in a range of community and hospital settings with children, young people and adults and, in most situations, as part of a multi-disciplinary team.

What specific duties and responsibilities does the Psychiatrist have under the Mental Health (Northern Ireland) Order 1986?

The Psychiatrist has a number of key duties and responsibilities under the Order. In relation to the assessment and treatment of a patient detained under Part II psychiatrist will be involved at the point of admission right through, if necessary, to the detention for assessment, treatment and discharge of the patient from detention.

The Order permits any doctor on the staff of a mental health, learning disability or general hospital to use a "holding power" (**Form 5**) under **Article 7 (2)** of the Order, to prevent a patient, not liable to be detained, from leaving hospital for up to 48 hours to allow an assessment in relation to an application for detention for assessment to take place.

If that application is made, a doctor on the staff of the hospital (this also applies when admission under the Order is sought in a General Hospital) can then carry out the initial medical examination of the person for whom admission for assessment is sought (**Form 7**).

However other duties and powers can only be exercised by a medical practitioner who has been appointed by RQIA for the purposes of **Part II** (Compulsory Admission to Hospital and Guardianship) of the Order and **Part IV** (Consent to Treatment) of the Order. These doctors are commonly known as **Part II** and **Part IV** doctors respectively.



A range of health and social care professionals are involved in the care and treatment of patients detained under the Order but it is the Responsible Medical Officer (RMO) who has overall and continuing responsibility for the patient's clinical management. **Code 5.2**

What is a Responsible Medical Officer?

A **Responsible Medical Officer** (RMO) is a **Part II** doctor in charge of the assessment or treatment of an individual detained patient. The RMO may also provide certain medical recommendations for guardianship which are required by the Order. In the absence of the RMO another Part II doctor may complete the duties of the RMO in relation to the Order.

The RMO has specific duties within each of the following parts of Order:

- Compulsory admission to hospital for assessment and treatment
- Consent to treatment (Part IV)
- Reception into Guardianship
- Patients concerned in criminal proceedings or under sentence (Part III)
- Mental Health Review Tribunal (Part V)

COMPULSORY ADMISSION TO HOSPITAL AND DETENTION FOR ASSESSMENT AND FOR TREATMENT

Has the Psychiatrist any powers in relation to the person whose detention is sought prior to their arrival in hospital?

Yes, in exceptional circumstances, it may not be possible for the applicant to ensure that the patient is conveyed to the hospital, to which admission is sought, within the 48 hours period permitted by the Order. In this situation a Part II doctor, but not specifically the RMO, on the staff of the admitting hospital may complete a **Form 4** extending this period to up to 14 days.

What is the role of the Psychiatrist following an application for a person to be detained in hospital for assessment under Part II?

Once the patient has been conveyed to hospital, he must be immediately medically examined by a doctor on the staff of the hospital, the RMO or another Part II doctor. The outcome of the examination is recorded on **Form 7**.

Form 7 is usually completed by a doctor on the staff of the hospital, in which case it allows the patient to be detained for 48 hours (A decision to reject the application at this stage should not be taken lightly and should only be made by, or following discussion with, a Part II doctor). During this time the patient must be examined by the RMO or another Part II doctor and **Form 8** completed.

If the **Form 7** is completed by the RMO or another Part II doctor, then the patient may be detained for up to 7 days and **Form 8** need not be completed.

The Part II doctor has a statutory responsibility to examine the patient again during the first 7 days of the admission, and again within the second 7 days for the assessment period to be extended to the maximum 14 days. If the period is to be extended **Form 9** must be completed.

What must the Psychiatrist do prior to the end of the assessment period?

Following the 14 day assessment period the RMO, or another Part II doctor in the absence of the RMO, must decide if the patient will be detained for treatment of his mental disorder or discharged from detention.

If the decision is made that the patient should be detained for treatment a **Form 10** must be completed by the RMO/Part II doctor before the expiry of the 14 day assessment period and will also be required to formally examine the patient again at 6 months, 1 year and annually thereafter.



At the end of the second 6 month period of detention the patient is examined by 2 Part II doctors, one of whom must not be on the staff of the hospital. This is an extra safeguard for the patient. One of these doctors will be usually be the RMO.

CONSENT TO TREATMENT (PART IV)

What is the role and what are the responsibilities of the Psychiatrist in relation to consent to treatment?

The Order acknowledges that modern psychiatric care is a team activity involving several disciplines. The team approach need not undermine the professional independence of the various team members. However, it is necessary to reconcile the need for team involvement in patient care with continuing responsibility for the patient's clinical management. The responsibility is recognised by The Order to rest with the RMO, as the doctor, who is in charge of the assessment or treatment of the patient.

In certain circumstances, patients are unable to provide consent for treatment of their mental illness, or are unwilling to do so, and the Mental Health (Northern Ireland) Order 1986 allows for treatment without consent in these cases. See Consent to Treatment Chapter in these Guidelines

a. The Administration of Medication (Article 64)

A detained patient may be administered medication with or without his consent, for the purposes of ameliorating his mental disorder, for up to a period of three months. The Responsible Medical Officer should make an appropriate entry in the clinical notes.

Beyond the 3 month period the administration of medication becomes a more complex issue:

For detained patients capable of giving consent to treatment, consent must be validated by the Responsible Medical Officer or a Part IV doctor, the outcome documented on **Form 22** and the Treatment Plan specified.

For detained patients unwilling or unable to give consent to treatment the matter is referred to another Part II doctor (or a Part IV) doctor for a second opinion.

The Part II doctor may be a doctor on the staff of the hospital in which the patient is detained

The Part II doctor will examine the patient, discuss his case with relevant staff and consider the likelihood of the treatment alleviating or preventing a deterioration of the patient's condition.

If he is satisfied that it will, then **Form 23** must be completed authorizing the Treatment Plan specified.

b. The Administration of ECT (Article 64)

In the case of ECT, for voluntary patients consent to treatment must be obtained in the usual way.

For detained patients capable of giving consent to ECT, this must be validated by the Responsible Medical Officer and **Form 22** completed.

For detained patients unable or unwilling to give consent to ECT, a second opinion is sought from a Part IV doctor through RQIA and **Form 23** completed.

c. Withdrawal of consent for treatment by a patient

A patient may withdraw consent for treatment at any time and where he does so the common law applies, except where statute overrides it. In such circumstances treatment should cease immediately unless the RMO considers that its discontinuance would cause serious suffering to the patient. A second medical opinion must then be obtained from another Part II doctor or a Part IV doctor as described above.



d. Review of Treatment

Where a patient is given treatment under the Mental Health (Northern Ireland) Order 1986, the RMO must report to RQIA each time the patient's detention is renewed, on the treatment and the patient's condition. RQIA may revoke the treatment order if legislation has been used inappropriately.

RECEPTION INTO GUARDIANSHIP

What Responsibilities does the Psychiatrist have in relation to Reception into Guardianship?

The psychiatrist also has duties in relation to persons received into Guardianship.

The recommendation of a Part II doctor is required as one of the two medical recommendations required for the reception of a patient into guardianship. The other recommendation should (if at all possible) be made by the patient's own GP or by a medical practitioner who already knows the patient.

What additional responsibilities does the Psychiatrist have in relation to Guardianship?

The RMO/Part II doctor has statutory responsibilities in relation to both the renewal of guardianship, if required, and in the transfer of a patient from detention in hospital to guardianship.

PATIENTS CONCERNED IN CRIMINAL PROCEEDINGS OR UNDER SENTENCE (PART III)

What role does the Psychiatrist have in relation to patients concerned in criminal proceedings or under sentence (Part III)?

Psychiatrists may be involved in a number of processes in relation to patients concerned in criminal proceedings or under sentence.

a. Remand to Hospital

The Court may remand to hospital a person who has been accused of an offence, for a report of his mental condition or for treatment. Before doing this, the Court must be satisfied that there is reason to suspect mental illness or severe mental impairment and it will seek oral evidence by a Part II doctor.

b. Hospital Order and Restriction Order

The Court may order the hospital admission under the Order, of a person convicted of an imprisonable offence, or make a Hospital Order for an accused person without conviction, if it is satisfied that he committed the act of which he is accused. The Court may also make an order restricting discharge from hospital. The Court must be satisfied that the person is suffering from mental illness or severe mental impairment and will require oral evidence from a Part II doctor and written or oral evidence from another medical practitioner.

c. Interim Hospital Order

The court may 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 is justified. The court must firstly be satisfied that the convicted person is suffering from mental illness or severe mental impairment. Oral evidence by a Part II doctor in addition to oral or written evidence by another medical practitioner is required.



d. Admissions directed by the Department of Justice (previously the Secretary of State)

Transfer directions

The Department of Justice may direct the hospital admission of a person serving a sentence of imprisonment or of certain other persons who are in custody, most commonly those on remand. Written reports by a Part II doctor and 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 his detention in hospital for medical treatment. In practice these reports are commonly made by a consultant psychiatrist in attendance at the prison and a prison medical officer.

Guardianship ordered by a court.

Courts are empowered to make Guardianship Orders where the criteria, which are similar to those applying to a hospital order, are met and the court considers reception into guardianship of the Board, or any other person appropriate. The court's decision will be based on the oral evidence supplied by a Part II doctor, written or oral evidence from another medical practitioner and written or oral evidence from an Approved Social Worker.

THE MENTAL HEALTH REVIEW TRIBUNAL (PART V)

What is the role of the Psychiatrist in relation to the Mental Health Review Tribunal?

The Psychiatrist has a number of tasks in relation to the Tribunal. The Mental Health Review Tribunal Rules require that, following a request for a review of a patient's detention or reception into guardianship, a medical report and social circumstances report must be prepared and submitted to the Tribunal.

The medical report is normally prepared by the RMO with responsibility for the patient's care and treatment. The RMO is acting in a professional capacity but also as a representative of the Health and Social Care Trust, as the detaining authority or authority who has received the patient into guardianship.

The RMO is also required to attend the Tribunal hearing to formally adopt the medical report and to give evidence in relation to the needs for the patient's continued detention or reception in guardianship.

In a separate capacity, the Psychiatrist has a professional role as a member of the panel in a Mental Health Review Tribunal. Under Article 70 and Schedule 3 of the Order each MHRT Panel is required to include a medical member (usually a Consultant Psychiatrist who is not employed by the detaining authority and has no personal connection with the patient and has not recently treated the patient in a professional capacity).



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THE ROLE OF THE POLICE SERVICE NORTHERN IRELAND

INTRODUCTION

This section of the Guidance sets out the legal responsibilities of police officers when in contact with persons with a mental disorder, and provides the general principles to inform local protocols between the Police Service of Northern Ireland (PSNI) and Health and Social Care Trusts and Board to ensure the appropriate management of persons detained for protection and assessment under the **Mental Health (Northern Ireland) Order 1986** (MHO). Protocols are essential in ensuring that all parties are clear about the factors to be considered when deciding if police involvement is necessary in a particular situation. For example, agencies can agree criteria which indicate whether a situation is low, medium or high risk in terms of the likelihood of it resulting in violence and the nature of that violence.

The PSNI have a key role to play in providing an appropriate response to people with mental ill health and/or learning disabilities and facilitating access to a range of other agencies when required.

The PSNI is committed to equal access to services and social inclusion for all groups, particularly in relation to age, disability, gender, race, religion or belief and sexual orientation. This means that all police officers and police staff will be sensitive and responsive to people's differences and needs and will integrate this into the service they provide ensuring that nobody is disadvantaged as a result of their belonging to a specific social group.

The Police Service does not have primary responsibility for every task relating to people with mental ill health or learning disabilities and should not assume, directly or indirectly, responsibility for dealing with all related issues the public or other agencies may present them with. Other partner agencies are often better placed to deal with certain situations, and may in fact have statutory responsibility for them. The police, therefore, should always be ready to support, guide and assist, but not necessarily to lead. Taking on other agencies' responsibilities has a number of disadvantages for the police, including that it may mean the police are legally liable



in the event of something going wrong, and it can set up risks for the police, for example, problems arising from not responding to other calls for which they have direct responsibility.

Although the police are expected to consider the **Guide and the Code of Practice for the Mental Health (Northern Ireland) Order 1986**, the Order does not place a statutory duty on them to have regard to it. Where the Code addresses areas that are relevant to policing police officers will continue to be governed by the primary legislation which provides the relevant power.

With this in mind, we fully accept that it is only by working effectively with other agencies that we can truly safeguard vulnerable people.

When supporting Health & Social Care agencies in the management of patients under the MHO, the police will consider their role under a number of other key pieces of legislation. Ultimately the PSNI will carry out their duties as outlined within **Article 32 (1) of the Police (Northern Ireland) Act 2000**. This outlines the general functions of the PSNI as follows:

- (1) It shall be the general duty of police officers:
 - (a) To protect life and property;
 - (b) To preserve order;
 - (c) To prevent the commission of offences;
 - (d) Where an offence has been committed, to take measures to bring the offender to justice

Other key legislation includes:

- The European Convention on Human Rights (ECHR). **Article 5 (1) (e)** provides for the 'lawful detention... of persons of unsound mind'.
- Police and Criminal Evidence (NI) Order 1989 (PACE) and Common Law provide the legal basis for police actions and the appropriate procedures prescribed by law must be strictly followed.

[LINK TO Police and Criminal Evidence \(NI\) Order 1989 \(PACE\)](#)

- Section 75 Northern Ireland Act 1998 considerations

Article 65, PACE outlines that the Secretary of State (now the Department of Justice) shall issue codes of practice in connection with:

- (a) The exercise by police officers of statutory powers:
 - (i) To search a person without first arresting him;
 - (ii) To search a vehicle without making an arrest; or
 - (iii) To arrest a person;
- (b) The detention, treatment, questioning and identification of persons by police officers;
- (c) Searches of premises by police officers; and
- (d) The seizure of property found by police officers on persons or premises.

The above is particularly important when Police are exercising **Article 19** PACE (NI) Order 1989 in entering premises if there is no time to obtain a warrant in an emergency situation.

1. POLICE POWER TO REMOVE A PERSON TO A 'PLACE OF SAFETY'

Article 130 of the MHO empowers a police constable, who finds a person in 'a place to which the public have access' who appears to be mentally disordered and to require immediate care and control, to take that person to a place of safety. The police officer who removed the person has a duty under **Article 130 (3)** of the Order to inform, where practicable, the nearest relative and a responsible person residing with the removed person.

If all elements of **Article 130** MHO are present, and the person is not arrested for an offence, they should always be detained under the MHO and taken to a place of safety.



The power to detain a person, and remove them to a place of safety under **Article 130** of the MHO is a preserved power of arrest by virtue of Schedule 2 of the **Police & Criminal Evidence (NI) Order 1989 (PACE)**. The police officer should explain to the person that s/he is being detained under **Article 130**. It is important to recognise that although the Order uses the term “remove”, it is deemed to be an “arrest” for the purposes of the PACE (NI) Order 1989.

There is no requirement to caution a person detained under **Article 130** MHO and this need not be done, unless questions are put to them to obtain evidence that may be given in court or it is impracticable due to their condition or behaviour at the time.

Whilst a person detained under **Article 130** MHO is entitled to know that their liberty is being temporarily restricted, formally telling them that they are ‘under arrest’ is likely to be counter-productive in that it may:

- Cause the person to feel that their mental health needs are being criminalised thus contributing to stigma
- Increase the person’s agitation and possible resistance to help
- Lead to an increased risk of having to use restraint.

The police officer should ensure that an ambulance has been called.

2. CONVEYANCE FROM PUBLIC PLACE

The preferred option at all times is that a patient should be transported via an ambulance. Police should travel in the ambulance with the person, as police are unable to delegate the authority to convey. A person should only be transported in a police vehicle in exceptional circumstances. These exceptional circumstances might include when the person whose detention is sought, is behaving in a way that might cause serious harm to themselves, is extremely violent, is making threats against others involved in the conveyance process or is causing a serious breach of peace. On the rare occasions that this occurs, the police vehicle should be accompanied

by an ambulance vehicle so that rapid assistance can be provided if a medical emergency arises.

Where an ambulance is requested, police have a responsibility to provide the Ambulance Control with appropriate information in respect of a detainee. Ambulance staff have responsibility for all decisions regarding the clinical treatment of a detainee following their arrival at the location of the detainee.

3. PLACE OF SAFETY

A place of safety is defined in the Order as “any hospital of which the managing Board or HSC Trust is willing temporarily to receive persons who may be taken there under this Order, any police station or any other suitable place the occupier is willing temporarily to receive such persons”.

The Guide contains a list of hospitals that could be used as a place of safety. However this list is now out of date and police should continue to bring persons detained under **Articles 129 and 130** to the local A&E department until further guidance in relation to which hospitals can be used to fulfil this function is provided by Health and Social Care Trusts.

It should not be automatically assumed that because a person is violent, that the police station is an appropriate place to detain them. Violent behaviour may be connected to conditions for which appropriate medical assessment and treatment is required.

A police station should only be used as a ‘place of safety’ in exceptional circumstances and for the minimum length of time possible. By design and functionality, police cells are not suitable for people suffering from a mental disorder and can exacerbate their conditions.



A person moved to a place of safety may be detained there for a period not exceeding 48 hours. Once suitable arrangements have been made, the person can no longer be detained at a police station under **Article 130**.

Where police convey a person to an A & E Department, it will be the responsibility of the relevant Trust to make the necessary arrangements for assessment under the MHO. A person is defined as 'arriving' at a place of safety when their care is formally accepted by a relevant healthcare professional managing that location.

Police Officers bear legal responsibility for the health and safety of this person until a handover has taken place. During the 'handover' period the Trust staff should be able to co-ordinate their staff and obtain all relevant information from the police officer attending.

At the hospital premises, the doctor/medical staff are responsible for the assessment of the detainee and their physical and mental welfare.

For those who have committed an offence, Police will accompany and remain with a detained person during the period that they are removed from the custody unit and remain under arrest and in police custody. The number of police staff present will be determined by police following consultation with hospital healthcare and security staff, as appropriate, and will be sufficient to manage any identified risk to the detainee, police, hospital staff and members of the public.

Police may remain after the handover has taken place if they wish to consider an arrest once the mental health assessment has been completed or because the joint risk assessment has indicated the need for continual police presence due to a medium to high risk of violence or absconding or breach of the peace.

In an event of any disagreement concerning whether police officers shall remain in attendance, this should be resolved by the Hospital Staff and a Police Officer of at least Inspector rank. If issues cannot be resolved, then contact should be made with the Medical Director and appropriate Senior Representative within the PSNI.

Local protocols are required to be developed with the relevant Health Trust or Health & Social Care Board to specify the time period that an officer could reasonably be expected to remain there. These procedures should also specify police actions in respect of a person who is intoxicated and/or exhibiting signs of drug taking.

On police leaving hospital premises, responsibility for the security of the detainee will be retained by hospital security staff. Should a risk of violence by the individual subsequently escalate to a level requiring police intervention, police will be called via 999.

4. TARGET TIMES FOR A MENTAL HEALTH ASSESSMENT

The assessment by the doctor and Approved Social Worker (ASW) should begin as soon as possible after the arrival of the individual at a place of safety. Where specific issues exist, for example the detained person is believed to have consumed alcohol and/or drugs the mental health assessment may be delayed until they are deemed fit to be assessed. A decision as to whether or not a mental health assessment is to be delayed should be made by the ASW in conjunction with the doctor and the police. Police should not remain with the individual unless a joint Risk Assessment states that the person is behaving in a way that might cause serious harm to themselves, is extremely violent, or is making threats against others involved.

If police officers are delayed from being released, this should be brought to the attention of a police officer of at least Inspector rank.

5. POLICE ROLE IN FACILITATING COMPULSORY ADMISSION TO HOSPITAL FOR ASSESSMENT.

There is no legal requirement for police to become involved in the routine management or movement of mentally ill persons. It should be borne in mind that the stigma associated with police involvement may prolong the symptoms of person's mental illness long after treatment interventions have been concluded. Furthermore



the routine presence of police officers at such situations could be considered a breach of the person's right to privacy under **Article 8** of the European Convention on Human Rights.

In most cases, police presence is requested where this process is taking place on private premises (typically the person's home address) and:

- An application for compulsory admission to hospital for assessment has been made; or
- The application process for compulsory admission to hospital for assessment has not yet taken place.

Local protocols should specify that an ASW or a GP should only request police presence at an application for assessment where they have carried out a risk assessment, and the result of that assessment is that the presence of the police is both proportionate and necessary. Police presence may be called where the ASW or GP identifies a significant risk of:

- Violence or the threat of violence being used against those involved in the application for assessment or other persons present
- Self harm by the individual to be assessed
- Entry to the premises being refused and where it is necessary to obtain a warrant issued under **Article 129** of the MHO, authorising a Constable, accompanied by a medical practitioner, to remove the patient to a place of safety

It is for the police to make the decision whether or not to provide a police presence. Where police presence is refused, the circumstances should be thoroughly documented.

6. WARRANTS

There are additional powers under the MHO for an ASW to apply for a Warrant, in order that access to premises is gained using force if necessary and, if necessary, remove that person to a place of safety with a view of detaining them under the MHO.

Where the risk assessment for a non-emergency event indicates that either entry will be refused, or that the process will be obstructed by the behaviour of the person, or other persons, police will require the ASW to apply for an Article 129 warrant. Where an ASW declines to make such an application in relation to a non-emergency event, police should decline to provide assistance. The need for and the use of such warrants are extremely rare, and is not a routine matter in every assessment.

Although in possession of a Warrant, it is preferable to gain consent to enter the premises. Formally serving a warrant may have an adverse impact, given the sensitivities and public perceptions surrounding such situations, and given that the subject may be fearful and/or confused.

When a 129 warrant is executed, it shall be the responsibility of the endorsing police officer to deliver the Warrant to Court Services. Unexecuted warrants will be delivered to Court Services by the ASW.

In emergency situations where there is no time to apply for a Warrant, the circumstances may necessitate recourse to powers of entry to prevent a breach of the peace under Common Law or **Article 19** PACE (NI) Order 1989.

There may be circumstances that delaying action to facilitate an ASW to seek an **Article 129** warrant based upon a presumption of denial of access could leave the individual or others within the household at risk of violence or injury. Police Officers should therefore consider the need to protect others within the household, especially children or other vulnerable adults.



7. POLICE RESPONSE TO AN ASSESSMENT IN PROGRESS

As well as pre-planned police involvement, unforeseen circumstances may occur whereby the ASW/GP/Ambulance personnel consider it necessary to call police to the scene of an assessment in progress. In all such cases, officers in attendance at the scene will be required to carry out a dynamic risk assessment and ensure that any action taken by police is legal, proportionate and necessary. Police will not attend in cases involving a difficult, but non-violent subject whose past history and present diagnosis gives no rise for concern for the safety of other agencies present. Before any police intervention, officers will have due regard for what other options were considered by the ASW/GP/Ambulance personnel in attendance, including the provision of adequate resources to manage the situation.

8. REQUEST FOR POLICE TO ASSIST WITH HOSPITAL PATIENTS WHO PRESENT PARTICULAR MANAGEMENT PROBLEMS

Nothing contained in this section shall compromise the statutory and professional duty of a police officer to protect life and property, preserve order, and to prevent the commission of offences.

The MHO Code of Practice sets out how hospitals can prevent and respond to conduct presenting particular problems of management. It makes no mention of using police to assist in the controlling or restraining of patients. Whilst hospital staff have powers under the MHO to do so, this power does not extend to police officers.

However, healthcare staff should be afforded the same level of protection from violence as any other person, and therefore should feel able to report violence in whatever form it takes to the police, so that appropriate action can be taken. Whilst police may be called to assist hospital staff with in-patients who are receiving treatment or assessment, either as patients detained under the MHO or voluntary patients, they should not be routinely involved in patient management. Only in exceptional circumstances where it is beyond the capability of the hospital staff to manage the situation, and a serious breach of the peace has, or is likely to occur,

will police respond to such situations. In all such cases, officers must ensure that any action taken by police is legal, necessary and proportionate, and that the rights of the patients are preserved.

9. TRANSPORTATION AND ESCORT BETWEEN HOSPITALS

Nothing contained in this section shall compromise the statutory and professional duty of a police officer to protect life and property, preserve order, and to prevent the commission of offences.

There are no general powers under the MHO for police officers to transfer existing detained persons between hospitals.

Requests from Trusts for police involvement based solely upon patient history (e.g. is potentially violent) will be refused. Only in exceptional circumstances, it may be considered proportionate and necessary to provide a police escort during transportation. Such circumstances are cases where there is information to indicate that intervention by the public or other parties may occur, and that this intervention may present:

- A significant danger to the public or Trust staff and/or
- Risk of escape

10. PERSONS WITH A MENTAL DISORDER WHO HAVE ABSCONDED (AWOL)

Persons who are liable to be detained under the MHO, and who are absent without leave, or fail to return within a prescribed period, may be arrested by the police without Warrant, and returned to the relevant hospital. This power exists for 28 days, beginning with their first day of their absence without leave. The person should be informed in simple terms that the return to hospital is under the provisions of the MHO, and that a fuller explanation will be given at the hospital.



Where patients, who are for the time being subject to Guardianship, absent themselves without the leave of their Guardian from a place at which they are required by the Guardian to reside, they may be taken into custody and returned to that place by any constable or other authorised person.

Any person required to be conveyed, kept or detained by virtue of the MHO shall be deemed to be in legal custody. Such a person may be retaken by the person who had custody immediately before the escape, or by a constable, or ASW. 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 expiry of 48 hours, beginning from the time when they escape or the periods during which they are liable to be so detained, whichever expires first.

If the person has absconded from Hospital after Police have left them in the care of Trust staff, then the Trusts bears the legal responsibility for the health and safety of this person.

Persons subject to Part III of the Order

A court may remand an accused person to a hospital for the purpose of reports or treatment. Where such a person absconds, they may be arrested without warrant and brought before the court that remanded them, as soon as practicable.

In certain circumstances, a court may make an 'Interim Hospital Order' which commits a convicted person to hospital for treatment. If an offender absconds from a hospital in which they are detained in pursuance of an Interim Hospital Order, or whilst being conveyed to or from such a hospital, they may be arrested without Warrant, and brought as soon as practicable before the court that made the Order.

11. PATIENT RESTRAINT

If persons are being transferred from a Public Place to a place of safety the Police have the power to use reasonable force, if necessary, in the exercise of powers under **Article 130**. The legal authority for the use of force in the exercise of this power is to be found in Section 3 of the Criminal Law (Act) 1967. Any use of force in these circumstances must be based upon a need to ensure the provision of 'immediate care and control' and must be necessary and proportionate.

If force and/or restraint have been used, the arresting officer should inform clinical staff upon arrival at the place of safety (which is not a police station) and the type of restraint used and for how long.

There is no power under the MHO for police to assist in the controlling or restraining of patients already within Hospital. There is power for Hospital Staff to do so for detained patients.

In circumstances where there is no obvious risk of harm to the patient or others, police officers will not restrain a patient unless they are carrying out an arrest for an offence, e.g. an assault on hospital staff or breach of the peace.

There is also the issue in relation to restraint for 'voluntary' patients. Police officers do not have the powers to restrain under the MHO for voluntary patients. However Common law could allow them – but this is under special conditions.



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THE ROLE OF THE NORTHERN IRELAND AMBULANCE SERVICE

The Northern Ireland Ambulance Service Health & Social Care Trust (NIAS) is the statutory agency tasked with the delivery of an emergency ambulance response across Northern Ireland. This is delivered through a combination of the Accident and Emergency tier which is responsible for emergency and unscheduled response work and the Patient Care Service which undertakes routine and elective transport of patients

Communication and organisation of emergency ambulance responses is handled by the regional Emergency Ambulance Control (EAC) based in Belfast which receives all ambulance 999 calls as well as urgent requests from other healthcare professionals and facilities, while elective transport requests are handled by the Non-Emergency Ambulance Control (NEAC) based in Altnagelvin.

Emergency response work is presently undertaken by HPC-registered paramedics and/or Emergency Medical Technicians who may at times be the first point of contact with the health service for patients with mental health needs, and their roles include:

- Assessment of patients to determine their medical and/or social need including a judgement on the patient's capacity to consent to treatment and an assessment of the risk of harm to the patient or other parties.
- Treatment of patients, including safeguarding of vulnerable patients and those who are deemed to lack the capacity to give or withhold consent.
- Liaison with other appropriate healthcare professionals.
- Transport of patients to appropriate healthcare facility, including the transport of patients subject to formal admission under the Mental Health (Northern Ireland) Order 1986.

Where patients have already been assessed by other healthcare colleagues and an appropriate course of action determined, ambulance staff will observe their professional primacy, and the role of the ambulance service is primarily supportive



in the provision of transport either to or between healthcare facilities. However, during this journey an ambulance crew has a professional responsibility to a patient, and must always act in their best interests. This will include a risk assessment of the proposed method of transporting the patient and in cases where it is believed that there may be a significant risk of flight or harm, the ambulance service may be accompanied by the approved social worker or mental health staff, or in case of a substantial risk of harm or violence they may also request the assistance of the police to mitigate the risk. In acting in best interest of a patient who lacks capacity or is subject to formal admission, they may also apply the legal use of appropriate restraint in order to safeguard a patient.

While Patient Care Service Staff are primarily involved in the elective transport of patients they are trained to render emergency first aid care to any patient and can request backup from colleagues in the emergency tier if required.

ARTICLE 129 MENTAL HEALTH (NORTHERN IRELAND) ORDER 1986 GUIDE AND PROTOCOL RE COMPLAINTS AND WARRANTS

Article 129 of the Mental Health (Northern Ireland) Order 1986 makes provision for **four** different categories of complaints and warrants in relation to persons suffering from or thought to be suffering from a mental disorder within the meaning of the Order.

The criteria and recommended protocol in relation to these is set out below:

Article 129 (1) is concerned with persons, not currently subject to the Order but who, an officer of an authorised Trust believes to be, suffering from a mental disorder and who:

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

PROTOCOL

Article 129 (1) requires an officer (in most cases this will be an approved social worker (ASW) of an authorised Health and Social Services Trust (HSCT) or a PSNI constable to swear a written complaint on oath, outlining the circumstances of the case, to a Magistrate/lay magistrate¹. **LINK TO Article 129 (1) Complaint**

The written complaint should include the name of the person if this is available (**Article 129 (6)** directs that it is not necessary to name the person concerned in this particular warrant), the address of the premises where the person is believed to be and a brief outline of the basis to the suspicion that the person meets the criteria.

¹ The Officer of the Health and Social Care Trust should choose a Magistrate/lay magistrate from a list provided by the Northern Ireland Courts Service for that area.



The officer of the Trust should ensure that a copy of the complaint is left with the lay magistrate and another is retained for agency records.

The Magistrate/lay magistrate may in turn issue a warrant authorising a PSNI constable, accompanied by a medical practitioner, to enter the premises using force if necessary and, if necessary, remove the person to a place of safety with a view of making an application for assessment under Part II of the Order or to make other arrangements for the person's care or treatment. **LINK TO Article 129 (1) Warrant**

The officer of the Trust should ensure that the warrant is correctly completed, leave two copies with the lay magistrate, retain another for agency records and deliver the original to the PSNI in the area where the person, subject to **Article 129 (1)** is located.

The officer should, if necessary, offer advice to the PSNI regarding arrangements for the service of the warrant including the requirement for a medical practitioner to be present.

Following entry the medical practitioner can assess whether or not the person requires to be removed to a place of safety or if other arrangements need to be made for the person's care or treatment.

Article 129 (1) does not require an Approved Social Worker (ASW) or other officer of the Trust to be present when the warrant is served. However, if an ASW is involved and the person is willing to allow the ASW or other worker to enter the premises, a joint assessment with the medical practitioner of the person's needs can take place on the premises identified in the Warrant. If an ASW is present and if considered necessary, the patient can, on completion of **Forms 2** and **3**, be transported for admission to hospital.

If the person is unwilling to allow the ASW to enter the premises and if the medical practitioner considers that a medical recommendation (**Form 3**) should be completed for the person's admission to hospital for assessment, the person can be removed to

a place of safety where an ASW will undertake an assessment in relation to making an application (**Form 2**) under Part II or to allow for other arrangements to be made for his care and treatment.

In this Article “**place of safety**” means any hospital², of which the managing Trust is willing temporarily to receive persons who may be taken there under this order, any police station³, or any other suitable place the occupier is willing temporarily to receive such persons.

The patient may be detained in the place of safety for a period not exceeding **48 hours**. The Guide states that patients should be kept in places of safety for as short a time as possible while other arrangements are made for their care are made. A police station should only be used as a place of safety in exceptional circumstances and for the minimum length of time necessary.

If the warrant is served, it shall be the responsibility of the endorsing police officer to deliver the Warrant to Court Services. If not served the ASW and PSNI should consider whether or not it should be retained in the event that it may be used within 28 days. The Warrant cannot be used after 28 days on which the warrant was signed. Unexecuted warrants should be delivered to Court Services by the ASW.

Article 129 (2) is concerned with patients who are absent without leave from the hospital where they are liable to be detained or from the place where they are required to be. This includes:

- (a) A patient subject to detention who leaves the hospital without leave granted under **Article 15**; or
- (b) A patient who fails to return to hospital within the time period granted under **Article 15**; or

2 The Guide contains a list of hospitals that could be used as a place of safety. However this list is now out of date and police should continue to bring persons detained under Articles 129 and 130 to the local A&E department until further guidance in relation to which hospitals can now be used to fulfil this function is provided by Health and Social Care Trusts.

3 The most appropriate and available place of safety should be carefully considered by the police officer/s involved and should take account of any risks to the person and to others.



- (c) A patient who leaves, without permission, any place where he was required to reside under the conditions of leave; or
- (d) A patient subject to guardianship who leaves, without permission of his guardian, any place where he was required to reside by the guardian.

In the case of (a) to (c) **Article 29** allows for these patients to be taken into custody and returned to the hospital or place where the patient was required to reside by any officer on the staff of the hospital, any PSNI constable or approved social worker or any person authorised in writing by the responsible authority.

Article 29 also allows for patients subject to guardianship (d), to be taken into custody and returned to the place where they were required by the guardian to reside by any constable or ASW or by any person authorised in writing by the guardian or by the responsible authority.

However if any of the above persons authorised under **Article 29** are unable to gain entry to the premises where the patient is thought to be, **Article 129 (2)** allows for a lay magistrate to issue a warrant allowing a constable accompanied by a medical practitioner to enter the premises, if need be by force and to remove the patient to the hospital or place where he was required to reside.

The criteria for **Article 129 (2)** are:

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

PROTOCOL

Article 129 (2) requires an officer of an authorised Health and Social Services Trust (HSCT) or a PSNI constable to swear a written complaint on oath, outlining the circumstances of the case, to a Magistrate/lay magistrate (see footnote page 1).

LINK TO Article 129 (2) Complaint

This will include the name and address of the premises where the patient is believed to be and the basis of the belief that the person is liable to be removed from the premises under this article, i.e. the criteria above is satisfied.

The officer of the Trust should ensure that a copy of the complaint is left with the Magistrate/lay magistrate and another retained for agency records.

The Magistrate/lay magistrate may in turn issue a warrant authorising a PSNI constable, accompanied by a medical practitioner, to enter the premises using force if necessary and to remove the patient to the place where he is required to be under the Order. **LINK TO Warrant 129 (2)**

The Officer of the Trust should ensure that the warrant is correctly completed, leave two copies with the Magistrate/lay magistrate, retain another for agency records and deliver the original to the PSNI in the area where the person, subject to **Article 129 (2)** is located.

The officer should, if necessary, offer advice to the PSNI regarding arrangements for the warrant to be served including the requirement for a medical practitioner to be present. **Article 129 (2)** does not require that an ASW or officer of the Trust to be present when the warrant is served.

If the Warrant is executed (i.e. served), it shall be the responsibility of the endorsing police officer to deliver the Warrant to Court Services officer. If not served the Trust or the PSNI should agree to retain the Warrant in the event that it may be used within 28 days.



The Warrant cannot be used after 28 days on which the warrant was signed.

N.B. Article 29 directs that a person subject to detention or to guardianship under Part II of the Order shall not be taken into custody after the expiration of the period of 28 days beginning with the first day of his absence without leave.

Article 129 (3) is concerned with patients liable to be detained under the Mental Health Act 1983 or Mental Health (Care and Treatment) (Scotland) Act 2003 but does not apply to any person subject to guardianship under these legislative Acts.

The Criteria for **Article 129 (3)** is:

- (a) That there is reasonable cause to believe that a person who may be taken into custody by virtue of the Mental Health Act 1983, amended by the Mental Health Act 2007 or Mental Health (Care and Treatment) (Scotland) Act 2003 is to be found on any premises; and
- (b) That admission to the premises has been refused or that a refusal of such admission is apprehended.

PROTOCOL

Article 129 (3) requires an **ASW** authorised to act in the Trust area in which the patient is currently to be found or a PSNI constable to swear a written complaint on oath, outlining the circumstances of the case, to a Magistrate/lay magistrate (see footnote page 1). This will include the name and address of the premises where the patient is believed to be and the basis of the belief that the person is liable to be removed from the premises under this article, i.e. the criteria above is satisfied. **LINK TO Article 129 (3) Complaint**

The officer should ensure that a copy of the complaint is left with the Magistrate/lay magistrate and another is retained for agency records.

The Magistrate/lay magistrate may in turn issue a warrant authorising a PSNI constable, accompanied by a medical practitioner, to enter the premises using force if necessary and to remove the patient to the hospital where he / she is required to be under the Mental Health Act 1983, amended by the Mental Health Act 2007, or Mental Health (Care and Treatment) (Scotland) Act 2003. **LINK TO Warrant 129 (3)**

The officer of the Trust should ensure that the warrant is correctly completed, leave two copies with the lay magistrate, retain another for agency records and deliver the original to the PSNI in the area where the person, subject to **Article 129 (3)** is located.

The officer should, if necessary, offer advice to the PSNI regarding arrangements for the warrant to be served including the requirement for a medical practitioner to be present. **Article 129 (3)** does not require that an ASW or officer of the Trust to be present when the warrant is being served.

If the Warrant is executed (served), it shall be the responsibility of the endorsing police officer to deliver the Warrant to Court Services. If not served the Trust or the PSNI should agree to retain the Warrant in the event that it may be used within 28 days. Unexecuted warrants will be delivered to Court Services by the ASW.

The Warrant **cannot** be used after 28 days on which the warrant was signed.

Article 129 (4) is concerned with those patients for whom an application for admission has been completed but it has not been possible for the applicant to convey or acquire the necessary assistance to convey the patient to hospital.

The Criteria for **Article 129 (4)** are:

- (a) The application has been duly completed in accordance with Part II;
- (b) There is reasonable cause to believe that the patient is to be found on any premises;



- (c) 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 him; and
- (d) That the responsible authority has been requested to do so but has failed to do so.

PROTOCOL

Article 129 (4) requires that the applicant, i.e. nearest relative or authorised approved social worker swear a written complaint on oath, outlining the circumstances of the case, to a Magistrate/lay magistrate (see footnote page 1). This will include the name of the patient and address of the premises where the patient is to be found. **LINK TO Article 129 (4) Complaint**

If the applicant is the nearest relative who has requested assistance from an ASW, the ASW should guide and support the nearest relative in exercising their powers under this Article.

The Magistrate/lay magistrate may in turn issue a warrant authorising a PSNI constable, accompanied by a medical practitioner, to enter the premises, if need be by force and to convey the patient to the hospital specified in the application. **LINK TO Warrant 129 (4)**

If the applicant is the ASW they should ensure that the warrant is correctly completed, leave two copies with the Magistrate/lay magistrate, retain another for agency records and deliver the original to the PSNI in the area where the person, subject to **Article 129 (4)** is located.

The officer should, if necessary, offer advice to the PSNI regarding arrangements for the warrant to be executed including the requirement for a medical practitioner to be present. **Article 129 (4)** does not require that the applicant (an ASW or nearest relative) or an officer of the Trust be present when the warrant is served.

However the Code of Practice requires the ASW to assist the nearest relative, on request, in conveying the patient to hospital and if the ASW is the applicant he/she has a professional responsibility for ensuring that all necessary arrangements are made for the patient's conveyance and admission to hospital.⁴

Article 8 of the Order requires that the patient is taken and conveyed to the hospital specified in the application at any time within the period of two days beginning with the date on which the medical recommendation was signed or a longer period (not exceeding 14 days) as stated in **Form 4** (Medical Certificate to Extend Time Period For Conveying Patient to Hospital). Therefore the exercise of the Warrant in relation to **Article 129 (4)** is limited to the above time periods.

When a 129 warrant is executed, it shall be the responsibility of the endorsing police officer to deliver the Warrant to Court Services. Unexecuted warrants will be delivered to Court Services by the ASW.

⁴ Article 8 of the Order requires that the patient is taken and conveyed to the hospital specified in the application at any time within the period of two days beginning with the date on which the medical recommendation was signed or a longer period (not exceeding 14 days) as stated in Form 4 (Medical Certificate to Extend Time Period For Conveying Patient to Hospital). Therefore the exercise of the Warrant in relation to Article 129 (4) is limited to the above time periods.



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APPENDIX: CONSENT TO TREATMENT

What does 'consent to treatment' mean?

Consent to treatment is a patient's agreement for a health professional to provide a particular form of treatment. For consent to be valid, the patient must:

- Have received sufficient information to make that decision;
- Have the mental capacity to make it;
- Not be acting under duress.

What does 'mental capacity' mean?

Mental capacity relates to an individual's ability to make a particular decision. In England and Wales there is a statutory Mental Capacity Law that does not apply in Northern Ireland, but is guiding good practice.

What factors should be considered when assessing a person's decision-making capacity?

The assessment of decision-making capacity is a matter of clinical judgment guided by current professional practice and subject to legal requirements. To demonstrate capacity the patient should be able to:

- Understand in simple language what the proposed treatment is, its purpose and why it is being proposed;
- Understand the main benefits, risks and possible alternatives, and the consequences of not receiving the proposed treatment;
- Retain the information for a sufficient period of time in order to consider it and arrive at a decision;
- Communicate the decision.



When seeking a person's consent to treatment, what information should that person receive?

There is an obligation on the treating healthcare professional to ensure that the person fully understands the nature, purpose and likely effects of the proposed treatment. Any misrepresentation of these elements will invalidate consent.

Information should be presented in a way that is easiest for the person to understand, for example, by using simple language or visual aids. A support worker, interpreter, speech and language therapist, family member, or advocate may help with communication.

In considering what information to provide, the healthcare professional should try to ensure that the person is able to make a balanced judgement on whether to give or withhold consent. It must be tailored to an individual's needs and abilities. It is advisable to inform the person of any 'material' or 'significant' risks in the proposed treatment, any alternatives to it and the risks incurred by doing nothing. If the patient asks specific questions about the treatment and associated risks, these should be answered truthfully.

Some individuals may wish to know very little about the treatment or care that is being proposed. If information is offered and declined, it is good practice to record this fact in the notes. However, it is possible that individuals' wishes may change over time and it is important to provide opportunities for them to express this.

In the very rare event that the health or social care professional believes that to follow this guidance in full would have a deleterious effect on the person's health or well being, this view, and the reasons for it, should be recorded in the patient's notes. When such concerns arise it is advisable to discuss the issue within the team caring for the individual. The mere fact that the person might become upset by hearing the information, or might refuse treatment or care, is not sufficient to act as a justification.

How can you ensure consent is given voluntarily?

To be valid, consent must be given voluntarily and freely, without pressure or undue influence being exerted on the person either to accept or refuse treatment or care. Such pressure can come from partners or family members as well as health or social care professionals. Professionals should be alert to this possibility and where appropriate should arrange to see the person on their own to establish that the decision is truly theirs.

When individuals are seen and treated in a setting such as a prison or psychiatric hospital where involuntary detention may be an issue, there is a potential for offers of treatment or care to be perceived as coercive, whether or not this is the case. Coercion invalidates consent and care must be taken to ensure that the individual makes a decision freely.

Coercion should be distinguished from providing the individual with appropriate reassurance concerning their treatment or care, or pointing out the potential benefits of treatment or care for the person's health or well-being. However, threats such as withdrawal of any privileges or loss of remission of sentence for refusing consent, or using such matters to induce consent are not acceptable.

Acquiescence, where the person appears to agree but does not fully understand what the treatment entails, is not valid consent. This may be a particular issue for people with a learning disability which staff should be alert to and take measures to avoid.



Is good practice guidance available for Northern Ireland?

Good practice guidance is available for Northern Ireland:

Guide to Consent for Examination, Treatment or Care (2003). Department of Health, Social Services and Public Safety. **LINK TO Guide to Consent for Examination, Treatment or Care (2003)**

Further detailed guidance for children, older people, people with learning disabilities, prisoners and other detainees, is available in different languages at **http://www.dhsspsni.gov.uk/public_health_consent**

These Consent Guides for Healthcare Professionals include:

- **LINK TO HSS (MD) 7/2003 Circular: Good Practice in Consent (PDF File)**
- **LINK TO Reference Guide to Consent for Examination, Treatment or Care (PDF File)**
- **LINK TO Good practice in consent: Implementation guide for health care professionals (PDF File)**
- **LINK TO Good practice in consent: Desk Aid 12 Key Points on Consent (PDF File)**
- **LINK TO Seeking Consent: Working with children (PDF File)**
- **LINK TO Seeking Consent: Working with older people (PDF File)**
- **LINK TO Seeking Consent: Working with people with learning disabilities (PDF File)**
- **LINK TO Seeking Consent: Working with prisoners and other detainees (PDF File)**

Consent Guides for Social Workers, Social Care Staff and Students:

- **[LINK TO Consent in Social Care \(PDF File\)](#)**
- **[LINK TO Good Practice in Consent - Social Work Students \(PDF File\)](#)**

Patient Information Leaflet

- **[LINK TO Consent - it's up to you \(PDF File\)](#)**
- **[LINK TO Consent - it's up to you - Cantonese Translation \(PDF File\)](#)**
- **[LINK TO Consent - it's up to you - Mandarin Translation \(PDF File\)](#)**
- **[LINK TO Consent - it's up to you - Irish Translation \(PDF File\)](#)**

Consent - What you have a right to expect - Guides for

- **[LINK TO Adults \(PDF File\)](#)**
- **[LINK TO Parents \(PDF File\)](#)**
- **[LINK TO Children and young people \(PDF File\)](#)**
- **[LINK TO People with learning disabilities \(PDF File\)](#)**
- **[LINK TO Relatives and Carers \(PDF File\)](#)**



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APPENDIX: SCRUTINY AND RECTIFICATION OF DOCUMENTS

The Forms used in the assessment, detention, consent to treatment and guardianship processes under the Mental Health (Northern Ireland) Order 1986 provide legal justification for those actions taken under the Order.

The errors or defects in an application for assessment, the medical recommendation on which it is based, or in one of the medical reports may mean that the authority for the detention of the person is open to challenge and could be found to be invalid.

Those who complete and sign applications, medical recommendations and reports should therefore take care that they are accurate and fully comply with the requirements of the Order. In addition, those with responsibility for receiving and taking action on the basis of these forms should also ensure that they have been properly completed.

Trusts should make arrangements, usually through their Medical Records departments, to ensure that all documents are carefully scrutinized as soon as they are received, and before they are issued to RQIA.

As part of their role in safeguarding the rights of individuals subject to the Order, RQIA receives copies of all documents and has a duty to ensure that no patient is improperly detained. It will therefore draw immediate attention to any defects observed in documentation and will require appropriate action to be taken.

Can the Mental Health (Northern Ireland) Order 1986 forms be amended?

Yes, **Article 11** of the Order details circumstances under which documents found to be inaccurate or defective can be rectified after they have been acted on.



Faults fall under 3 categories:

- Those which invalidate the application completely and cannot be rectified
- Those which may be capable of amendment under **Article 11**.
- 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**.

Which faults would completely invalidate an application?

Documents that are left incomplete, not signed or signed by a person, who is not empowered to do so, can invalidate an application. Therefore in relation to an admission for assessment under the Order:

- The application must have been signed by the person's nearest relative or acting nearest relative, or by an approved social worker
- A practitioner who is not excluded under Schedule 1 of the Order must sign the medical recommendation
- The medical reports must be signed by practitioners who are empowered to do so.

If a fault of this kind is discovered in the documents there is no proper authority for the person's detention unless steps are taken for a new application to be made.

Under what circumstances may documents be amended?

If, within a period of 14 days from the date of admission, the application for assessment, medical recommendation or any of the medical reports is found to be incorrect, they may be amended by the person who originally signed them within the same 14-day period and with the consent of the Trust.

Faults that may be amended include the leaving of blank spaces on the form (other than the signature), or failure to delete one or more alternatives in places where only one can be correct.

The person's forenames and surname should agree in all places where they appear in the application, the supporting medical recommendation and subsequent medical reports.

Any amendment carried out as stated is considered to have always had effect.

How are medical recommendations or reports amended?

In addition to the scrutiny of Forms for errors of a technical nature, medical recommendations and reports will be checked to ensure that clinical details and reasons given to support expressed opinions, meet the requirements of the Order.

If during the same 14-day period it appears that the medical recommendation or any of the medical reports are insufficient to warrant the detention of the person they will be disregarded and RQIA will inform the Trust immediately.

The applicant (nearest relative or approved social worker) must be notified of this fact in writing by the Responsible Trust, which will delegate the role to a Medical Records staff member. The application for assessment will, however, be considered sufficient if a fresh recommendation or report that complies with the provisions of the Order is supplied to the responsible Trust within 14 days of the patient's admission.

In some cases it may be acceptable for the fresh medical recommendation (**Form 3**) to be made by another doctor on the staff of the hospital, provided he did not complete the **Form 7**.



Time Limits - Why are they important?

As soon as documents are received by Medical Records staff compliance with stipulated time limits will be checked. RQIA will also perform compliance checks on the time limits once the forms are forwarded to them.

These include:

1. The date on which the applicant last saw the person must not be more than 2 days before the date on which the application is made
2. The date of the medical examination of the person by the doctor giving the medical recommendation must not be more than 2 days before the date on which the recommendation is signed
3. The person's admission to hospital must take place within 2 days of the medical recommendation being signed
4. The person must be examined immediately after admission to hospital and a **Form 7** completed
5. The **Form 8** must be signed no more than 48 hours after the **Form 7** is signed
6. The **Form 9** must be signed no more than 7 days after the **Form 7** is signed

If the dates on the application, medical recommendation or medical report do not conform to these time limits, the persons signing them will be asked to clarify whether dates or times entered are correct.

If they are not correct, and the correct dates or times do conform to the time limits, they can be amended as per **Article 11** (see above). If the time limits have not been complied with the application is invalid.

Similar processes of scrutiny are in place in relation to the forms used in Consent to Treatment (Part IV) and Guardianship.

CASE LAW

Those carrying out duties and responsibilities under the Mental Health (Northern Ireland) Order 1986 must ensure that they do so in compliance with the legislation (Statute Law) and must also take account of relevant case law.

Case law can be defined as the body of law that has been established by the higher courts and provides practitioners with guidance and helpful clarification of legislation.

A selection of relevant case law is set out below. Please note, this is not exhaustive list. We recommend, if you have any specific queries in relation to any of the cases mentioned, that you read the case in more detail or alternatively seek assistance from your legal advisor.

Re JR 45 Application (2011) NIQB 17 – *substantial risk of serious physical harm (psychological Vs physical)*

Re AN Application by JR50 for Leave to Apply for Judicial Review Neutral Citation No:[2011] NIQB 43 TRE8176 – *Limits on the power of guardianship*

Re JR49 (Application for Judicial Review) (2011) NIQB 41 – *The order authorising removal from a hospital in NI to a hospital in England pursuant to MHA 1983 s82 was quashed.*

Re WEAL4810. An Application by JR18 (MENTAL HEALTH) 2007 for Judicial Review – Consent to Treatment

In the Matter of an Application by HM Secretary of State for Northern Ireland for Judicial Review. Neutral Citation no. [2006] NIQB 94 DEE B4732

SSNI, Re Judicial Review (Oswald Brown) (2006) NIQB 94 – *It was lawful for the hunger-striking prisoner, who lacked capacity, to be given nutrition.*

Re BS (2009) NIFam 5 STE7418 – *A medical examination of BS in the context of an application for a Controller to be appointed in respect of her affairs would not breach **Article 8** and should take place.*

Magowan, Re Judicial Review (2009) NIQB 6 – *Unsuccessful judicial review of failure of social services to make arrangements which would have allowed discharge from hospital.*

X's Application (2008 – J Gillen) – *Tribunal Decisions and reasons given. 'Containment' vs 'Detention'*

X's Application No2: Judicial Review (2009) NIQB 2 – STE7349 – *Based on the general legislative purpose underlying Article 77(2) Mental Health (NI) Order 1986 and the constitutional principle in favour of liberty, the MHRT in Northern Ireland does not have the power to direct the discharge of an unrestricted patient at a future date where there is a mandatory duty to discharge the patient; a deferred discharge is only lawful for a discretionary discharge*

R v Warwick (2008) NICC 42 – *As the **Mental Health (Northern Ireland) Order 1986** does not allow detention for personality disorder, the risks in this case could only be addressed by the imposition of a discretionary life sentence (which would be followed by a transfer to Carstairs) rather than a hospital order.*

McGrady, Re Application for Judicial Review (2003) NIQB 15 – *(1) The ability to disclose material to the representative on condition that it was not revealed to the patient was compatible with the Convention (obiter, since no decision had been taken on this yet). (2) The medical member's role is to form a provisional view on the patient's mental condition, rather than on the statutory criteria, and he discloses his conclusion during the hearing; if this approach is taken then there is no violation of **Article 5**.*

Re: MW (Mental Health) Re Application for Judicial Review by (2008) NIQB WEAH4847 – *role of medical member.*

McGee, Re Judicial Review (2007) NICA 38 – *The detention of the claimant under Article 7 of the Mental Health (NI) Order 1986 (similar to s5(2) MHA 1983) following a MHRT decision to discharge was lawful: (1) the authorities had formed the bona fide opinion that his mental state had since deteriorated; (2) Article 7 applied since the claimant had not divested himself of his in-patient status.*

R v Francis (2008) NICA 6 – *Both hospital orders to which the claimant was subject were quashed, on the basis that when sentenced he had not been suffering from severe mental impairment as defined in the Mental Health (Northern Ireland) Order 1986.*

Re An Application by D H for Judicial Review (2004) NIQB WEAC5119 – *Definition of Severe impairment of Intelligence (often informally referred to as the Mr Justice Weatherup Judgement).*

Re An Application by N&WBHSST for Judicial Review (2003) – *Severe Impairment of Intelligence and Social Functioning.*

Re: Connor, Re An Application for Judicial Review [2004] NICA 45, CA – *need to satisfy requirement of proportionality when limiting a fundamental right – Article 8 ECHR.*

OTHER RELEVANT CASE LAW INCLUDES:

Re: Nearest Relative

Re Winterwerp v Netherlands 6301/73 (1979) ECHR 4 – *Except in emergency cases, the individual concerned should not be deprived of his liberty unless he has been reliably shown to be of 'unsound mind'. The very nature of what has to be established before the competent national authority – this is, a true mental disorder*

– calls for objective medical expertise. Further, the mental disorder must be of a kind or degree warranting compulsory confinement. What is more, the validity of continued confinement depends upon the persistence of such a disorder.

Re: 'Bournewood' HL v United Kingdom – (ECHR - 2004) - Deprivation of liberty of person lacking capacity.

R (IH) v SSDH (2001) EWHC Admin 1037 – Section 73 Mental Health Act 1983 is compatible with Article 5 ECHR: Deferred discharge is a provisional decision; the Tribunal can monitor progress and reconsider and amend the decision if appropriate.

R (E) v Bristol City Council (2005) EWHC 74 (Admin) – Section 11 and practicability of informing Nearest Relative.

Re Briscoe (habeas corpus) (1998) EWHC Admin 771 – “The essence of consultation is the communication of a genuine invitation to give advice and genuine consideration of that advice.” Merely informing the NR of s3 admission would not suffice for the purposes of s11(4).

DP v South Tyneside DC (2011) Admin Court 14/7/11 – It was not practicable to consult the nearest relative because (1) DP was perceived to be potentially at risk from him (forced marriage/death) and (2) consultation was not possible without disclosing DP's location (the duty of consultation not being one of mere notification): therefore the application for habeas corpus was refused.

CX v A Local Authority (2011) EWHC 1918 (Admin) – A writ of habeas corpus was granted: (1) there had not been sufficiently informed consultation with the nearest relative before the s3 application was made; (2) the withdrawal of the nearest relative's objection was not full and effective, since it was the result of the incorrect and misleading advice that she could not maintain the objection without legal representation. [Judgment originally published under a different name.]

Re D (mental patient: nearest relative) (1999) MHLR 181 – The approach to whether a relative “cares for” a patient so as to become their nearest relative by reason of s26 (4) Mental Health Act 1983 involves the provision of more than minimal care services; the social worker’s decision as to who “appears to be” the nearest relative for the purposes of consultation under s11 (4) of the Act has to involve an acceptable approach to the question of who is the nearest relative but did not require the making of enquiries (unless it would be irrational not to make enquiries). [MHLR.]

CV v South London and Maudsley NHS Foundation Trust (2010) EWHC 742 (Admin) – (1) In cases involving consultation under s11(4), the AMHP is to be judged according to the circumstances as they appear to her at the time. (2) Given that the AMHP believed (albeit wrongly) that 7 hours remained of the s5 (2) detention, the decision not to consult the nearest relative on the ground that it “would involve unreasonable delay” was unlawful. (3) It was inappropriate for the AMHP (the applicant) to assume, based on a previous consultation, that the NR would not object. (4) Subsequent rectification under s15 (1) could not be relied upon in the circumstances of this case.

Ex Parte Smyth R v MHRT for South Thames Region (1998) – *Nature & Degree*

CM v DHNHSFT and Secretary of State (Justice) [2011] UKUT 129 (AAC) – Mental Health Review Tribunal, nature and degree must be read separately, currency of mental disorder.

Savage v South Essex Partnership NHS Foundation Trust (2008) UKHL 74 – Article 2 ECHR imposes, in addition to general obligations, a further “operational” obligation on health authorities and their hospital staff: if members of staff know or ought to know that a particular patient presents a real and immediate risk of suicide, they must do all that can reasonably be expected to prevent the patient from committing suicide.

REFERENCES AND RESOURCES

LEGISLATION

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[LINK TO The Mental Health Northern Ireland\) Order 1986](#)

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[LINK TO Human Rights Act 1998](#)

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[LINK TO Children Order \(Northern Ireland\) Order 1995 and amendments](#)

Personal Health and Social Services Order (Northern Ireland) 1972 –
and amendments

**[LINK TO Personal Health and Social Services Order \(Northern Ireland\) 1972 – and
amendments](#)**

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Ordinarily Resident Regulations (Northern Ireland) 2005

**[LINK TO Health and Personal Social Services Provision of Health Services to Persons
not Ordinarily Resident Regulations \(Northern Ireland\) 2005](#)**

Northern Ireland Act 1998

[LINK TO Northern Ireland Act 1998](#)

The Race Relations (Northern Ireland) Order 1997

[LINK TO The Race Relations \(Northern Ireland\) Order 1997](#)

Sexual Offences (Northern Ireland) Order 2009

[LINK TO Sexual Offences \(Northern Ireland\) Order 2009](#)

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LINK TO Guardianship under the Mental Health (Northern Ireland) Order 1986 – A Model for Operation 2008

HEALTH AND SOCIAL CARE TRUST DETAILS

List of Trust Headquarters Addresses

LINK TO List of Trust Headquarters Addresses

ASW Contacts List

LINK TO ASW Contacts List

SERVICE USER/PATIENT/NEAREST RELATIVE INFORMATION

Patient Information Leaflet (Customised for Belfast Health and Social Care Trust leaflet)

[LINK TO Patient Information Leaflet](#)

Nearest Relative Information Leaflet (Customised for Belfast Health and Social Care Trust leaflet)

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Guidance MHRT Guardianship Social Circumstances Report

[LINK TO Guidance for MHRT Social Circumstances Report Guardianship](#)

Pro-Forma MHRT Detained Patient Social Circumstances Report

[LINK TO Pro-Forma MHRT Detained Patient Social Circumstances Report](#)

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[LINK TO Guidance for MHRT Social Circumstances Report concerning patients subject to detention in hospital](#)

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[LINK TO Tribunals Mental Health Review Guide for Patients](#)

OFFICE OF CARE AND PROTECTION

Article 107 referral form (the Office of Care and Protection's Form 1)

[LINK TO Article 107 referral form \(the Office of Care and Protection's Form 1\)](#)

Medical Certificate (A5)

[LINK TO Medical Certificate \(A5\)](#)

OCP Article 107 Checklist

[LINK TO OCP Article 107 Checklist](#)

Dealing with the Financial Affairs of the Mentally Ill

[LINK TO Dealing with the Financial Affairs of the Mentally Ill](#)



CONSENT TO TREATMENT

The ECT Handbook. The Royal College of Psychiatrists 2005

LINK TO The ECT Handbook, The Royal College of Psychiatrists 2005

Guide to Consent for Examination, Treatment or Care (2003). Department of Health, Social Services and Public Safety.

LINK TO Guide to Consent for Examination, Treatment or Care (2003)

Good practice in consent: Implementation guide for health care professionals

LINK TO Good practice in consent: Implementation guide for health care professionals (PDF File)

Good practice in consent: Desk Aid 12 Key Points on Consent

LINK TO Good practice in consent: Desk Aid 12 Key Points on Consent (PDF File)

Seeking Consent: Working with children

LINK TO Seeking Consent: Working with children (PDF File)

Seeking Consent: Working with older people

LINK TO Seeking Consent: Working with older people (PDF File)

Seeking Consent: Working with people with learning disabilities

LINK TO Seeking Consent: Working with people with learning disabilities (PDF File)

Seeking Consent: Working with prisoners and other detainees

LINK TO Seeking Consent: Working with prisoners and other detainees (PDF File)

Consent Guides for Social Workers, Social Care Staff and Students:

Consent in Social Care

LINK TO Consent in Social Care (PDF File)

Good Practice in Consent - Social Work Students

[LINK TO Good Practice in Consent - Social Work Students \(PDF File\)](#)

Patient Information leaflet

Consent - it's up to you

[LINK TO Consent - it's up to you \(PDF File\)](#)

Consent - it's up to you - Cantonese Translation

[LINK TO Consent - it's up to you - Cantonese Translation \(PDF File\)](#)

Consent - it's up to you - Mandarin Translation

[LINK TO Consent - it's up to you - Mandarin Translation \(PDF File\)](#)

Consent - it's up to you - Irish Translation

[LINK TO Consent - it's up to you - Irish Translation \(PDF File\)](#)

Consent - What you have a right to expect - Guides for

Adults

[LINK TO Adults \(PDF File\)](#)

Parents

[LINK TO Parents \(PDF File\)](#)

Children and young people

[LINK TO Children and young people \(PDF File\)](#)

People with learning disabilities

[LINK TO People with learning disabilities \(PDF File\)](#)

Relatives and Carers

[LINK TO Relatives and Carers \(PDF File\)](#)



PRACTICE GUIDANCE

ASW/Social Work Recording

Guidance for Approved Social Workers – Assessment for Admission. 2010

LINK TO Guidance for ASW Assessment for Admission

ASW MHO A Proforma

LINK TO MHO A

ASW Report Pro-forma and Guidance MHO B.

LINK TO Pro-Forma MHO B

ASW Report Pro-forma and Guidance MHO B.

LINK TO Guidance ASW Report MHO B

Proforma MHO C (Second ASW)

LINK TO MHO C

Pro-forma for Social Circumstances Report (MHO D) and Guidance

LINK TO Pro-Forma MHO D

Social Circumstances Report Pro-Forma and Guidance (MHO D) (Article 5)

LINK TO Guidance Article 5 Social Circumstances Report

Guidance MHRT Guardianship Social Circumstances Report

LINK TO Guidance MHRT Guardianship Social Circumstances Report

Pro-Forma MHRT Guardianship Social Circumstances Report

LINK TO Pro-Forma MHRT Guardianship Social Circumstances Report

Pro-Forma MHRT Detained Patient Social Circumstances Report

LINK TO Pro-Forma MHRT Detained Patient Social Circumstances Report

Guidance MHRT Detained Patient Social Circumstances Report

LINK TO Guidance for MHRT Social Circumstances Report concerning patients subject to detention in hospital

Medical Reports

MHRT Guidance for Medical Report

LINK TO Guidance for Medical Report

FORMS

Prescribed Forms

These are the legal forms used to record and justify the use of statutory powers under the Mental Health (Northern Ireland) Order 1986.

- | | |
|----------------|--|
| Form 1 | Application by Nearest Relative For Admission for Assessment |
| Form 2 | Application by an Approved Social Worker For Admission for Assessment |
| Form 3 | Medical Recommendation For Admission for Assessment |
| Form 4 | Medical Certificate To Extend Time Limit For Conveying Patient To Hospital |
| Form 5 | Medical Practitioner's Report on Hospital In-Patient Not Liable To Be Detained |
| Form 6 | Nurse's Record in Respect of Hospital In-Patient Not Liable To Be Detained |
| Form 7 | Report of Medical Examination Immediately After Admission For Assessment |
| Form 8 | Extension of Assessment Period From 48 Hours to 7 Days – Medical Report |
| Form 9 | Medical Report to Extend Assessment Period For a Further 7 Days |
| Form 10 | Medical Report For Detention For Treatment |



Form 11	Report By Responsible Medical Officer For Renewal of Authority For Detention For 6 Months or One Year
Form 12	Joint Medical Report For First Renewal of Authority For Detention For One Year
Form 13	Guardianship Application By Nearest Relative
Form 14	Guardianship Application By Approved Social Worker
Form 15	Joint Medical Recommendation For Reception Into Guardianship
Form 16	Medical Recommendation For Reception Into Guardianship
Form 17	Recommendation By An Approved Social Worker For Reception Into Guardianship
Form 18	Report By Responsible Medical Officer For Renewal Of Authority for Guardianship
Form 19	Report by Approved Social Worker for Renewal of Authority For Guardianship
Form 20	Assignment of Functions By Nearest Relative
Form 21	Certificate of Consent to Treatment and Second Opinion
Form 22	Certificate of Consent to Treatment
Form 23	Certificate of Second Opinion
Form 24	Medical Report on Patient Removed to Northern Ireland

LINK TO FORM 1

LINK TO FORM 3

LINK TO FORM 5

LINK TO FORM 7

LINK TO FORM 9

LINK TO FORM 11

LINK TO FORM 13

LINK TO FORM 15

LINK TO FORM 17

LINK TO FORM 19

LINK TO FORM 21

LINK TO FORM 23

LINK TO FORM 2

LINK TO FORM 4

LINK TO FORM 6

LINK TO FORM 8

LINK TO FORM 10

LINK TO FORM 12

LINK TO FORM 14

LINK TO FORM 16

LINK TO FORM 18

LINK TO FORM 20

LINK TO FORM 22

LINK TO FORM 24

Non-Pre scribed (Internal) Forms

These are the forms used to facilitate the operation of other functions under the Mental Health (Northern Ireland) Order 1986. These are sample forms only and are customised for the use within BHSCT.

Form 1	Report To Responsible Medical Officer On Patient's Social Circumstances
Form 2	Record Of Time At Which Power To Detain Under Article 7(3) Elapsed
Form 3	Notification To Regulation And Quality Improvement Authority Of Any Amendments Made To Applications, Recommendations Or Reports
Form 4	Order Of Discharge Of Patient Liable To Be Detained In Hospital By Responsible Medical Officer/Responsible Health And Social Care Trust
Form 5	Discharge Of Patient Liable To Be Detained In Hospital By Nearest Relative
Form 6	Report Barring Discharge From Hospital By Nearest Relative
Form 7	Notification To Regulation And Quality Improvement Authority Of Patient's Discharge From Detention
Form 8	Notification To Regulation And Quality Improvement Authority Of Leave Of Absence From Hospital Or Extension Of Leave
Form 9	Notification To Regulation And Quality Improvement Authority Of Recall Or Return To Hospital From Leave Of Absence
Form 10	Notification To Regulation And Quality Improvement Authority Of Any Amendments To Guardianship Applications Or Recommendations
Form 11	Renewal Of Authority For Guardianship Report By Second Medical Practitioner
Form 12	Discharge Of Patient From Guardianship By Responsible Medical Officer
Form 13	Discharge Of Patient From Guardianship By Authorised Social Worker
Form 14	Discharge Of Patient From Guardianship By Nearest Relative
Form 15	Report By Responsible Medical Officer/Authorised Social Worker Barring Discharge Of Patient From Guardianship By Nearest Relative
Form 16	Notification To Regulation And Quality Improvement Authority When Patient Is Discharged From Guardianship



- Form 17** Notification To Regulation And Quality Improvement Authority On
The Transfer Of Guardianship On Death, Incapacity, Etc Of Guardian
- Form 18** Notification To Regulation And Quality Improvement Authority Of
Detained Patient's Transfer To Another Hospital
- Form 19** Notification To Regulation And Quality Improvement Authority Of
Detained Patient's Transfer Into Guardianship
- Form 20** Notification To Regulation And Quality Improvement Authority Of
Transfer Of Patient Between Guardians

[LINK TO Internal Form 01](#)

[LINK TO Internal Form 03](#)

[LINK TO Internal Form 05](#)

[LINK TO Internal Form 07](#)

[LINK TO Internal Form 09](#)

[LINK TO Internal Form 11](#)

[LINK TO Internal Form 13](#)

[LINK TO Internal Form 15](#)

[LINK TO Internal Form 17](#)

[LINK TO Internal Form 19](#)

[LINK TO Internal Form 21](#)

[LINK TO Internal Form 23](#)

[LINK TO Internal Form 02](#)

[LINK TO Internal Form 04](#)

[LINK TO Internal Form 06](#)

[LINK TO Internal Form 08](#)

[LINK TO Internal Form 10](#)

[LINK TO Internal Form 12](#)

[LINK TO Internal Form 14](#)

[LINK TO Internal Form 16](#)

[LINK TO Internal Form 18](#)

[LINK TO Internal Form 20](#)

[LINK TO Internal Form 22](#)

WARRANTS AND COMPLAINTS ARTICLE 129

Article 129 (1) Complaint

LINK TO Article 129 (1) Complaint

Article 129 (1) Warrant

LINK TO Article 129 (1) Warrant

Article 129 (2) Complaint

LINK TO Article 129 (2) Complaint

Warrant 129 (2)

LINK TO Warrant 129 (2)

Article 129 (3) Complaint

LINK TO Article 129 (3) Complaint

Warrant 129 (3)

LINK TO Warrant 129 (3)

Article 129 (4) Complaint

LINK TO Article 129 (4) Complaint

Warrant 129 (4)

LINK TO Warrant 129 (4)



ADDITIONAL RESOURCES

Safeguarding Children

Sharing to safeguard: information sharing about individuals who may pose a risk to children. Circular HSS CC 3/96 (revised).

Department of Health, Social Services and Public Safety (DHSSPS), 2009

Guidance on when agencies should share information about individuals who may pose a risk to children.

LINK TO Sharing to Safeguard Information Sharing about Individuals Who May Pose a Risk to Children - September 2008

Co-operating to safeguard children Department of Health, Social Services and Public Safety (DHSSPS), 2003

Guidance to assist Area Child Protection Committees develop strategies, policies and procedures to safeguard children who are assessed to be at risk of significant harm.

This document can be accessed through:

http://www.dhsspsni.gov.uk/show_publications?txtid=14022

Regional child protection policy and procedures. Area Child Protection Committees
Department of Health, Social Services and Public Safety (DHSSPS), 2005

LINK TO Area Child Protection - Regional Policy and Procedures

A short guide to child protection policy and procedures. Area Child Protection Committees. Department of Health, Social Services and Public Safety (DHSSPS), 2005

LINK TO Area Child Protection - A Short Guide to Regional Policy and Procedures

Preventing Harm to Children from Parents with Mental Health Needs
HSC (SQSD) 02-10

LINK TO Preventing Harm to Children from Parents with Mental Health Needs HSC (SQSD) 02-10

Resources for People with Learning Disability

Caring for People with a Learning Disability in General Hospital Settings. GAIN Guidelines 2010

LINK TO Guidelines on Caring For People with a Learning Disability in General Hospital Settings

Caring for People with a Learning Disability in General Hospital Settings. GAIN Guidelines 2010 – Easy Access Version

LINK TO Caring For People with a Learning Disability in General Hospital Settings - Easy Access Version

Recent Inquiry Reports

Executive Summary and Recommendations from the report of the Inquiry Panel (MCCLEERY) to the Eastern Health and Social Services Board May 2006

LINK TO Executive Summary and Recommendations from the report of the Inquiry Panel (MCCLEERY) to the Eastern Health and Social Services Board May 2006

Independent Review Report of Agency Involvement with Mr Arthur McElhill, MS Lorraine Mc Govern and their children.

LINK TO Independent Review Report of Agency Involvement with Mr Arthur McElhill, MS Lorraine Mc Govern and their children

Madeline and Lauren O Neill. Report of Independent Inquiry Panel to the Western and Eastern Health and Social Services Boards – May 2007.

LINK TO Madeline and Lauren O Neill. Report of Independent Inquiry Panel to the Western and Eastern Health and Social Services Boards – May 2007

RQIA Independent Review of **The McDermott Brothers' Case**

LINK TO RQIA Independent Review of The McDermott Brothers' Case

Violence

Violence – The short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments 2005. National Institute of Clinical Excellence

LINK TO Violence The Short-Term Management of Disturbed/Violent Behaviour

Violence: Managing disturbed/violent behaviour. Understanding NICE guidance – Information for service users, their advocates, families and carers and the public. National Institute of Clinical Excellence.

LINK TO Violence: Managing Disturbed/Violent Behaviour

Suicide and Homicide

Suicide and Homicide in Northern Ireland. Published by The University of Manchester (June 2011). National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

LINK TO Suicide and Homicide in Northern Ireland - June 2011

Filicide - A Literature Review. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness.

Commissioned by The Department of Health, Social Services and Public Safety, Northern Ireland (October 2009).

LINK TO Filicide: A Literature Review - June 2009

LINKS

<http://www.gain-ni.org>

<http://www.dhsspsni.gov.uk>

<http://www.rqia.org.uk>

<http://www.courtsni.gov.uk>

<http://www.legislation.gov.uk>

This site provides information on Judicial Decisions, Office of Care and Protection, Mental Health Review Tribunal and other court services.

<http://www.scie.org.uk>

The Social Care Institute for Excellence (SCIE) is an independent charity working with adults, families and children's social care and social work services across the UK. It also works closely with related services such as health care and housing. The Website provides access to practical resources, practice guidance and learning materials.

<http://www.rcpsych.ac.uk>

This is the official website of The Royal College of Psychiatrists, the professional and educational body for psychiatrists in the United Kingdom. It hosts the e learning package for the Gain Guidelines.

This site contains very useful information, training materials and other documents which can be accessed by other professionals, service users and carers.

<http://guidance.nice.org.uk/Topic/MentalHealthBehavioural>

This link goes directly to all the NICE Guidance on mental health conditions and recommended treatments.



http://www.whoguidemhpcuk.org/page_view.asp?c=16&fc=006003&did=2230

This site provides a very useful overview and guidance on the role of the General Practitioner in relation to the Mental Health (Northern Ireland) Order 2011.

<http://www.cause.org.uk/>

CAUSE is a peer-led charity and emotional support to relatives and carers of people with serious mental illness

<http://irishadvocacynetwork.com/>

This website contains useful information for people who live with mental health difficulties and provides a number of other useful links.

<http://www.publichealth.hscni.net/search/node/mental%20health>

The Public Health Agency contains a number of useful publications including those relating to positive mental health.

<http://www.niamh.co.uk>

This is the website for the Northern Ireland Association of Mental Health. It contains useful information for those who live with mental health difficulties, carers and mental health professionals as well as an overview of the services offered by NIAMH. The site also contains a number of interesting research reports and useful links.

<http://www.familysupportni.gov.uk/>

This site provides details of a wide range of services provided by statutory, voluntary and community organisations. Up-to-date information on a range of services available to support families can be accessed including those relating to the mental health needs of children and young people. This information will help Families, Young People, Children and Practitioners in Northern Ireland to find local services to meet their needs.

<http://www.mencap.org.uk>

Mencap offers information, support and a range of services for children and adults with a learning disability

<http://mindwisenv.org/>

This is the website for MINDWISE (previously known as Rethink). It contains useful information for those who live with mental health difficulties, carers and mental health professionals plus an overview of the services offered by MINDWISE.

<http://www.praxisprovides.com/>

Praxis Care provides a range of supported living services, home response domiciliary care, along with a variety of day care services.

<http://autismni.org/>

This is the website for Autism NI, Northern Ireland's Autism charity. The website contains useful information in relation to autism and the services offered by the organisation.

<http://www.dementiacentreni.org/>

The DSDC Northern Ireland office is an operational service of the Dementia Services Development Centre, University of Stirling. The centre exists to improve people's understanding and knowledge of dementia.

www.alzheimers.org.uk/site/scripts/documents.php?categoryID=200140

This site contains useful local information, including information re advocacy services.

<http://www.ageuk.org.uk/northern-ireland/>

This site also contains useful local information, including information re advocacy services.

<http://www.medicine.manchester.ac.uk/mentalhealth/>

This site contains useful materials re suicide research including a local report "Suicide and Homicide in Northern Ireland". June 2011. The site also contains a report produced by the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, commissioned by the DHSSPS following the publication of the Inquiry report following the deaths of Madeline and Lauren O'Neill.



<http://www.dhsspsni.gov.uk/bamford.htm/>

This site hosts a series of useful reports produced by the various working groups of the Bamford Review of Mental Health and Learning Disability (NI) and includes "A Comprehensive Legislative Framework" 2007.

<http://www.saarih.com/>

The SAaRIH (Safeguarding Adults at Risk Information Hub) Project is an on-line central information resource for practitioners, managers, researchers, educators and policy makers (across all relevant disciplines and agencies and sectors) with an interest in adult safeguarding and protection.

http://www.caada.org.uk/practitioner_resources/MARACresources_NI.htm

This site contains Guidance and professional resources in relation to Multi – Agency Risk Assessment Conference (MARAC) arrangements in Northern Ireland can be found on this website.

GLOSSARY

Applicant, the	The patient's nearest relative or an Approved Social Worker, 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 to act as an ASW for the purposes of the Order
Trust	A Health and Social Care Trust
Board	Regional Health and Social Care Board
Code, the	"Mental Health *Northern Ireland) Order 1986 - The Code of Practice" prepared in accordance with Article 111 of the Order by the Department of Health and Social Services 1992
Department	Department of Health, Social Services and Public Safety Northern Ireland
Detained Patient	Detained patients are patients who have been assessed by a approved medical doctor as meeting the criteria for detention for assessment or treatment in hospital under the Mental Health (NI) Order 1986, following the procedures required by the legislation to do so. The purpose of detention for treatment in hospital is to allow for the implementation of the treatment and care plan agreed as part of the assessment in hospital, in circumstances where the patient meets the criteria for detention for treatment.



Forms (numbered)	References to “Forms” are references to the forms prescribed by Regulation 7 of the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 as amended by the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms)(Amendment) Regulations (Northern Ireland) 1992. A complete set of the forms is also contained in Appendix 1 of the Mental Health (NI) Order 1986 Guide issued by DHSSPS. These are listed on page 74/75 of the Guide (see Appendix 1).
Guardianship	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 him achieve as independent life a life as possible within the community. Arrangements for giving effects 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.
Guide, the	“The Mental Health (Northern Ireland) Order 1986 – A Guide” published by the Department in 1986
Medical Practitioner	A fully registered person within the meaning of the Medical Act 1983.
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, and discussed in paragraphs 8 to 14 of the Guide



Mental Health Review Tribunal	Appeal Tribunal constituted in accordance with Article 70 of the Order
Nearest Relative	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 his position on the list.
NIAS	Northern Ireland Ambulance Service
Order, The	The Mental Health (Northern Ireland) Order 1986
Patient	A person suffering or appearing to suffer from mental disorder
PSNI	Police Service Northern Ireland
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 the Code, The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) (Amendment) Regulations (Northern Ireland) 1998
Responsible Authority	For a hospital patient the Health and Social Care Trust administrating the hospital or for guardianship the Health and Social Care Trust in which the patient resides.
Responsible Medical Officer	The Part II doctor in charge of the patient's assessment or treatment or who provides certain medical recommendations required by the Order for the purposes of guardianship
Regulation Quality and Improvement Authority	The Regulatory body whose responsibilities include those statutory functions previously carried out the Mental Health Commission as established under Article 85 of the Order



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Informal Support	
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Further copies of this guideline can be obtained by logging on to the GAIN Website and printing the pdf version.

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