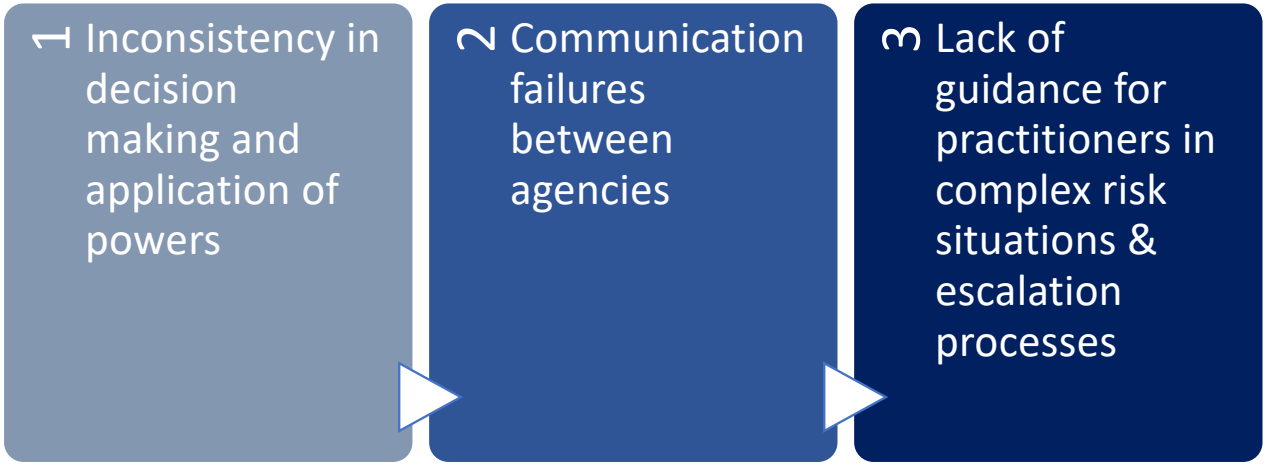
Introduction to Revised Mental Health Order Code of Practice & Right Care Right Person

An Introductory Session for Primary Care Staff

Background

- Deaths of Michael & Marjorie Cawdery 2017 – inquest determined deaths were preventable
- Coroner identified significant gaps in operational clarity and application of Mental Health (NI) Order 1986



Key Recommendations

- Training for HSC staff
- New extensive training on mental health for police officers
- A holistic review of the Code of Practice, regional Interagency Protocol and GAIN guidelines is required to ensure clarity, and consistency in application, together with multi-agency training to reflect the emerging challenges in our society.
- Clear, collaborative, multi-agency working, across all interfaces in dealing with mental health. To include meaningful engagement, interface meetings and shared learning.

THE REVISION:

THE 2025 DRAFT CODE REVISES AND CONSOLIDATES THE 1986 CODE, GUIDE TO THE ORDER, AND GAIN GUIDELINES.

IT PROVIDES A SINGLE, RIGHTS-BASED REFERENCE FOR ALL PROFESSIONALS UNDER THE ORDER.

MCA (NI) 2016 INTERFACE

INTRODUCES REGIONALLY AGREED TEMPLATES EG ALTERNATIVE CARE PLAN, POS TEMPLATE /HANDOVERS.

REAFFIRMS THE NECESSITY OF EXPLORATION OF LESS RESTRICTIVE ALTERNATIVES.

PROVIDES CLEAR GUIDANCE ON COLLABORATION WITH PSNI AND NIAS (ARTICLES 129 & 130).

INTRODUCES CHANGES TO ARTICLE 130 PROCEDURES

CLARIFIES THE NECESSITY AND CONDITIONS FOR WARRANTS

CLARIFIES THRESHOLDS FOR PSNI INTERVENTION USING THE ‘RISK MATRIX’

How Right Care Right Person (RCRP) Fits?

- RCRP is a collaborative model, which will change the way key public services respond to certain calls for service.
- Aims to ensure vulnerable people get the right support from the right services, with appropriate skill and experience
- Applies to calls relating to concern for the welfare of a person; people who have walked out of a healthcare setting; and police involvement in cases under Article 129 and 130 Mental Health (NI) Order 1986.
- Parallel to the recommendations from Cawdery, work has been ongoing to plan for implementation of in N.I
- Strategic oversight & implementation of CoP will be managed under RCRP arrangements

Phase 1	**Mental Health Order Article 130, voluntary assessments and handovers**
Phase 2	**Concern for the welfare of a person**
Phase 3	**People who have walked out of a healthcare setting, or who are absent without leave (AWOL) from a mental health establishment**
Phase 4	Conveyancing of patients

RCRP does not override existing agreed ways of working between safeguarding partners

The revised Mental Health (NI) Code of Practice reinforces the health-led, rights-based responsibilities that Right Care, Right Person will operationalise—placing greater expectation on HSC staff to respond promptly, proportionately and lawfully to mental health crisis where police involvement is not justified.

1 Why is it Being Introduced?

1. It seeks to reduce inappropriate police involvement
2. It aims to strengthen multi-agency working
3. It aims to clarify thresholds for intervention & role responsibilities

Improve patient safety, outcomes & experience

Phase 1

Launch: 9th July 2026

Operational: 1st September 2026

Mental Health Order: Article 130, voluntary assessment and handovers

Understanding Police Powers

Article 19 (1)(e) of PACE (NI) 1989 may enable police **power of entry,** but it is for the purpose of saving life & preventing serious harm. If a warrant is being considered to gain access for purpose of mental health assessment, the question will be whether there is sufficient evidence of an immediate threat to life or safety, or whether another legal power may be more appropriate. It is important to note that power of entry does not grant power o remove a person from a private residence. This would require a warrant under the MHO 1986

Police Powers Under Articles 129 & 130

Articles 129 and 130 define police powers to protect individuals with mental disorders at risk to themselves or others.

Article 129 (1) Warrant sought by ASW to allow access to patient for purpose of assessment. If ASW not granted permission to enter the home. Police may enter premises under warrant and remove a person to a place of safety

Article 130: Police may remove a person from a public place to a place of safety, provided specific criteria met

Both allow PSNI to detain person in PoS for **48 hours**

Articles 129 & 130 are intended to be short term powers, intended to facilitate:

- **Medical examination**
- **ASW interview**
- **Arrangements for care and treatment**

They are not intended to be stand alone police powers

The new Code clarifies:

➢Health professional involvement must occur early.

➢Police powers are exceptional and only when necessary (aligning with RCRP)

➢Place of safety should normally be a health setting – regionally agreed as ED at this time.

➢Flowcharts detail joint response procedures.

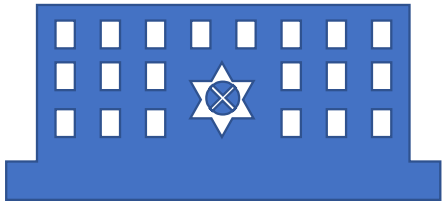
Police powers aim to enable care, assessment, and protection rather than punishment

Place of Safety

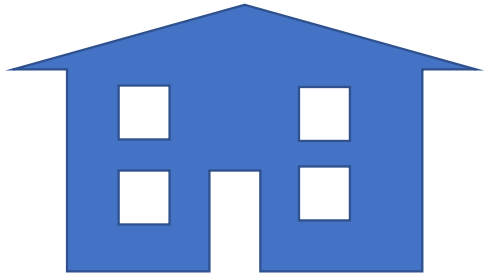
Article 129 defines

as…

Any Hospital



Any Police Station



Any suitable place

Function of PoS: To keep patient safe, provide continual supervision, prevent patient from absconding, and respond in line with regional guidance.

Decision to Step Down Art. 129/130

- A decision to step down Article 129 or Article 130, before the medical assessment and ASW assessment under the Order have taken place, **may be made by the senior decision makers (*Medic or Nurse in Charge*) in the place of safety, based on their own examination, collateral history, and all available information, including relevant past history**.

- It is asked that the medical practitioner assesses the patient within 4 hours. If the medical practitioner determines that the patient **does not** have a mental disorder, Article 130(2) must be stepped down immediately, as to further detain the patient would be unlawful.

- Once Article 130(2) is stepped down, the patient must be informed of this and kept updated on their care plan.

Medical & ASW Assessment

- The medical assessment, may conclude that the patient has a mental disorder. In these circumstances further consideration is needed to determine if:

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

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

- A verbal ASW response is expected within 1 hour. In person 4 hours.

The legal prescribed forms for detaining a patient under the MHO remain the same

Voluntary Attendee Recording Templates

- A patient may present in mental health crisis and be willing to attend ED. However, they may not necessarily meet the statutory criteria to use Article 129(1) or 130(1). Police may support and transport a patient who is seeking medical support in relation to their physical or mental health to hospital on a voluntary basis. On these occasions, it is equally important to record and communicate the necessary information, including the fact that the patient is a voluntary attendee, and assessment of risk between the police and HSC staff so that HSC staff can, where appropriate, manage the associated risks to the patient or others. This will include the risk of leaving.

- **PSNI will complete the Best Practice Voluntary Attendee PSNI Template Vol-A1**, outlining the reason for attendance at ED, description of patient's presentation and any know risk information which HSC staff should aware of

- The **Voluntary Attendee – Risk Assessment Template for HSC Staff in Emergency Departments Vol-A2** should be completed by HSC staff. Section 1 is intended for completion by nursing staff. Section 2 by HSC doctor.

Handovers & Recording Templates

Existing Statutory Forms Remain Unchanged

- **Form 2** – Application for Admission for Assessment (by ASW)
- **Form 3** – Medical Recommendation (Admission for Assessment)
- **Form 5** – Report on Patient Liable to be Detained
- **Form 7** – Medical Recommendation (for Admission and Treatment)
- **Form 9** – Renewal Report on Patient
- **Form 10** – Authority for Detention
- **Article 129/130 Warrant Forms** – used by PSNI / Trusts under regional xxxxxconveyance protocols

New Standardised Templates for Non-Statutory Documentation

- **Place of Safety** Template (PoS_1)
- **Voluntary Attendee** Template (PSNI) (Vol_A1)
- **Voluntary Attendee Risk Assessment** Template (Vol_A2)
- **Record of Decision Making for staff by HSC Advice Line**
- **ASW Assessment Alternative Care Plan**
- **Places of Safety Information Leaflet for patients**

Increased Importance of Family and Carer Involvement

- View family engagement as a core part of assessment, risk management and patient safety
- Family & carers may hold critical information regarding risk, safeguarding concerns and recent presentation. They will know person's baseline functioning &recognise early warning signs. Their views should be sought and documented as part of assessment process
- Involving young people in discussions and decision making
- Actively seek family/carers views
- Document disagreements /concerns
- Listen even if information cannot be shared
- Involve in safety planning /discharge arrangements
- Balance involvement with young person's rights and confidentiality
- Consider safeguarding where family involvement increases risk

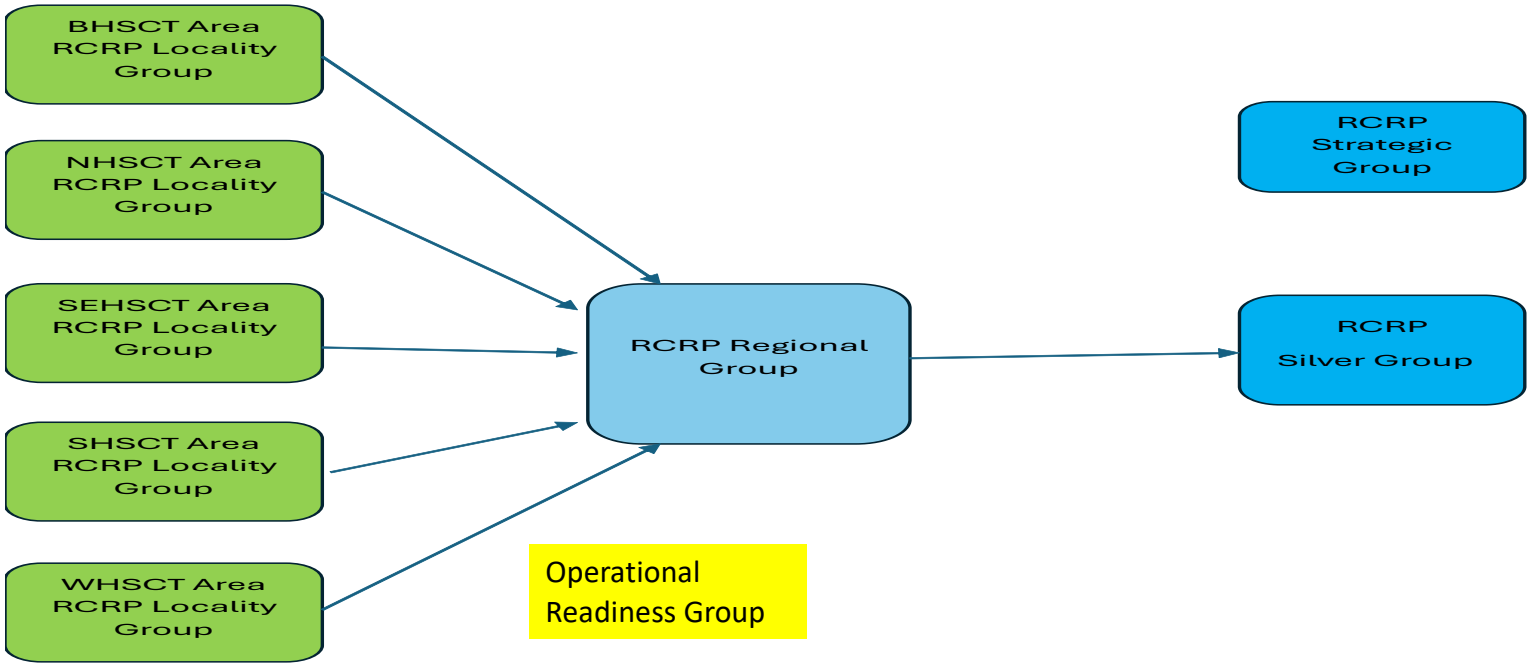
Risk Matrix to Support Inter-Agency Decision Making

Previous History of Person	Current Circumstances	Actions Required (HSC Trusts / NIAS)
LOW RISK – Police Assistance is unlikely to be required		
Person has a history of • violence; • active self-harm; • absconding; • other risk behaviour indicators currently present (other than very mild substance use) History is • *Infrequent AND historic* ***OR*** • *Irrelevant due to circumstances*	Person is ***NOT*** • Presenting with behaviours likely to cause Serious Physical Harm to others • actively self-harming; • presenting in a manner which would suggest a risk of absconding; • other risk behaviour indicators ***currently present*** (other than very mild substance use)	HSC Trusts excluding NIAS • Provide reassurance and explanation to person • Offer support to person • Offer physical support for conveyance e.g. providing assistance out of chair to get into vehicle etc • Utilise family / friends to encourage person • HSC Trusts to consider use of support worker model with staff trained in physical intervention • HSC Trusts to consider escort model to support person through conveyance NIAS • Supporting the complaint/disoriented patient from their location, especially if immobile. Moving into carry chair or trolley to transport to the ambulance using normal ambulance moving and handling techniques. • Applying seat belts. • Closing the ambulance door. • Building rapport and trust with patient. • Re-assuring the patient regarding the need for transport and the safety of this process. • Negotiation, influence and persuasion techniques to ensure the patient feels safe to travel. • Involving family members, carers, neighbours etc who may be able to influence the patient's decisions.

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

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

Governance Arrangements



*Note these are not new groups – they are building on the already stabilised Trust – PSNI interface groups

* the Regional RCRP group will be a newly established group

Phase 2

Concern for Welfare

31st October 2026

Defining a Concern For Welfare:

A concern for welfare generally refers to a report that someone may be at risk because of their physical health, vulnerability, age, disability, self-neglect, or inability to care for themselves, and there is a wish to establish their safety or wellbeing.

RCRP Does Not Remove or Transfer Statutory Duties

Health & Social Care

Dynamic clinical and professional risk assessment

Care planning, treatment and safeguarding

Less restrictive alternatives

PSNI / NIAS

Undertake their own assessment

Apply their statutory duties, operational policies and available powers

Determine their own operational response

Shared Work

Timely and proportionate information

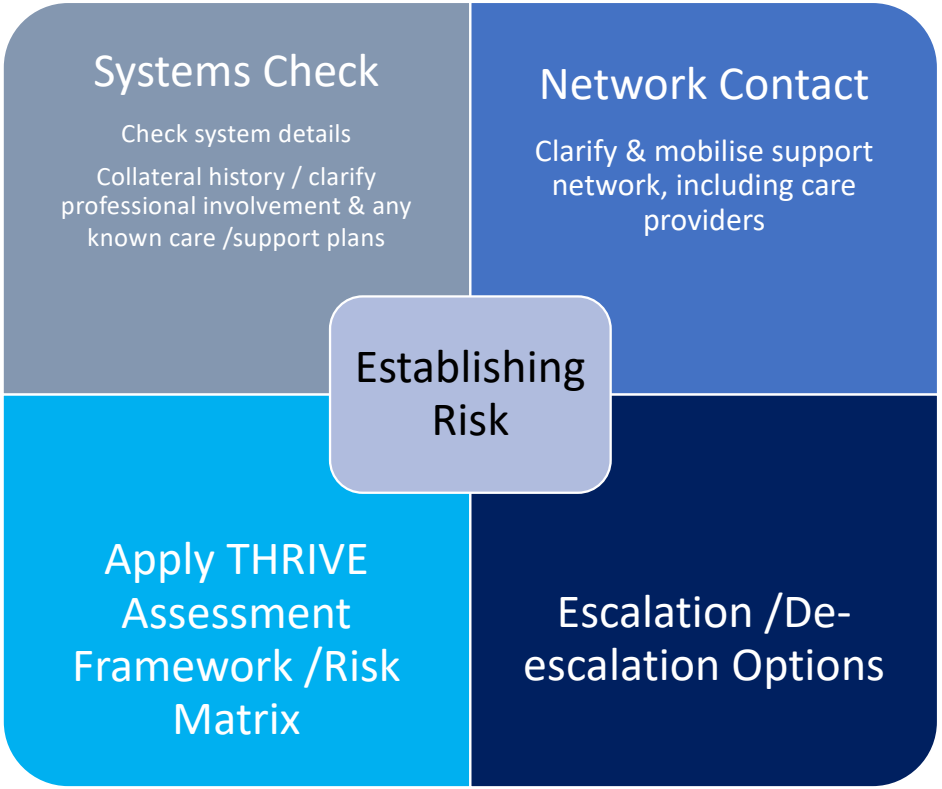
Clear roles and contingency arrangements

Reassessment when circumstances change

Where the concern is primarily related to health, social care or safeguarding, the expectation is that the relevant health or social care service should lead the response rather than police.

Under RCRP, the key question is whether the police are the most appropriate agency to respond?

Establishing Risk & Shared Responsibilities



- ✓Assessment
- ✓Information sharing
- ✓Care planning
- ✓Crisis intervention
- ✓Risk management
- ✓Escalation
- ✓Safeguarding
- ✓Multi-agency decision making

THRIVE ASSESSMENT FRAMEWORK

A structured approach to understanding risk and need to inform proportionate and appropriate intervention.

T — THREAT

What is happening now?

- What has happened or is happening?
- Who is involved?
- Where is it happening?
- When did it start?
- What are the current concerns?

H — HARM

What harm is likely if no action is taken?

- What harm could happen to the person?
- What harm could happen to others?
- What is the impact on their wellbeing?

R — RISK

How likely is that harm and how is the situation escalating?

- How likely is the harm?
- What factors increase or reduce the risk?
- Is the situation escalating, changing or stabilising?

I — INVESTIGATION

Are there safeguarding or criminal concerns?

- Is there a safeguarding concern?
- Is a crime suspected or has a crime been committed?
- What information needs to be gathered?

V — VULNERABILITY

Why is the person particularly vulnerable?

- What personal characteristics or circumstances increase vulnerability?
- Are there any protective factors?

E — ENGAGEMENT

What interventions have already been attempted?

- What has been tried already?
- What has worked or not worked?
- What are the barriers to engagement?

THRIVE helps us ask the right questions, share information effectively and take the right action at the right time.

Proportionate. Person-centred. Partnership focused.
Working together to keep people safe.

Risk is Dynamic – How We Communicate it Matters

CURRENT	IMMINENT	ESCALATING	MANAGEABLE
Risk is present, but there is no evidence that serious harm is about to occur immediately.	Serious harm is likely very soon without intervention—for example current intent, access to means and movement towards action.	The situation is worsening, de-escalation is failing, protective factors are reducing or presentation is deteriorating.	Risk remains, but can currently be managed through engagement, a credible plan and available support

What does this mean for primary care?

- Ensure discussions, referrals and treatment decisions clearly explained and patient actively involved
- Explore voluntary engagement wherever possible & community alternatives before crisis escalates
- Multi-agency expectations re: communication, assessment and crisis management
- Understanding of roles and responsibilities
- Communicate, share and apply relevant risk information promptly
- Document decision making & actions
- Involve families/ carers /significant others

Training

- Online Training in Development
- CEC Updated Mental Health Training
- Royal College of Psychiatry free MHO Training Modules
- Mental Health Training Delivered to Police
- Mental Health training Delivered to NIAS
- Awareness Sessions & Resources

https://www.health-ni.gov.uk/news/department-health-launches-revised-mental-health-order-code-practice