COPNI Commissioner for Older People for Northern Ireland

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RE: Consultation on a revised Code of Practice for the Mental Health (Northern Ireland) Order 1986

To whom it may concern

I am writing on behalf of the Commissioner for Older People for Northern Ireland regarding the revised Code of Practice of the Mental Health (Northern Ireland) Order 1986 (MHO).

The Commissioner commends the Mental Capacity Unit for their efforts to update the Code. The new Code of Practice addresses situations that required clarification, drawing on the experiences of practitioners, stakeholders, and public authorities, as well as on "serious adverse incidents"[1] that revealed the need for prompt revisions.[2]

However, the consultation acknowledges that amendments to the Code are limited by the primary legislation—the MHO itself. The Code is intended to provide a framework and guidance on the application of the Order, but it cannot override or circumvent its statutory requirements.

> *There are limits to the changes possible within the rewrite of the Code as terminology used within the Mental Health (NI) Order 1986 remains the legislative basis upon which decisions must be made.*[3]

Therefore, while the efforts to revise the Code are commendable, the limits imposed by the primary legislation may no longer align with current regulatory requirements,

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[1] "The Code will be used by PSNI and NIAS to inform practice, building on learning from Serious Adverse Incidents that highlighted the need for better communication and understanding of roles and responsibilities across agencies." Department of Health (2025) EQIA - Revised MHO Code of Practice; page 3.

[2] See Campbell, C. (2023, July 7) Cawdery killings: Deaths of pensioners could be repeated, coroner warns, BBC News.

[3] Department of Health (2025) EQIA - Revised MHO Code of Practice; page 3.

particularly human rights frameworks. This misalignment may expose service users and practitioners to various risks, underscoring the need to progress toward full implementation of the Mental Capacity Act (Northern Ireland) 2016 (MCA).

Key Aspects of the Draft Revised Code

In exercising the powers under Articles 129 and 130 of the MHO, collaboration between the Police Service of Northern Ireland (PSNI), Authorised Social Workers (ASWs), the Northern Ireland Ambulance Service (NIAS), and medical staff is essential.

The conveyance of individuals to places of safety under the MHO involves significant risks and a range of responsibilities.[4] These powers are also extremely serious, as they imply stripping a person of their liberty, and clarification on their practical application is essential. Clear guidance on the functions and responsibilities of each of these actors, and how they relate to those of other professions and public bodies, is essential for the wellbeing of patients, professionals, and others.

Many of the actions in which the PSNI are involved in relation to people with mental health disorders carry significant risks. Similarly, the NIAS supports the conveyance of patients and often requires assistance from the PSNI when a patient presents challenging behaviour or has a relevant history. Conveyance may involve aggressive behaviour, manual handling, support, and restraint.[5] It is therefore important that all parties clearly understand the boundaries of their respective roles and responsibilities.

The depth of the Mental Capacity Unit's consultations with professionals, public and independent bodies, and practitioners provides a solid understanding of the issues experienced by those involved in applying the MHO. The solutions offered in the current draft are therefore likely to reflect their needs and priorities.

Clarifying the role of RQIA is also a key aspect of the revised Code, as RQIA provides an essential safeguard for patients and promotes safe practice, including by conducting formal investigations and making recommendations when evidence suggests improvements are needed.

Another important aspect of the revised Code is the terminology used to refer to individuals with lived experience of mental health issues. The Department proposes

[4] Department of Health (2025) Draft Revised Code of Practice Mental Health Order (Northern Ireland) 1986; sections 3.52-3.58.
[5] Department of Health (2025) Draft Revised Code of Practice Mental Health Order (Northern Ireland) 1986; sections 3.52-3.58.

alternative terms to those included in the Order, as the existing language is considered outdated or inappropriate in the present context.

However, the Mental Capacity Unit notes the complexity of updating the Code in this area. While the Department recognises that the terms legally required for practitioners to refer to individuals with lived experience are no longer socially acceptable, it acknowledges that these terms must still be used "for procedural or evidential purposes".[6] While their use in the Code "does not imply endorsement", it "reflects the current statutory language that professionals are required to work within."[7]

In conclusion, most revisions to the Code aim to enhance the safety, dignity, and well-being of patients, staff, and others. It is therefore positive that the Department has ensured the new Code clarifies these duties through cooperative work with the public bodies responsible under the Order.

However, challenges in updating the terminology used to refer to individuals with lived experience also extend to other areas of the revised Code, particularly its compliance with human rights standards. As will be shown in the following section, primary legislation sets boundaries and limitations that cannot be overridden.

Human Rights, Capacity, and Compliance

As noted above, the primary aim of this revision is to clarify roles in response to serious adverse incidents. In addition, the revision also seeks to reflect modern mental health practices and human rights standards, including the Human Rights Act 1998 (HRA) and Section 75 of the Northern Ireland Act 1998. This includes promoting person-centred care, aligning the Code with the rights-based principles of the Bamford Review, and supporting the partial transition to the MCA for individuals aged 16 and over.[8]

As noted in the consultation, the previous update of the Code of Practice dates from 1992, before the introduction of the HRA and landmark cases such as *Bournewood*[9] and *Cheshire West*,[10,11] which shaped the current interpretation of human rights law applicable to mental health legislation. This means that the existing Code of Practice

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[6] Department of Health (2025) Draft Revised Code of Practice Mental Health Order (Northern Ireland) 1986; page 5.

[7] Department of Health (2025) Draft Revised Code of Practice Mental Health Order (Northern Ireland) 1986; page 5.

[8] Department of Health (2025) EQIA - Revised MHO Code of Practice; page 3.

[9] R v Bournewood Community and Mental Health NHS Trust Ex p. L [1997] EWCA Civ 2879; R v Bournewood Community and Mental Health NHS Trust Ex p. L [1998] UKHL 24; HL v UK [2004] ECHR 720.

[10] P v Cheshire West and Chester Council and another; P and Q v Surrey County Council [2014] UKSC 19.

[11] For a thorough discussion on these issues see COPNI's report: Leira Pernas, Á. (2025) Freedom, care and wellbeing: Review of deprivation of liberty safeguards, Commissioner for Older People for Northern Ireland.

was last reviewed in a legal context that differs significantly from today's human rights framework.

The revised Code of Practice aims to balance protections for service users and professionals in line with current human rights legislation and guided by case law, while acknowledging the limitations of outdated—but still valid—primary legislation. While clarifying powers and responsibilities is an achievable goal through revising the Code, fully aligning it with the current human rights framework is a far more complex task, and may fall outside the remit of the Mental Capacity Unit.

The MHO was enacted prior to the incorporation of the European Convention on Human Rights (ECHR) into UK Law through the HRA. In light of the difficulties to align the MHO with contemporary human rights legislation, the Bamford review of mental health in Northern Ireland made the clear recommendation that mental health legislation had to be updated to meet these requirements.[12] Similarly, the Mental Health Act 1983[13] is under a process of revision in England and Wales, and it is being replaced by updated legislation.[14]

The issue of capacity is central to these discussions. The revision of the Code can bring it closer to Article 5 of the ECHR and the HRA, but full alignment is not possible, as case law and High Court rulings on Article 5 are incompatible with the MHO regarding capacity. In this context, the Mental Capacity Unit's effort to produce an updated Code that reflects the spirit of the HRA is commendable. However, due to the limitations imposed by the legislation, risks will remain for both professionals working under the Code and the patients detained under its provisions.

An example is the basis for detention and restraint in the Code:

> *Detention and restraint have direct implications for Articles 3, 5, and 8 of the ECHR and should only be used when strictly necessary, lawful, and proportionate. Any detention under the Order must meet the Winterwerp v Netherlands [1979] ECHR 4 criteria:*
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> - *A true mental disorder must be established by objective medical expertise.*
> - *The disorder must be of a kind or degree warranting compulsory confinement.*

[12] Department of Health (2007) Bamford review - A comprehensive legislative framework.

[13] Mental Health Act 1983.

[14] Garratt, K., and Laing, J. (2025, May 16) Reforming the Mental Health Act: Independent review to draft bill (House of Commons Library Research Briefing No. CBP-9132), House of Commons Library.

- *Continued confinement must be based on the persistence of the disorder.*[15]

As shown above, the issue of capacity—which is central to any deprivation of liberty under current human rights law—is not addressed. For this reason, the Code seeks to bridge this gap through the following mandate:

> *Those tasked to carry out duties and functions under the Order should consider the following list of considerations before proceeding with any action:*
>
> *…*
>
> *Has the patient's capacity and wishes been considered?*[16]

Consideration of the patient's capacity is welcome, positive, and essential. However, it may not be sufficient to protect patients and staff in light of current human rights standards. For example, the MCA not only requires that patient capacity be taken into account, but also establishes strong safeguards when taking actions that engage Article 5. "Due consideration" falls short of providing an adequate safeguard. Detentions based on individual judgment, without robust capacity safeguards, may still contravene human rights law.

In addition, decisions regarding removal and detention under the Order continue to be based on medical assessment and remain condition based. In cases where a lack of capacity is assumed—despite due regard being given to capacity—safeguards are not applied. In practice, this absence of safeguards creates risks for both patients and practitioners, potentially resulting in breaches of human rights law.

In essence, amendments to the Code do not address the fundamental absence of capacity provisions and safeguards within the MHO, and this gap cannot be resolved through new guidance in the Code of Practice. The only way to legally address this gap for patients aged 16 and over is through full implementation of the MCA in all relevant settings.

Conclusion

The Mental Capacity Unit of the DoH has made a commendable effort to balance risks and limitations with the present draft Code of Practice.

However, the new Code operates within the boundaries and limitations of a piece of legislation that in some instances does not reflect current terminology to refer to people

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[15] Department of Health (2025) Draft Revised Code of Practice Mental Health Order (Northern Ireland) 1986; page 23.
[16] Department of Health (2025) Draft Revised Code of Practice Mental Health Order (Northern Ireland) 1986; page 23.

with lived experience and, most importantly, human rights legislation. While the Code has attempted to circumvent the limitations of the legislation regarding terms used, it cannot circumvent human rights incompatibilities in full. This necessarily opens risks for patients and staff.

For this reason, the most effective and legally robust way to ensure a person-centred approach that aligns with current human rights standards is the full commencement of the MCA in all settings for which it was designed. Only primary legislation that enables a more robust safeguarding and person-centred process will enable these grey areas to be fully addressed, people's rights strengthened, and practitioners protected.

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