Royal College of Psychiatrists in Northern Ireland (RCPsychiNI) Response to:

DoH Consultation on the Draft Revised Code of Practice for the Mental Health (Northern Ireland) Order 1986

1.0 Introduction about RCPsych in NI:

The Royal College of Psychiatrists (RCPsych) is the statutory body responsible for the supervision of the training and accreditation of Psychiatrists in the UK and for providing guidelines and advice regarding the treatment, care, and prevention of mental and behavioural disorders. Among its principal aims are to improve the outcomes for those with mental illness and to improve the mental health of individuals, families and communities.

The College has approximately 450 Members in Northern Ireland (including Doctors in training) who provide the backbone of the local Psychiatric service, offering acute and community treatment, as well as specialist care and consultation across a large range of settings.

This response is submitted on behalf of the Devolved Council of the Royal College of Psychiatrists in Northern Ireland (RCPsychiNI).

2.0 Substantive Response to the Questions raised:

Question 1. Will the revisions to the Code help protect patient rights and promote person centred care?

- Within the constraints of the 1986 legislation, the draft Code goes some way to helping protect patient rights and promoting person-centred care.

- Recognising that this is dealt with in Section 1.27, we think it would be helpful in Section 1.10, which lists the broad principles, to state that all actions under the Mental Health (NI) Order 1986 (MHO) should comply as

fully as possible with The UN Convention on the Rights of Persons with Disabilities (UNCRPD) and the Human Rights Act 1998. We also think it would be appropriate to emphasise the principles of treatment stated in Section 8.3 by reiterating them, or referring to them, in Section 1.10.

Question 2. Does the Code reflect modern mental health practices and human rights standards, including the Human Rights Act 1998 and section 75 of the Northern Ireland Act 1998?

- The College welcomes the recognition that some of the terms used in the Order are outdated and do not reflect contemporary understanding, and the need for inclusive practice, especially in the area of learning disability. However, the use of the table on P.5, in its attempt to map the categories used in the MHO (which are unique to the MHO in terms of the use of mental handicap and severe mental handicap) to modern equivalents, leads to confusion. The table implies that profound learning disability is equivalent to severe mental handicap, which is not the case. We think that the table, insofar as it discusses terms used in the field of learning disability, should be discarded and replaced with reference to, and explanation of, the terms used in ICD 11- Disorders of Intellectual Development- which is currently being implemented globally.

- There appears to be an error in Paragraph 1.19. The content of this paragraph applies to 'severe mental impairment' rather than 'severe mental handicap.'

- Notwithstanding our concerns outlined above, we think that the Guide should be stronger in ensuring that respectful and person-centred language is the default mode of professional communication and practice. We recognise that the Code 'encourages' staff to use respectful, person-centred language (P.5), but we think this should be strengthened (using the terminology in Fig 1 (P.17) to state that staff 'should' use such language except when it is legally not permissible to do so.

Question 3. Does the Code align with the Bamford Review's rights-based principles and the partial transition to the Mental Capacity Act (NI) 2016 for those aged 16+?

- The importance of compliance as far as is possible with the Human Rights Act 1998 is emphasised in section 1.27 and this is welcome.

- The draft Code does not make any reference to the use of advance choice documents, a key driver for promoting the Bamford principle of autonomy. Please see below.

Question 4. Are the professional responsibilities, including interagency collaboration, clearly defined in the Code? If not, what changes could be made to the Code to improve this?

- Section 2.32: It should be noted that PQC guidance is currently under review.

- Section 2.34: The question of the role of the medical practitioner in making a medical recommendation should be further clarified to reflect the exigencies of the service. Section 2.34 states that the medical practitioner giving the medical recommendation is usually the person's General Practitioner. We do not think that this reflects the realities of modern general practice, especially the delivery of out of hours primary medical care. This is a particular concern for a patient presenting to an emergency department (ED); there is often a significant delay in obtaining a primary care medical practitioner to attend the ED to make the medical recommendation. This can lead to an unreasonable delay in admission, which could be considered to be unlawful detention. The balance of risks between the potential for reduced independence of medical recommendation versus unreasonable delay in making the recommendation needs to be further clarified. The Code of practice should consider under what circumstances ED medical staff, who are independent of the psychiatric medical staff, could, with suitable training, provide the medical recommendation, thus reducing the length of time a patient has to wait in the ED.

- This also applies in Section 3.20 (medical assessment in a place of safety). There is a strict 48-hour limit for a patient to remain in a place of safety. There is a lack of guidance in the Code about the management of anticipated delays in obtaining the medical recommendation. The Code should describe an escalation trigger to ensure that adherence to the 48-hour limit is the primary driver of operational decisions to provide a robust safeguard against improper detention. Section 4.54 (application for

assessment in respect of a patient already in hospital) recognises that GP response times can vary due to other clinical pressures and priorities and describes steps to be taken in this eventuality. This is not similarly recognised in Sections 2.34 and 3.20 and this omission should be rectified.

Question 5. Are there any gaps in the Code, in relation to guidance, for professionals (e.g., PSNI, NIAS, or HSC staff)?

- Section 3.3: Care must be taken to ensure that the Code is consistent with other guidance documents, which generally recommend that the patient be taken to the **nearest** appropriate place of safety

- The Code does not make reference to advance care planning. It does not reference the Department of Health guidance, *For Now and for the Future (2022),* the Advance Care Planning Policy for Adults in Northern Ireland. We recognise that the concept of advance care planning is currently outside the statutory provisions of the MHO. However, given that the Code of Practice is intended to provide authoritative guidance on good professional practice and align practice with modern human rights standards, we believe that reference should be made to the above document and a link provided.

- Section 4.24(c): It is regrettably the case that, such are the pressures on acute bed occupancy, there are an increasing number of occasions when the patient's admission is delayed beyond 48 hours, necessitating the use of the Form 4. The Code should provide more guidance on best practice to inform clinicians when a patient's admission is delayed beyond 48 hours.

- Section 8 (Principles of treatment): needs to be strengthened to reflect the principle of therapeutic benefit. A recent judgement (Rooman v Belgium, ECtHR 2019) concluded that compulsory admission and treatment are only justified when real therapeutic measures are available in the appropriate place. To strengthen the human rights compliance of the Code, we recommend adding an explicit principle of treatment that clearly articulates the need for therapeutic benefit confirming that detention or compulsory treatment is only justifiable when there are demonstrable real and appropriate therapeutic measures available. This is in keeping with the principle of reciprocity, one of the key guiding principles of the Code. This will help ensure that all compulsory measures are grounded as a necessary component of a robust active and clinically appropriate treatment modality.

- Sections 8.4 and 8.19: Reference should be made to the importance of following up to date professional guidelines and case law when considering questions of consent.

Question 6. Does the Code effectively address the needs of under-16's? If not, what changes are required?

- The statement in the table on P.48, that the young person aged 16 to 17 is presumed to have capacity to consent but parental rights may still apply, is legally ambiguous.

- The needs of under 16s in this area raise many complexities in terms of the interaction between issues of developmental capacity, impairment of capacity because of impairment of brain or mind, and parental responsibility. It is important that the Code reflects developments in case law and legal judgements in this area, especially as the MHO (and therefore the Code of Practice) will continue to be used for those under the age of 16 when the Mental Capacity Act (NI) 2016 (MCA) is fully implemented.

Question 7. What additional measures could enhance the Code's implementation?

- We believe that a statutory committee should be set up the update the Code regularly. This is important to ensure the Code reflects contemporary legal judgements, especially in the area of children and young persons.

- Training (both multidisciplinary and unidisciplinary) events are necessary.

- An electronic version of the Code with the facility to navigate easily to different sections of the Code should be widely available.

Question 8. Are the actions/proposals set out in this consultation document likely to have an adverse impact on any of the nine equality groups identified under Section 75 of the Northern Ireland Act 1998? If yes, please state the group or groups and provide comment on how these adverse impacts could be reduced or alleviated in the proposals.

- No

Question 9. Are you aware of any indication or evidence – qualitative or quantitative – that the actions/proposals set out in this consultation document may have an adverse impact on equality of opportunity or on good relations? If yes, please give details and comment on what you think should be added or removed to alleviate the adverse impact.

- No

Question10. Is there an opportunity to better promote equality of opportunity or good relations? If yes, please give details as to how.

- Promotion of equal access to care for those with mental disorder and comorbid physical illness.

Question 11. Are there any aspects of this Code where potential human rights violations may occur?

The lack of emphasis on the importance of assessing a patient's capacity in the Code could potentially lead to a human rights violation.

Dated: 19th December 2025

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- on behalf of RCPsych NI

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