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Revised Mental Health (NI) Order Code of Practice (2025 Draft)

Summary and Awareness for Social Workers

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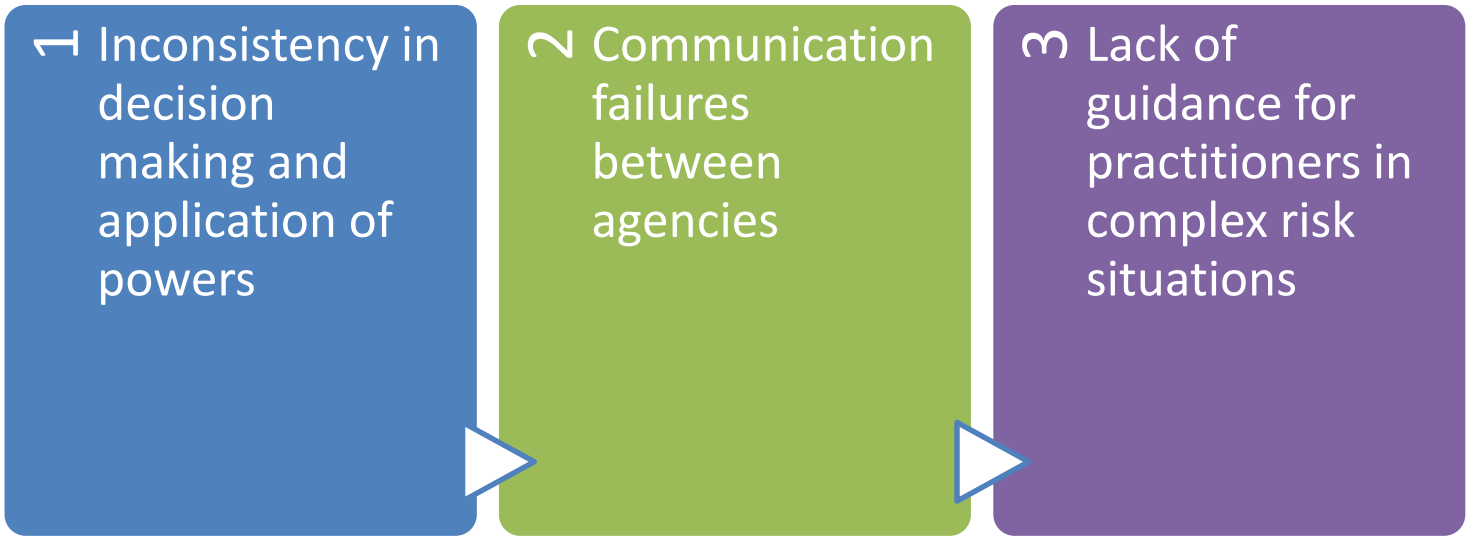
Revised Mental Health Order Code of Practice

- Launch of Revised Mental Health Code of Practice 9th July 2026.
- This is an Introductory Awareness Session
- Online Training Package Currently Being Developed
- Code Will Be Accessible on DoH Website from 9th July
- Follows Consultation with Trusts, Service User Representatives and Key Stakeholders

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



Recommendations

- Urgent review & strengthening of the Code of Practice
- Need to: clarify roles, responsibilities, and thresholds & to support defensible decision-making
- Reduce variation in practice across Trusts
- Provide guidance on interface between MHO /MCA
- Training for frontline staff
- Risk Escalation frameworks

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Introduction

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.

THIS REVISION:

INTRODUCES REGIONALLY AGREED TEMPLATES EG ALTERNATIVE CARE PLAN.

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'

Core Principles Relevant to Social Workers

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Approved Social Worker Role and Accountability

- ASWs remain the applicant for admission under Articles 4 & 5.
- Independence from clinical direction reinforced.
- Trusts must ensure ASWs receive regular refresher training.
- MHO Forms remain the same, but any locally used templates will be replaced with regionally agreed ones.
- ASW involvement under Article 130 clarified and indicates a change in current processes.

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Coordination and Collaboration with PSNI and NIAS

ASWs lead coordination when police or ambulance are involved.

The Code consolidates GAIN and regional guidance into one unified process.

New handover and conveyance templates (Art 130) required

Risk Matrix to be used to determine thresholds for PSNI involvement

Warrants to be utilised where appropriate and necessary

Escalation Protocols established

Police Powers – Articles 129 & 130

- Article 129: Police may enter premises under warrant and remove a person to a place of safety (up to 48 hrs).
- Article 130: Police may remove a person from a public place to a place of safety (up to 48 hrs).

The new Code clarifies:

- Health professional involvement must occur early.
- Police powers are exceptional and only when necessary.
- Place of safety should normally be a health setting – regionally agreed as ED at this time.
- Flowcharts detail joint response procedures.

Police Powers – Articles 129 & 130

- The ASW service should be already involved with patients subjected to Article 129(1) and be prepared to follow up with their ASW assessment where needed. The ASW service should be alerted by place of safety staff to the arrival of patients detained under Article 130, so this can be considered as part of their workplan and reduce the likelihood of delays in responding. A shared mailbox will be utilised by PSNI to inform of an Article 130 detention.

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

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

Police Powers – Articles 129 & 130

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

- 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. If ongoing treatment is required, they should be advised of their right to remain for such treatment and encouraged to do so. Should the patient decline to remain, their decision should be clearly documented, with evidence that they have the capacity to make this choice.

Police Powers – Articles 129 & 130

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

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

- The patient does have a mental disorder and is not consenting to engage in services and is presenting with risks to themself or others. A medical assessment (Article 6) and ASW interview is required to determine if the statutory criteria for admission for assessment are met; and for consideration of their care and treatment. As the GP 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.

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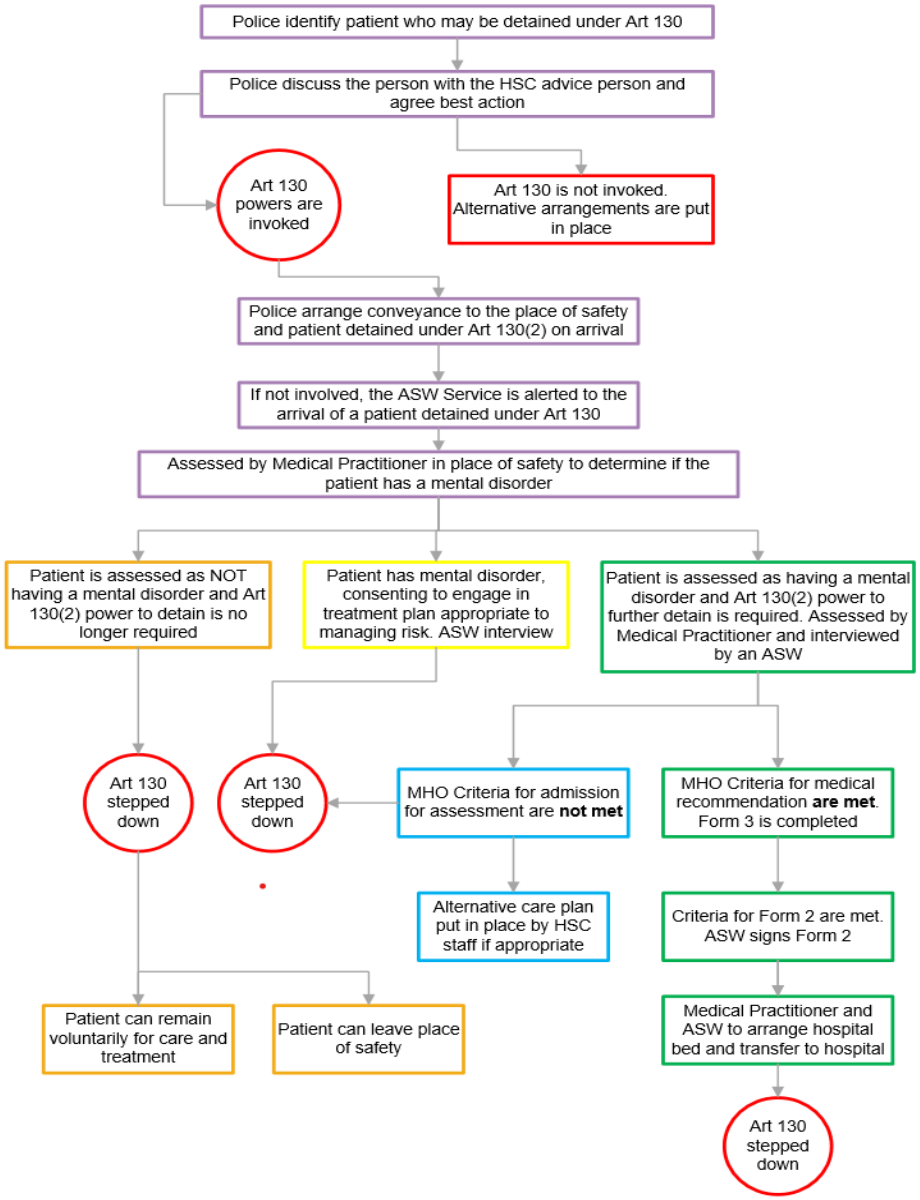
Flowchart 3: Best practice process for Article 130 (when the place of safety is a designated HSC setting such as an Emergency Department)



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

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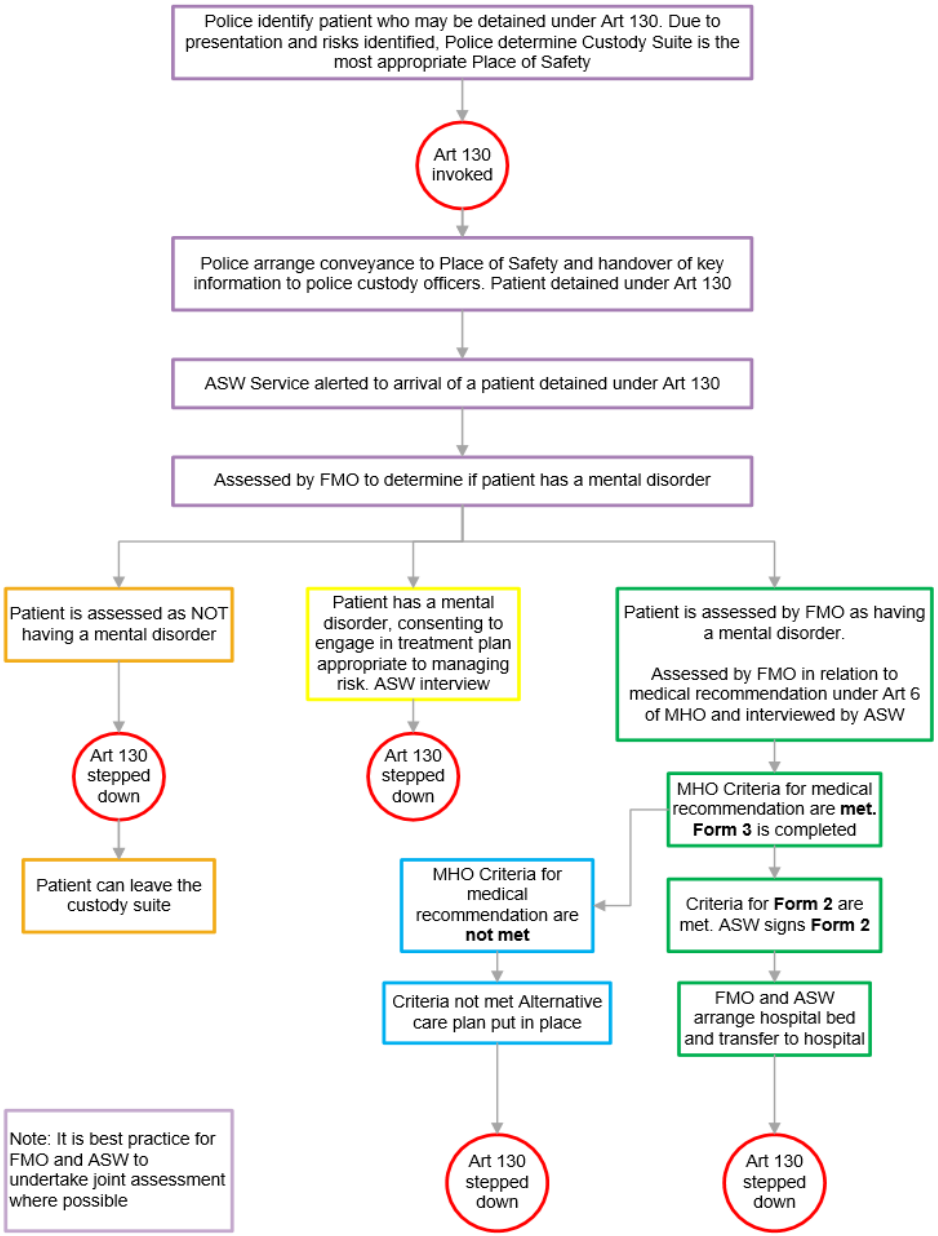


ASW Responsibilities During Police Powers

- Liaise immediately with PSNI / NIAS / Emergency Dept / GP to coordinate assessment.
- Attend the place of safety promptly, responding verbally by telephone within 1 hour.
- Record all actions, timings, and rationale.

Retain copies of:

- ❑ Warrant Forms (for upload to EPIC)
- ❑ Article 130 Template / Joint Handover Record at place of safety.

Note: further guidance required on what the ASW statutory responsibility is when a patient has consented to their care plan when being assessed by the medical practitioner.

Warrants

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

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

Warrants

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

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

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

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

Warrants

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

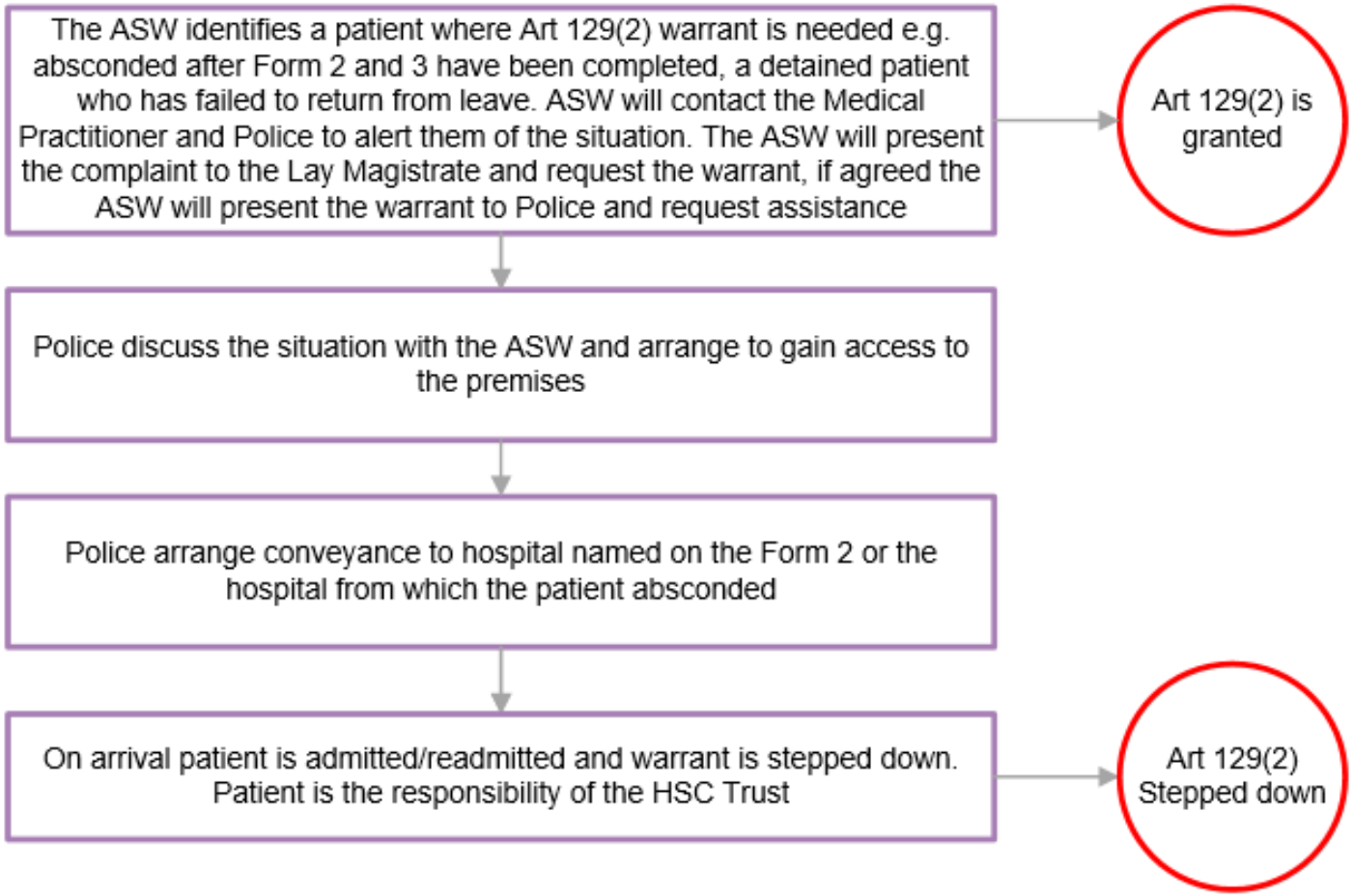
- There may be a scenario where an application for assessment has not been fully completed and police are not in the property and their assistance is required. In such cases, if consent for police to enter is denied, and there is no other lawful basis for entry, then a warrant is needed to provide authorisation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

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

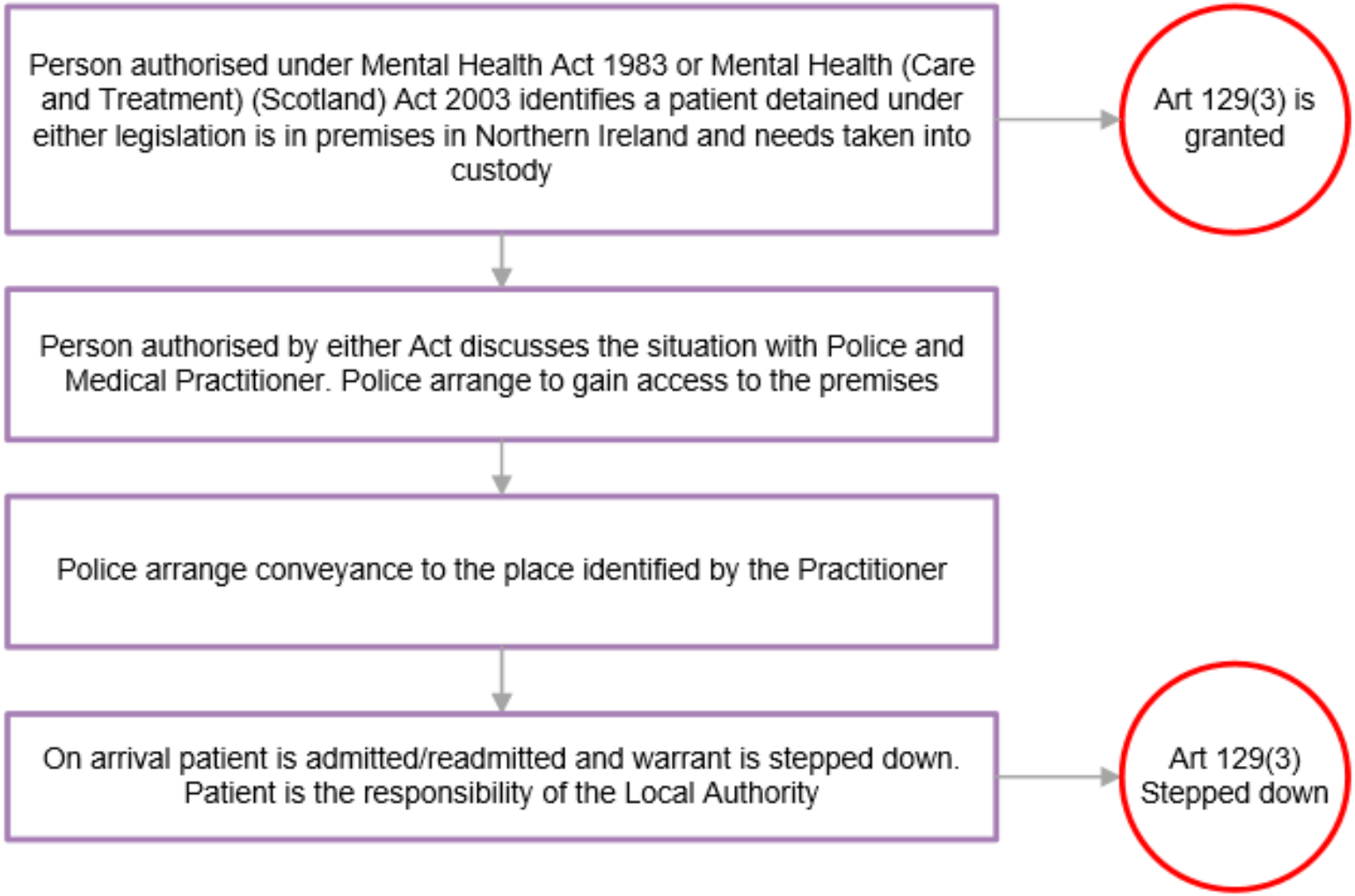
- Where an application for assessment has not been fully completed and, during the process of assessment, consent for the ASW and medical practitioner to be present is withdrawn, the ASW and medical practitioner should leave the premises. If there is no other lawful basis for entry, a warrant will be required for the medical practitioner to regain entry with police assistance and to remove the patient to a place of safety to allow an assessment to take place.

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

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

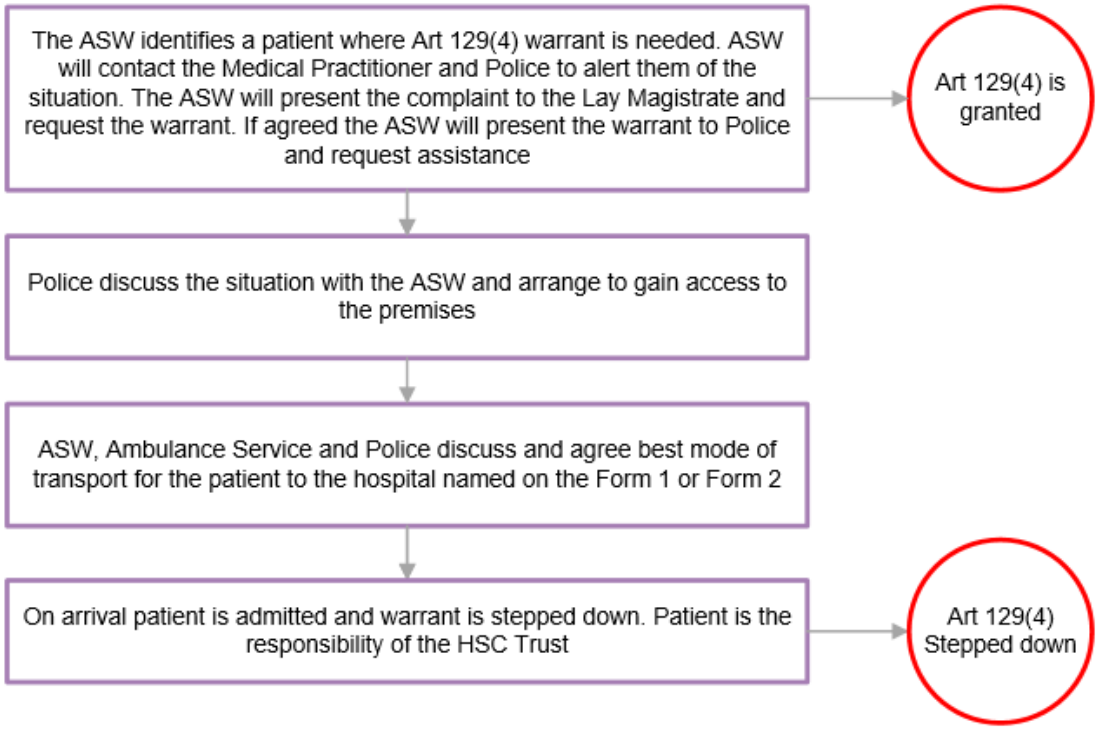


Flowchart 9: Best practice process for Article 129(3)



Flowchart 9: Best practice process for Article 129(4)

Article 129(4) is concerned with those patients for whom an application for admission has been made but it has not been possible for the applicant to convey the patient to the hospital or to acquire the necessary assistance to do so. It is most likely that Article 129(4) is intended to provide for cases in which the application for assessment was made by the nearest relative who is unable to get the patient to hospital for assessment, and they require assistance from the Trust. In these situations, the nearest relative should be supported to seek the warrant. The warrant is also available to ASWs. However, as ASWs are agents of Trusts they should not have any difficulty requesting Trust assistance without a warrant.



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Requesting PSNI Assistance

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

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

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

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

In the event of urgent and immediate assistance being required, the ASW and NIAS should use the 999 system, giving as much information about the situation as is practicable in the circumstances. The police incident number will be used by the ASW and NIAS staff for all communications with the police call handler.

Where the police have been urgently requested, due to an escalation of risk it would also be advisable to contact NIAS and upgrade the response so that there is an immediate ability to transport the patient.

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Risk Matrix (3.92)

THE MATRIX IS NOT INTENDED TO REPLACE PROFESSIONAL DECISION MAKING AND SHOULD BE USED ONLY AS AN AID TO INFORM DECISIONS.

EACH AGENCY WILL BE REQUIRED TO UNDERTAKE THEIR OWN RISK ASSESSMENT AND THEN, THROUGH DISCUSSION WITH OTHER AGENCIES, COME TO AN AGREED INTERAGENCY LEVEL OF ASSOCIATED RISK.

THE RISK MATRIX WILL INFORM ASSESSMENTS THROUGHOUT ALL INTERACTIONS WITH THE PATIENT.

POLICE AND HSC STAFF SHOULD DISCLOSE AND DISCUSS ANY KNOWN RISKS AND BE CLEAR ABOUT ANY HANDOVER OF RESPONSIBILITY.

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

MEDIUM RISK – Police assistance MAY BE required		
More than infrequent history of violence or more than AOABH[1], involving weapons, sexual violence, violence towards HSC staff or a vulnerable person **OR** ***LOW RISK patients*** who have disengaged from treatment and where there are MEDIUM RISK threats when disengaged	Person currently presenting with ***some*** behavioural indicators (including substance use) **OR** Some recent criminal / medical indicators that the individual may be violent OR poses a risk of absconding OR is a threat to their own or anyone else's safety	HSC Trusts excluding NIAS: - provide reassurance and explanation to person; - offer support to person; - offer physical support for conveyance e.g. providing assistance out of chair to get into vehicle etc; - utilise family / friends to encourage person; - consider use of support worker model with staff trained in physical intervention; - consider escort model to support person through conveyance; - consider use of medication to reduce levels of anxiety / distress to person NIAS: - support the compliant/disoriented patient from their location, especially if immobile; - move the patient into carry chair or trolley to transport to the ambulance using normal ambulance moving and handling techniques; - apply seat belts; - close the ambulance door; - build rapport and trust with patient; - re-assure the patient regarding the need for transport and the safety of this process; - use negotiation, influence and persuasion techniques to ensure the patient feels safe to travel; and - involve family members, carers, neighbours etc. who may be able to influence the patient's decisions.

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

Key Differences – 1986 vs 2025 Code

Language & Terminology – Modern, rights-based, inclusive.	Human Rights – Proportionality test embedded.	Capacity Interface – Fully aligned with MCA (NI) 2016.
Implementation of regionally agreed templates eg Alternative Care Plan,	Police Powers – Comprehensive guidance and forms in Code.	Oversight – Stronger RQIA and Trust audit expectations.

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Practice Changes for ASWs

- Adoption of new templates
- Greater focus on rights, capacity, and proportionality.
- Risk Matrix established for determining PSNI intervention thresholds.
- Formalised PSNI liaison using new templates.
- Changes to Art 130 procedures
- Clarity provided on warrants

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Governance and Implementation

SOPs and protocols must align with 2025 Code.

Local Interagency Groups established in each Trust to explore and address issues and challenges; co-chaired by Trusts and PSNI

Escalation Protocol arrangements shared by PSNI and NIAS with Trusts, and by Trust ASW and ED Departments with PSNI and NIAS

Ongoing audits will focus on proportionality and least restrictive practice.

Dual-form piloting recommended before new templates are finalised.

Summary

The 2025 Code modernises statutory practice.

Embeds human rights and capacity in all decisions.

Integrates police powers and interagency guidance.

Reaffirms ASWs as guardians of legality, liberty, and dignity.

Establishes consistent, transparent documentation across Northern Ireland.

Introduces changes to Art 130 processes in practice

Clarifies arrangements and requirements for warrants

Reaffirms the necessity of less restrictive alternatives to compulsory admission

Clarifies risk thresholds for PSNI intervention

Right Care Right Person (RCRP)

- Right Care Right Person (RCRP) is a Policing and Health partnership model that ensures people with health or social care needs are responded to by the most appropriate agency, with the right skill set –not automatically police.
- Already implemented in England, DoH are currently working with Police, Trusts and key stakeholders re: implementation of RCRP in N.I

Connection Between Revised Code and RCRP

- The revised Mental Health Code of Practice underpins the principles of RCRP, by clarifying health led responsibilities, reducing inappropriate police involvement, and strengthening lawful, rights based responses to mental health crisis.
- Sets clearer thresholds for police involvement
- Reduces ambiguity in crisis decision-making
- Improved multi-agency coordination