PATIENT & CLIENT COUNCIL

Mental Capacity Act Unit

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BY EMAIL ONLY

Dear Sir/Madam

RE: PCC Response to the Consultation on the Draft Revised Mental Health (NI) Order 1986 Codes of Practice

The PCC would like to thank the Department of Health for facilitating a short extension of time to respond to this consultation.

The PCC is not a mental health specialist body. This response is submitted on the basis that it relates to our broader statutory functions to include; experience of providing generalist advocacy support across health and social care, to concerns about vulnerable individuals navigating an already complex system and healthcare delivery environment. The promotion by HSC bodies of the provision of advice and information to the public, as essential ingredients to improve patient safety, and in that regard, the need for professionals to be provided with all necessary guidance, training and information to deliver safe high quality service, culture and care.

The Role of the PCC

The PCC is a statutory corporate body established under the Health and Social Care (Reform) Act (2009). The HSC Framework Document (2011), produced by the Department, describes the roles and functions of the various health and social care bodies and the systems that govern their relationships with each other and the Department.

The document stipulates that ‘the overarching objective of the PCC is to provide a powerful and independent voice for patients, clients, carers and communities on health and social care issues through the exercise of its legislative functions’ which are:

- Representing the interests of the public;
- Promoting the involvement of the public;
- Assisting people making, or intending to make, a complaint;
- Promoting the provision by HSC bodies of advice and information to the public about the design, commissioning and delivery of services; and
- Undertaking research into the best methods and practices for consulting and engaging the public.

The HSC Framework document further outlines that the PCC has an important independent assurance role for the Minister of Health, based on our statutory functions. The only other organisation that has such a role is the RQIA. The PCC is directly funded by the Department of Health to safeguard its independence from HSC organisations. Paragraphs 6.40 to 6.42 of the HSC Framework Document (2011) further outlines the independent challenge function the Department conferred on the PCC and the RQIA.[1] The RQIA and other bodies were formally consulted on the development of the Code of Practice, however PCC, as a body corporate, were not formally engaged in the development process of the Code. Given PCC's statutory functions, and remit, and the role of PCC Council as a representative body of the public, this was a potential missed opportunity.

PCC facilitate engagement platforms and bring members of the public, with common interest and lived experience, into direct conversation with decision makers from the Department of Health and HSC organisations to improve existing HSC services and plan for the future. The Department and Trust Boards need to continue and promote the integration of the voice of lived experience in their membership, representing the most vulnerable groups including looked after children, people with learning disabilities, people who suffer with their mental health and older people.

PCC provide advocacy services for the public, which range from helpline advice, early resolution of issues, individual advocacy, to supporting people through complaints and serious adverse incidents. If we identify a specific need that we cannot help with, we will try to connect individuals to a partner organisation within the voluntary and community sector or beyond, with the aim of ensuring people do not fall through gaps in the system.

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[1] DHSSPS Framework Document - September 2011 | Department of Health 6 Independent Challenge4:
"6.40. *In considering how the HSC system is held to account, special mention should be made of the Regulation and Quality Improvement Authority and the Patient and Client Council, both of which have a particular role to play. They each provide an independent perspective on the performance of the HSC system, one which validates and challenges the system's own performance management arrangements.*
6.41. The RQIA focuses on the quality and safety of services, using statutory and other standards agreed by the Department to benchmark not only the services but also the governance frameworks within which they are provided. PCC focuses on the interests of patients, clients and carers in HSC services. This goes beyond a straightforward information or advocacy role; it includes working with HSC bodies to promote the active involvement of patients, clients, carers and communities in the design, delivery and evaluation of services. The RQIA and the PCC also have the power to look into specific aspects of health and social care and report their findings publicly to the Department.
6.42. Both of these organisations provide important independent assurance to the wider public about the quality, efficacy and accessibility of health and social care services and the extent to which they are focused on user needs.

Revised Codes of Practice

PCC acknowledge the work carried out, within Cawdrey Workstream 2, to review and create the draft Revised Code of Practice in relation to the Mental Health (NI) Order 1986. It is a welcome, albeit overdue revision of guidance for professionals that aims to provide necessary and clear guidelines for professionals who treat the public under the Mental Health (NI) Order 1986, and follows recent updated guidance under the Mental Capacity Act 2016. It is welcome that the document sets out the expectations, process, and potential interactions between Departmental, Trust and Policing representatives.

PCC recognises the significant advancements in the draft and the work carried out to revise and develop the guidance document in a way that has practical benefit, in that it contains immediate easy access, via links, to the necessary information and resources that professionals may require on the ground, including the provision of guidance flow-charts to provide a visual aid.

It is welcome that the draft revision of the Code of Practice has provided a clearly referenced glossary of definitions of the outdated, no longer universally acceptable, language referred to in the Order, alongside current terminology, which will be of practical benefit to professionals in preventing unnecessary confusion or upset to patients/carers/public.

Implementation and Public Engagement

The Revision to the Code of Practice has stated that it is patient-centred and the introduction from the Regional Service User Consultant, John Morgan, states that everyone including carers and families need to know about the Code and all the communication channels that work together to share information and help professionals make the right decisions. The PCC would highlight the need for a considered and dedicated approach to how the Code will be communicated and socialised with the public in order to achieve this aim. This is a complex and lengthy document, and it is crucially important that it is communicated in a way that is understood by patients, carers, family members and the public and that it is consistently and equitably applied throughout the various Trust areas.

This raises issues around communication, training and independent advocacy, which are further articulated below.

In our recently published People to Partners[2] report, PCC outlines the systemic thinking and changes that we consider are fundamental to meaningfully embed a shift to a ‘do with’ approach across the HSC, moving away from a ‘do to’ approach. This requires a cultural shift across the system, at different levels of engagement and across the HSC, to deliver change. We would encourage the Department to consider a ‘people to partner’ approach when communicating implementing, reviewing and revising this Code. This should include meeting people where they’re at, continuing to seek out opportunities to engage with marginalised groups and those perceived to be hard to reach. This would maximise the engagement of those who may not usually be heard, or who ordinarily would not seek out or access services, in order help address health inequalities.

An agreed understanding of Independent Advocacy – towards a regional model

Independent advocacy support is not only vital for individuals and families, it is a key part of assurance within the Health and Social Care System. Advocacy is not a ‘nice to have’. It:

- Reduces potential for compounded harm
- Addresses inequality and subsequently inequity in complaint and engagement processes.
- Provides assurance and can be a key part of the governance and assurance of any review process
- Enhances potential learning

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[2] PCC (2025) *People to Partners Report.* Accessed here: people-to-partners-final-for-print-081025.pdf

The importance of adequate information provision and advocacy support cannot be underestimated in relation to adults at risk or those treated under the Mental Health (NI) Order or any other Mental Health legislation. The Department has referred to importance of, and the adequate provision of, independent advocacy support, for both individual patients, and in addition to family members/carers, in its recent consultations to which PCC have submitted a response[3].

The findings of recent Inquiries, the outcome of recent SAIs, and the voices of those with lived experience have all raised the provision of adequate, clearly understood information, and access to advocacy support as essential to ensuring a clear partnership with the public that reduces and removes confusion, and as a critical safeguard to patient safety. It was also a key consideration raised by the PCC Mental Health Engagement Platform as referred to below in this consultation.

Advocacy:

- Safeguards people who can be treated unfairly as a result of institutional and systemic barriers as well as prejudice and individual, social and environmental circumstances that make them vulnerable.
- Empowers people who need a stronger voice by enabling them to express their own needs and make their own decisions.
- Enables people to gain access to information, explore and understand their options, and to make their views and wishes known.
- Speak up on behalf of people who are unable to do so for themselves.”

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[3] PCC (2025) *PCC Response to Adult Protection Bill.* Accessed here: pcc-submission-to-the-health-committee-on-the-adult-protection-bill-311025.pdf
PCC (2025) PCC Response to Learning Disability Service Model;
PCC (2025) PCC Response to Response to Neighbourhood Model of Care.

The importance of advocacy services was recognised by the Inquiry into Hyponatraemia-Related Deaths (IHRD) report8, with its recommendations outlining the need for service users, and families, to ***have access to independent advocacy support***. Recommendation 37 (iv) being: '*Trusts should seek to* maximise *the involvement of families in SAI investigations and in particular: a fully funded Patient Advocacy Service should be established, independent of individual Trusts, to assist families in the process. It should be allowed funded access to independent expert advice in complex cases'.*

The availability of independent advocacy assists in creating a culture of openness and transparency and plays a fundamental role in governance, assurance and addressing inequality.

PCC have demonstrated that access to early resolution through independent advocacy saves money and delivers better outcomes for the public, for services and for staff, preventing concerns from escalating and enabling earlier intervention. "*Our drive towards early resolution and a focus on restorative practice is reflected in 60% of cases being resolved, an increase from 57% in 2023-24 and 45% in 2022-23.*"

The current landscape of advocacy support provision across the HSC service is fragmented. Based on experience and insights from listening to, and working with, members of the public, along with the evidence provided to a number of public inquiries, PCC believe that the independence of independent advocates, understood in ***financial, psychological and structural terms***, is critical and is the expectation of the public.

PCC considers that for the Department to practically support the increasing reference and potential reliance on independent advocacy support in its various policy initiatives[4], including these Codes of Practice, a Regional Independent Advocacy Service model that is structurally, financially and psychologically independent, needs to be established.

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[4] Neighbourhood Model of Care; Adult Protection Bill; Mental Health Codes of Practice; Learning Disability Service Model.

Independent Advocacy v Legal Support

To that end, within this revision of the MH Codes of Practice Guidance, PCC has identified, and is concerned to note, that provision for advocacy support is not distinguished at all from that of legal support.

PCC ask the Department to reconsider this section of the Revised Code, and in particular, how the Revised Code will provide guidance to professionals on the provision of advocacy support, or specialised mental health advisors, in advance of, or in absence of, any deprivation of liberty or legal process.

At paragraph 1.1, the Revised Code of practice states:

*All patients detained **or treated** under the Order have a fundamental right to understand, exercise, and challenge decisions affecting their liberty, treatment, and wellbeing. The provision of timely, **independent advocacy** and **legal advice** is a critical safeguard against unlawful detention and supports informed decision-making.*

It thereafter sets out how and where to find access to **legal advice** but does not provide any guidance on the provision of **independent advocacy** support.

The final paragraph of the section states:

> *"Trusts should ensure that the patient information they provide includes information on how the patient or their family can access specialist mental health advisors and Tribunal and Appeal information. Trusts should also ensure arrangements are in place both for the provision of patient information and their assurance arrangements"*.

In the current form, the Revised Code has the potential to equate the two and create confusion in the understanding of the difference between independent advocacy support and that of legal support.

Advocacy support is not legal support or legal advice. They each have distinct functions and roles and will need to be clearly articulated in this document. Professionals who use the Codes of Practice will need clear guidance and clarity on this matter given that the Department has indicated that adherence to the Code will be relied upon in future proceedings.

The language of the final paragraph in this section should also be revisited, as it leaves the provision of access to specialist mental health advisors to Trusts and places it alongside Tribunal and Appeal information.

Clarity for Professionals

There does not appear to be any reference to the provision of independent advocacy support for those being "**treated**" under the Order or adequate clear guidance for professionals as to how to access, or when to access independent advocacy support, ***at treatment stage*****.** This is a critical safeguard to support informed decision-making.

The guidance document refers to "All patients detained or treated under the order". It is imperative that professionals are provided with clear guidance on the *need to* provide advocacy support to those being *treated under* the order, not just those who *are detained* and that they understand what the process is, what is happening, and why it is happening. This is, as stated, a critical safeguard and supports informed decision-making.

PCC believe that the Code of Practice should be revised to set out a clear process for professionals to follow (that can be clearly understood by patients/families/carers/public) for provision of, and access to, locally available independent advocacy support at the earliest opportunity and not as a reactive crisis intervention.

Support for the public

In this regard, the revised Code of Practice, PCC believes, does not provide adequate assistance to patients/families/carers, in its current form to access independent advocacy services.

Katherine McElroy (Principal Professional for Advocacy at the Patient and Client Council, PCC) highlighted this recently in Freedom, Care and Wellbeing – A review of the deprivation of Liberty Safeguards COPNI[5]:*Katherine McElroy - stresses that communication with the people involved in the DoLS process should improve. According to McElroy, members of the public often do not understand the process that begins when one of their loved ones is suspected of lacking capacity. McElroy stressed that most of the people who contact the PCC do so because they do not understand what's happening. They have been told that their loved one is going to be assessed under the MCA, and they don't understand what that means for them as a family and for their loved one. They probably have been given paperwork, or they've probably been given leaflets, but how it practically impacts on them as a family member or their loved one is something that they find very difficult because there are so many stakeholders involved, you know there could be social workers, there could be mental health professionals and there's maybe a DoLS assessor and there's people in the nursing home or whatever. They're overwhelmed".*

PCC considers that greater consideration should be given to how the public access and are informed of independent advocacy services within the Code, and how this then links to a consistent and regionally delivered independent advocacy model.

Independent Mental Capacity Advocates

In relation to the Mental Capacity Act, the provision of Independent Mental Capacity Advocates is also provided for but not implemented, which has implications for patients, families and carers within the broad context of the issues with the Code of Practice. Independent Mental Capacity Advocates need to fit into a regional approach to advocacy services providing the right service, at the right place, and at the right time.

As Katherine McElroy (Principal Practitioner for Advocacy at the Patient and Client Council, PCC) stated in Freedom, Care and Wellbeing – A review of the deprivation of liberty safeguards, "*there was an opportunity to implement IMCAs at the commencement of the Act, which would have fostered a better environment to safeguard P's best interests amid family and institutional dynamics. She explains that IMCAs could represent P's interests, particularly in cases involving challenging*

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[5] COPNI (2025) *Freedom, Care and Wellbeing: Review of Deprivation of Liberty Safeguards* Accessed here: [Freedom-Care-and-Wellbeing.-Review-of-Deprivation-of-Liberty-Safeguards.pdf]

family relationships. McElroy notes that one Trust has contacted her office on a number of occasions, asking PCC to "almost step in as mediator," a role that they could not take on. She argues that adequately trained IMCAs could provide valuable support in these and other situations. McElroy concludes that the advocacy issue "should have been a priority and should still be a priority before anything else is addressed.

PCC Mental Health Engagement Platform - Key Considerations:

PCC Engagement Platform is a space to bring together a group of people, with a common theme or interest and lived experience, to work together and make change in health and social care. PCC Engagement Platforms allow participants to communicate their experiences and insights, related to a policy programme, with the PCC, as well as being able to share their views directly with decision-makers in health and social care. Engagement Platforms are a significant opportunity for decision makers in health and social care to have meaningful input from experts by experience, in service areas or policies under review, development and reform.

The PCC Mental Health Engagement Platform has operated since 2021. It brings together the lived experiences of those living with and caring for family members with Mental Health issues.

The Platform have regularly met with the Department of Health (DoH) on a number of matters. In relation to the proposed Revised Codes of Practice, Phil Hughes MBE attended and delivered a presentation. As such the MH Engagement platform provided high-level generalist feedback on lived experience of the areas covered by the code directly to the Department, highlighting:

- Poor communication, lack of information, failure to keep families/patients updated. Access to accessible user-friendly information.
- The importance of timely access to independent advocacy support.

- Mental Health Care Provision should be properly resourced and funded – raising recent concerns arising from the Mental Health Strategy and the lack of funding to deliver it.
- Delay in access/Availability of professionals (recruitment of new professionals)
- The need for updated adequate training for staff/professionals to include interagency training that is regularly updated – so that interconnected agencies each knew their own role and responsibilities and how they interact with each other in the best interest of the patient.
- Tensions within the system on overlap between various elements of Mental Health Order, Mental Capacity Act, and other legislation.

Understanding Professional obligations, Training and Resources

The Revised Codes of Practice will be a go-to guide for professionals in relation to the provision of care for patients/families/carers and the public. There is a clear professional responsibility to follow the Revised Code of Practice.

As such it is imperative that the Code of Practice is clear and adequately provides the necessary information, processes, pathways, access to reference material including legislation and updated case law/learning materials, to support and ensure that they can carry out their duties to the highest possible standards of care as a critical safeguard to patient safety.

It is important for the safety of staff and patients that they are provided with up to date, fully resourced, training and that this is provided to all those expected to use and rely upon the Guidance, and that such training is regularly reviewed to include updated, or specific training, in light of learning opportunities. This should include training in relation to engaging with the patients, public families and carers, reflecting on the objectives of patient centred care.

There is a particular need to ensure that staff are fully trained on the interface tensions and overlap between various elements of Mental Health Order, Mental

Capacity Act, and other legislation and how they operate in practice. In addition, such training should include interagency training – so that interconnected agencies each know their own role and responsibilities and how they interact with others in the best interest of, and seeking the best outcomes for the patient. PCC welcome the development of Memorandums of Understanding that should be co-designed and developed with appropriate and adequate engagement of those with lived experience.

Resources

PCC remain concerned that there is a lack of resources to implement the Mental Health Strategy and the MH Care Pathway in full. A lack of availability of staff, including Approved Social workers, and sufficiently trained professionals can cause delay and difficulties. This remains a source of constant concern for both staff and patients and their families/carers.

Regular, timely revisions triggered by significant learning opportunities.

The Mental Health (NI) Order 1986 contains a requirement on the Department to review the code from time to time. Revisions of the Codes of Practice have been sparse and irregular in the intervening 40 years despite advancements in HSC care provision and the practical application of the Order. This has not been assisted by the phased and only partial implementation of this Order, and the only partial implementation of the subsequent Mental Capacity Act 2016.

It is PCC's position that future reviews of the Codes of Practice, as necessitated by the 1986 Order, should be both regular and timely and based on appropriate engagement with those with lived experience and learning opportunities.

In addition, PCC believe that the Department should consider that a revision of the Code of Practice, under the 1986 Order, should be triggered following significant learning opportunities such as Patient Safety Incidents, regulatory / official reports, and public inquiries; demonstrating a clear commitment to being a learning system, committed to meeting the statutory duty of quality, and to ensure professionals have access to fully informed, up- to-date guidance at the earliest opportunity.

Such an approach assists in fostering a positive cultural change to improving patient safety, improving workplace culture in HSC by listening to and involving all health care professionals and staff in service delivery, care and culture. Recognising the importance of health care professionals, staff and patients' voices in improving the culture, and recognising the need for them to be at the core of implementation and action is key - involving the public in HSC processes in a way that is transparent, open and embraces them as assets, as set out by PCC in our Professionals and the Public: In Partnership for Patient Safety' report.[6]

According to the projected timeframe contained within the consultation it is proposed that the Revised Code of Practice is anticipated to be completed by February 2026. PCC notes that it is anticipated that the revised Code of Practice will be operational just in advance of the publication of the report into the Muckamore Abbey Hospital Inquiry (expected in March 2026) and the introduction of the Adult Protection legislation.

It is critical that consideration is given to how this Revision of the Code of Practice will include any recommendations from the anticipated Inquiry Report, and any matters arising from the final draft and implementation of the Adult Protection Bill.

There are real challenges for professionals and patients, carers and their families, in treating adults at risk, or requiring assistance or treatment under the Mental Health (NI) Order 1986 or under the Mental Capacity Act.

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[6] NHS Scotland. (2013) *Independent Advocacy Guide for Commissioners*. Accessed here: Independent Advocacy Guide for Commissioners
Independent Advocacy Guide for Commissioners Inquiry into Hyponatraemia related Deaths (2018) *The Inquiry into Hyponatraemia-related Deaths Report.* Accessed here: Full-Report.pdf
9 PCC (2025) *PCC response to Being Open Framework Consultation.* Accessed here: being-open-framework-pcc-response.pdf
10 Reference the ICS report which will be forthcoming
11 PCC (2025) *Chief Executive's Summary, page 6, PCC Annual Report 2024-2025*. Accessed here: pcc-annual-report-and-accounts-2024-2025-final-with-cert-october-2025.pdf

Adult at risk legislation remains at Bill stage as the Adult Protection Bill, and the current applicable law has never been fully implemented. Therefore, professionals, across both health and social care and policing, and the public, are navigating a web of legislation that is complex, only partially implemented and confusing. The proposed phased implementation of the Adult Protection Bill will only add to that confusing picture and these Codes will operate within that context. Clarity will therefore be required where the legislation intertwines, and where it interfaces with the Codes and practice.

PCC reiterate our concern that the revised Code of Practice is proposed to be operational just in advance of the publication of the report into the Muckamore Abbey Hospital Inquiry (expected in March 2026) and the introduction of the Adult Protection legislation. Further consideration should be given to how the Code of Practice will be revisited or updated in light of the anticipated findings/recommendations, as key learning opportunities that will be applicable to professionals in order that they adequately comply with the Code and will be necessary to alleviate public concern.

Yours faithfully

M. Monaghan

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Chief Executive