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Assembly

COMMITTEE FOR HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Departmental Briefing on Mental-Health Services

12 November 2009

NORTHERN IRELAND ASSEMBLY

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AND PUBLIC SAFETY

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Members present for all or part of the proceedings:
Mr Jim Wells (Chairperson)
Mrs Michelle O’Neill (Deputy Chairperson)
Mr Alex Easton
Mr Sam Gardiner
Mrs Carmel Hanna
Mrs Dolores Kelly
Mr John McCallister
Mrs Claire McGill
Ms Sue Ramsey
Mrs Iris Robinson

Witnesses:
Dr Maura Briscoe)
Mrs Linda Brown) Department of Health, Social Services and Public Safety
Dr Ian McMaster)
Ms Christine Smyth)

The Chairperson (Mr Wells):

I welcome the delegation from the Department of Health, Social Services and Public Safety (DHSSPS). Linda, you have worn many hats over the years.

Mrs Linda Brown (Department of Health, Social Services and Public Safety):
So many hats.

The Chairperson:
You worked in the Department of the Environment, the Department for Regional Development, and you are now working on mental-health legislation in the DHSSPS. Linda is the deputy secretary of the social policy group. We are also joined by Dr Maura Briscoe, the director of mental-health and disability policy, Ms Christine Smyth, the acting assistant chief officer of the office of social services, and Dr Ian McMaster, who is a medical officer. You will have an opportunity to make a presentation, and members will then ask questions.

Mrs L Brown:
Thank you for affording us the opportunity to say a few words as we open the discussion on the important topic of mental-health legislation. We have provided the Committee with a short paper on the legislative proposals. I will begin by speaking about the key elements of those proposals.

I want to give some background details, which are important in understanding what actions we need to take. The Bamford review, with which we are all familiar, first identified the need for new legislation in Northern Ireland. It recommended the development of a single legislative framework for the reform of the Mental Health (Northern Ireland) Order 1986 and the introduction of new mental-capacity legislation.

The Department took advice from the Office of the Legislative Counsel, and it, supported by the Executive of the time, took the view that the most pragmatic way to ensure that legislation was enacted in this Assembly was through the development of two separate pieces of legislation — one piece on mental-capacity legislation and one piece on mental-health legislation — underpinned by a common set of principles, as recommended by the Bamford review. Subsequently, on 2 January 2009, the Department issued a consultation booklet, ‘A Legislative Framework for Mental Capacity and Mental Health Legislation in Northern Ireland’.

The consultation ran for three months and ended on 31 March 2009. Seventy-six organisations and individuals made substantial responses. They all indicated a measure of general approval for the direction in which we wish to move in Northern Ireland. However, a strong body of opinion wanted only one piece of legislation rather than two. The Royal College of Psychiatrists, the Royal College of Nursing, the British Association of Social Workers, voluntary groups such as the Mental Health and Learning Disability Alliance and organisations representing service users and carers all said the same thing.

Respondents recognised that a single Bill would take longer to deliver but maintained that the Department should get it right and produce one piece of legislation rather than two. The Minister then took a decision and, on 10 September 2009, issued a press release in response to the consultation in which he advised of his intention to proceed with a single Bill, based solely on the responses that he had received.

The Bill will mean that people with impaired mental capacity, regardless of the underlying cause — a physical illness such as a brain injury or a mental-health issue — will be dealt with under the same legislation. Such an approach aims to drive societal change and will promote the de-stigmatisation of those suffering from mental disorders. The stigma that is attached to mental health is a major problem in advancing services. The Bill will also provide additional safeguards for people with an impaired decision-making capacity on their health, care, welfare and finances.

The timing of the process has now changed. A single Bill will be a long piece of legislation. In fact, it will be the largest piece of legislation ever passed in Northern Ireland with some 250 to 300 clauses. It will also be a world leader in its innovation, and there is no existing legislative model that we can use for our legislation. Therefore, it will not be possible to bring forward draft legislation in the lifetime of this Assembly. More time will be required to prepare and deliver this significant social legislation. It is expected that a draft Bill can be prepared and introduced into the Assembly in late 2011, with enactment in the 2012-13 session. However, the Committee for Health, Social Services and Public Safety will be responsible for legislation to amend the existing 1986 Order. I will explain the reasons for that and outline the timetable for the Committee's engagement on that matter.

A substantial amount of policy development will be required, involving extensive engagement with service users, carers and professionals to ensure that the Bill is fit for purpose. Consequently, members, as political representatives, can expect to hear debate in wide-ranging circles in Northern Ireland on those issues as the Department begins to elaborate on them to the public. An assessment of the implementation costs of the new legislation and an equality impact assessment (EQIA), which is normal in such cases, will be undertaken in the coming months.

The Executive will consider the costing details as well as a policy memorandum in spring 2010. The issues will be raised again in a new Assembly.

Although we do not know the details of future policy, we have an outline for the Bill that will help to shape its content. We are also clear that the Bill will include individuals with a personality disorder, who are excluded under the 1986 Order. An easy way for members to remember the intention of the Bill is that it concerns three Ps: principles, powers and protections. The three Ps are designed to support the more vulnerable people in society. There will also be safeguards for those who lack capacity, and there will be support for carers.

The Bill will be principles-based, in that its provisions will be compatible with the Bamford principles — I will explain them later — and that, once implemented, decision-makers will be required to take account of them. If those principles are embedded in this huge piece of legislation, they will help the drafting process to ensure that the correct elements are being included and that we are doing everything correctly.

There are four principles: autonomy, which means respect for a person's capacity to decide and act in his or her own right and not to be subject to restraint or coercion by others; justice, which means applying the law fairly and equally; benefit, which means promoting the health, welfare and safety of the person while having regard to the safety of others; and least harm, which means acting in a way that minimises the likelihood of harm and is the least intrusive way.

The additional powers in the legislation will be capacity-based, which means that there will be a statutory presumption of mental capacity for all of us. The only gateway into the legislative provisions will be when an individual lacks capacity. The only way that the state will intervene and take control will be if a person lacks capacity and has no additional safeguards in place. That means that individuals who retain the mental capacity to make their own decisions will be allowed to do so — for example, with regard to their treatment, welfare and finances. In circumstances in which an individual lacks capacity, substitute decision-making arrangements will be put in place that will include the power to make decisions to assess and treat mental disorder.

The protection of the individual and of society will remain at the heart of the mental-health provisions of the single Bill, although the inclusion of the benefit principle, which provides for the safety of the person and of society through the retention of a risk factor, will be among the criteria to be met. All that has still to be worked out.

Members will, no doubt, hear some of the substitute decision-making arrangements being discussed, even in their day-to-day lives. There will be a general authority that will allow practitioners and carers to undertake routine tasks on a person's behalf; approved interventions for more serious decisions; powers of attorney and court-appointed deputies to take decisions within the limit of their authority; advanced decisions may be taken on future treatment when capacity is lost; and there may be guardianship in situations in which long-term decision-making is required.

I will move on to protections. Improved safeguards will be provided for those vulnerable individuals who are affected by the legislation. Those safeguards include respect for decision-making by those with capacity — if a person has capacity, his or her wishes and ability to take decisions will be respected; the need for decision-makers to take account of the statutory principles; and a system of safeguards that is proportionate to the seriousness of the decisions that are to be made. There will at all times be a requirement to act in the best interests of the incapacitous person; improved access to the Mental Health Review Tribunal to ensure that the right decisions are made; new protections for those who are deprived of their liberty for their care and protection; provision of advocacy services; and a system of nominated persons to ensure that the views of those who are incapable of making decisions are taken into account.

Those provisions are innovative and will make us a world leader, and members will want me to relate what is happening in England and Scotland that has led us to this point. Substantial legislative change has already occurred in the neighbouring jurisdictions. England, Wales and Scotland have introduced new mental-capacity and separate mental-health laws in the past decade. The Republic of Ireland is also preparing separate mental-capacity legislation. There is much to learn from those pieces of legislation, in particular, the mental-capacity legislation in England and the mental-health legislation in Scotland, which have given us useful models.

Leading UK experts, however, continue to identify big interface problems between the two pieces of legislation. Those experts contend that separate mental-health legislation continues to have a stigmatising effect on those who suffer from mental-health difficulties. The Department hopes to resolve those issues by way of its single Bill approach. The timetable for the work shows that much preparation will take place up to the end of June 2011, but the current Executive cannot clear the Bill. That will be the job of another Committee and Executive to do.

I will briefly conclude by turning to the job that is more closely at hand for the Committee, which is the interim measures that must be put in place for the 1986 Order. The non-delivery of the single Bill in this Assembly's mandate will require us to change the law with interim measures to mitigate the risk of a challenge from European Court of Human Rights decisions. Those judgements relate to the "nearest relative" provisions in the Mental Health (Northern Ireland) Order 1986. Currently, patients cannot challenge the appointment of their nearest relative, who could influence decisions that may not be in a patient's best interest. For example, the relative may have been the person's abuser yet, in law, he or she will be nominated as the nearest relative. Therefore, the Department intends to amend the 1986 Order to give patients the right to apply for displacement of their nearest relative and to add grounds of unsuitability. That proposal will be brought forward during the lifetime of this Assembly, and the Department proposes to use the safeguarding board Bill as a vehicle through which to carry the amendments to the 1986 Order. Christine's branch will sponsor the Bill, which will be introduced to the Assembly in the first part of 2010.

The second issue deals with compliant incapacitous patients who have been deprived of their liberty. Additional safeguards are required to prevent unlawful deprivation of the liberty of compliant patients — that is, patients who have been informally admitted to a hospital or a nursing home for their own safety but lack capacity to make decisions themselves or to object. The Department intends to issue interim guidance in advance of the legislative provision in the single Bill to advise the health and social care trusts of the implications of the judgement and to outline the actions that they should take in the interim.

In conclusion, the Minister's decision to proceed with the single Bill has been broadly welcomed by major service users and professional bodies. In response, the Royal College of Psychiatrists, the Royal College of Nursing and the Mental Health and Learning Disability Alliance swiftly issued press releases that endorsed the Minister's approach. The Bill represents a transformational approach in Northern Ireland and will ensure that individuals with a mental disorder or a learning disability are treated in the same way as other people and that their dignity and human rights are fully protected. The drafting of amendments to the 1986 Order is an important job. The legislation will come to the Committee and will use the vehicle of the safeguarding board Bill.

I hope that our presentation and the briefing paper help to outline the big picture for the way ahead. Policy formulation is at an early stage, and we have not yet reached conclusions on several issues that are outlined in the paper. However, I hope that we can answer the Committee's questions at this early stage.

The Chairperson:
Will any other members of the delegation speak?

Mrs L Brown:
No; that is our collective view.

The Chairperson:
Is it correct to say that the Assembly does not have much option but to amend the 1986 Order because it must comply with European directives? The amendments will be introduced to bring us into line with European decisions.

Mrs L Brown:
It is compulsory, given our much longer timetable for the introduction of legislation that deals with mental capacity and mental health. If two Bills had been introduced in parallel and if they were to be completed during the lifetime of this Assembly, the European Court of Human Rights would have been satisfied. However, given the lengthy timetable for the larger piece of legislation, we must amend the 1986 Order. We cannot proceed with the Order in its current form.

The Chairperson:
The Assembly has little latitude on that matter because it is compelled to amend the 1986 Order early to adhere to European decisions. In essence, we will rubber-stamp the legislation because we have no other option.

Mrs L Brown:
It is not a case of rubber-stamping. Yes, the Assembly must introduce the legislation. However, I expect that the Committee will want to discuss the proposals during the drafting of the

legislation. The issue of the nearest relative must be worked out more fully, and the Committee should be aware of the implications of that.

The Chairperson:

There is a constant theme in the Assembly. We are promised that major legislation will be introduced at a certain date. However, we could put our life savings on the fact that members will receive a letter, as we did this afternoon, that states that legislation has been delayed. That sometimes happens with basic legislation. Is there any guarantee that you will keep to the timetable, given that such a huge undertaking is bound to raise all sorts of complexities?

Mrs L Brown:

Our legislative team is working flat out to go through the policy issues and to deal with matters that are timetabled at the forefront of the legislation. However, there is no accounting for how long it will take for such lengthy and complicated legislation to make its way through the Assembly. It covers functions that are not yet devolved. The proposed legislation covers the courts, prisons, our Department and other interests. Therefore, the legislation is complex, and, given the number of clauses, its ultimate resolution will be determined by the speed of its Assembly passage.

The Chairperson:

I know how difficult the 1986 mental-health legislation was — I was here for it — and that that Order was much less complicated than the proposed new Bill.

Mrs L Brown:

That is right.

The Chairperson:

I am showing my age by saying that, but I remember clearly how difficult that issue was. I wish the Department well in trying to adhere to the timetable. Success may lead to a couple of OBEs.

Mr McCallister:

You are welcome. There is much public support for the Bill, but, like all good things, the devil will be in the detail. Groups on the ground have given me the impression that there is a move towards mental-health services routinely directing people to Muckamore Abbey Hospital, bypassing some parts of the system. Will the Bill, and even the interim measures, put power firmly back in the hands of patients and their carers to prevent their being pushed down an avenue with which they are neither happy nor compliant?

Mrs L Brown:
Is that a reference to the patients' resettlement policy?

Mr McCallister:
It refers to both resettlement and to people who are going through the system. Groups have lobbied me strongly that Muckamore Abbey Hospital is being presented to people in need as the only option on offer. I want to know how the proposed new Bill, and the Department's amendments to the safeguarding board Bill that are due to be introduced early next year, will guarantee that that will not happen and that services will work with people. The public give me the impression that there is a conflict between what carers and health professionals wish to happen. I want clarity: will the Bill empower people to reject a course of action for the loved one in their care?

Mrs L Brown:
The amendments to the 1986 Order will not take us in that direction, because those amendments are quite small, albeit important — for instance, the provision for a nearest relative.

However, the large Bill, which will cover mental capacity, is all about the human rights and dignity of individuals, their advocates and family to make decisions in their best interests. The Bill will include increased statutory provisions for advocacy so that people who have difficulty speaking up for themselves, or who do not have nearest relatives as observers, will have an advocate in the system if that is needed.

Mr McCallister:
Thank you; that is very welcome.

Ms S Ramsey:
I welcome the witnesses and thank them for their presentation. I do not want to appear to be too negative. It strikes me that the Bamford review was seen as one of the most radical ways forward in dealing with mental-health and related issues. The Bamford report was published in 2007. If I

have picked it up correctly, the Department is now saying that the legislation, which it regards as the way forward, will be introduced in 2012 or 2013. That is nearly seven years after the Bamford report was published. We are dealing with individual human beings and problems in the community.

My concern is about a letter in members' packs today that states that a piece of DHSSPS legislation has been delayed; the Chairperson referred to it earlier. Is the Department happy that the proposed new Bill will not be brought forward until 2012 or 2013? Is there another reason for the legislation not being introduced? Is the Department simply employing another stalling tactic?

Mrs L Brown:
As I pointed out in my presentation, the original proposal from the Minister and the Executive was that the changes to the legislation would be made in the lifetime of the current Assembly — in other words, as soon as it was possible to get legislation through.

However, the Minister agreed with the strong body of opinion from the service users and carers, and from the professional bodies, who said that they knew that the single piece of legislation would delay the process but that they wanted that single piece of legislation because of what they had seen happening in England and Scotland. They believed that the continuance of a separate mental-health Order in Northern Ireland would have a stigmatising effect. Those people knew that, if their comments were accepted, the legislative changes could not happen in the lifetime of this Assembly. The Minister and the Executive wanted to introduce legislation earlier, but a strong body of opinion changed that position.

Ms S Ramsey:
I want to come back on that quickly.

The Chairperson:
Feel free. We have plenty of time.

Ms S Ramsey:
I am not always happy about parity legislation. What is right for people in England is not necessarily right for people here. You mentioned the legislation in England and Scotland, and I am happy to lift good ideas, if they are good, and run with them.

I am concerned that the legislation will be put back on a different time frame. The public do not understand all that needs to be done in relation to legislation. The public want something done now, and, without being critical, I stress that the legislation must be enacted as quickly as possible. Seven years after the Bamford review, we must get information to the public about why the legislation has been delayed.

Mrs L Brown:
When the Minister said that he would take account of the body of opinion that emerged from consultation and would introduce a single piece of legislation, he said that, because of the length of the legislation that would be needed, it could not be completed yet. I accept that. I do not wish to mislead the Committee; we share your view on wishing to pass the legislation quickly, but that cannot be done in the lifetime of this Assembly because it is too lengthy. It could not be done in the time that is available. As I said, that issue was clear to those who lobbied for a single piece of legislation.

You raised a wider point about the time taken to implement the Bamford review. Legislation is one element of the implementation of the Bamford review. The review made 700 recommendations, and the action plan has been published and dealt with. The money required was gathered through the comprehensive spending review (CSR): £44 million in addition to the baseline, and £87 million in total, will be available by the end of the CSR period. The money and the action plan are in place, and many of the actions are well advanced. Legislation is intended only to be one part of the implementation the Bamford review.

Mr Gardiner:
Thank you, Mrs Brown, for your presentation. It is welcome that you are trying to take steps to protect people with mental-health issues; that is to be encouraged. How do you cost it? We know how tightly the Health Service is run, and, if the legislation is to be implemented, the costs for the years ahead will have to be taken into consideration so that the Minister of Health, Social Services and Public Safety is not running to the Minister of Finance and Personnel with a begging bowl to ask for funding. The funding should be allocated if it is to be done correctly.

Dr Maura Briscoe (Department of Health, Social Services and Public Safety):
Costing is one issue with which we have to deal in our project structure. We have not costed it

yet because we are still at the policy development stage. The policy paper that we are due to present to the Executive in March or April 2010 will include the high-level costs that will be needed for implementation and the equality impact assessment. Several areas need to be costed, and it is important to realise that the issue does not impact only on health or, indeed, on mental health. It impacts across a range of conditions in which an individual might be incapacitous, including housing, finance, welfare and care. It will impact on the Court Service. It will impact on how Mental Health Review Tribunals are conducted. To do that, there will have to be a major training component for staff and public information awareness. Proposals will have to be made and costed. That is why it is a cross-governmental Bill as opposed to a DHSSPS Bill, although we will be the lead organisation

Mr Gardiner:

Thank you for that response. At the end of the day, to implement all of that will cost millions of additional pounds.

Mrs L Brown:

There will be additional costs — for example, those that are associated with new advocacy arrangements. A court protection arrangement may have to be put in place. There will probably be costs for Mental Health Review Tribunals. At present, those are probabilities. There will be additional costs. However, none of those costs will happen until the next comprehensive spending review. Therefore, we have time to work them out. The Assembly, of course, will not agree to any legislation unless it has been costed, and Members understand what they are getting into.

Mr Gardiner:

It is good to ring the signal bell to let us know what to expect.

Mrs L Brown:

Absolutely. It cannot be done without cost implications.

Ms S Ramsey:

If we do it correctly, millions of pounds will be saved in the long term. That is the key issue.

Mrs D Kelly:

Thank you for your presentation. To pick up on your point, Chairperson, if we are going to comply with EU directives on mental-health legislation, we are not starting with a blank sheet of paper.

Some of the costs represent good practice in policy proposals. Therefore, much groundwork can be done in the absence of legislation — for example, to ensure that community treatment facilities are already available. Surely we are not saying that current advocacy and guardianship arrangements are below standard: they are already of a high standard. It is the role of many professionals, particularly social workers, to be advocates for their patient or client. Therefore, we are not starting with a blank sheet of paper.

Particularly with regard to matters of guardianship and nearest relative, I would have thought that those were fairly straightforward pieces of legislation and amendments that could have been brought forward earlier to provide some certainty for a person who is subject to the test for mental-health capacity. I would like more information on those amendments.

The Committee Clerk's briefing paper mentions equivalence for forensic patients. I am not sure that everyone knows what is understood to be a forensic patient. Does that mean — to use a crude definition — the criminally insane, or does it mean people who have been through the courts and are then detained in healthcare institutions or wards rather than in prison? Clarification on that would be useful.

What resources will be put into community treatments? We have learned lessons from what has happened in England and Wales, where, according to your own submission, the system did not work because facilities were not provided in advance of the legislation's becoming law.

Mrs L Brown:

I will begin to respond to those important questions and will, perhaps, bring my colleagues in on some specific points. The entire direction of Bamford's recommendations is towards putting more skills, resources and emphasis on treatment in the community rather than in hospitals. We want to ensure that people go into and remain in hospital only when they really have to. The best option for most people is to be treated in the community in their own homes. That is Bamford's entire direction: the money that we have secured and the strategies that we have put in place are designed to do that.

Mrs D Kelly:

I am sorry to interrupt. As someone who worked in mental health at one stage, I am aware that that was also the policy of the Griffiths report, which was not only about mental-health patients. That report was published some 22 years ago.

Mrs L Brown:

I have been around for that long. Committee members know better than anyone about the dreadful state of mental-health services in Northern Ireland, which is why we needed the Bamford report. All of the things that you say were wrong actually were wrong. The aim of the Bamford report was to map out a way for the future.

The difference between what we are trying to do now and what may have happened in the past is that we are not attempting to improve mental-health services piecemeal by fixing small elements here and there. We are attempting to move the entire issue forward so that community health can be improved without ignoring the advances that need to be made in dealing with seriously mentally ill people in hospital. That can also be improved through providing them with more therapeutic arrangements, better care plans, advocacy, and so forth, as your colleagues said. The situation has changed now, and we are trying to do that. Money has been invested to move matters forward in that way.

In England, Scotland and Wales, people can be treated through a community-based treatment order. If people are assessed as needing treatment, it may be decided that they need to be detained and treated in a hospital or that the treatment can be given in the community. In Northern Ireland, if people need to be detained for treatment, they can be detained only in a hospital. We do not have the legislation or the infrastructure to enable that to be done in the community.

The reason why we cannot deal with some issues by way of amendments to the 1986 Order is because we have no capacity legislation. That is the key point. In England, Scotland and the Republic of Ireland, there is mental-capacity and mental-health legislation. Northern Ireland has only mental-health legislation. We do not have the legislation to allow people to be trained to measure a person’s capacity. If someone’s loved one visits a doctor and appears to be mentally ill, there will be a system in law in the future that will mean that a doctor has to assess that person's capacity to make a decision.

If people are offered medical treatment and want to refuse it, a doctor will have a system to test their capacity to make that decision and whether their illness is affecting their ability to understand what should be done for their own good. That must be set in law because, as members will appreciate, there must be an entire structure and assessment regime, and people must be trained, and so on. It has to be enshrined in law or people will not do it. My colleague Ian McMaster will now outline what "forensic" means in that context. If members wish to, they may ask Christine questions about the role of social workers. We can work only within the legislation that we have, and we do not have mental-capacity legislation.

Dr Ian McMaster (Department of Health, Social Services and Public Safety):
Mrs Kelly is correct, in that the definition of a forensic patient is someone with a mental disorder who has come into contact with the criminal justice system. One would expect forensic services to manage people who may pose a significant risk but, for whatever reason, have not appeared before a court. It is probably also worth making the distinction that many people who are in contact with the criminal justice system do not necessarily pose a significant risk that would require specialist forensic services. They may suffer from general anxiety, depression or alcohol or drug misuse, and they would, therefore, benefit more from generic mental-health services than a forensic input.

Mrs D Kelly:
There are concerns that the removal of the current exemptions on alcohol or drug dependency might weaken the definition of mental disorder. The 1986 Order removed psychiatrists' ability to admit people while under the influence of drink or drugs; I remember that well. That was not always a good thing not only from a carer's perspective but for a patient in the longer term. Will that change in the new legislation?

Dr McMaster:
If someone suffers a lack of capacity and fulfills other criteria, he or she could still be compulsorily admitted. It is unlikely that someone in a short-term intoxicated state would be admitted to a mental-health facility.

Mrs McGill:

I thank the witnesses for their briefing. Will those interim measures eventually be included as provisions in the single Bill?

Mrs L Brown:

We must introduce the interim measures to go as far as we can in making changes to the nearest relevant provision. However, when the single Bill is introduced, we can do much more to link all the nearest relative measures into all the other provisions on mental capacity. To enable us to do that, we must have the mental-capacity legislation. Therefore, we can go as far as possible with an amendment, at present.

Mrs McGill:

I am unclear. Is it correct that we will deal with the interim measures in the first instance?

Mrs L Brown:

That is correct.

Mrs McGill:

Therefore, will we go through the interim measures based on the timetable that brings us up to April 2011?

Mrs L Brown:

Yes, we will.

Mrs McGill:

What happens to those interim measures after 2011? Will they be included in the single Bill?

Mrs L Brown:

Yes, they will. The issues raised by the need for the interim measures are being worked on for the single Bill. That means that, while we await the single Bill's becoming law, we will have changed the legislation to give people as much added protection as we can, at the moment.

Mrs McGill:

If I understand the issue correctly, the single Bill will deal with mental capacity — that is, whether someone is able to decide for themselves or relies on another to do so. How do the interim measures affect the nearest relative provisions? What happens there? To follow up on Dolores Kelly's question, does a doctor decide? How does that work? In the absence of legislation contained in the single Bill, how will the interim measures or mental-capacity provisions work?

Dr Briscoe:
The power of a nearest relative is defined in a provision of the 1986 Order. In the interim, we propose to change the nearest relative provision so that an individual could go to a County Court to seek to have that nearest relative stood down and deemed unsuitable to exercise their powers in relation to admission or detention in hospital. That is the interim solution.

We may introduce a slightly different concept in the final single Bill, when we establish the best thing to do in the context of the entire single Bill, which is not just about mental health; it is much broader. Nearest relatives may be blood relatives, but the eventual solution in the single Bill may move from a nearest relative to a person who might be the primary carer — the person closest to the individual — as opposed to his or her nearest relative. It may be that nine times out of 10 that person is a nearest relative, but that will not necessarily always be the case. The Department is introducing those interim changes following a decision of the European Court of Human Rights, which highlighted the need for such provisions. In that case, the nearest relative of the patient did not act in the patient's best interests because he or she was an abuser.

There is good reason to introduce extra protections now and allow for a patient's nearest relative to be deemed unsuitable. That may not be the final solution in the single mental-capacity and mental-health Bill, but the Department is introducing an amendment now in the context of mental health.

Mrs McGill:
I understand the reason why we need that provision, but I am trying to work out how it will work in practice. It is proposed that:

> "The Department intends to amend the … Order to give patients the right to apply for displacement".

The witnesses have explained what that means, but how will it work? Will it be a doctor, a social worker or someone else who allows for that displacement?

Ms Christine Smyth (Department of Health, Social Services and Public Safety):
One of the powers of a patient's nearest relative is that he or she can apply for someone to be compulsorily transferred to hospital where an assessment can be made on whether the patient should be detained. The proposed amendment will remove that power if the nearest relative is registered as unsuitable. The other people with that power are social workers, and there are 210 specially trained mental-health social workers in Northern Ireland.

The figures that the Department has for the applications for compulsory admission to hospitals indicate that the number of nearest relatives using the power has decreased significantly in recent years. However, social workers can enact that power until the new provisions are introduced in the single mental-capacity and mental-health Bill

Mrs McGill:
Is a social worker currently in the position to determine whether a nearest relative can commit someone or not?

Ms Smyth:
No; a social worker would not make that determination. A patient's nearest relative can apply independently by visiting the patient's GP, expressing his or her concern for the relative's mental health and telling the GP that the patient made need to be compulsorily admitted. The relative can then sign the form along with the GP. The nearest relative does not require permission from anyone to do that, but he or she does require a GP's countersignature to activate a compulsory transfer to hospital, where a medical assessment will determine whether the patient should be detained.

Mrs McGill:
What is the role of social workers in the process?

Ms Smyth:
Social workers have the same powers as a patient's nearest relative. Often, the nearest relative does not want to be the person who signs the application as they must live with the person afterwards.

Often, a GP will contact a social worker to tell him or her that a patient is not well, may be a danger to himself, herself or others, needs to go to hospital for treatment but is unwilling to go. Under the current legislation, a social worker has the power to make that application and be a co-signatory with a GP.

Mrs McGill:
Therefore, a GP and a social worker can make the decision on the nearest relative's behalf?

Ms Smyth:
Yes.

The Chairperson:
How many clauses does the Department expect to have in the safeguarding board Bill that deal with the issue of who will be responsible for an individual mental-health patient? Do you expect that to be an extensive part of the legislation?

Mrs L Brown:
No.

The Chairperson:
We have seen how difficult it has been for the Assembly to draft legislation to allow for the cutting of high hedges — *[Laughter.]* Two and a half years later, we still cannot get our heads around lopping three feet from a hedge.

Having examined what the Department is taking on and the number of bear traps that members' questions have brought to light today, I envisage huge problems ahead. I also fear that much good legislation will become bogged down by many complex issues if the single Bill approach is taken.

Mrs L Brown:
I cannot reassure you on the larger Bill. It will be complex, and it will be hard work for all of us, particularly for the Assembly. However, I can reassure you about the amendments that will be tabled. The Assembly will have to consider about four relatively straightforward clauses. They will cover the small amendments that are required in order to comply. They will be part of the safeguarding board Bill and will be dependent on the speed with which it goes through. Those

clauses should not impede the progress of the Bill or prove to be particularly difficult for the Committee.

The Chairperson:
I am concerned about the subsequent Bill.

Mrs L Brown:
That will be complex legislation.

The Chairperson:
I envisage much good legislation being grounded while the more complex issues are being thrashed out, because those will be controversial and difficult to deal with.

Mrs L Brown:
That was an enormous dilemma at the beginning of the process, and that was why the Government decided to ask the public to agree to two separate pieces of legislation. The plus side of that would have been that at least one of the two pieces of legislation could probably have been passed in a given period. As the two pieces of legislation would not have been dependent on any one clause, each could have gone through according to its own timetable.

However, a strong body of professional and public opinion did not want separate pieces of legislation because it believed that choosing separate mental-health legislation would continue to stigmatise people with mental-health issues. It was impossible to ignore the public opinion that emerged from the consultation, and, therefore, we are now dealing with one piece of legislation.

To be fair, even with two pieces of legislation, the interface issues between them would have had to have been addressed when they were being drafted. There are huge interface issues between proposed mental-health legislation and much other legislation, including the Children (Northern Ireland) Order 1995.

The legislation was always going to be difficult. When it is complete, those who have been involved with it politically and at other levels will be able to take some satisfaction that they have passed legislation that will give rise to huge societal change in Northern Ireland. However, it will not be an easy journey.

The Chairperson:
I mentioned an OBE earlier; if you get the legislation through, you deserve a seat in the House of Lords.

Mrs L Brown:
It would definitely be worth a gold star in the jotter.

Mrs Hanna:
I welcome the Department's decision to go with a single Bill. Everyone to whom I have spoken, including users, carers and psychiatrists, made the same argument as you in favour of a single Bill, as opposed to having parallel processes that would require an interface to join them. A single Bill will be complex and groundbreaking, but it should also be exciting.

Some of those amendments are important and new. Will further consultation take place on the amendments that are to be drafted for the new legislation? .

I have dealt with people with personality disorders, and some fall between many stools. Will you explain how those people will fit in?

What major issues made you decide that it was a good idea to go with a single Bill?

Mrs L Brown:
We shall answer your questions in reverse order. I will answer your final question on the single Bill; Ian McMaster will answer the question on personality disorder, and Maura will deal with the first question that you asked.

The main consideration is the removal of the stigma from mental health. In addition, everyone in Northern Ireland will have to transform their thinking on the freedom and dignity of the person, regardless of their condition. People who have the capacity to make decisions for themselves must be allowed to do so.

Those of us who have been dealing with social issues in Northern Ireland for a few decades know that society has changed. We have increasingly adopted the modern view of human rights, which is that people wish to be treated in a certain way, wish their affairs to be dealt with in a certain way and wish to decide whether or not they receive medical treatment. If a person has the capacity to decide, it is a matter for him or her to do so. That is a big change from even a few decades ago, when people thought that the state knew best and would intervene when it considered a person to be at risk, no matter what that person's wishes were.

We desperately need mental-capacity legislation in Northern Ireland. In a way, we are fortunate that we are the final jurisdiction in these islands to create such legislation. We have been able to consider what others have done and assess the outcome of their evaluations. I hope that we can do better.

Mrs Hanna:

We need to define capacity and do the right thing by empowering people with the freedom to make decisions. However, that will result in problems, which, I presume, you will have to anticipate.

Mrs L Brown:

That is exactly right. Furthermore, the three Ps of principles, powers and protections must operate together. Protections must work in tandem with powers; if the state intervenes, there must be a system whereby it is clear that people have adequate protections. For example, someone with a mental disorder who is compulsorily treated in hospital or in the community will have the statutory right to attend a mental-health tribunal to ask for that decision to be reconsidered at various intervals. It is not the case that a decision taken at one point in a person's life will never be reviewed.

We do not want a situation in which people are held in hospitals for long periods. Moreover, as others said earlier, an advocacy role will be necessary. Some people cannot speak well for themselves and need, in this new and complex world, others to advocate for them. That role must be carried out by a statutory authority so that it is not one organisation's whim as to whether to provide such a service.

Dr McMaster:

I will explain the service aspects of personality disorder and, thereafter, the legal aspects. As members are probably aware, there are no local, dedicated personality-disorder services in

Northern Ireland; we lag behind other parts of the UK. The Department has identified investment to develop specialist services. In December 2008, a draft strategy was consulted on, and a final strategy should be issued soon to support a model to develop local, dedicated services.

The difficulty with personality disorders is the focus is often on the risk to others posed by some people with antisocial personality disorders. Legislation that is based on capacity is problematic, because the majority of people with antisocial personality disorders do not lack capacity and, therefore, would not be covered by that legislation. It must be recognised that people who have capacity but who still pose a risk to others would be better managed by the new public protection arrangements and the criminal justice sector. The process is at an early stage, and the policy has not been developed fully.

Dr Briscoe:
The first consultation period began in January 2009 and lasted for three months. As part of policy development, we consult continually with professionals and a range of other organisations that have an interest. We have an infrastructure, or reference group, that comprises groups with interests in mental-health and other services. That has helped us to determine policy.

There is a process within our infrastructure that requires Departments, the Court Service, the judiciary, and so on, to consult on the other aspects of a single Bill. Furthermore, we will produce an equality impact assessment in early 2010, which will provide an overview of the high-level policies in a single Bill for the purposes of consultation against those groups that are referenced in section 75. That will be important in the final determination of the policy in March 2010. Once the Bill has been introduced to the Assembly, due process means that it will be subject to consultation.

Mrs Hanna:
Are users and carers always consulted? That issue comes up regularly.

Dr Briscoe:
Although we cannot consult every user and carer, we have a mechanism whereby we engage with key interested organisations. We have been open in trying to engage with others: for example, I attended a dementia forum this morning, and it was clear from speaking to people there that the legislation will have a big impact on dementia sufferers. Therefore, other opportunities for

consultation exist, and we have formal mechanisms in place in our project management system to give a voice to users and carers.

Mrs I Robinson:
I wish to deal with an issue that stands out for me. The Department said that there is a need to extend the assessment period from up to 14 days to up to 28 days. How will that impact on bed availability, and why will it take four weeks rather than two weeks to assess someone?

Mrs L Brown:
First, an assessment period of 28 days is now the standard in England. However, that does not necessarily mean that we should apply the same standard. The assessment period should be extended to 28 days to be fair to the patient. If doctors have to test capacity under the new legislation, they will need time to do that. In addition, a patient's capacity can fluctuate, so one appointment is not always enough, and he or she may require assessment over time.

Given that serious judgements are being made about people's liberty, the medical advice suggests that adequate time should be given to assess a patient properly. After assessment, a person can appeal to a tribunal to determine his or her future care pathway. Therefore, the assessment period is being extended to account for the new capacity test that is coming into play.

Mrs I Robinson:
Surely that will impact considerably on the amount of beds available.

Mrs L Brown:
I do not think so. As you know, we are in process of dealing with the number of inpatient beds that we need and the amount of treatment that is required in the community. Therefore, by the time the legislation is in place, we hope that there will be a better balance so that it should not impact on the number of beds.

Mrs I Robinson:
That is a strange argument. If the assessment period is increased from two weeks to four weeks, more beds will be occupied for a longer period, and, therefore, others will be prevented from being admitted.

Mrs L Brown:

If the changes were to be introduced overnight, we might have an issue with the number of beds in the system. However, that new regime will not be in place for some considerable time, and, therefore, we have time to plan and to assess the required number of beds versus the number of places in the community. Given the length of the planning period, we will not suffer from that problem.

Mrs I Robinson:

In tandem with the Bill going through its legislative stages, will you be planning to make adequate resources available to keep people in hospital for a period of four weeks?

Mrs L Brown:

That is all part of the costings mechanism of the legislation. The Department will consider the cost implications of the legislation for training and facilities.

Mrs I Robinson:

Will newbuilds also be required?

Mrs L Brown:

No; I do not think so, but we must work through all the options. According to the equation in the Bamford review, there are too many beds in the mental-health service. Bamford wants us to reduce the number of inpatient beds and increase provision in the community. Therefore, the plan is to decrease the number of beds in the mental-health service so that more people are treated in the community. During the planning period for the implementation of the legislation, we will seek to create a better balance between inpatient provision and community provision. I do not think that there will be a problem with that plan, but it will have to be costed.

Mrs I Robinson:

You said that there are too many beds in the mental-health service, but from speaking to constituents — I do not know what other members are hearing — I do not get the impression that that is the case. Young people with high levels of stress and anxiety and no coping skills turn up at A&E needing a bed yesterday, but there is nothing there for them. I continually hear that there are insufficient resources in place to deal with those young people never mind people with complex eating disorders. Such disorders are not just about trying to lose weight, and the background problems being experienced by people who suffer from them must be identified and addressed. Linda, with the greatest respect, I do not find that people are happy with the current mental-health provision.

Mrs L Brown:
Are you referring to general mental-health services or specifically to beds?

Mrs I Robinson:
I am talking specifically about the availability of beds and resources to children and young people who are struggling to cope with seriously difficult experiences. I am aware of cases in which the required help has not been available, and young people have sadly taken their own lives. Unfortunately, many young people here have done that, and, often, their families say that the system let them down. I am amazed by the requirement to reduce beds rather than adding more. That would be a more appropriate course of action.

Mrs L Brown:
The Bamford proposals aim to reduce the number of beds in line with the population. Our inpatient provision was too high compared with other jurisdictions. I appreciate that you have listened to the views of people on the ground, but let me talk this matter through. When there is a large number of inpatient beds, the ethos is to fill those beds rather then treating people in the community. We have adopted, and are working towards, an equation that is proposed in the Bamford review, which outlines how many inpatient beds we should have relative to the size of our population. I will ask Maura to talk about the specific figures and how the action plan is working.

As regards the availability of beds at any one time, the Department recently implemented a protocol for bed management in the mental-health service to improve the system of bed allocation when people who are in crisis present to A&E. If you wish, we can talk further about that protocol. Specific beds and skills are required to treat people in specialist areas, such as addictions and eating disorders; we can talk more about that too.

We have no difficulty in accepting that it is right to implement Bamford’s proposals to reduce the number of beds in line with the population level. That does not mean that people are not treated; it means that we try to treat them in the community rather than in a hospital bed. I am sure that you agree, from talking to your constituents, that people want treatment, but not necessarily in hospital. Our priority is to deliver treatment to the person who needs it, and that is central to the direction in which we are going.

Mrs I Robinson:
I do not wish to go back and forth on this issue, but I feel that that is the wrong way to go. As an elected representative, I have a duty to my constituents to raise my concerns and theirs. I know a young girl who has been sent back and forth to St George's Hospital because she has an eating disorder and other major psychological problems. After 12 weeks away, that young girl came home, and, at one point, she was literally standing on the edge of a harbour ready to throw herself into the sea. Had father not followed her, she would have done exactly that. I had to fight tooth and nail to get that girl seen by one of our top psychiatrists, and she is now making progress. She is seeing the person that her father wanted her to see and has said that finally someone understands her.

That is only one case. I can think of a many more, and I have also heard my colleagues discussing the issue. Given that we are to have such a long lead-in time before the right Bill is put in place to look after those with mental-health issues, we must ensure that everything in it is correct.

There are not enough beds. From the information that I have received from my constituents, Sue Ramsey and other Committee members, people cannot get the help that they need. For their own safety, those people must receive help immediately but the message that comes back is that the resources are not available.

Mrs L Brown:
I am aware of the case to which you referred. Any Committee member who is made aware of an individual case should inform the Department. The Department learns a great deal from the various problems that arise, and sometimes change can happen only through the experience of dealing with individual cases.

Mrs I Robinson:
With the greatest respect, I should not have had to battle and make many threats to get that young girl the help that she needed. When a patient presents with serious psychological problems, has

eating disorders and is dying on her feet, that help should be made available automatically. In such instances, the Department should not need to learn lessons; it should treat those patients.

Mrs L Brown:
I agree that the issue is getting treatment to the people who need it, but, as I said, a bed is not always required. Eating disorders are particularly difficult —

Mrs I Robinson:
They involve additional psychological problems.

Mrs L Brown:
Eating disorders are particularly difficult because, in many cases, the skills that are required to treat people with those conditions are not available in Northern Ireland. Unfortunately, some of the most seriously ill people must be sent elsewhere for treatment.

We have a psychiatrist with us today in the form of Dr McMaster, and I am sure that he will be happy to talk about eating disorders. However, at the earliest stages of an eating disorder, the best outcomes for sufferers are often attained through treatment in the community. Such treatment allows the patient to be near their families, whereas hospitalisation often involves their being removed from the family environment.

Mrs D Kelly:
No one is arguing that point. We are saying is that the resources must be in place before the number of beds is cut.

Has the Department addressed the severe shortage in child and adolescent psychiatry? Are we now at a stage of no lengthy waiting lists and young people not being inappropriately placed in adult care?

The Chairperson:
Is that issue tied to the legislation?

Mrs I Robinson:
The issues are beds and resources.

Mrs D Kelly:

The Committee has heard that one of the Bamford review's findings was that there were too many psychiatric beds here. However, that review also recommended that the resources to treat patients with mental-health issues should be put in place. Are those resources now in place?

Ms S Ramsey:

I think that we should separate Dolores and Iris for the next Committee meeting. *[Laughter.]*

Mrs L Brown:

That issue is not directly tied to the Order. However, I will ask Dr Briscoe to talk about that because she has some information on the number of available beds.

Mrs D Kelly:

I asked whether the shortages in child and adolescent psychiatry have been addressed in accordance with the recommendations of the Bamford review. That question demands a yes or no answer.

Dr Briscoe:

There has been considerable investment in child and adolescent mental-health services. For example, the new child and adolescent inpatient unit will open early in 2010.

Mrs D Kelly:

How many beds will be in that unit?

Dr Briscoe:

There will be 18 beds in the child and adolescent unit. Adjacent to that unit will be a family and child centre with a replacement of 15 beds.

Mrs D Kelly:

A replacement?

Dr Briscoe:

Therefore, in total, a new and bespoke 33-bedded unit will be available for inpatient child and adolescent mental-health services. Specific investment has been made in multidisciplinary teams and crisis intervention for children and adolescents, and the number of consultant psychiatrists in that area has increased.

I want to return to Iris's initial point. The increase in the assessment period from 14 days to 28 days is for people who are detained under the mental-health legislation. The majority of people who are admitted to hospital or treated in the community are not in any way detained, and, therefore —

Mrs I Robinson:
Is that increase in the assessment period for people who have been sectioned, Dr Briscoe?

Dr Briscoe:
Yes. Therefore, the increase from 14 to 28 days relates to an important but small patient population, relative to the size of the overall mental-health population. Although assessment is one reason for their being detained, treatment also starts at that stage.

It is also proposed that the single Bill will make provision for community treatment orders. Thus, it may be that, following a period of assessment and treatment, people will be discharged under a community treatment order that has additional safeguards attached to it. Therefore, it is not just about beds; it is about the whole package of care. It must be understood that the majority of people, including the vast the majority of people with eating disorders, are not detained — or what you call sectioned — under a mental-health order.

Mrs I Robinson:
I appreciate the Chairperson's patience. Will Dr Briscoe tease out the community aspect of that for me? If the whole thrust is to release people into the community rather than institutionalising them, how many staff will you need to look after them?

Dr Briscoe:
We are continuously building up the community infrastructure. In the current CSR period, £44 million will be spent, a considerable proportion of which is being invested in community teams and on developing multidisciplinary services. It would be difficult to cost just one element of the single Bill; we must cost it all, because it is not only about mental health, it is also about people

who have strokes, people with dementia, people with acquired brain injuries or anything that requires decisions on their capacity.

Mrs I Robinson:

I am simply saying that all that requires a large number of staff to provide the appropriate level of care in the community.

Dr Briscoe:

Bamford recognised that this would be a 10- to 15-year journey that needed additional investment.

Mrs I Robinson:

Will we be able to care for children and young people with eating disorders and other complicated psychological problems in Northern Ireland, rather than sending them off to England? Is that what you are saying?

Dr Briscoe:

I took into account the number of children who go to England to be treated for eating disorders. From memory, fewer than five children under the age of 18 are in England for treatment at any given time.

Mrs I Robinson:

The truth is that no more than that can be taken, because the specialists involved cover the whole of England.

Dr Briscoe:

No, that is not the case. Moreover, we are trying to develop a tiered approach to eating disorders. We recognise that at the top super-specialist tier, there will always be a potential need for the most complex cases to receive super-specialist treatment. We have invested in community eating disorder teams. Over the next few months, the Minister will announce a psychological therapy strategy that will provide additional investment for psychological interventions, because we recognise the need to increase availability of such a service for adults and young people.

Mrs I Robinson:

I went to England to see Professor Lacey, and he told me that many people fall by the wayside. He cannot take on all the young people who would like to go there for treatment.

The Chairperson:

I am sorry; our time is up. There have been no pregnant pauses on this issue. Thank you for your presentation. I realise that the representatives of Infertility Network UK have been waiting for a while, but I am under pressure to take the traditional coffee break. As a non-tea, coffee or alcohol drinker, I do not know why people do that, but I have lost that vote. We will hear the next presentation in five minutes' time.