Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Autism Bill: Committee Stage: Department of Health, Social Services and Public Safety

20 January 2011

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 Mickey Brady
Mr Pól Callaghan
Dr Kieran Deeny
Mr Alex Easton
Mr Sam Gardiner
Mr Paul Girvan
Mr John McCallister

Witnesses:

Mr Charles Bamford	)	
Dr Maura Briscoe	)	Department of Health, Social Services and Public Safety
Mr Peter Deazley	)	
Dr Ian McMaster	)	

The Chairperson (Mr Wells):

We will now receive evidence from witnesses from the Department of Health, Social Services and Public Safety. I welcome Dr Maura Briscoe, who has been before us many times and who is the director of the mental health and disability policy directorate; Peter Deazley, who is also from the mental health and disability policy directorate; Charles Bamford — there is an obvious question, but I will ask it later on — who is a social services officer; and Dr Ian McMaster, who is a medical officer. You are all very welcome.

You have given evidence to us before on this important private Member's Bill. You have had the benefit of hearing the evidence from various organisations, particularly the charity groups, and you sat in on the Department of Education's evidence session this morning. As normal, feel free to give us a 10-minute introduction. I am sure that there will be many questions from members for you to answer.

Dr Maura Briscoe (Department of Health, Social Services and Public Safety): Good afternoon, everyone. Thank you for giving us the opportunity to come back. We look forward to having a fruitful discussion. Given the time constraints, rather than rehearsing the debate that we had previously, I propose to concentrate mainly on the clauses of the Bill. Therefore, what we say this morning represents the Department's view, which has been informed by legal advice.

The Department does not believe that it needs legislation to drive forward service change. Indeed, from our perspective, the legislation has the potential to cause disruption to current policy action and implementation.

Clause 1 would amend the Disability Discrimination Act (DDA) 1995. The Office of the First Minister and deputy First Minister (OFMDFM) is responsible for anti-discrimination legislation, and you may wish to consider whether to seek its views on the Bill. It remains our view that autism is covered by the DDA, as evidenced in practice by case law. Non-specific changes may have far-reaching consequences as well as potential costs that were not intended by the sponsor of the Bill.

Serious and specific in-depth consideration should be given by the Committee to the proposed changes to the DDA. I heard only the end of the previous evidence session, but we noted previous discussions in the Assembly and elsewhere about the linkage between the DDA and access to social security benefits. The proposed changes to the DDA will not improve access to social security benefits. The Department for Social Development takes the lead in that field, and you may wish to seek direct advice from it.

Clauses 2 and 3 relate largely to the development and content of a strategy. The objective of those clauses is not clear. If, for example, the objective is to protect the right of individuals to have their needs met, it could not be achieved without additional resources. That is the case not just for children but, as was said earlier, for adults and carers. However, it has been said that no significant costs are attached to the Bill.

On the other hand, if the objective of the Bill is to produce another strategy, the strategy itself will not necessarily improve front-line services. As a general principle, most legislation is underpinned by sound policy rationale. From the Department's perspective, this piece of legislation is not underpinned by sound policy. We already have an autism strategy, an infrastructure in place and resources that are attributable to autism.

The Committee will have received our paper, which notes that the Autism (Scotland) Bill was defeated at Stage 1 by 109 votes to five votes. It is worth noting that one of the reasons for that was that the Committee that was responsible for scrutinising the Bill was not convinced that legislation that is specific to autism would necessarily improve autism services. In addition, and perhaps more importantly for us, it was recognised that such an approach could have created a perception of "two-tierism", whereby some disabilities are deemed more worthy than others. That has resonance for us when it comes to compliance with the European Convention on Human Rights, particularly articles 14 and 8. For example, does someone with autism have more rights than an individual with an equally disabling or a more disabling condition?

Perhaps what underpinned the Scottish approach was the perception that people with a certain condition, in this case, autism, would benefit from the legislation while people with other disabilities would not.

Therefore, we ask the Committee to consider the competence of the Assembly to legislate for the matters that are addressed by clauses 2 and 3. I am not saying that they would be, but if those provisions were challenged under the European Convention on Human Rights, what would be the defence?

The human rights of all people with disabilities are important to us, but so too are the budgetary constraints of the environment in which we all have to live. I note that Minister

Wilson wrote to the Committee this week, and he recognised that there is a financial cost to the Bill.

I will now turn to the costs of the Bill. The strategy has not been costed. As I said, one would first need to be clear about the objective of the Bill. Assuming that the strategy would have content, it would generate additional cost. In addition, it is noteworthy that clause 3 refers to training civil servants who deal directly with the public. As members will see in our paper, we estimate the cost of that to be £1·8 million. One could argue that additional resources would have to be found to pay for that, and that such resources would be better targeted at front-line services.

A public awareness campaign is also referred to in the Bill, which would not be without cost. In our paper, we have provided the low-end and the high-end costs. The low-end cost, which assumes that existing campaign material would be built on, is approximately £25,000. However, if there were a media campaign to raise public awareness that involved, for example, TV and Adshels, the cost could be more than £200,000. Therefore, there is a cost attached to the Bill.

I do not propose to address clause 4, which is about the definition of autism. We had a long discussion about that at a previous meeting. Our view remains the same: it is not in anyone’s interests to define autism in legislation. That is because research on, and experience of, autism could potentially change, particularly as it is a spectrum disorder.

The Department’s view is that the Bill would create bureaucracy and would not necessarily improve front-line service provision. It may be disruptive to our current autism action plan and the infrastructure that we have in place to deliver on that. We do not want to see any additional resources being directed away from front-line services. The Committee needs to give serious consideration to the potential unintended impact of clause 1 and the legislative competence of the Assembly on the provisions that I identified in clauses 2 and 3.

The Chairperson:

Thank you, Dr Briscoe. To try to give some coherence to the questioning, we will start, as we did previously, with questions on clause 1, which seeks to amend the DDA. We will deal with any questions that members have on that first. We will then move on to questions on the strategy and co-operation between Departments. After that, members can ask questions on any other issues.

Clause 1 seeks to amend the DDA by inserting, ", social (including communication)". What do you see as the potential risk of that? To many in the Committee, that seemed to simply plug a loophole for children who fell between two stools. Some have physical needs, some have mental needs and some have neither but have real problems with social interaction and communication with their fellows. Where is the danger in what seems like such an obvious measure?

Dr Briscoe:
The Department believes that autism is covered by the current DDA, which is evidenced by case law, and I am happy to talk about case law if you want me to. The Office of the First Minister and deputy First Minister guidance on the existing DDA clearly states that autism is covered. There are a number of examples in that guidance that are covered.

On the one hand, autism is covered in the DDA, and there is case law to support that, so why would you want to change it? Secondly, terms such as "social (including communication)" and "forming social relationships" are very non-specific. What do they mean? They do not mean anything specific to autism but are generic terms. What would such changes mean for the whole of society? What about the special adjustments that may have to be made by employers and so on?

The Chairperson:
We are getting some research information later this afternoon on that specific issue. It is something that the Committee will have to look at.

Dr Deeny:
I heard somebody on the radio this morning talking about people who have speech impediments. Those people have communication problems. Are you saying that including "social (including communication)" will mean that it will apply to people other than those who have autistic spectrum disorder (ASD)? There are people out there who have communication difficulties who are not autistic.

Dr Briscoe:
The definition of disability and the impairment that arises from disability is specific in the DDA. There are a number of capacities included in that, including speech. Therefore, people with a disability that involves speech or communication difficulties that affect their day-to-day activities

are covered by the DDA.

I draw your attention to case law. There is case law that involves a primary school and the behaviour of a child with attention deficit disorder. I came in at the end of the previous evidence session when Alex Easton was talking about similar case. The National Autistic Society joined the case, because, rather than the child's condition, the fundamental issue was whether the reasons for the child's disruptiveness in school were covered in the DDA. The case law went through due process, and it was found to be covered.

Another case involved a secondary school. Again, it was about behavioural issues, and involved a child with autism. That case went through the system, and the judge was very clear that the child's circumstances and autism were covered by the DDA. I am happy to quote that case law, if you let me.

The Chairperson:
It would be helpful to have the reference so that we could have a look at it.

Dr Briscoe:
I will give you the reference. The first case that I referred to took place in 2009, the reference is EWHC 1842 and the judgement was made by Justice Lloyd Jones. The second took place in 2003, its reference is EWHC 3045 (Admin) and Justice Silber made the judgement. Justice Silber said:

> "The Act makes it unlawful to discriminate against a person who has a disability which for the purposes of the Act means that 'he has a physical or mental impairment which has a substantial long-term adverse effect on his ability to carry out normal day-to-day activities'': section 1(1). It is common ground that IC has a disability for the purpose of the Act."

The Chairperson:
Basically, you are saying that the case law shows that autistic children and adults are covered by the DDA.

Dr Briscoe:
Yes. *[Interruption.]*

The Chairperson:
Order. Only members of the Committee are to ask questions, please.

Is there a fear that, as others said, the inclusion of the term “social (including communication)” could weaken the definition of “mental” and “physical”?

Dr Briscoe:

As I said, the text of the DDA relates to the schedules, which, in turn, relate to capacities, and those are about the impacts of impairments on day-to-day activity. This legislation would add “social (including communication)” and “forming social relationships” to the list of capacities. A person needs only one thing from that list to impact on their day-to-day activities on a long-term basis to receive additional protections under discrimination law. The inclusion of the non-specific terms of “social” and “forming social relationships” would potentially widen what was intended by the DDA. It could also widen what was intended by the proposer of the Bill. The proposer of the Bill was interested in autism, but many people with conditions of varying severity also have difficulties in forming social relationships. Indeed, there are many people who do not fall into a clinical category but who have difficulty in communicating socially and in forming social relationships. Therefore, it could be argued that amending the DDA will dilute the mental and physical impairment side.

Mrs O’Neill:

You said that the Bill could be subject to challenge under the European Convention on Human Rights.

Dr Briscoe:

No, I did not say that.

Mrs O’Neill:

It is in your paper.

Dr Briscoe:

I said that clauses 2 and 3 of the Bill might be subject to challenge. I was not talking about the amendment to the DDA clause.

Mrs O’Neill:

Are you aware that, in its paper to the Committee, the Northern Ireland Human Rights

Commission stated that it believes that there will be no adverse impact from amending the Disability Discrimination Act?

Dr Briscoe:

I am not talking about the Disability Discrimination Act; I am talking about clauses 2 and 3.

Mrs O'Neill:

Your paper states:

> "It is also of note that the proposed changes to the DDA, in our view, will not have the desired effect of increasing access to Social Security Benefits".

Dr Briscoe:

Indeed.

Mrs O'Neill:

What was the basis for that assessment?

Dr Briscoe:

Although I recognise that there is an interrelationship between the DDA and some aspects of benefits, such as the blue badge, the issue is how an individual meets the criteria for receiving, for example, disability living allowance. Therefore it is the impact of the disability and not necessarily the condition itself that has to be adjudicated. The Committee should take evidence from the Department for Social Development on the issue. In our view, it is the underlying need that arises from the disability rather than the condition itself that must be considered. That need would have to meet the criteria for access to certain benefits.

Mrs O'Neill:

With respect, Maura, that is how it should work; however, the reality is different. The Committee has heard evidence, and I have seen a tribunal decision, that autism is nowhere included in the Disability Discrimination Act.

Dr Briscoe:

I can quote from at least three case law examples that make it absolutely clear that the judge considered autism and the behavioural disability that arose from it, in those cases, to be covered by the DDA. I do not want to talk about social security benefits because they are not in our remit. However, it is our understanding that, when applying for benefits, what is important is the need of the individual.

The Chairperson:

Tim Moore’s paper, which we will consider at 2.00 pm, will look at that important issue.

Mr Gardiner:

Thank you for your presentation, Dr Briscoe. We are all concerned about children with autism and we want the best for them.

Dr Briscoe:

As do we.

Mr Gardiner:

If an autistic child is admitted to hospital, will specialist care be available or will there be someone there who has been trained to look after the child?

The Chairperson:

Sam, that is an important point that should be discussed under the next clause, but it has absolutely nothing to do with clause 1.

Mr Gardiner:

OK, I will keep it for the next clause.

The Chairperson:

I suspect that I know the answer. I will let you in second when we move on, but I do not think that the definition of the DDA would have any impact on how a child would be treated in hospital; that would depend entirely on his or her condition.

Dr Briscoe:

I am sorry; I did not hear that.

The Chairperson:

Sam asked whether special treatment would be available for an autistic child who was brought to hospital. Treatment would be based on the condition of the child rather than on any definition —

Dr Briscoe:

If a case was complex and involved comorbidities one of which was autism, there would be a full care plan based on the needs of the child at the time of its admission to hospital.

Mr Gardiner:

There is no need to call me again, Chairman; I have the answer. Thank you.

The Chairperson:

Is your question about the DDA, Pól?

Mr Callaghan:

It is very specific to the DDA. Thank you for coming before us once again. We tested some of the issues last time; therefore I do not plan to rehearse them. They are in Hansard for everyone to enjoy or otherwise.

Did both the case law examples that you mentioned relate to education?

Dr Briscoe:

They were both behavioural cases.

Mr Callaghan:

Did they both relate to access to educational services provided by the state.

Dr Briscoe:

Yes.

Mr Callaghan:

Is the Department aware of any case law — and since you represent the Health Department, let us stick in the silo mentality for a wee second — on access to health or social care services that demonstrate that the DDA definition covers ASD?

Dr Briscoe:

The DDA is not about health. *[Interruption.]* It is anti-discrimination legislation. The question is whether autism is covered by anti-discrimination law, regardless of the setting in which it finds itself. Our view is that it is.

Mr Callaghan:

Obviously, the — I am sorry, Chairperson, but there is some distraction.

The Chairperson:

We welcome members of the public, but interruptions can distract members and witnesses. I know that people feel passionately about the Bill, but please try to keep quiet so that the witnesses can give their evidence without interruption.

Mr Callaghan:

I am happy to come back to it in the afternoon. We can test it in other ways.

Dr Briscoe:

My colleague has just reminded me that there is case law in respect of DDA through employment tribunals and the impact on employment. There was a case recently that was much bigger, but its underpinnings related to autism. There was a case in the Health Service, but it was not directly about autism. However, the judge clearly said that autism was covered by the DDA.

Mr Callaghan:

If the Department is making that submission, it would be helpful to have case law references.

Dr Briscoe:

I can give you the Hewett case reference now. It is UKEAT/0526/03/ILB.

Mr Callaghan:

This is a composite point on the DDA clause: does the Department not think that it would be helpful to take the consideration and testing of ASD under the DDA definition at present and remove it from the sphere of judicial interpretation entirely to provide clarity?

Dr Briscoe:

The proposed definition is not related to autism but to “social (including communication)” and “forming social relationships”, which is a much bigger. The connection between clause 2 and the amendment to the DDA is not real as the latter is a stand-alone amendment.

There are at least three examples in the guidance on autism from the Office of the First Minister and deputy First Minister, including Asperger’s syndrome and a child and an adult with autism, that clearly indicate that autism is covered by the DDA.

Mr Callaghan:

There are different views. The view that has been expressed by the Department is not held universally. You are entitled to your view as a Department, but it is not universally held. We are talking about judicial interpretation, but a judge would also interpret the context in which the DDA amendment came forward, which, in this case, is as part of an Autism Bill. We dealt with that before and we agreed to disagree. We will leave it at that.

Dr Briscoe:

You are obviously right to say that that is the view of the Department. As was stated previously, the responsibility for anti-discrimination legislation rests with OFMDFM. Although our view is informed by legal advice and so on, you would really need to seek the view of the Office of the First Minister and deputy first Minister if you still have concerns about the coverage of anti-discrimination law.

The Chairperson:

Assuming that no one has anything more to ask about clause 1, we will move on to the strategy and cross-departmental co-operation. Obviously, as MLAs, we have received a huge volume of correspondence and representations on the Bill. Other members and I have met numerous groups that represent the needs of autistic children, mostly, but also adults in the Province. There is a huge sense of frustration about the present service delivery. There are cries of help from parents who, frankly, cannot cope with the huge demands that are placed on them while looking after one or several autistic children. They support the Bill because they feel that it will force government to take autism seriously and drive forward real programmes that will meet their needs.

You and the Department of Education seem to indicate that everything is fine because you are doing your best and you are delivering what you think is a suitable programme. However, the service users feel that there is an enormous chasm because of a lack of delivery. That is why there is such strong support for the Bill. How come there is that huge difference between the two viewpoints?

Dr Briscoe:

First, as my colleagues from the Department said, there is always room for improvement in any service. We recognised that and brought forward an autism strategy, an action plan and additional resources. Everyone would, of course, like additional resources. However, do we want to target resources at front-line services or do we want to divert them to bureaucracy and so on through the Bill?

The question has resonance for me in that the implication is that the objective of the Bill is to give rights to individuals with autism to meet their needs, which includes children, parents and carers. If that is so, that objective is not clear in the Bill. In contrast, the Autism Bill in England is set out very differently. It outlines improvements to service provision and contains guidance on what that means. Our concern is about clauses 2 and 3 and that, as it is currently drafted, the Bill's objective may not be clear. If the Bill's objective is to, in some way, give individuals with autism rights beyond those of a person with another disability — Scotland talked about "two-tierism" — people with autism will be the beneficiaries of legislation whereas people with other disabilities may not be. How does that fit with article 14 of the European Convention on Human Rights?

The Chairperson:

We have heard glowing reports from the Department of Education about what it is doing. You emphasised what you are doing and have told us all about the wonderful co-operation between the various Departments. If that is happening, what is wrong with a Bill that simply brings that wonderful co-operation and all those strategies into legislation? As the Deputy Chairperson said, that will not do any harm.

Dr Briscoe:

My previous point was that it could potentially do harm. Depending on how we interpret clauses 2 and 3, those who live with autism will be beneficiaries of legislation that underpins a strategy and, in some way, will have a right to have their needs met. Therefore, that begs the question:

what about the human rights of all other people with disabilities? What is the Committee's view on that? How could that position be justified against a challenge under the European Convention on Human Rights?

The Chairperson:

The Bill asks you only to draw up a cross-departmental strategy.

Dr Briscoe:

That is an interesting interpretation. If that is the Committee's interpretation, the other argument is that a strategy will not, in itself, necessarily improvement front-line services.

The Chairperson:

You question the competence of the Assembly to create a cross-departmental strategy. I cannot understand that. Your submission questions whether the Bill is competent at all.

Dr Briscoe:

I questioned clauses 2 and 3 only.

The Chairperson:

They are fundamental clauses. You questioned the competence of the Assembly.

Dr Briscoe:

I questioned its competence to legislate on this.

The Chairperson:

Health matters are entirely devolved. There are no reserved matters.

Dr Briscoe:

The Committee should consider the intention of clauses 2 and 3 and whether there are any issues or potential interference with the European Convention on Human Rights.

The Chairperson:

Yes, that might question the wisdom of having the Bill, but the competence test is normally whether we are within our legal rights to do it. These are bread-and-butter devolved issues; none of this impinges on Europe or on Westminster. You may say that Mr Bradley may not be very wise in sponsoring the Bill, but I cannot understand how you can say that it is not a competent Bill.

Dr Briscoe:

Perhaps a legal definition of competence needs to be brought, but it is our view, informed by legal advice, that there would need to be careful consideration of clauses 2 and 3. There is no issue about the competence of clause 1, but there are, potentially, issues of competence with clauses 2 and 3 because of what I said about clarity of intent, language and the potential interface with the European Convention on Human Rights. That must be considered carefully.

The Chairperson:

Our Business Office, draftsmen and legal folk have all looked at that, and they think that it is absolutely watertight. They have said that the 1990 Act enables us to produce legislation on the subject.

Dr Briscoe:

Bills are competent only if they are in compliance with European conventions.

The Chairperson:

We will go back and check that.

Dr Briscoe:

That is our view. Obviously, you will need to consider that.

The Chairperson:

The best brains in here would differ with you on that. Talking of best brains, John McCallister is next.

Mr McCallister:

That was a seamless introduction. Not to split up the Chairperson’s compliment, I agree with a huge volume of what he said. Some of the earlier arguments against clauses 2 and 3 were that what the legislation proposes is being done anyway. I wonder why you object to clauses 2 and 3 and dispute their competence when you say that a lot of those issues are being pursued anyway in your strategy. Given that you are doing that in your strategy, how do you make the case that the Bill would add so much to the bureaucracy in the system? It means that you would have to co-operate with other Departments, but surely it is easier to get cross-departmental agreement than cross-party agreement. You have your strategy completed, and the Department of Education is also working on it. Is a lot of that not in place? You can tie in other Departments, including the Department for Employment and Learning and the Department of Justice, to do that. Where would the extra bureaucracy be?

Dr Briscoe:
For starters, we would have to develop a new strategy when we already have one.

Mr McCallister:
Presumably, you could lift a huge amount of your new strategy from the existing strategy.

Dr Briscoe:
We would have to put in a cross-departmental infrastructure to do that, and that in itself would cost money. There are fundamental issues about one Department monitoring another in the way that the Bill identifies. We secured an action plan and secured the resource for it, and we feel that we have an appropriate infrastructure that interfaces with education.

As you saw in the paper, additional money, albeit a small amount, was set down for adults with autism. There are the beginnings of a uniform diagnostic pathway for adults. Clearly, more needs to be done for adults, and, in the care planning for adults, there are issues about how an individual might live independently in society. Those issues are part of the care planning process in relation to interface with employment agencies, housing and so on. We do not need legislation. As colleagues said earlier, it will not help us to improve service provision.

Mr McCallister:
The Chairperson’s earlier point is right: if all of those things were happening, a huge lobby would not be saying that the rights need to be enshrined in law, which would force agencies to work together. If that were happening, a lot of the people who are sitting behind me would not be at Stormont today, and we would not be having this discussion.

Dr Briscoe:

I fully understand that autism is a big topic and is very important. The fact that we were one of the leaders in bringing forward an action plan means that the Department recognises that it is a very important topic. However, the Bill will not help us, particularly if the intention and objectives of clause 2 and clause 3 are not clear. It will not help us to do our job better. We have systems to communicate with other Departments as required. I fully acknowledge that there is more to be done, but legislation alone will not help us. A strategy alone will not help front line provision. In contrast, although there was a particular policy rationale for the English strategy, it is about improving service provision, and it clearly sets out how to do that. However, the Bill's objectives are not clear, and then there is the issue of —

The Chairperson:

Is that not, then, an argument for beefing up the Bill to include the English model of service provision and —

Dr Briscoe:

As I said, any Bill that goes forward has to have a clear policy rationale. In England, the policy rationale was that the Secretary of State for Health had no jurisdiction in respect of local authorities, gathering data and so forth. England does not have an integrated health and social care service, so there was a clear policy rationale in bringing forward an Autism Bill. It should be noted that that was for adults only; there is no Bill for children.

We have an integrated health and social care system, so we do not need legislation to foster good relations across Departments or at local level. For evidence of that, John, look at the care pathway that was developed recently by the regional ASD group for children. It clearly refers to youth clubs, play groups and all of the other things that are important to children on that care pathway. Stephen Bergin is on the five-board education and library board group on autism. The regional ASD group includes linkages with education, employment and housing. It is not perfect, and nobody is saying that it is. It can always be improved. However, legislation will not help us to do that.

Mr McCallister:

I take it, therefore, that the Department does not propose any amendments to beef up the Bill or set it in the context of that policy background?

Dr Briscoe:
As I said in the paper, from our perspective, there is no policy rationale for the legislation.

Dr Deeny:
I have taken on board what you are saying. I have worked as a professional with people with all disabilities for 30 years now. Every one of them needs our full support in health, education and in legislation. I noted your concerns. Scotland talked about having two tiers in autism-specific legislation. Would this Bill be setting a precedent? Would it be the first disability-specific legislation, for example?

I take on board and share your concerns. I work with a number of people with cerebral palsy and Down's syndrome. Are they likely to say that they should have a Bill to support them as well? I am just trying to tease that out. I was going to ask you about what was done in England, but you have partly answered it. There is a Bill in England, but I had forgotten that there is not one for children. I was going to ask you whether you would support a Bill such as that in England, but I think you have answered that. Why do you think they approved a Bill for adults but not for children in England?

There are a few questions there. Would it set a precedent for other people who are equally disabled and who I know and work with to say that they will seek legislation for their disability and get their own specific Bill? Is that a concern for the Department? Secondly, why did Scotland not approve its legislation by a huge margin? Thirdly, why did England not proceed with an autism Bill for children?

Dr Briscoe:
I cannot answer the latter question on why the Bill in England does not cover children specifically. However, in my view there was a clear policy rationale for introducing an adult Autism Bill in England, particularly given the fact that they do not have an integrated health and social care system. That is in contrast to here, where, in my view and my Department's view, there is no policy rationale for doing that. As you have said, we are doing work; we do not need legislation to progress that work.

You are right in saying that, in Scotland, it was felt that bringing in an autism strategy would not in itself improve front line services. That was one issue; the second was the issue of two-tier legislation. This Committee will need to give due consideration to that and to human rights. Article 14 of the European Convention on Human Rights deals with protection against discrimination. As I understand it, that includes a whole lot of things, such as protection against discrimination on the grounds of sex, religion, etc, “or other status”. My understanding is that autism is included in that “or other status”. In that sense, and given article 8, which deals with the impact on the individual’s private and family life, it might be argued that individuals with autism might have greater protections because they are included in “or other status”.

I share your concerns about people who have other, perhaps more disabling, conditions. Are they not also entitled to that protection? Potentially, autism might be a beneficiary because it is underpinned by legislation, whereas other conditions might not be.

Mr Callaghan:
The business of the hierarchy is obviously important, but I think people may be getting a bit carried away. You put it to the Chairperson — I hope I am not misinterpreting what you said — that you took it from some of the things that have been said that the objective of the Bill is to meet the needs of people with autism. In a way, I am not sure that that is what clauses 2 and 3 of the Bill actually purport to do. Clause 2 effectively purports to improve co-ordination by imposing statutory duties, and clause 3 purports to set out how needs will be addressed. That is not quite the same thing as giving a statutory guarantee that needs will be addressed in every circumstance.

What would you say to people who will argue about whether the particular needs of people with autism are being met? Those needs were clearly demonstrated to us by the autism community and lobby. If you give Cinderella a ticket to the ball, it does not mean that everybody else has to leave the ballroom. It just means that Cinderella gets to go to the ball.

Mr Easton:
He is not asking you to dance by the way.

Dr Briscoe:
He gave the analogy of a nightclub the last time we met, so I am just thinking through what he has said about Cinderella. Obviously dancing is a big issue.

Mr Callaghan:

Dr Briscoe, I have become a father since the last time we met, so maybe I am becoming a bit more Disney-like in my aspirations.

Dr Briscoe:

Wales is often held up as the exemplar in respect of developing a strategy, but it did not need any legislation to do that. In fact, it still does not have any autism legislation. Therefore, we question the need for legislation. We do not need it in order to move forward. Some individuals in the discussions will quote from the Welsh example of how to develop a strategy, but Wales does not have any legislation underpinning that.

Clause 3(1) states:

> "The autism strategy must set out how the needs of a person with autism are to be addressed throughout their lives."

Therefore, it is a matter of the interpretation and the absolute understanding of the objectives of clause 3 in its entirety. If you go for the former, that the objective is that the rights and needs of individuals are to be met, potentially the rights of other individuals could be called into question. If you take it that it is a strategy that just does what it can, it does not say that the strategy has to improve service provision. If you argue that that is what the strategy is intended to do, the Bill states that it is without significant additional cost. For me, there are issues on reconciliation of the argument in relation to clauses 2 and 3, depending on what you consider the objective to be.

As we indicated to you, we do not believe that the Bill has no significant cost. Indeed, we believe that it will divert resources from front line services. I am trying to answer the question on Cinderella without actually referring to her.

The Chairperson:

To follow on from that, the accusation was made that if you develop a strategy for autism, others will come to the table demanding similar treatment. The autism lobby will say that there is absolutely no evidence of that actually happening, because autism is such a special set of circumstances involving such complex needs and encompassing so many Departments. Lobby groups representing other conditions such as ADHD or Down's syndrome are not demanding a similar type of treatment. Therefore, they all go to the ball, rather than anybody being excluded.

Dr Briscoe:

I have to challenge that. I do not want to go into specific conditions, but there is a broad range of specific conditions, such as multiple sclerosis, muscular dystrophy, and a lot of neurological conditions, and the whole Bamford ethos indicates that there is a range of conditions that want considerable improvement in service provision. The fundamental basis of the Bamford review, which covered mental health and learning disability, was that there was recognition that there was a long way to go in respect of enhancing provision and that it was underfunded in relation to the rest of the UK.

The Chairperson:

You frequently mentioned Scotland and Wales. Due to the nature of the Northern Ireland Act 1998, we have ministerial Departments and a mandatory five-party coalition. Therefore, we have 12 or 13 silos, and, for obvious reasons, people will jealously guard the boundaries of those silos. In Scotland, there is a novel concept of not so much ministerial posts but themed Departments, which cover the specific needs of children or the elderly, etc. It is a very forward-looking way of doing things, but it would not work in this country for at least the next century because of the tribal nature of the way in which we live.

Equally, in Wales, there is no mandatory coalition. There is a one-party Government with minority support, which means that it is much easier for Departments to work across boundaries. Do we not need something in Northern Ireland that will legally force our Departments to co-operate, given the nature of the settlement that we have here? With all its flaws, I think that it is the only one that we will have for a long time.

Dr Briscoe:

We believe that we have all the legislation that we need to work across Departments, and we can provide you with evidence to that effect. All you have to do is look at some examples, such as the inter-ministerial group on Bamford and the inter-ministerial group on domestic and sexual violence. There is a range of public health issues concerning children, and Dorothy Angus mentioned the OFMDFM subcommittee on children and young people. Therefore, there is a range of examples of how Departments work together. I will say again that we do not need legislation.

The Chairperson:
On what basis do you make the assertion that the objective of clauses 2 and 3 are not clear?

Dr Briscoe:
I have tried to explain that.

The Chairperson:
I am not 100% certain that I understand.

Dr Briscoe:
OK. You started off by asking something along the lines of, is the objective that the needs of persons with autism should be addressed? If that is the objective, it makes autism and people with autism beneficiaries of legislation, whereas other people who have equally disabling conditions will not have that. If that is the objective, we believe that there are issues there, especially as autism is a spectrum disorder. There are issues in respect of other client groups and other people with significant disabilities.

If the objective is to write a strategy that endeavours to do something to raise awareness of autism, a strategy alone will not improve front line services. That is particularly the case when the Bill states that there are no significant costs attached.

The Chairperson:
Clause 3(1) states:

> "The autism strategy must set out how the needs of a person with autism are to be addressed throughout their lives."

Is that not clear?

Dr Briscoe:
I am saying to you that, if that is the objective, what about other people who have equally disabling conditions? What about their ability to have additional benefits in legislation that people with autism will have by virtue of the Autism Bill? Therefore, it depends on how you interpret clauses 2 and 3. One would need to be sure that clauses 2 and 3 are compliant with the European Convention on Human Rights, with particular reference to articles 8 and 14, as I have already indicated.

Mr Easton:
I am sorry that I missed part of your presentation. I like you, but I do not like you enough to go to the ball with you on this issue.

The Chairperson:
I do not know how you will interpret that statement. A mobile phone is switched on, and it will interrupt the recording.

Mr Easton:
What I like about the Autism Bill is that its strategy involves all Departments. Does your strategy involve every Department?

Dr Briscoe:
It is designed primarily for health and social care. There are five themes in the strategy, and the last theme relates to engagement and partnership working. A number of actions under that theme promote inter-agency working. We specifically put that in there because we recognise the importance of inter-agency working. Therefore, we are trying to build on what we have, improve our services and, as we develop, the interface with other agencies — I gave the example of the care pathway for children — and the commencement of additional services in relation to adult diagnostic services.

I want to bring in some of my colleagues on this issue. In respect of care planning for children, inter-agency working is fundamental, regardless of whether it relates to autism or not.

Mr Charles Bamford (Department of Health, Social Services and Public Safety):
Yes, indeed. There have been a number of recent improvements, which we have already mentioned. I am not too sure what the advantages would be of compelling something to happen through legislation. There is already a degree of accountability for staff on the front line, and that accountability is leading to improvement across agencies, not just in the statutory sector but in voluntary organisations.

Social care staff and social workers in particular are very sensitive to the needs of parents and look at providing support mechanisms for parents by way of timely information and good communication across the education and housing sectors, so that an adequate care pathway is provided for their sons or daughters. I fully recognise that there are huge pressures out there. I also recognise that staff are saying that there have been significant improvements. There is still a lot to be done, but there is now accountability and recognition that the issue needs to be profiled in the future.

Mr Easton:

I accept that your strategy will work with some agencies, but can you guarantee that every Department is working with you on autism issues?

Dr Briscoe:

We have produced our strategy, but our job relates to policy. The implementation of our policy, which is on the action plan, is the responsibility of the regional ASD network group in collaboration with the local fora, which I am sure you will have heard about from Stephen Bergin. Therefore, our job is not implementation. Our job is policy. As has been stated, we recognise the importance of inter-agency working, and we will continue to do that. We have strong interfaces in lots of areas, and we meet regularly with our colleagues from the Department for Employment and Learning (DEL) and the Department for Social Development (DSD). We have a good interface there at policy level, but the outworkings of our action plan are through the ASD network group. I suggest again that you look at the children's diagnostic care pathway if you have not already done so. Stephen and others worked on it, and it will show you that there is wide inter-agency work.

Mr Easton:

I accept that you are involving other agencies, and you are trying to pass the buck to somebody else who will deliver the strategy, but I am looking for a cast iron yes or no. Does it involve every Department?

Dr Briscoe:

We interface with every Department.

Mr Easton:

On autism?

Dr Briscoe:

Yes, as we need to.

Mr Easton:

As you need to?

The Chairperson:

There might not be a huge interface with Departments such as the Department of Agriculture and Rural Development (DARD).

Dr Briscoe:

These things are not just about autism; they are about disability in the round. It is very important to hold onto that. For example, we are developing a physical and sensory disability strategy, which is nearing completion. In that context, we have interfaced with DARD, recognising the importance of transport, housing and employment issues, and so on. Therefore, it is about how we look at disability in the round. We recognise and interface with all Departments as we need to.

Mr Easton:

It is commendable if you are doing all of that, but does that mean that the other Departments will train all their staff who deal with the public on issues that they will have to face when they deal with people with autism? Can you guarantee that all Departments will do that?

Dr Briscoe:

I am glad that you brought up the training of civil servants because there is a lack of clarity around that issue. The Bill states that all civil servants who deal directly with the public will be trained. It is interesting that, in a previous iteration, it was about training public sector staff. It could potentially cost £1·8 million to give civil servants autism awareness training. However, is that the right training? What does “Civil Service staff” mean in this context? Would it not be better to train front line staff, such as doctors, nurses, etc, and to widen that out into other areas? There must have been good reason for the sponsor to change the wording from “public sector” to “Civil Service”. I do not know the reason for that, but, either way, there is a substantial cost to that. Training civil servants will not impact significantly on front line service provision.

Mr Easton:

Finally, I would have thought that it would be beneficial for staff who deal with welfare and benefits to get that autism awareness training. I think that that type of training is important. It is equally important that people with autism who apply for grants to set up their own businesses get help to do that.

Dr Briscoe:

We talked about the DDA earlier, and we said that this is our Department's perspective. You might wish to take advice from the Department for Social Development in respect of benefits and access to benefits, etc.

The Chairperson:

I will let Pól ask one more question because no one else has indicated that they wish to speak on this section. We are running slightly over time, so this will be the final question.

Mr Callaghan:

I am sure that the Chairperson will be happy if the precursor to my question is a request for more information on how much training the £1·8 million that you mentioned would deliver, who it would be delivered to, and your definition of who deals with the public. That is interesting for considering the clause and sub-clause.

My question is on costs in general. As you portray it, the monitoring requirements of the Bill would create unnecessary bureaucracy. Has the Department assessed what the costs would be? You told us that there is a lot of collaborative work going on, and you talked about the mechanisms behind the care pathways, care planning, interdepartmental work, inter-ministerial work, and subcommittees and everything else. If the collaboration were more streamlined, presumably there would be cost advantages to that.

Drilling down into the actual substance, one of the points behind the Bill is that better co-operation does not, ipso facto, lead to more cost. It can actually lead to savings. One of the complaints that we are getting is that there is almost too much overlap and duplication. Different agencies are trying to do different things with the same objectives, rather than having high-level aims, and there is frustration on the part of some families that one hand does not know what the other hand is doing. Therefore, presumably, there would be better savings if there were better co-ordination.

I appreciate that some of that seems to be because, for good reasons, different Departments have tried to ramp up over a reasonably short time and in a historical context over the past few years. Therefore, it is a case of everyone getting out into the field. You are firing shots and so is the guy beside you, but, maybe if you have the one target, you would fire fewer bullets. That is a horribly anti-pacifistic analogy. There is a question in there somewhere.

Dr Briscoe:

In relation to your first question on civil servants, we estimate that, based on 25,000 civil servants, it will cost £65 each for training, which would lead to a training bill of £1·8 million. In one way or another, civil servants deal — and the word "deal" is in the Bill — with lots of people, but is it appropriate that we spend £1·8 million in training civil servants who deal with the public? Even if £1·8 million were available, at a time of budgetary constraint, would it not be better to train public sector workers in front line service provision — people who work in local councils, in the Housing Executive, doctors, nurses, social workers, the PSNI, and the broader range of public sector workers — rather than civil servants.

This is a time of budgetary constraint, and, from meetings with colleagues in the Department, you will be aware of our financial position in respect of the global finances of the draft settlement. The Bill is not without cost. Where will that money come from, and is it an appropriate use of money to train civil servants at a cost of £1·8 million? We have given you a minimal and a significant cost in respect of what the public awareness campaign might be. Again, that is a significant cost.

As regards your second point about interface with Departments, you asked why we do not streamline our interface, but the Bill is asking us to create an infrastructure specifically for autism. We interface on a number of issues, such as public health, and there are a lot of issues in there on Bamford, on mental health and learning disability, and the whole range of conditions in that. Equally, we have a lot of discussions on physical and sensory disability, yet you want us to create another bureaucratic layer specifically for one condition.

In saying that, I want to emphasise to colleagues in the audience and to the Committee that the Department is absolutely committed to trying to improve autism services. That is our aim, but we honestly do not believe that the Bill will assist us to do that. We have all the legislative power that we need, and we do not need any more.

The Chairperson:

Thank you very much. I am sure that your colleagues are annoyed that they did not get an opportunity to speak.

Dr Briscoe:

I was just going to ask whether Ian and Peter would like to say something.

The Chairperson:

I was only being facetious. They actually look quite relieved that they were not asked to speak.

Dr Briscoe:

The Bill has clinical implications. We talked about clause 4 the last time, and there were important issues in respect of definition, etc, and we still hold that view. Ian was very articulate on that the last time.

The Chairperson:

Unfortunately, we have run out of time, but thank you very much, Dr Briscoe and your team, for your helpful information.