Northern Ireland
Assembly

COMMITTEE FOR
HEALTH, SOCIAL SERVICES AND
PUBLIC SAFETY

OFFICIAL REPORT
(Hansard)

Mental Health (Private Hospital) Regulations (Northern Ireland) 2011: Royal College of Psychiatrists in Northern Ireland

5 October 2011

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Members present for all or part of the proceedings:
Ms Michelle Gildernew (Chairperson)
Mr Jim Wells (Deputy Chairperson)
Ms Michaela Boyle
Ms Paula Bradley
Mr Mickey Brady
Mr Gordon Dunne
Mr Sam Gardiner
Mr Kieran McCarthy

Witnesses:
Dr Philip McGarry) Royal College of Psychiatrists in Northern Ireland
Ms Liz Main)

The Chairperson:

We now have an evidence session with the Royal College of Psychiatrists on the Mental Health (Private Hospital) Regulations 2011. Members will recall that, following a briefing from departmental officials regarding the proposed statutory rule at its meeting on 21 September, the Committee agreed to seek the views of the Royal College of Psychiatrists and the Children's Law Centre on the legislation. Today, we hear from the Royal College of Psychiatrists; the Children's Law Centre will brief the Committee at its next meeting.

The purpose of the legislation is to allow private hospitals to treat patients who are detained under the Mental Health Order 1986. The legislation currently permits a private hospital to treat only voluntary patients. The Department of Health, Social Services and Public Safety (DHSSPS) has advised that there are no private mental health hospitals here but that the Priory Group is planning to open a facility in Ballyclare to treat children and adolescents.

I welcome Dr Philip McGarry. I nearly called you Tim.

Dr Philip McGarry (Royal College of Psychiatrists in Northern Ireland):
I deny responsibility for any of his jokes. *[Laughter.]*

The Chairperson:
A few of us have been at the butt of those jokes, but we will treat you both separately.

Philip is the chairperson of the Royal College of Psychiatrists here, and Liz Main is the college's communications and public affairs consultant. I believe that you are going to make a presentation, after which we will bring members in for questions. You are both very welcome. Tá fáilte romhaibh.

Dr McGarry:
Liz has a sore throat. Although I am a pretty good psychiatrist, I am not brilliant as an otolaryngologist, so I have offered to do most of the talking. However, Liz will come in if necessary. Thank you for the invitation to today's meeting, which came at relatively short notice. We were aware that there were rumours of an organisation coming to the Newtownabbey/Ballyclare/Templepatrick area. I know that there was debate at the last Committee meeting about its geographical location. Nevertheless, we were asked to comment on the issue, so we produced a brief paper. We are also open to any questions.

I will give the background. I am the chairperson of the Royal College of Psychiatrists in Northern Ireland. The college is a UK-wide organisation, and we are neutral about the principle of private practice. Some of my colleagues in England work full-time in private practice. Indeed, in certain areas, that is what they have to do if they want to work. I feel that it is not a great thing in principle, but, in some cases, there is no alternative. Places such as the Ulster Independent Clinic on the Malone Road have been going for many years and have done no harm to the health

service and have probably done some good. We will talk about that issue later. In principle, there is nothing wrong with private practice, and, legally, people are entitled to set up a private practice if they so wish.

If we are to have a private inpatient unit that provides psychiatric care for the first time in Northern Ireland, one understands why we need to consider what would happen if someone in the unit became so unwell that he or she required to be detained. It would seem reasonable that we would permit that to happen by implementing the appropriate legislation.

In England, the private sector provides an increasing proportion of healthcare. In particular, on the forensic side of the spectrum, there are individuals who have had mental illness, who have engaged, or are engaged, in the threat of criminal behaviour, and a large number of inpatient forensic psychiatry facilities are run by the private sector. However, some of those facilities are set up to take only people who have been detained; people cannot go in voluntarily. They seem to have cornered the market in large parts of England, as opposed to Scotland and Wales.

There is a proposal for a child and adolescent unit in Ballyclare. However, if legislation comes in, it will apply to anybody, including children, adults and elderly people. If the legislation is changed, it will apply for good for the full age spectrum. Another group could come in and set up a facility for elderly people or for adults. We have no objection in principle with allowing people to be detained in such hospitals, but standards and human rights protections must be as robust as they are in the statutory sector under the aegis of the Regulation and Quality Improvement Authority (RQIA), and the Mental Health Review Tribunal will operate in the same way. There cannot be one set of standards for people in the National Health Service (NHS) and another set of standards for people in the private sector.

As well as the broader issue, there are three specific issues on which I want to comment, one of which is the safeguards against financial incentive. The detention process in England and Wales is different from Northern Ireland. In England and Wales, a psychiatrist goes out to a person's house and makes a decision to detain a patient. A doctor in the hospital then completes the detention form. In Northern Ireland, a general practitioner sees a patient at home, and a psychiatrist operates only at the hospital end. In England, it is perfectly acceptable for a doctor from an NHS hospital to go out to see a patient and to sign the forms for a patient to be detained. A patient then comes in to a hospital, and another doctor in that same NHS hospital can complete

the detention. However, when the private sector is involved, there is always an issue about financial incentives. A protection was, therefore, put in place in England to ensure that any doctor or psychiatrist who goes out to admit a patient cannot work in the private hospital to which a patient is sent, the reason being that there could be a potential conflict of interest. A doctor or psychiatrist may wish to bring that person to a hospital at which he or she is either moonlighting for the NHS at night-time or working full-time because he or she could benefit financially from doing so. In England, the need for extra protections was recognised.

The situation is slightly different in Northern Ireland in that a GP goes out to a patient — not always but almost invariably — with an approved social worker, so the same conflict does not arise. However, many patients do come from NHS hospitals. Our submission states:

"referrals were predominantly from NHS inpatient services."

A situation might arise whereby a patient who is being detained at an NHS hospital in London is then sent to a private hospital because the hospital staff feel that that patient needs extra support that they cannot give. I am not exactly sure what protections are in place at that point where there is a potential conflict of interest. The Department may, therefore, wish to ask colleagues in the other three jurisdictions how such cases are dealt with to make sure that there is not a conflict of interest.

Let us say that I was working as a consultant psychiatrist at the Mater Hospital and was treating a patient who was quite unwell. If, perhaps, I also did a few sessions at weekends at the facility in Ballyclare, I could be in danger of being seen to send many of my patients to that facility. So we need a method to ensure that such conflicts of interest are dealt with in an upfront way and that doctors are not placed in a difficult position. I do not know the precise details of the mechanism in England, but the same principles will apply if someone works in an NHS hospital and also in the private sector. That issue needs to be examined.

Another issue concerns safeguards against what is called informal coercion or leverage. This issue probably feeds back into the discussion about detention in the previous evidence session, which is sometimes the appropriate course. We need to make sure, as a matter of principle, that people's human rights are protected against those in authority in any institution. A paper in the August edition of 'The British Journal of Psychiatry' stated that we need to be aware of the fact that it sometimes seems like benign paternalism: if you leave the ward, we will detain you. It is important that we are aware of that, and most of us are well aware of it.

The Chairperson:

This is the "helping the police with their enquiries" bit.

Dr McGarry:

There are all sorts of things in that area that we need to be careful about. As is stated in our submission, the General Medical Council (GMC) makes it clear that some people may be vulnerable. If such people are subject to legislation, they may be told that, unless they adhere to their treatment plan, which may include medication and occupational therapy, their detention form may not be allowed to lapse. We just need to be aware of that issue.

We need to be aware of the financial incentives to keep people in hospital. If somebody detained in the Mater Hospital wants to go home, my decision, as the consultant, would be based purely on clinical reasons. Is it in the person's interests to go home? Is it safe for him or her to do so? It would not benefit me financially whether the individual went home or was detained in the Mater. If I were in a private hospital in Templepatrick of an evening — which I have no intention of doing — that did not have many patients, and I allowed a voluntary patient to go home, the hospital would lose, we are told, £4,500 a week. I want members to be aware of those issues. It will not be terribly easy to write that into legislation. However, I recommend that the Department consult its colleagues to work through the implications of that issue.

On the issue of data collection, it is well recognised in England that information from the private sector does not always flow with the same ease as information from the NHS. The data collection system is not always the same. Obviously, we are concerned that the same principles and protections apply, and that the public and the Committee have the same information.

For a long time in Northern Ireland, much mental-health care has been provided by the so-called third sector. I am sure that many people have been to some of the facilities run by organisations such as the Northern Ireland Association for Mental Health, Praxis Care, MindWise and Threshold. Those not-for-profit organisations provide excellent care. I am on the board of Threshold, for example, and it has 98 places in Northern Ireland for people with severe mental illness who in the past would have been in long-stay hospitals but are now managing in the community. We are well used to that, and it generally works very well indeed. There is quite a good partnership between the statutory and the voluntary sectors.

However, this is the first time that we have ever had residential facilities on a private, for-profit basis. The college has no objection in principle to the development of private health services. That is a matter for those who wish to set up and offer their services. Some of our colleagues work in private practice, which is absolutely fine. However, there are implications for the NHS once the private sector starts to become heavily involved in healthcare. The vast bulk of funding will come from the health service, which means that health service facilities will have to close, and consequently people will lose their jobs. It is important to say that.

Scotland and Wales have not followed the English model. In fact, Scotland and Wales, having developed a purchaser/provider split in the 1990s, completely reversed that and now seem to take the view that we should have a universal system of healthcare that is comprehensive, free at the point of delivery, publicly funded and largely publicly delivered. Scotland and Wales are very clear about that. That is a matter for politicians, not for the Royal College of Psychiatrists, but we do feel that the NHS has provided an entirely equitable system of healthcare throughout the UK. It is also, by miles, the most cost-effective healthcare system.

Figures from the Organisation for Economic Co-operation and Development (OECD) and the World Health Organization (WHO) show that the American system is 2·4 times the cost of the UK system. Some 62% of bankruptcies in America are due to health bills. Three quarters of those have health insurance, and so on. At the bottom end, people are frightened of becoming ill, and there is a two-tier system. At the top end, there is clearly over-investigation, over-diagnosis and over-treatment, which is not good either.

The college has a commitment that it feels, like our Welsh and Scottish colleagues, that the NHS provides excellent value to the public as well as excellent quality of care across the spectrum. We can certainly learn from some private sector business models, but we do not believe that health can in essence be run as a market system based on legally enforceable contracts.

You may have been aware that the biggest contract ever awarded in the NHS to the private sector happened a couple of weeks ago in Surrey. That was to the value of £450 million to £500 million for community health services in Surrey, and it was awarded to a company that is an offshoot of Richard Branson's Virgin. The competitor for that contract was a social enterprise

unit that was the first winner of a Big Society award, and it clearly was not going to compete with the marketing, salesmen, finance people and lawyers that the Virgin empire can bring to bear. I know that some of our English colleagues are concerned about that. However, that is a broader background matter.

We have never been made aware by the DHSSPS — although it would not necessarily come to us — that there is a great need for many more adolescent mental health beds in Northern Ireland. As you know, we currently have 18 beds in Beechcroft; I checked yesterday morning. There can be an occasional shortage of beds there, and at times there have been up to four patients in the Rathlin ward at Knockbracken Healthcare Park. Yesterday, there were no patients in Rathlin, and Beechcroft is currently meeting the demand in Northern Ireland for acute care.

As you know, the Bamford review stated clearly that funding should be moved from hospitals to the community and that the situation in which 60% of funding goes to hospitals and 40% goes to community services should be reversed. We are moving along that line. We have been aware of a need for more inpatient beds, which are very expensive, and we know that there is a dire shortfall in alternative-to-hospital admission. This morning, I talked to the manager of the Belfast Health and Social Care Trust's child and adolescent mental health services (CAMHS). His plea was that we need more community services.

What do those community services look like? I work in home treatment in Belfast. I was in Knockbracken, the Mater Hospital and clinics in the Royal Victoria Hospital. I now see people in their own homes. Home treatment does what it says; rather than being admitted to hospital, a patient can be seen at home two or three times a day, seven days a week, 365 days a year. Most of us, I presume, would prefer to be seen at home rather than be admitted to a psychiatric hospital. At the same time, of course, we want to ensure that we have good-quality beds, if necessary.

Over the past number of years, we have seen a major reduction in the number of inpatient psychiatric beds in adult psychiatry, coupled, paradoxically but not surprisingly, with the availability of an acute bed when it is needed. Three years ago, the then Minister asked us to look at that situation. There had been an incident in which an individual had not been able to get access to a bed at night, and it turned out that, although a number of beds had been available, there was no joined-up system throughout Northern Ireland.

Last year, I carried out an audit. Following the then Minister's request, all the trusts put bed managers in place to co-ordinate bed flow. Quite often, when a bed is not available, the reason is that the person occupying a bed could be elsewhere — in the community, for example. At the same time as we have cut beds, in the past 17 months, to my knowledge, not a single patient had to be admitted out of sector for acute care, which is pretty excellent. We have home treatment for adults and intensive day treatment, and we have tried to beef up some community services. Those are not cheap options, but they are certainly less expensive than going down the hospital line, and there is better-quality care. CAMHS has no day treatments, which is quite surprising. It has no home treatments that I am aware of. The community CAMHS teams could be beefed up. If you talk to any of the professionals, they say that they would like more community facilities as a key priority. If someone were to come along and give us more money, we might not necessarily use it to provide more beds; we need to create more community alternatives. That means that, over time, we could reduce the number of beds.

Finally, we have lagged behind in funding compared with England over many years, particularly in funding for psychological therapies and treatments for personality disorder. I have picked out those examples because two excellent strategies were produced over the past couple of years, and great credit is due to the Department, which involved all the professional groups, users and carers.

The problem is that, when those strategies were produced, money was pretty limited. Many people with personality disorders or challenging behaviours end up having to go to England, but we have very little in the way of community resources to stop them getting to the stage at which they need such treatment. We have one consultant who deals with adolescents with eating disorders but who can devote only four hours a week for outpatient eating disorder work. Rather than starting off at the extremely expensive end, we should be asking whether we can create a robust community-based eating disorder service. Other young people tend to go to England with forensic problems. My understanding is that we have no forensic adolescent psychiatry at all. We believe that more community alternatives in both specialist and general areas should be a key priority.

To recap: we have no difficulty in principle with what is being proposed. If the beds come in and the people are there, we need the capacity to detain them in their own best interest. However,

safeguards need to be put in place. It is also worth raising the broader issues that I mentioned.

The Chairperson:

Thank you, Philip. There is a lot in there. I think that your submission is very interesting. The SL1 came to the Committee, and I think that the Department simply expected us to nod it through. However, there were questions to which we were not getting answers, and we felt that we needed to dig in a wee bit deeper.

You said that there are 18 beds in Beechcroft. The unit in Ballyclare will be a 30-bed unit. Your submission states that people are more likely to be detained in a facility in the private sector than one in the NHS. A 30-bed unit is planned for Ballyclare, but we currently do not have that level of throughput of children and young people. The number of young people who need treatment and are sent across to England is in single figures.

The Committee Clerk:

Seven a year.

The Chairperson:

You cannot help but wonder, if it is seven a year, why we need a 30-bed unit. Philip, you pointed out the difficulties about protections and conflict of interest and all of that. I presume that there is quite a small pool of people who do what you do — psychiatrists and forensic psychiatrists — in the North. It would be difficult to have that level of separation for treatment. If you are going to try to do away with conflicts of interest, the critical mass in the Six Counties does not give us a huge number of young people who need that kind of treatment or a huge number of clinicians who are in a position to treat them in order to have that separation.

I have concerns about that. I accept the fact that we need excellent facilities for vulnerable young people. It is interesting that you mentioned the preventative strategy. I know that eating disorders is one area that is being worked through as an INTERREG proposal, whereby European funding is used on a cross-border basis to provide eating disorder clinics here before that extreme level of need is required. It is an awful pity, but no surprise, that efficiency savings released by bed closures are not released back into the community. We have pressed the Department that, if it is moving resources — equally, if it is a four-hour bed stay in a maternity unit — and savings are released, those need to go into the community midwifery team, who are picking up the pieces

at home and who need proper support to do that.

I believe that your submission gives the Committee more questions than answers. It is probably good that we have been able to probe that. I am going to let other members come in. That is just food for thought at this stage. I imagine that other questions will be along those lines.

Mr McCarthy:

Thank you, Philip, for your presentation. I am delighted that you mentioned the Bamford report and how important it is to follow its recommendations. I also 100% support your analysis that mental health services are underfunded. We have always known that they have been regarded as a Cinderella service. I hope that we can turn that situation around. I have three simple questions. You have probably answered them somewhere along the line, but I will ask you again.

How would you describe the value or otherwise of a stand-alone private mental health unit compared with NHS mental health provision? Do you think that it is valid to consider a 30-bed unit in isolation, without considering other treatment factors that may be required for a patient's mental-health care? What would you recommend as the best approach to planning and providing appropriate levels of mental-health care in Northern Ireland, including CAMHS? You have already touched on most of those issues.

Dr McGarry:

To me, the case, not least at a time of economic recession, is that we look at the service in Northern Ireland as a whole and make sure that the bits join together. In the previous evidence session, the word "joined-up-ness" was mentioned. It is a very useful word, even if it is not in the dictionary. It is important to have that "joined-up-ness" between the statutory and voluntary sectors, and everything that goes with that. We have not been great at that in Northern Ireland, including, at times, in the NHS. We can always learn. I think that it must be an integrated service.

The way in which home treatment works is that one of the senior nurses in my team is on a ward every day of the week. For example, he went into Windsor House this morning. Before I came here, someone whom I was seeing at home was admitted to hospital. The nurse found that beds were available on the ward. He spoke to the consultant, they looked at the caseload and considered who could go home early with home treatment support if the situation became very

tight with beds. The nurse said to the consultant on the ward: "We have people who are quite unwell, and we may need to bring them in to hospital quite soon. If I cannot hold them, what is the bed situation like?"

It is an entirely integrated system, and it all works together. We talk to our colleagues on the mental health teams every day, so there is a completely clear flow. At times in the past, NHS hospitals stood alone. Belfast had six trusts under the old system, which was not a good thing because the trusts did not always get on with one another. They always talked together but did not work as effectively as they perhaps could; that caused problems. There is now one system for each trust based on clinical need and nothing else, whether people are inpatients or outpatients.

It is important to have integration, so a stand-alone unit creates huge difficulties. On the wards, we have home treatment and day treatment as a step-down. There are also urgent outpatient appointments, so there is a huge range. Community nurses come into wards to see their patients. It is not that community equates with good and hospitals equate with bad. It is all one system. A few people will need to go into hospital, but most people will not. If people do need to go into hospital, that is fine. That is why I think that a stand-alone unit does not really work well because how can it be integrated with everything else that is going on?

I cannot comment on the idea of 30 beds in isolation. Someone may make a business case, and I cannot comment on what the private sector wishes to do. I do not know whether patients other than adolescents are expected. As the Chairperson said, I cannot see how the number of beds would be filled with adolescents.

The Chairperson:

It is just children and adolescents at this stage.

Ms Liz Main (Royal College of Psychiatrists in Northern Ireland):

The planning permission enables it to be changed from that. Although the group may have got planning permission on the basis of a children/adolescent hospital, the extra permission enables them to use it for any health or educational purpose. Therefore, that could change.

Dr McGarry:

Population-wise, you need to plan for a small region, not a huge geographical region. We must

also plan throughout Northern Ireland, and the more integrated that is, the better. The private sector is entitled to be there, but that involves legally enforceable contracts. If I want to admit a patient to the private sector, it has to be through a contract. However, if I want to admit a patient to Windsor House, I simply ring up, and my bed manager will say whether a bed is available. Dead easy. At the same time, Windsor House will say that a patient should stay but wants to leave and can I manage him on home treatment, to which I say yes. Those decisions are based purely on clinical need. So the more integrated the system, and the more we can plan for Northern Ireland as a whole, and looking at the spectrum from the very early stage to inpatient, the better.

Mr Wells:

I am very aware of that planning application in south Antrim. If the truth be known, there was a bit of a battle about it. At the end of the day, however, investors will make an appraisal and draw up a business case. They will assess whether the market is there, and they have a right to be wrong. They have a right to invest and find out that they do not get the numbers. Provided those numbers are not stimulated artificially — in other words, nothing is done to try to encourage people who would not otherwise be in that unit to be there — surely any problems will be picked up immediately by the RQIA. Is that not the same principle as for nursing homes, residential homes and hospitals?

Dr McGarry:

The provision of acute care by a large corporate entity is a new development. However, such people are entitled to come into the market. Clinically, I find it hard to understand how the unit will be filled with 30 patients if it is for adolescents. If the business fails, it fails. The RQIA comes in purely with regard to the quality of the environment.

It is well recognised that independent sector treatment centres (ISTCs) in England were stimulated by government funding to encourage the private sector into the system. I presume that the Executive have no plans to do that because that would be a bad thing. However, people are absolutely entitled to make a business decision to invest.

Mr Wells:

Is there any difference between this and any other form of patient care in which the RQIA has an automatic right of admission to check up anything and address complaints? Why have we

anything more to fear from this?

Dr McGarry:

To detain someone under the 1986 Order — or under the forthcoming Mental Capacity Bill — is a huge thing. The taking away of someone's liberty is a huge fundamental decision. That is why it is invested in GPs, approved social workers and consultant psychiatrists. It is a huge decision, and we never take it lightly. We are also aware of broader pressures in society to do more. I am straying into the topic of the previous evidence session and, for example, community treatment orders, and there is great pressure to have more coercion. This type of facility is fundamentally different from a nursing home because it can detain people. It is also the first input for acute psychiatric treatment in the private sector here. It is a new development.

Mr Wells:

Why would one of your patients be more likely to be detained in a private facility than in an NHS ward?

Dr McGarry:

It would depend on the profile of the unit. In England, if we consider the private sector overall compared with the NHS, people are more likely to be detained in the private sector. The private sector has seen a market for the forensic population, which is the case in England. If a certain group had an acute general hospital in England, I am not sure that there would be any evidence to suggest that people would be more likely to be detained there than in an acute NHS hospital. However, such a group has a focus on the forensic population, who are more likely to be detained.

Ms Main:

The problem there has been the lack of data collection on the profile of those detained who are outside the forensic system. It is difficult to compare like for like on the demographic of the detained population in the private sector or the public sector.

Another issue involves insurance companies, and the GMC notes them when it talks about leveraging and coercion. There may be an incentive from an insurance company's point of view to say that, if patients do not comply with a treatment plan, they may not have their treatment funded. From the hospital's point of view, if an insurance company is paying for treatment, it is

hard for an insurance company to say, clinically, that a patient no longer requires that treatment once he or she has been detained. There may be that conflict outside the NHS as well.

The Chairperson:

I had the privilege, pleasure or whatever of attending a stakeholder conference with a constituent and his family in Carstairs in Scotland. It might be helpful to explain the difference between psychiatry and forensic psychiatry.

Dr McGarry:

Forensic psychiatry involves individuals whose mental illness has led to an interaction with the legal system. There is a medium-secure facility in the Shannon clinic in Knockbracken Healthcare Park, and members may have heard of Broadmoor Hospital, which is a high-security facility for the most severely unwell and the most dangerous. Forensic psychiatry in the community comes under the community forensic psychiatry team; it is a mental illness that has brought someone into conflict with the law.

The Chairperson:

In most instances, mental illness has contributed to those people's brush with the law or to their involvement with the criminal justice system. We previously raised the issue of the high number of prisoners in Maghaberry who are on medication of some sort or other. It is a chicken-and-egg scenario. We need proper community facilities and proper preventative strategies to keep people from becoming so ill that they need forensic specialism. We have forensic psychiatrists in the North who deal with adults, do we not?

Dr McGarry:

We do. My understanding is that there is no forensic psychiatrist or dedicated sessions for children and adolescents. There would not be a huge number of individual children, but there are some, and some of the ECRs come from that category, although it is a relatively small number.

The Chairperson:

ECRs?

Dr McGarry:

ECR means "extra-contractual referrals". I apologise.

Mr Wells:

Everyone on the street is saying it.

Mr Brady:

My point may or may not be relevant. Obviously, this facility seems to be a one-off, and the evidence seems to be that there may not be the full capacity for it. In my constituency, 20 or 25 years ago, a number of residential homes were run by a trust or were government-funded or whatever. There is now a proliferation of privately owned residential homes, some of which are owned by multinationals. People are now seen almost as a commodity, and it strikes me that this facility may be a first step. Essentially, the private sector has, to a large degree, taken over care for the elderly.

I wonder whether what you describe constitutes a first strike. You paint a very comprehensive picture of joined-up communication and interaction between community nurses, psychiatric social workers, psychiatrists and that entire infrastructure, whereas what seems to be happening in Ballyclare will initially be in isolation and may at some stage be assimilated into the wider structures. It seems that it is private, and you cited costs of £4,500 a week. That would be paid for by the NHS, and surely, even if there are relatively few cases, it will put a tremendous burden on an already stretched budget. Perhaps I am, in a sense, scaremongering; but if it happens with elderly people, who is to say that it will not happen more generally? What are your views on that?

Dr McGarry:

This is a decision for politicians rather than for me. Your observation is correct that a lot of elderly care is in the private sector, and that level of care is very good. There can be problems, as we saw with the Southern Cross issue. That arose not out of care issues but out of high finance, which is the risk that people take.

I sit on the policy committee of the Royal College of Psychiatrists, which meets every six weeks in London — the Welsh, the Scots, the English and us. It is fascinating that many English colleagues join our meetings because they see the three jurisdictions doing things differently to the way in which they are done in England. They seem to prefer the direction that we are going in. However, it is a decision for politicians.

The NHS is incredibly efficient. In America, 30% of the health budget is spent on administration. That is inevitable because, as soon as everything is a legally enforceable contract, it is complex. Therefore, even administration eats up a huge amount of money. There is much to criticise in the NHS, especially in the old days. However, it has become progressive in psychiatry, in moving into the community and trying to develop policies, using more psychotherapy, a greater range of treatments and trying to work with the voluntary sector. However, politicians must pursue those issues. I cannot directly pursue them here.

Mr Brady:

I have one small point. We are in a bad recession. As resources contract and people's lives become more difficult, the likelihood is that more people will suffer from acute mental health problems. At this point, we have had cuts in the health service, and so-called welfare reform is coming down the road. It seems to me that there will be a greater need for the services that you provide.

Dr McGarry:

We are seeing more referrals, year-on-year. I was asked to produce a briefing for the Chief Medical Officer last Friday. I spoke to my colleagues in CAMHS, and the old age, learning disability and adult services, and I received the same message from all those specialties independently, which is that there is pressure on the acute sector and what we need is not more beds but more community services. Part of the concern has been that it is easier to cut some community services but much more difficult — dare I say it — to cut a bed. I understand that there is a strike today. However, if community services are taken away, that can sometimes lead as a back route to people being in hospital. The college did an audit two years ago. We surveyed all the inpatient units in Northern Ireland, which showed that 20% of people in acute inpatient beds did not need to be there but could be somewhere in the community if the facilities were there.

More referrals are coming through. The recession will increase the incidence of depression; you do not have to be a psychiatrist to work that out. Those people who are already mentally ill will be affected by the recession. Many of our patients are earning less than the average person, almost by definition, and the recession will cause problems that will lead to depression and other consequences; there is less money and an increase in demand.

Mr Dunne:

Thank you for your presentation; I found it very interesting. You talked about safeguards against financial incentives and said that the admission process in Northern Ireland is different to that which pertains in England. Will there be a risk if we run with our existing processes? Does something need to be addressed if we go down the private sector route?

Dr McGarry:

Given that a GP makes a referral here, and there is a psychiatrist is at the receiving end, there is less likely to be conflict because the GP is not likely to be employed in a private hospital. Therefore, the actual admission process is less likely to be a difficulty. In England, however, a psychiatrist from a hospital goes out to undertake the detention. The 1986 Order is good, enlightened legislation, because it states the need for a GP who is independent of a hospital doctor. Subsequently, there is an approved social worker and a psychiatrist, who gives a second medical opinion when a patient comes in to a hospital. Over the years, that has helped us to separate out and give a patient extra protection. Furthermore, a GP often knows a patient very well and can give a considered view.

Ms Main:

The 1986 Order states that it has to be a medical practitioner, but the practice has been to forward it to a GP. The Order states that it has to be a medical practitioner who is authorised by the RQIA. Perhaps that should be inserted into these regulations. That would ensure that the two doctors are not from the same provider.

Mr Dunne:

That would ensure that there is no conflict of interest.

Dr McGarry:

The issue needs to be addressed. In England, the issue has been specifically addressed. In theory, a GP could have sessions in a private hospital. Under the 1986 Order, it is possible for a psychiatrist or another doctor who is a non-GP to complete the forms to admit someone, should a GP be unavailable, but that is not best practice. There is currently some debate about that because GPs are not legally obliged to undertake the detention, but they almost always do. Take, for instance, a very unwell individual from Fermanagh or Derry who comes to A&E at the Royal.

That individual's GP will be 70 miles away. Occasionally, the A&E doctor at the Royal will admit an individual to hospital. It can, therefore, be somebody other than a GP, but I think that we need to make sure that any regulations are clear. It is not that we expect doctors to behave other than honourably, but it is to make sure that there is no potential conflict. It needs to be thought through.

The Department should talk to its colleagues in England, Wales and Scotland to find out exactly how it happens in the private sector there. That would be useful. We have not had experience of such private sector facilities here, so I do not know how they work. I know intimately how our system works, but I have not quite got my head round this one.

Ms Main:

I am thinking about the wording of the 1986 Order. It states that it is preferable that a doctor knows a patient well. If someone is seeing a psychiatrist privately, for example, he or she will probably be the person who knows that individual well. That is the area where safeguards are needed. It should be ensured that the medical professionals are not from the same provider. At present, we are talking about one hospital. In the private sector in England, they say that it should not be somebody from the same provider, not just from the same hospital. That means that there will not be a broader financial interest.

The Chairperson:

The Committee is concerned not only about the rights but the needs of children and young people. There are children and young people who find themselves in need of a forensic psychiatric bed. Approximately seven children and young people a year who come through the system need that additional level of care. What is your opinion on the current treatment and the fact that we do not have those beds here?

I suppose that, ideally, I would like a unit at Beechcroft with a forensic psychiatrist attached, so that we do not have to send such children across the water. However, at the same time, it is a big jump from our current gap in provision to the proposed 30-bed unit in Ballyclare. The word "vulnerable" was used earlier: our most vulnerable young people are likely to become a commodity. Your view on that would be useful, Philip.

Dr McGarry:

It is clearly better to manage people as close as possible to home. A number of young people go to England, which should be the last resort. You will be aware of a judicial review earlier in the year. My view is that we should try to enhance what we have locally in the Beechcroft set-up because, if we consider what happens in England, I am not sure that what it has to offer, albeit being good, is radically different from what we have here.

The Chairperson:

Really?

Dr McGarry:

Now I am not a CAMHS expert, but it may be useful to get some thoughts on what may be needed here to beef up our service. There will always be the occasional individual for whom England or the other side of the border would be the least-worst option; I imagine that that is what the forensic side would argue. There will always be a few individuals who need that expertise. However, if we can enhance what we have here, bearing in mind the points that we laboured about prevention and community alternatives as well as at the other end, you are right: we need to think about whether we need to review those 20 people who went away over the past three years. We need to ask what it would have taken to provide for them in Northern Ireland.

The answer could be as simple as bringing an expert over once a week to support consultants here. Or do we have somebody, perhaps an expert on eating disorders, video linking from St George's in London with consultants and nurses here. There are ways that are worth exploring. We want to reduce the number of people who go to England, which is very expensive. It may be that we can spend less money on that and more on our long-term service here.

The Chairperson:

Yes.

Dr McGarry:

It is about trying to think imaginatively rather than always thinking that we must go somewhere else. There will always be a small number of people in any system who need that extra level of expertise, but it should be the minimum possible.

The Chairperson:

If we have exhausted our questions, I thank Philip and Liz for coming along. That has been very helpful. From our point of view, there are more questions that we need to ask the Department. With members' agreement, we will look at the Hansard report of this evidence session and collate the questions that we want to put to the Department. I certainly think that we must explore Mickey's point that we do not want our elderly and most vulnerable adults to become a commodity in the private facility that now exists for them, or become something that appears as a bottom line in a balance sheet. We want them to be treated properly, with dignity and respect as close to home as possible and preferably in their home. However, we want them to have the right access to treatment and to the professionals that they need to see. Are members content that the Committee writes to the Department on that basis?

Members indicated assent.

The Chairperson:

Thanks a million, Philip and Liz, for coming up today to help to enlighten us on that complex issue.

Mr McCarthy:

May I say that we highly admire voluntary organisations such as Praxis Care and others for all the work that they do.

The Chairperson:

Thanks a million and all the best.