Northern Ireland Assembly

Committee for Health

OFFICIAL REPORT (Hansard)

Mental Health (1986 Order) (Amendment) Order (Northern Ireland) 2021

28 January 2021

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Colm Gildernew (Chairperson)
Mrs Pam Cameron (Deputy Chairperson)
Ms Paula Bradshaw
Mr Jonathan Buckley
Mr Gerry Carroll
Mr Alan Chambers
Ms Órlaithí Flynn
Ms Cara Hunter
Mr Pat Sheehan

Witnesses:
Mr Tomas Adell Department of Health

The Chairperson (Mr Gildernew): Members will recall that the Minister wrote to us earlier this month to advise of changes proposed to mental health legislation and guidance in response to coronavirus pressures. These include a statutory emergency code of practice, as well as the statutory rule (SR) that is before us today. The Minister's letter is at tab 6.5 of your pack. An official is here to brief us on the temporary changes, including this SR. I welcome Mr Tomas Adell from the adult mental health unit in the Department of Health. Broadcasting, will you bring Tomas into the spotlight, please? Good morning, Tomas. Can you hear me?

Mr Tomas Adell (Department of Health): I can hear you.

The Chairperson (Mr Gildernew): We can hear you clearly. Please go ahead with your briefing on the background and content of the SR.

Mr Adell: Thank you for the opportunity to give the briefing. You asked me to talk about the Mental Health (1986 Order) (Amendment) Order (Northern Ireland) 2021 and the other changes that we have made in relation to the Coronavirus Act 2020, which has been revised. As you know, mental health services across Northern Ireland exist to provide care and treatment to those suffering from mental ill health. These services are more important than ever because of the pressures and effects of the pandemic. As you are aware, mental health services are under significant pressures. They were before the pandemic, and the impact of the pandemic has caused an increased demand in the number of people being seen and in the acuity of those who are seen. At the same time, staff are not available at the same level as they were before.

The pandemic has had direct impacts on the ability to deliver services. The increased levels of acuity of mental health inpatients during the pandemic has meant increasing requirements on special

observations — that is, care that is one-to-one, two-to-one, three-to-one and so on. The Southern Trust, for example, has estimated that that has created an additional staffing demand *[Inaudible.]* This has led to staff being redeployed to inpatient services or redirected towards special observations. There have also been a number of outbreaks *[Inaudible]* staff. The effects of the staff outbreaks have had an impact on the ability to deliver services properly. In the Northern Trust, for example, a recent staff outbreak in Holywell has impacted on 56 staff, and the recent outbreak in a mental health inpatient ward in the South Eastern Trust affected 20 staff in one ward, including 55% of the nurses. Those extra pressures and outbreaks are having an impact on the ability of staff to carry out their normal functions and could, unless mitigated, limit their ability to carry out the statutory requirements of the Mental Health (Northern Ireland) Order 1986.

We will look now at the amendments that have been made. The amendments to the second-opinion provisions and the revival of the mental health coronavirus regulations are mitigating actions to ensure that we do not end up in situations where we cannot deliver the services. As was the case last year, we hope that they will not be required, but it is my view that it is better to be prepared and have them in place and not need them, than not have them in place and then need them. The amendment Order amends one of the safeguards in the Mental Health Order around second opinions. For some patients who are detained for treatment and receive continued medication, a second opinion is required for that medication to continue. The SR changes the time period in which this is required from three months to six months. It is the same legislative change that was made in March last year, and, as during the first period of change, the Department is committed to reverting to three months as soon as it is safe to do so. The second-opinion safeguard exists to ensure that patients who are detained are not receiving medication unless it is needed. It is essentially to avoid arbitrary medication.

When the second opinion is carried out by a doctor who is appointed by the Regulation and Quality Improvement Authority (RQIA) for this purpose, that person is commonly referred to as a "part IV doctor". Across Northern Ireland, there are currently five part IV doctors, and one of those doctors is unavailable long term due to COVID-19. That means that we currently have four of these doctors. If there were further reductions in the number of part IV doctors available for any reason, it could jeopardise the ability to carry out second opinions. If a patient receives medication, the time period is complete and a second opinion has not been provided, the medication must stop; otherwise it is unlawful. Stopping medication for these patients could lead to a worsening condition of the patients, slower recovery and increased risks of harm to the patient and others. To ensure that the medication can continue even if there are no part IV doctors available, an amendment to the time period has been made.

To mitigate the decrease in safeguards, we have advised the trusts to still do second opinions at three months, if at all possible. We are also reviewing the need to keep amendments at weekly meetings. I will come back to that. We have also been in contact with RQIA and will jointly work to increase the number of part IV doctors available so that we will not end up in this position again. That was considered last year, but, because of the continued COVID pressures, we have not been able to do it yet. However, it is high on our agenda.

We have also revived the temporary modifications in the Coronavirus Act that amend the Mental Health Order in certain areas. These are the same provisions that were commenced in April last year and then suspended in August. Broadly speaking, these provisions allow a wider group of people to carry out certain functions and extend some timelines to give professionals a longer time when carrying out certain actions to meet the requirements under the Mental Health Order. To mitigate the risks of reducing the safeguards — and it is a reduction in safeguards — we have issued an emergency code of practice, which includes guidance on how provisions should be used and stating that they are permissible, which means that they can be used but do not have to be used and should only be used if all other options have been exhausted. Usage of some of the provisions carries reporting requirements where the Department must be informed of the use.

When the immediate pressures on mental health staff are reduced and the risk of large-scale outbreaks and staff absences is removed with, for example, increased levels of vaccinations, the second-opinion amendment will be reversed and the Coronavirus Act provisions will be suspended. That is a firm commitment. The issue of standing down the emergency provisions is a standing order item at the weekly COVID-19 mental health meeting, attended by service users, the board, the Public Health Agency (PHA) and the Department. I sit on those meetings and discuss this issue every time. It is our clear intent to only keep these emergency provisions in place for as short a time as possible. These measures are clearly undesirable and not something that we want to do. However, without these measures, it may not be possible to provide safe care and treatment to some of the most vulnerable patients in the mental health system, and that would create a more undesirable outcome. It

is a balance between safeguards and the ability to treat patients, and we believe that making these amendments is right at this point.

I am happy to take any questions or provide clarification.

The Chairperson (Mr Gildernew): Thank you for that, Tomas. Previous versions of this SR were more explicitly time-limited, and the explanatory memorandum here indicates that this relaxation in standards will remain in force until:

"the end of the Coronavirus pressures period."

Can you explain why that approach is being taken on this occasion, and can you also explain how the end of the coronavirus pressures period is being defined?

Mr Adell: The approach that we are taking is the statutory approach that we have available to us. We can amend the time period. We do not believe that we can set a sunset clause in this SR as easily as it can be done in other legislation. We intend to keep it in place for as short a time as possible. We are reviewing it weekly. We hope that it will be for only a number of weeks, not months. The intention is to step it down. We are looking at the availability of staff to carry out the statutory functions. We currently have four second-opinion doctors available to us. The fifth will become available after they have had vaccinations and a time period to let the vaccine work. At that point, and if the trends continue with fewer staff being affected by COVID, we will reverse this as soon as we can. It is about the availability of staff to carry out statutory functions. When we have an outbreak in a ward, as happened in the South Eastern Trust, where a significant proportion of the staff are unavailable, that is when those things become problems. If one more doctor becomes unavailable, we might be in a position where we cannot provide the second opinions, which would lead to worse outcomes. It is simply to cover that scenario.

The Chairperson (Mr Gildernew): I was struck by what you said; it almost gave an impression that that is a fundamental weakness in the provision of qualified or certified doctors to roll this out. There is a concern that emergency public health measures might need to be deployed in that situation, where it is maybe more a fundamental case of supply. That is a concern, and I note that it appears to be a very shaky foundation of a protective measure for a very vulnerable cohort of people. It is something that needs to be addressed very quickly in that respect. Every member represents 20% of the supply provision. You could very easily see, in the current circumstances, another 20% and another 20% going, which would create significant problems.

The Minister's letter mentioned a weekly review of the measures, and you have mentioned that yourself. What detail can you share? How many times was this used in the initial period, and how many times has it been used since it has been in place again?

Mr Adell: We do not believe that it was used a single time in the initial period last year. *[Inaudible]* were within three months. As of yet, its use has not been reported to me. The most recent meeting was on Tuesday of this week. We hope that it will not be used. The trusts are not putting in procedures to use this unless we have to. The second opinion should happen at three months, if at all possible. We hope that it *[Inaudible]* six months. If it is not three months, we hope that it will be very shortly afterwards.

The Chairperson (Mr Gildernew): You remarked that it is difficult to have a sunset clause. It was possible before, so I do not understand what makes it difficult now.

Mr Adell: I am following the advice that I receive in terms of drafting. I know the policy well, but I am not an expert in how to draft these regulations. I can only follow the advice that is given to me, and I have been advised that this is the best way to draft these regulations. You have my full assurance — the Minister supports this as well — that we do not want to keep this in place for longer than required. Last year, we took them back as soon as it was practical to do so. We intend to do that again.

The Chairperson (Mr Gildernew): There has, at times, been some reassurance for the Committee in the fact that there are sunset clauses that put a focus on removing these from the books. Will you commit to bringing that issue back and looking at the drafting? If it was possible before, I do not understand why it is not possible now. Will you look at that again?

Mr Adell: I will certainly look at it and come back to you.

The Chairperson (Mr Gildernew): The final one from me is about engagement with stakeholders around this measure coming in again at this point in time. How have you engaged, or how do you intend to engage, with relevant stakeholders who have an interest in this area, given the serious issues involved?

Mr Adell: We have regular discussions with service users, the trusts, the Health and Social Care Board, the Public Health Agency and professional bodies on these issues. It has been discussed at those meetings at which we talk about coronavirus pressures and coronavirus in general. All those groups are represented in various forums. That has been discussed with representatives from all those groups.

The Chairperson (Mr Gildernew): What about the advocacy sector around rights and mental health champions and those types of interested parties? What discussions have there been with those?

Mr Adell: We shared the proposal to do this with the champion before we did it, and we got her views before decisions were taken, so the champion was informed at all times. There are no advocacy groups on the groups where we discussed this, but there are service user representatives, so we have service user engagement in that way. We also discussed this at other regular mental health meetings, where there are representatives of service users and community and voluntary sector groups. When these things are brought up at those regular mental health meetings, they are taken seriously. The meetings take place at intervals of between one per week and one per month.

The Chairperson (Mr Gildernew): How content would you say those stakeholders are, Tomas, with this being reintroduced?

Mr Adell: They are content. We all agree that these changes are undesirable. We do not want to do this, and that view is shared by all. We also understand the risks of not doing this. Therefore, there is agreement that we really do not have much of a choice. This is what we have to do to make sure that patients can receive the medication that they need. The risk of not doing it is too high. I stress that we need more part IV doctors so that we are not in this position again. It is a fundamental flaw in the system, as you note. It is a fundamental problem that we need to address.

The Chairperson (Mr Gildernew): OK. Thank you, Tomas. I am going to move on. We are going first of all to our Deputy Chair, Pam Cameron, and then to Órlaithí Flynn.

Mrs Cameron: Thank you, Tomas, for your presence again at the Committee. As a party, we have always said that these powers to waive established practice should be used only when necessary and proportionate, so I am glad to hear that that has been the practice to date. We do not question the rationale for their use, because obviously there is a very bleak picture out there of a 30% increase in acute mental health inpatient admissions in Belfast. That really does highlight the challenges facing the mental health workforce.

You referred to outbreaks in Holywell etc. *[Interruption.]* Apologies; my dogs are getting excited because the binman is outside. How many inpatient mental health staff are currently absent from work due to COVID, and to what extent is that absence linked to illness, isolation or being moved to other roles? My second question is about whether these powers relate to a particular set of medical professionals — for instance, doctors — or are relevant to those in multiple disciplines.

Mr Adell: I do not have today's figures in front of me. I can certainly get them to the Committee quickly if that is the best way of doing that. The outbreaks that have happened have been isolated to particular wards or areas, and they have been contained well in those areas, which indicates that our procedures are working when it comes to tracing and making sure that people do not mix where they should not mix. The recent outbreaks at Holywell, which affected four wards, were different outbreaks, and they affected 56 members of staff. They are not all off at the moment. The outbreaks have, thankfully, *[Inaudible.]* They affected a total of 56 staff across those four wards, across different professions. The recent outbreak at Lagan Valley Hospital mental health unit, in the South Eastern Trust, affected 20 members of staff. That was just before Christmas, so that outbreak has been declared closed and is not an active outbreak there at the moment.

If you prefer, I can get you the latest exact figures so that I am not quoting the wrong figures to you. I will get them to the Committee as soon as I can.

Mrs Cameron: That would be great.

Mr Adell: Sorry, can you remind me of your second question?

Mrs Cameron: Yes. It was whether the powers related to a set of professionals. Are they relevant to doctors or to multiple disciplines?

Mr Adell: The second-opinion powers relate to only part IV doctors. The Coronavirus Act provisions relate to different professions *[Inaudible]* different things. Usually, when someone is detained for assessment or compulsory mental assessment, there has to be a report by an approved social worker. The powers allow a relevant social worker who is not an approved social worker to carry that out. The advice is that it should not be used by a relevant social worker if at all possible, and that should not happen. However, the power will be there. The holding powers of nurses and doctors while a person is waiting for an assessment to be made are affected. Normally, a nurse has the power to hold a patient for six hours until after assessment has been made on a ward. The holding powers have been extended to 12 hours for nurses, and there are similar permissions for doctors. There is a range of measures that affect different professions in slightly different ways. There is a table attached to the letter from the Minister that sets out the exact meaning of each power.

Mrs Cameron: That is great. Thank you very much.

Ms Flynn: Thank you, Tomas. I will follow on from Pam's point about getting those figures on the numbers of staff that have been affected by COVID and are not available for work. Can you also give a breakdown of the figures? You talked about an increase in demand as well as the staff shortages; can we get those figures as well? Pam mentioned the 30% increase in the Belfast Trust, but it would be useful to get an overview of the increased demand across the North.

It is good that you are having the weekly meetings on the decisions and that this is the last resort that, hopefully, you will not have to use, but it is there if you need it. Even outside of the pandemic, it is worrying that we only have four or five doctors and we are reliant on that small number of individuals to carry out this work. At any one time, a number of those doctors might not be available, and, in the longer term, the Department may need to look at that. Can you explain the rationale for the decision to extend the time period from three months to six months? Why do you need to double that to six months? Was the option of extending it to four or five months looked at? Can you explain that a wee bit more?

Mr Adell: The decision to extend to six months follows the decision that was taken last year. There was a discussion with legal professionals in the trusts, trust professionals, the PHA, the board, service users and the former Attorney General's office about the appropriate time limit to give a meaningful effect. The agreement was that six months was an appropriate limit and gives a backup if something goes wrong, and we can make sure we do not end up without second opinions. As we all know, if someone has been self-isolating for 10 days, if these things happen in a bad sequence, it can have longer-term effects. While one month should be sufficient in most cases, we do not want to risk not having enough second-opinion doctors. Six months should carry us through the period until we get people back to enable us to deal with the backlog and deal with all patients within the period so that we do not accidentally end up with someone not having a second opinion.

Ms Flynn: Thank you, Tomas.

The Chairperson (Mr Gildernew): There has been a previous reliance on these measures, and we have had discussions about the potential need for them to be reinstated. Why did the Department not follow normal procedure and come forward with an SL1 prior to the SR?

Mr Adell: It was a reaction to pressures that we did not expect to come in mental health services. In the first surge, as we have discussed before, mental health services were fairly unaffected by COVID to a large extent. Both among staff and patients, we did not have any outbreaks in inpatient units during the first surge. Over Christmas, we had a number of unexpected outbreaks that impacted on mental health staff. When that was assessed at the beginning of January, we came to the conclusion

that there was a very urgent need. We ran the risk of not being able to complete statutory provisions in a short time period, and that is why those procedures have been used.

The Chairperson (Mr Gildernew): That in itself is an issue of concern. I was struck by the high numbers in Holywell and, indeed, in the South Eastern Trust. What is your assessment of why those settings are being impacted so much more widely this time?

Mr Adell: Research is ongoing on that. One of our colleagues in the South Eastern Trust is looking at the structure of the wards. As you are very aware, we have some newer mental health units that have single bedrooms, while some of the other units do not. Both Holywell and the South Eastern Trust have open-bay mental health units. For mental health patients, things like isolation are difficult. Such units may not be compliant with isolation rules and with social distancing rules. It is also difficult to take some protective measures. Face masks among patients are often not a safe measure because of the ligature risks. That means that it can be hard to contain COVID-positive patients and maintain those distances in delivering safe care. That is an unfortunate effect of the mental health infrastructure that we have and the type of patients.

The Chairperson (Mr Gildernew): Were those not largely the same factors that were in place previously? I am wondering what has changed. I take it that nothing fundamental has changed in the period since the first surge to the pre-Christmas period.

Mr Adell: No, and that is what we are not quite sure of. We simply do not know at this point what changed. It was managed very well in the first surge. Something has been different in this surge, and we are not fully sure what that is. Work is ongoing to try to understand that. It is a very unsatisfactory answer, but it might be pure chance: that we have been unlucky this time and were not unlucky the first time. We are trying to figure out the reasons to see what has changed, if anything, and to see what we can do better going forward.

The Chairperson (Mr Gildernew): Is focused testing going on for the new strain in conjunction with your investigation into that? Is that potentially a factor?

Mr Adell: I know that some trusts have mentioned the new strain. I am not an expert in how the testing happens and the different strains, so I do not want to comment on whether that is part of that work. I know that some trusts have noted that they have a fear that they have the new strain. One factor that we think has an impact is that we are testing more staff, so we have a number of asymptomatic staff who are coming up as COVID positive and who probably would not have been tested in the first surge. Therefore, that has a bigger impact. It is quite early days to say exactly what these things are. We are trying to figure out what it is, but there is a clear difference between the first surge and this surge.

The Chairperson (Mr Gildernew): Can you commit to coming back to the Committee as soon as possible? Obviously, that is an area of some concern, given the vulnerabilities and given some of the additional challenges that there are in that sector. I think that that will be a particular concern. Can you commit to coming back to us as soon as possible with an update on your findings on that, Tomas?

Mr Adell: Of course. Obviously, we do everything that we can to make sure that these services are safe, so the more we know, the easier it is for us to do that. When and if we know anything, I will have no problem sharing that with the Committee.

The Chairperson (Mr Gildernew): Finally from me, Tomas, the Minister's letter refers to a wider range of temporary changes to the mental health legislation. When is it anticipated that those will come before the Committee, and what is the plan for consultation on those wider issues?

Mr Adell: The revival of the Coronavirus Act provisions happened on 18 January. They are not subject to Assembly control, so they will not come formally before the Committee. The Assembly was notified that they have been revived, but there is not a formal notification to the Committee in the same way.

The Chairperson (Mr Gildernew): I am not clear what you mean by that, Tomas. Are you saying that this wider range of temporary amendments will not come to the Committee at all?

Mr Adell: That is my understanding, yes. We have informed the Assembly that SR 7 has been revived. Those regulations were made at the same time as SR 8.

The Chairperson (Mr Gildernew): Is that being made via LCM? Have those previously come to the Committee and then been revoked, and are now being brought forward? I am not clear on that.

Mr Adell: They were commenced in April last year, suspended in August, and revived at this time. The suspension revival orders are deemed commencement orders and are therefore not subject to Assembly scrutiny.

The Chairperson (Mr Gildernew): OK. I will come back to that.

You said that this will remain in force until the end of the coronavirus pressure period. What is the measurement or definition of:

"the end of the Coronavirus pressures period"?

Mr Adell: The definition is when staff absence rates, and the risk of staff absence rates, are reduced, which will come with the increase in vaccinations and staff absence rates going down.

The Chairperson (Mr Gildernew): What level of staff absence triggers that decision?

Mr Adell: It is a qualitative level: when we do not see large-scale outbreaks among staff in mental health units.

The Chairperson (Mr Gildernew): OK. Tomas, thank you, as ever, for coming to the Committee and for answering our questions. Good luck in the time ahead. We will let you go now and continue our discussion on this.

Mr Adell: Thank you.

The Chairperson (Mr Gildernew): Can the broadcasting staff bring all members into the spotlight so that I can see indications? Thank you. Members, the Examiner of Statutory Rules has advised that she is exploring a number of concerns with the Department in relation to this SR. Are members content to note the rule pending further consideration at next week's meeting once the Examiner has reported? Are members satisfied to defer it until next week's meeting?

Members indicated assent.

The Chairperson (Mr Gildernew): Thank you, members.