Northern Ireland
Assembly

Committee for Social Development

OFFICIAL REPORT
(Hansard)

Welfare Reform Bill: Northern Ireland Association for Mental Health Briefing

25 October 2012

NORTHERN IRELAND ASSEMBLY

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Members present for all or part of the proceedings:
Mr Alex Maskey (Chairperson)
Mr Mickey Brady (Deputy Chairperson)
Ms Paula Bradley
Mrs Judith Cochrane
Mr Michael Copeland
Mr Sammy Douglas
Mr Mark Durkan
Mr Fra McCann

Witnesses:

Ms Iris Elliott	Northern Ireland Association for Mental Health

The Chairperson: I welcome Iris Elliott from the Northern Ireland Association for Mental Health (NIAMH). The association has provided a briefing paper to the Committee.

Ms Iris Elliott (Northern Ireland Association for Mental Health): I thank the Committee for giving me the opportunity to present the views of NIAMH on welfare reform. We have submitted written evidence to the Committee, and we circulated a briefing on mental health and welfare reform to MLAs on the day of the Bill's Second Stage. Rather than repeating the points that were made in the submission and briefing, I will highlight five key themes in our representations to date.

The first is the importance of ensuring that evidence on which decisions are made is timely and based on independent expert mental health opinion that is provided by professionals and services that have an established relationship with the individual. Second is the importance of ensuring access to independent advice and representation. Third is the importance of ensuring that the first stage of the sanctions regime is to provide access to independent advice and representation for the individual to assist him or her to compile their evidence. Fourth is the importance of supporting the individual's pace of mental health recovery by removing arbitrary time limits from the contributory employment and support allowance (ESA) work-related activity group (WRAG) and introducing provision for the individual to requalify for ESA, either the support group or the WRAG, if his or mental health deteriorates. Finally is the importance of supporting the individual's recovery of their mental health by introducing discretionary provision on the frequency of the personal independence payment (PIP) review and the requirement of being consistently unwell three months prior to and nine months following the prospective test for assessment. Underpinning these specific recommendations for amendments is our overarching concern that the Bill requires a human rights review for its compliance with the European Convention on Human Rights to maximise the potential protections for individuals who experience mental ill health.

NIAMH is the longest established and largest mental health charity in Northern Ireland. We provide community-based mental health services through Beacon in every constituency across Northern Ireland. Through Carecall, we provide access to counselling and psychological therapies and mental health and well-being programmes, mainly focused on workplace and educational settings. This presentation is infused with this organisational expertise and examples of the experiences of individual service users who we call members. However, we note that there are many individuals who are not engaged with services. We consider this to be a particularly vulnerable group who must be informed about welfare reform through an effective public information campaign and supported with independent advice and representation.

At the outset, I want to underline that we at NIAMH are committed to a recovery ethos in the services that we provide. We know that individuals do recover their mental health and, with support, can reduce the frequency and severity of relapses. Engagement in meaningful activity, including volunteering, caring, education and training, and employment can be important milestones in the recovery journey. However, this journey is, at its heart, an individual experience and does not always sit easily with a rigid social security system of time-limited benefits, assessments and review procedures and sanctions. We welcome the fact that there is widespread recognition that welfare reform will have specific and significant impacts on persons who experience mental ill health and that there is cross-party support for action to address this.Furthermore, we welcome Minister McCausland's assertion at Second Stage that the first principle of the welfare reform agenda is to "protect the vulnerable".

On behalf of NIAMH, I acknowledge and welcome the valuable changes to the operation of welfare reform that Minister McCausland announced earlier this week. As a member of the Northern Ireland Welfare Reform Group, we at NIAMH welcome progress on those issues that are of common concern.

There is recognition that welfare reform will have a much greater impact on mental health issues in Northern Ireland because of first, the prevalence of mental ill health due to the conflict, and secondly, the severity of mental ill health related to the high levels of post-traumatic stress disorder (PTSD). The relationship between mental health and the conflict is illustrated by research into our day support services that reported this year. That research demonstrated that 91% of our members were raised in Northern Ireland, and of that, 36·5% reported some or a lot of political violence in their neighbourhood, and 39·5% reported having personally suffered some or a lot as a result of the conflict. The reported impacts of the conflict included having to move due to intimidation, which affected 16·7%; 10·9% personally experienced damage to their home as the result of a bomb; 7·7% experienced personal injury as a result of cross-community violence; and 19·3% had family or friends injured in cross-community violence.

We consider the relationship between mental health and the conflict to be particularly relevant when looking to the protections that are afforded by the human rights provisions under the Northern Ireland Act 1998. This prevalence of mental ill health is reflected in the significantly higher levels of claims in Northern Ireland for benefits such as DLA. Northern Ireland has double the proportion of its population in receipt of DLA than is the case in Britain, and 23% of DLA recipients in Northern Ireland have mental health issues, compared with 17% in Britain. That profile is reflected in our members' reliance on social security. In our Beacon housing support service, research in 2012 found that 75% of residents were in receipt of DLA. In our Beacon day services, research in 2012 found that 95·8% of members are in receipt of state benefits, including 79% on DLA.

The high rates of mental ill health and the consequent high number of benefit claims are characteristics of contemporary Northern Ireland society. Significant investment in community mental health services, as well as actions to address the broader determinants of mental ill health, may impact those prevalence rates. Nevertheless, welfare reform will not alter the levels of mental ill health or the need for social security for that vulnerable group. However, if not sensitively implemented, there is a risk of removing necessary social protections and consequently destabilising an individual's mental health and stalling or reversing their mental health recovery.

We are seeing such negative impacts already, even in early contact with the changes. For example, a 58-year-old woman who lives in one of our 24-hour supported housing schemes in Belfast received a letter calling her for a work-focused interview, outlining that she would have to attend a series of interviews with a personal adviser. She has a diagnosis of bipolar disorder and complex physical difficulties, including a double mastectomy and chronic obstructive pulmonary disease. She has the propensity to self-harm by scratching at various locations on her body, usually at a low level. After receiving the letter, the frequency and intensity of that self-harm has increased to the point where the wounds are open and sores have developed. Assistance and reassurance from her GP and our service have done little to reduce the impact of simply receiving that letter.

Anticipatory fear of welfare reform has led to acute distress. When I visited one of our day support services in mid-Ulster, as soon as I started to speak about welfare reform, one woman became so distressed and fearful at the thought that I was there to take away her benefits there and then that she had to leave the room and be supported by staff. In contrast, during the same session, another woman asserted: "It is OK, Iris; welfare reform is nothing to do with me. I have asked my social security office over and over if I am OK on DLA, and they said that it is OK — I am on it for life." That underlines our recommendation that an effective public information campaign needs to be put in place.

Anxiety about welfare reform is causing people to withdraw from activities that support their recovery. The fear of being judged fit for work, despite being mentally unwell, is being felt across our services. Some members have reduced or stopped volunteering and are reluctant to be involved in public activities, such as welcoming the Olympic torch into Enniskillen and participating in a graduation ceremony, ironically for a live-and-learn programme on welfare benefits that the Big Lottery funded and that was run in partnership between NIAMH, CIB and the Open College Network. As well as being concerned about the costs of welfare reform to the individual, our experience to date has highlighted what could be called the hidden costs of welfare reform, which will result in a displacement of expenditure to the mental health sector and the advice sector. Those hidden costs include supporting individuals whose mental health deteriorates, building the capability of mental health staff on welfare benefits and providing evidence for assessments, reviews and appeals, as well as engaging in social security advocacy.

I will illustrate those costs with the example of a 46-year-old man who lives in one of our 24-hour supported housing schemes in Belfast. He has been diagnosed with psychosis and has an acquired brain injury and epilepsy, which are conditions that have significantly impaired his functioning and mental capacity. His mother is his legal guardian and deals with his finances. From October 2011 to September 2012, both our service and the statutory mental health service made representations that he was not fit to attend a work-focused interview. However, no amount of evidence or advocacy over the calendar year could persuade the social security system that he could not participate in an assessment of his capability of work-related activity. At the end of the process, the Beacon housing service's manager attended the ESA appeal, and the case was settled in our member's favour.

I want to move on to the specific recommendations in NIAMH's submission. In the first section, we look at the human rights review of the Bill. We are conscious that there has been debate this week, both in the Assembly and the Committee, on whether to progress a human rights review of the Bill. As the section on human rights includes detailed legal analysis of the issues in the Bill, the relevant provisions under the Northern Ireland Act and the contextual international framework, I will limit myself to the following remarks.

We concur with Minister McCausland that the first principle of welfare reform must be to protect the vulnerable. We have asked ourselves how we can make that principle a reality. What resources are available to us to safeguard individuals who experience mental ill health? We have referred to the high levels of mental ill health in Northern Ireland and said that they are the legacy of the conflict. The Northern Ireland Act and its human rights provisions represent a consensus by political leaders to address the legacy of the conflict. Traditionally, human rights have focused on civil and political rights in Northern Ireland. However, welfare reform reorientates us to look at the protections that are afforded under socio-economic rights and the obligations of the state, particularly under article 8 of the European Convention on Human Rights regarding the right to respect for private and family life.

To clarify the meaning of article 8 protections for persons who experience mental ill health, we note the judgement of the European Court of Human Rights in the case of Bensaid v. UK in 2001, which stated:

> *"Mental health must also be regarded as a crucial part of private life associated with the aspect of moral integrity. Article 8 protects a right to identity and personal development, and the right to establish and develop relationships with other human beings and the outside world. The preservation of mental stability is in that context an indispensable precondition to effective enjoyment of the right to respect for private life."*

Mental ill health is experienced by all sections of our society, and we at NIAMH believe that mental ill health creates a shared space in which we can meet to discuss the conflict and its impacts.

In realising the Executive's commitments to the Delivering Social Change agenda, we think that there is a need for all Government Departments to issue legislation that progressively realises the human rights of persons with disabilities, including persons who experience mental ill health. Clearly, that includes the Department for Social Development (DSD) and the Welfare Reform Bill.

We note that the Office of the First Minister and deputy First Minister (OFMDFM) has consulted on, and is expected to produce, a disability strategy and action plan this year that will progress the implementation of the UN Convention on the Rights of Persons with Disabilities in line with UK obligations. Our note of caution is that we consider it challenging, if not impossible, to understand the full outworking of the legislation and its potential impacts on human rights without the timely publication of the secondary legislation and draft regulations.

The second section of our submission deal with amendments to the Welfare Reform Bill. I will speak together to those subsections that cover evidence, sanctions and advice and representation. I aim to simply highlight that those sections in our submission have common themes.

The first theme is the statutory requirement to ensure that the cases of persons who experience mental health are considered on the best available independent mental health evidence and that the statutory right to access independent advice and representation is available at all stages, including the sanctions stage. Those recommendations are informed by our experience of the introduction of the employment and support allowance, particularly the lack of mental health expertise among assessors, decision-makers and appeals personnel; the failure to proactively seek independent mental health evidence in a timely manner; the focus on mental health evidence that is provided by generic medical professionals rather than mental health professionals or service providers with an established relationship with the individual; the success at appeal stage of overturning decisions based on assessment when there is appropriate evidence and representation; and the human and financial costs of the above inefficiencies in the welfare reform system and the distress and delay that they cause.

We have identified where we think those issues could be addressed in specific sections of the legislation, and they cross-cut a number of different sections. We have tried not to be too repetitive but to highlight where they are.

We are seeking the removal of the time limit of 365 days for the contributory ESA work-related activity group. In agreement with the debate in the House of Lords, which we cite in our submission, we consider that time limit to be arbitrary, unfair, stressful and without an evidence base. It is contrary to the ethos of supporting an individual to recover their mental health. For fluctuating conditions, it is unfair to require an individual to recover within a one-year period and to not make provision for them to requalify through the WRAG or, indeed, the support group, should their mental health deteriorate. We are very concerned that the time limit will prematurely move individuals out of a necessary benefit that they have contributed to.

Our view is that the arbitrary rotating assessment period for PIP and the requirement of the so-called perspective test, whereby an individual is consistently unwell three months prior to and nine months after the assessment, do not reflect the fluctuating character of mental ill health and work against an individual's attempt to stabilise and recover their mental health. Our knowledge of the potentially distressing experience of assessment, decision-making and appeals under the employment and support allowance causes us to be concerned about the impact of having to be in a perpetual cycle with those procedures. That is why we are strongly recommending a discretionary provision on the level of the disability in the test and the frequency of review.

In conclusion, we are asking the Committee to consider our overarching concern about the Bill and to progress a human rights review of it and the draft regulations. We ask the Committee to consider our five section-specific amendments on evidence, sanctions, independent advice and representation, the contributory ESA WRAG group, and the PIP assessment and review.

Beyond those specific legislative changes, we note that we raised a number of process issues about the implementation of the legislation, which we asked the Committee to consider. Those were: publishing the draft regulations, as well as their passage by affirmative resolution; resourcing an effective public information campaign for vulnerable groups; acting to address concerns about the digital-by-default approach; showing leadership as political representatives by the use of non-stigmatising language; and considering how procurement can be monitored and reviewed on an ongoing basis.

We appreciate that all parties are concerned that we are short of the time that will allow us to progress welfare reform legislation and that there are well-rehearsed consequences if we do not do so. However, time needs to be made to ensure that all opportunities are maximised to protect vulnerable groups in keeping with the first principle of welfare reform, as articulated by Minister McCausland.

Finally, we think that it would be valuable to consider the establishment of an expert group to provide advice on mental health and welfare reform.

Thank you again for this opportunity to contribute to the Committee's scrutiny of the legislation. We hope that our evidence is useful and that we can continue to be a resource to you and your work.

The Chairperson: OK, Iris. Thank you very much for that comprehensive contribution that you made in addition to your written submission.

Mr Brady: Thanks very much for a very comprehensive submission, Iris. I have a couple of points to make. You made a lot of very good points, but there is one in particular that I can empathise with. It is about the misunderstanding in the social security system that an individual's GP and mental health team are the best qualified to give evidence. As you say, if a person's condition has stabilised but fluctuates from day to day, people in the voluntary sector, such as you, may be in a better position to help them. The other thing is that independent advice from the voluntary sector should be a mandatory inclusion. That is very important.

Back in 2007, when the initial stages of welfare reform were coming through, particularly work capability assessments and job-focused interviews, we argued that an interview with someone who has mental health issues should be done by a specialist in that area, whether that is a psychiatrist, a clinical psychologist or a community psychiatric nurse.We were told at that time that staff would get training, but that has never materialised.

If a client claims universal credit, both parties involved have to sign the claimant commitment. If there is a mental health issue and one person refuses to sign the commitment, the couple and their family might be prevented from getting benefit, certainly in the initial stages, until that is clarified. Another issue is with people attending interviews. You said that there should be a specialist advocate for mental health. I know that an autism champion is supposed to be attached to each office, which seems sensible. Although you may have an advocate with a specialism, I think that it is incumbent on the Department to ensure that the person on the other side of the counter has some specialist knowledge, particularly concerning conditions like bipolar disorder or chronic clinical depression. Somebody with bipolar disorder might be fine today but not for the next month. So, it is about trying to pick that out and aggregating the person's condition over time.

The other point is the one-year time limit for ESA and people's being reassessed if their condition worsens and they go back on to that benefit. If I may discuss good practice in the South, many years ago, if someone had mental health problems and went off benefit, they were given three years to find out whether they had stabilised or whether they could carry on with work. If they came back within three years, they went back on the same level of benefit. Here, that applied for only one year or slightly less. So, that example from the South is a demonstration of good practice that could maybe be looked at.

A lot of universal credit is predicated on the notion that people will be going online and so forth. In the section of your submission entitled 'Digital by Default', you said that you have done assessments that indicate that the vast majority of people who use your centres do not have access to computers or the internet. That highlights the reason to have staff in local offices in particular, and, of course, for the specialist advocate being included even more in that kind of legislation. I wonder what your thoughts are on that.

The other point to consider is permitted work, which used to be the therapeutic alliance. We are not sure how that is going to work. That provision was particularly for people with mental health problems whose doctor felt that it would be beneficial. They were not working in the normal sense, but it would be beneficial to get them out of the house and to be involved. It really concerned their gradual rehabilitation from their condition. Has any information been forthcoming to you about that kind of situation? I am sorry to bombard you.

Ms I Elliott: I would expect nothing else from somebody who used to be an advice worker. Thank you very much for your really informed comments and questions. I will try to work through a few of them.

Our submission is based on the reality that some form of welfare reform legislation is going to pass. That is why we have tried to identify very specific actions that the Committee could recommend, across the entire the legislation, protective mechanisms for people who have mental health difficulties. That is also the reason that we are particularly focusing on the whole area of independent advice and representation. Part of that is predicated on the fact that we have very good relationships with independent advice organisations. We feel that they have been crucial for the staff and users of our services in understanding how to negotiate the welfare reform system. Evidence indicates that, when people have representation, they have much higher levels of success in receiving benefits or winning appeals. One of the strongest characteristics of mental ill health is that you feel very alone and isolated. I always think that it is very important for people with mental health difficulties to have somebody on that welfare reform journey with them. That is why we emphasise that people not only in our services but outside services completely need somebody to be with them on the journey through welfare reform.

A number of the points that you identified are issues for regulations. I am sure that we are not the only organisation to say that we are very concerned that we do not have draft regulations. The intention to pass the regulations by negative resolution, rather than having the scope through affirmative resolution for some scrutiny, is a huge source of concern for us, because we feel that a lot of the detail is in the regulations.

You mentioned a written basis for assessment. We would like good clarity in the regulations about how we can move people who have significant mental health difficulties, long-established relationships with services and a very good evidence base for their condition, needs and vulnerability into a paper scrutiny of their application and review. We have certainly had evidence of a distressing, lengthy detrimental process of face-to-face encounters. We have instances, for example, in some of our east Belfast services, of people who have made the transition from incapacity benefit to ESA with absolutely no difficulty whatsoever. The written evidence has been taken and respected, and there has actually been almost no difficulty with that. I can compare that with one of the services that I described in south Belfast, where we had a year of social security advocacy on such a transition. Looking at how the written evidence can be used could be really valuable for people with a mental health difficulty. Again, however, this is about the regulations.

We have also raised with colleagues in the Civil Service the detailed design of PIP and ESA and why it is not possible for people who have expertise in mental health to undertake the assessments and the decision-making by looking at what is presented to them. It should also be possible for the people who are making decisions to know, through their expertise, that we need to go after further evidence from services, including the voluntary sector. We are repeatedly being told that that is too difficult. I spoke about this earlier, but, given the statistics about the prevalence of mental health issues in Northern Ireland, we simply do not understand why it is not possible to identify claimants who, for example, are moving from DLA to PIP and who have mental health difficulties, to book them in for assessment and to have mental health experts available. There are examples of members of our services who have got into a great state of distress anticipating having to attend for assessment, and they have then turned up at the ESA assessment centre to be told that it does not have the expertise to see them and that they will have to be given another appointment. I see members nodding their heads at that, and I know that that is the sort of issue that is also coming through in constituency work.

I do not really have information about permitted work. I think that that is something that really needs to be part of the public information campaign. One of the reasons why we have difficulty with people withdrawing from voluntary activity, any kind of public activity or some forms of part-time work is because they are so terrified at this stage that, if they are seen to be functioning in any way, their benefits will be taken off them. So, it would be really helpful to have that clarified.

Mr Brady: I have two points to finish on. We argue that medical evidence should have primacy, but it has to be relevant to the person's condition and demonstrate the most up-to-date position on both their mental and physical health. Quite rightly, the medical evidence is often available only at tribunals. It would save all that hassle and trauma, particularly for people with mental health issues, if that relevant information were readily available. They should not have to go through all that, because decisions could be made. As you rightly say, they should be made by someone who has specialist knowledge.

The other point that I will make is that you rightly ask MLAs not to use language that stigmatises people or that might be inflammatory towards people, particularly those with mental health issues. However, quite large sections of the media are already doing that on the whole issue of welfare reform. I think that, in fairness, we are aware that we should not, but, unfortunately, quite large sections of the media have been instrumental in stigmatising people already. That applies not just to people with mental health problems but to those on benefit in general.

Mr Copeland: Iris, I should probably declare an interest. I think that my wife, Sonia, has attended a number of training courses in the WAVE trauma centre over the past couple of years. I think that I picked her up at one.

In my experience, mental health conditions are conditions that are generally diagnosed by the apparent behaviour of the constituent. In many cases, more than one thing is present. The most complex case that I have is a cocktail of conditions, some of which is diagnosed and some of which is suspected, including schizophrenia, bipolar disorder, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), personality disorder, mild-spectrum autism and low-end learning difficulties. In your professional view, is it possible that one doctor, one individual or one healthcare professional could be so competent that they could pass a judgement on the basis of the planned test on that person's ability to function in the real world?

Ms I Elliott: That is a very good question. There is a very real challenge for individuals who present with a complex range of issues.

Mr Copeland: Is that the norm? It is the norm that I see, in that there seems to be more than two or three issues. However, it is perhaps just an interpretation of symptoms; I do not know.

Ms I Elliott: There is a huge variety of presentations or issues in the field of mental health. I am sure that our colleagues in Mencap would say that some people have what is called a dual diagnosis of both an intellectual disability and a mental health condition. I think that it is very challenging for someone to have the ability to assess somebody with that degree of complexity of need. I think that that goes to the need for people to have somebody with them who can advocate and support them, to ensure that the information is as complete as possible and to bring any written evidence to that initial assessment.

One thing that I will stress is that we are trying to move away from the assessment of an individual as a series of medical diagnoses or conditions to looking at how the person presenting is able to participate in the world. Although somebody may have a number of complex conditions, it is more about how their skills in everyday living are affected and what support they require from the social security system to enable them to participate in society. If you take the case that you used from your constituency work, you will see that that might concern a series of issues about a person's ability to communicate. Now, that might be sourced in a number of medical diagnoses, but there might be more to look at, such as the person's ability to communicate, their ability to look after themselves and their ability to eat or to attend to personal hygiene, for example, as well as their ability to participate in social relationships and to engage in employment and education. That would be very much in keeping with the human rights approach that is advocated in the UN Convention on the Rights of Persons with Disabilities, through which we are trying to move away from a medical approach to understanding people's disability to looking at a social model of disability that concerns people's ability to participate in society. It is challenging, but that is all the more reason to have people who have some degree of competence in that field, rather than to have somebody who is a general nurse or doctor.

Mr Douglas: Thank you for your presentation, Iris. There was a hugely successful event in the Long Gallery earlier this week, where we all had our photos up on the wall. That was a good opportunity to raise the profile of the problems and the stigma that we talked about.

Your briefing mentions Beacon day services research. My family has been involved with Beacon and had an excellent response. It was very helpful. You said that, in 2012, nearly 96% of the members of those day services were in receipt of benefits. So, we are talking about a huge number of people who are in receipt of benefit and have mental health problems who use your centres. Over the past few hours, we have been talking about sanctions from the Housing Executive, which will have to evict people who do not pay. We also talked about sanctions that will have an impact on the likes of young people, which the members who spoke previously discussed, and children in a household where there will be sanctions. What will the impact on your members be? I am thinking of people who have acute depression who some mornings just cannot get out of bed, or other people who have agoraphobia and cannot go out. What will be the impact of the new welfare reforms on your members?

Ms I Elliott: To return to my comments about this almost anticipatory fear that people are experiencing, we are already seeing that happening through their becoming quite distressed and unwell.

It is useful to use the analogy of the Beacon centre, because the assessments seem to be coming in waves. So, if one or two people experience, for example, the changeover from incapacity benefit to ESA, it then goes like a wave around our services. When I visited some services, people were relatively calm because they had not experienced the assessment. However, among staff where it had happened, there were high levels of upset and concern.

We are trying to approach this issue by really thinking through the kind of information that we need to give to people, so that they will understand the changes that are happening, what the process will look like, and how we can support them in it. It is going to be important that people are as informed and assured as possible. Likewise, staff must be supportive, but there must also be support from the peer group.

We gave detailed figures about our services because welfare reform will affect our members. They comprise the group that this issue will massively impact, and you can see that from their 90%-plus reliance on state benefits. There will be a range of different impacts that will cause fear and distress. We have a lot of experience of people who have gone through the assessment process. A man in our south Belfast service described it as losing a year and a half of his life. He went through a distressing assessment process embodying all the things that people talk about — somebody rushing through the assessment on a computer, not making eye contact, not giving him time to talk and not explaining what they meant. Subsequently, he got zero points and then had a long and very anxious wait for his appeal. Although people were supportive, he found the appeal hearing very distressing again. He was then brought back to full points. He said to me that that year and a half finished a couple of weeks before Christmas, and he just took a deep breath. Then, a couple of weeks later, he got called for his DLA review, and he is now back into the same process again.

So, we are seeing people's mental health deteriorating. We are finding that they are destabilising and are not engaging in the activities necessary for their recovery.

My role is to lobby for changes. Locally, mental health services are trying to create supports and information for people to try to assist them. That takes me back to why we think that it is really important that people have independent advice and representation, which, at some level, will balance things. We say that particularly in respect of sanctions, because you can see that the language in the legislation is very much about people not engaging with the various procedures under the benefits system, "without reasonable cause", or "voluntarily" deciding that they are not going to "engage". Somebody with a serious mental health problem will not be doing that "without reasonable cause" or choosing to do that "voluntarily". They may not even understand what they have been called to engage with. They are very unwell. Depression is a good example. Somebody with depression may not even open their post for months at a time, and, because of the sanctions, they can quite rapidly go through losing benefits for three months or six months and then longer.

I know that the provision of independent advice and representation will need investment, but I think that it is how we will have early intervention, so that things do not get a lot worse.

Mr F McCann: I have a couple of questions, the first of which I have posed to a number of witnesses. Your presentation was comprehensive and the information in it was great. It is one of the first submissions that we have received that lays down some amendments that could be proposed, which is helpful.

I asked the Children's Commissioner whether, given the obvious impact that this will have on tens of thousands of people, and certainly on those suffering from mental health problems, whether consideration has been given to taking legal action against the DWP or the DSD to try and force changes in some aspects of the Bill?

I think that we discussed three amendments with the Human Rights Commission; and the Equality Commission is due here next week. We tried to set up an ad hoc Committee to look at the human rights implications and the same with equality, but it was defeated on both occasions. Have you considered taking legal action or bringing in the Human Rights Commission to advise you on the best way to proceed? Obviously, it is not happy that all this has been fulfilled.

I said this morning that I am also a member of the Committee for Employment and Learning. I asked senior people a question at that Committee's meeting yesterday. When this process starts to take shape, thousands of people will be migrated into one of their work focus groups. Will those groups be able to cope with that? Does DEL have staff with the experience to deal with people who have mental health issues? They were shocked at first, but they then came out with the obvious departmental answer and said: "We believe that we will be able to cope with it." I do not know whether a discussion has taken place between the two Departments, but I do not think that they realise what is coming. The other question is about the role of the decision-makers and client advisers who are dealing with people with mental health issues. What level of training will they get to allow them to make a decision that affects people with mental health problems?

Ms I Elliott: Thanks for your question. Your first question was about whether we had considered taking legal action. Now that the welfare reform legislation is in operation in Britain, there have been decisions to take judicial review based on different cases. We are looking at those cases with interest.

Our decision to include a whole section in our submission on legal analysis was very much to look at where we can provide advice, through evidence, to suggest where we think the Government are vulnerable if the legislation passes without specific changes due to the obligations under the 1998 Act and the requirements for legislation to comply with the ECHR. That is why we flagged those issues.

We will look at the legislation we get on the other side of all the debates and, in particular, the regulations. At the moment, we are taking that position to try to provide the best available information, including a legal analysis, to colleagues in the Assembly and in Departments, but noting that judicial reviews have been taken in other parts of the UK because of the welfare reform legislation. Our submission highlights the types of cases that we are already seeing in our services. We will look at different strategies, but we prefer to have some earlier intervention to stop those difficulties at an early stage.

You asked about cross-departmental discussion and work. Part of our earlier briefing concerned the need for other Committees, not only the Social Development Committee, and the Assembly to be aware of welfare reform. We talked about the displaced expenditure issue and the impact on people's mental health. We think that it should be a concern for the Health Committee as to whether it is anticipating the impact that welfare reform will have on health services.

DEL is another good example, and some of the consultation documents on the new employment programme, Steps 2 Success, name welfare reform as an issue whose impact needs to be anticipated. In our submission to DEL on Steps 2 Success and in meetings with colleagues in the Department, we have been raising that issue. People will be coming through, particularly, ESA and into a work-related activity group and moving on to jobseeker's allowance quite quickly — prematurely, in our view — and they may not be able to engage in the existing programmes.

Our beacon members need something akin to a pre-work programme, because they do not even have the social skills, work skills, communication skills or interpersonal skills to manage being in employment. That is an important area for consideration.

In our presentation, we mentioned the Government's Delivering Social Change agenda. We see welfare reform as one of the cross-cutting issues, about which all Departments need to consider how they are going to prepare.

Going back to Mickey's point about training for the decision-makers who will sit with the papers on the other side of the counter and make the decisions, there is a real need for training in mental health across the social security system. With welfare reform, in particular, we are going to push people into certain parts of the social security system where they have never been before. Colleagues who work in the Social Security Agency are now engaging with people with significant mental health problems. They will never have done that before and they really need some training and support around that.

Mr F McCann: One of the things that we were told when we raised this question is that the Department is taking advice from groups in the mental health sector and others. Have you been approached to provide advice or training to any of the decision-makers?

Ms I Elliott: We have offered. We are meeting with the DSD in the next few weeks to try to have a detailed conversation about welfare reform, the issues of training, the step-by-step customer journey and where we feel there needs to be mitigating activities, training and capacity-building for staff who will administer the system.

One of the difficulties for us is that some of the work will be done by people employed in the public sector and some will be done by private contractors. We raised this issue with colleagues in the Social Security Agency when we discussed the need for training for staff. The sense that we have been given about the public procurement contracts is that those workers cannot be required to engage in mental health training. That is a real issue. We have raised the issue about procurement, but what is actually in those procurement contracts about the competence of people who will operate welfare reform?

Mr F McCann: I have one last comment on sanctions. I listened to a programme this morning in which residents from a village in north Wales told of their experiences in dealing with the system. One of the things they discussed were the sanctions. You are right. What happened was that people, who did not know they were under a sanction, took the short sanction on the chin and walked away. Most of it was because, as far as the Department there was concerned, they had not fulfilled the requirements of seeking work.

Mr Brady: I have two points. I sit on the Health Committee, and you are right: there are so many overarching issues and they have to be raised with the Minister.

The other thing that we sometimes forget — it does not apply to these cosmopolitan Belfast and Derry MLAs — but in my constituency —

Mr F McCann: Mickey's constituency is semi-rural.

Mr Brady: According to Fra, 30% of West Belfast is rural —

Mr F McCann: It is 27%.

Mr Brady: In my constituency, we have a big rural hinterland. My experience in the advice sector is that mental health issues are an even bigger stigma for a lot of people who live in rural areas. I have represented people in tribunals who, had they sought specialist mental health treatment, would probably not have had to go through what they did. They felt that if their neighbours knew they were getting that kind of treatment they would think that they were completely mad and all of that. Sometimes that is forgotten.

You confirmed that we have a higher rate of mental health issues compared to Britain. However, we also have quite large numbers of people with those issues in rural areas. They are not always picked up on and they do not always go for the required treatment. Sometimes they will acquiesce to the system and get help. I think that this is sometimes forgotten.

In my experience in the advice sector, from 1997 to 2007, the number of young people who presented with mental health problems, in particular, just got larger and larger. Some of them were as young as 16, and they had really severe clinical or reactive depression and all sorts of other things. In rural areas, they do not necessarily always look for the help, and their parents do not always seek that kind of health because of the nature of the illness.

Ms I Elliott: Your comments really highlight the need for the Health Committee or the health sector to look at the impact of welfare reform. Some of the issues you raise are about rural mental health and people feeling stigmatised and being isolated.

Looking at the Transforming Your Care agenda, I think that the other issue is that mental health services are not often appropriate for rural areas. One of the things that NIAMH wants to do is to is to develop what we call services without walls, so that rather that requiring people to come into a centre in a town or city, we will provide what we call floating support and support people in their local areas or in their homes.

There is a real concern for us about those who are not in mental health services. That probably includes a lot of people in rural areas, or, as you say, younger people, who do not feel that the services that are provided are appropriate for their age group.

Mr Brady: You are right about the services without walls. I have gone to meetings with the trust in the mental health department of Daisy Hill Hospital, because there is an administration department upstairs. As you walk through the waiting area, people who know you try to avoid eye contact. They are there with family members or for treatment. They do not want people who know them to see them. That needs to be addressed.

Ms I Elliott: Absolutely.

Mr Brady: There are areas that deal specifically with mental health. People know about those and, sometimes, the stigma is reinforced.

The Chairperson: OK. Members, thank you. Iris, you are obviously happy with the session this afternoon. You have provided us with written material and spoke, as members said, quite comprehensively. Thank you for that, and for your help and support to the Committee in its deliberations.

Just to make you aware, the Bill is in Committee Stage, and the Committee is due to report on 27 November. Thank you once again for providing us with a lot of food for thought and very specific and direct information that will help us.