HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 25 September 2002
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE

23rd Meeting 2002, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

*Bill Butler (Glasgow Anniesland) (Lab)
*Dorothy-Grace Elder (Glasgow) (Ind)
*Janis Hughes (Glasgow Rutherglen) (Lab)
*Mr John McAllion (Dundee East) (Lab)
*Shona Robison (North-East Scotland) (SNP)
*Mary Scanlon (Highlands and Islands) (Con)
Nicola Sturgeon (Glasgow) (SNP)

COMMITTEE SUBSTITUTES

Brian Adam (North-East Scotland) (SNP)
Ian Jenkins (Tweeddale, Ettrick and Lauderdale) (LD)
Ben Wallace (North-East Scotland) (Con)

*attended

WITNESSES

Professor Juliet Cheetham (Mental Welfare Commission for Scotland)
Dr Denise Coia (Royal College of Psychiatrists)
Dr Jim Dyer (Mental Welfare Commission for Scotland)
Jim Kiddie (Millan Committee)
Bruce Millan (Millan Committee)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

LOCATION

Committee Room 1

Scottish Parliament

Health and Community Care Committee

Wednesday 25 September 2002

(*Morning*)

[THE CONVENER *opened the meeting in private at 09:25*]

10:14

Meeting continued in public.

Mental Health (Scotland) Bill: Stage 1

The Convener (Mrs Margaret Smith): Welcome to this morning's meeting of the Health and Community Care Committee. This is our first evidence-taking session on the Mental Health (Scotland) Bill. We have with us this morning representatives of the Mental Welfare Commission for Scotland, members of the Millan committee and a representative of the Royal College of Psychiatrists. We will hear from the Mental Welfare Commission first.

Welcome to the meeting. We have a series of questions to ask you, but first you might like to make a statement.

Dr Jim Dyer (Mental Welfare Commission for Scotland): Thank you for the invitation to speak to the committee. We are broadly happy with the bill. For years, the commission has pushed for mental health law reform and, as someone who had the privilege of serving on the Millan committee, I say that it is nice to be at the stage of considering a bill, especially one that we are supportive of.

Our submission sets out what we want to say about the bill at this stage, including some issues that we would like to highlight. We strongly supported the Millan committee's proposal that the bill be firmly based on 10 stated principles. That proposal was accepted in the policy document, but it is only partially expressed in the bill. Only four principles are explicitly stated early on in the bill and, although others are worked into the bill's provisions, we would still like the principles to be explicitly stated. For example, benefit, reciprocity and informal care could be included along with the other principles that are stated in the bill.

The principle of non-discrimination is particularly important. Its specific meaning in this context is that people with mental disorders should be treated as far as possible in the same way as people with other disorders would be. That is a profound statement and leads to the criterion that a person's illness must have impaired their decision-making capacity if long-term compulsion is to be applied. That would be the situation under civil procedure in relation to people who have not carried out an offence.

One of the reasons why there is a lot of trouble on the issue south of the border is that the proposals for England and Wales contain no such criterion for long-term compulsion. People there are worried that the gateway to compulsion is left too open and that too many people will be swept up into compulsion. Stating the principle of non-discrimination in the bill would give the bill a specifically Scottish stamp and would express clearly the principle that people with mental illnesses should be treated according to their capacities in the same way as people with a physical disorder would be.

Professor Juliet Cheetham (Mental Welfare Commission for Scotland): I would like to draw the committee's attention to a part of the bill that has been paid insufficient attention, as concerns have been focused on the tribunals and the compulsory treatment orders. Chapter 2 of the bill refers to the duties of local authorities to provide a full range of social care services. It also refers, in a heartening way, to the duty to provide services that will promote well-being and social development. That is a distinctive Scottish tradition and is redolent of the Social Work (Scotland) Act 1968. It has long been a part of Scottish policy to have a broad interpretation of welfare at the heart of legislation. That is well set out in the bill.

That approach is also consistent with what we know about what people with mental health problems need from a broad range of services, particularly services that promote employment opportunities and leisure and other activities that are at the heart of social inclusion. Such services are well described in the September issue of the Scottish Executive's *Well?* magazine, which communicates the Executive's mental health programme.

That is all very good, and distinctively Scottish. However, some things are missing. There is an absence of any reciprocal obligation on health authorities to provide a range of key services for people with mental health problems. The way in which the bill is worded is not in line with the joint future agenda or the community care agenda. That is surprising.

Perhaps the wording needs more attention. As worded, the bill could open up the possibility of quarrels over who does what—turf wars—when the whole thrust of policy in this area is for services to be provided jointly and for the distinction between what happens in hospital and what happens in the community to be broken down. Sections in the bill refer to services being provided after people have left hospital. We think that that distinction is old-fashioned.

Having said that, we should be proud of the part of the bill that I have mentioned. It is important and it represents the best of Scottish welfare and social policy. However, questions about the implementation of the bill and the resources available require more attention.

Shona Robison (North-East Scotland) (SNP): I will begin where you began—the principles of the bill. I share your concern about the omission of certain key principles. What could be the consequences of the omission of the principles of non-discrimination, benefit, reciprocity and informal care?

Dr Dyer: I prefer to turn the question the other way round and say that there would be distinct benefits in having those principles stated. In the Adults with Incapacity (Scotland) Act 2000, clear principles are stated at the beginning. In our experience, people give serious thought to those principles. If they are faced with a problematic situation or are in doubt as to whether to intervene under the act, they turn to the principles and consider whether intervention would be in keeping with the principles. That is the benefit of having clearly stated principles that people can turn to.

Millan suggested that the Mental Welfare Commission for Scotland should be a promoter of the principles. We would welcome that role; it might lead to a way of stating the principles in the act. The commission could be given the duty of promoting good practice by ensuring that interventions adhered to stated principles. Principles could also be stated in relation to particular interventions.

Shona Robison: Are you suggesting an amendment to the bill to include the principles and to clarify your role in relation to those principles?

Dr Dyer: Yes.

Shona Robison: That could certainly be considered.

Professor Cheetham has highlighted the issue of resources. My colleague Mary Scanlon will talk about the joint future agenda. Specifically on resources, however, you draw attention in your evidence to potential difficulties with local authority expenditure on mental health services. There are also concerns about health board expenditure on mental health services, so we should perhaps consider the issue as broadly as we can.

You talk about the large increase in the number of mental health officers that will be required to implement the responsibilities that are envisaged in the bill. You will have seen the financial memorandum that accompanies the bill—I know that you have said that it is for others to judge, but your opinion would be welcome. The memorandum refers to £2 million for improvements in packages of care and £2.5 million for 45 new full-time equivalent mental health officers. However, those moneys will be spread across all the local authorities in Scotland, so we are really talking about one or, at the most, two new mental health officers for each local authority. Will that be sufficient to bridge the gap? You are concerned that social circumstance reports are not being completed. Will the new moneys meet that need?

Professor Cheetham: Probably not, but the committee would need to listen to detailed evidence from the Association of Directors of Social Work. The commission and local authorities are aware of the serious shortage of mental health officers. I recently attended an ADSW meeting where a couple of large authorities said that they could call on only two or three mental health officers. That situation was partly due to staff sickness, but also due to the difficulty in recruiting people for the required additional training.

Social workers do not necessarily get any special financial award for being a mental health officer, but the work is rewarding. Some of the best-qualified and most energetic social workers want to be mental health officers. However, there are all kinds of deterrents to taking the training. There is a serious concern about the number of practising mental health officers.

The range of a mental health officer's extra duties and obligations makes me doubt whether resources are adequate. I am talking not just about financial resources, but the wider business of the recruitment and training of social workers. I know that that is not on the committee's agenda, but it takes three or four years to train a social worker and mental health officers are meant to have two years in practice before qualifying. That long lead-in time means that, if there are to be a sufficient number of mental health officers, practising social workers must be encouraged to take the training. Local authorities must also be able to provide substitute social workers for those who are training or involved in the duties of a mental health officer. Therefore, there is a big resource issue, about which the ADSW will be able to give you full details.

Shona Robison: You say that you are concerned about the resources that are mentioned in the financial memorandum. Could the issue of resources be a huge barrier to the bill's workability?

Professor Cheetham: It might be. That would be one of the saddest things to happen, given that the bill recognises the essential elements for people's packages of care in the community, which will be key to the tribunal's decision making. The bill is well expressed; it is much better expressed than other legislation that deals with similar affairs. The bill is distinctively Scottish, but it will be a tragedy if it remains aspirational and is not backed up by resources. There are serious issues. The funding of mental health services is a chronic and endemic problem, as we have discussed on other occasions.

Dr Dyer: Might I just add that, although I agree with what Professor Cheetham has said, we are content on this occasion with what the financial memorandum says about the increased costs for the commission that will arise from the bill. I say that to be fair, as we had to criticise that area on a previous occasion. However, we submitted a detailed business case, which the financial memorandum appears to have acknowledged.

Professor Cheetham: That is right, although it is perhaps a risky thing to say, as somebody might want to take some of the money away, which would mean that we could not do what will be required. However, questions must be asked about the resources that are available for local authorities compared with the settlement for the commission.

Dr Dyer mentioned how the principles in the Adults with Incapacity (Scotland) Act 2000 are working and described how people decide what they are going to do by considering those principles. One thing that has become clear as we have scrutinised applications for intervention orders and guardianship, which is one of the commission's duties, is how principles expose the arguments for doing one thing rather than another. Principles require people to produce evidence for claiming that something will be less restrictive and beneficial to somebody. That is good in an uncertain world in which the best thing to do is sometimes unclear. Principles make people think clearly and expose their evidence to argument. I believe that that is exactly what tribunals would be required to do with the onerous decisions that they will be required to take.

The Convener: Before I move on to Janis Hughes, I will put in a little plug for the Health and Community Care Committee's past work. I think that it was because of the committee's work that the principles were included in the Adults with Incapacity (Scotland) Act 2000. That may be a portent of things to come—who knows?

Janis Hughes (Glasgow Rutherglen) (Lab): I note from your submission that you support the use of the broad term "mental disorder" in the bill. I also note that you support the Millan committee's recommendation for an early review of whether it might be better for the law relating to learning disability to be provided for separately. Why do you support the inclusion of personality disorder and learning disability in the definition of mental disorder in the bill? What benefits would result from dealing with learning disability at a later stage?

10:30

Dr Dyer: On balance, we support the Millan committee's recommendation to include personality disorder in the bill. When people talk about personality disorder in the context of mental health, they often think about anti-social personality disorder, which used to be called psychopathy. Psychiatrists are concerned about the treatability of anti-social personality disorder. Limited evidence exists that the disorder can be helped in certain circumstances. It is important to stress that personality disorder is a lot wider than anti-social personality disorder. People with other kinds of personality disorder are detained from time to time and treatment is available for them.

It has been argued that the bill is not only about compulsion. People who come under the heading of "mental disorder", for example, are entitled to services from local authorities. In that context, it is important for mental disorder to be included in the bill. That will also enable future developments in treatment to be included, which could not be done if mental disorder were left out of the bill altogether.

We supported the inclusion of learning disability in the bill because some people with learning disability have challenging behaviour, which can cause them to offend in ways that include sexually inappropriate behaviour and fire setting. Without provision for the admission of such people to hospital, the danger would exist that they could go to prison inappropriately. In the short term, it was felt important to continue with the current provision on learning disability. However, we accept the strong view of learning disability organisations that learning disability is not best dealt with in law that deals primarily with mental illness. We accept that a review should take place to ascertain whether separate legislation for learning disability is a better option

Janis Hughes: You have covered the question of inclusion. Would it be helpful to have learning disability excluded from the bill? I am thinking of the provisions for exclusion under the Mental Health (Scotland) Act 1984. If so, what would those exclusions be?

Dr Dyer: We think that it is important to have exclusions. It is right for the bill to operate on a broad definition of mental disorder, so that it does not get too far down into current diagnoses. The function of the exclusions would be to prevent conditions that might be looked on as socially undesirable behaviour, or socially problematic behaviour, from being medicalised, so that mental health law is used as a means of social control.

That is one of the reasons for the anxiety that has been expressed south of the border about legislation that is seen as an open gateway to compulsion. The draft bill for England and Wales contains no exclusions from mental disorder. It was a disappointment that that is also the case in the Scottish bill. If the Parliament does not make clear what the definition of "mental disorder" includes and excludes, the courts will have to do so in due course. They may do that with less predictable results.

The commission believes that it is important for the bill to continue with exclusions from previous legislation, such as alcohol and drug dependency, sexually deviant behaviour and perhaps one or two new exclusions that were suggested in the policy statement. That would make it clear that people cannot be detained or subject to compulsion for those conditions alone. People may be subject to compulsion if those conditions are associated with other kinds of mental disorder, but not because of those conditions alone.

Mr John McAllion (Dundee East) (Lab): Does the bill do enough to protect the rights of children and young people who will come under its jurisdiction? If not, in what ways does it fail children and young people and how might those failures be addressed?

Dr Dyer: I believe that the bill broadly does enough, but I know that concerns have been expressed in that regard. The Executive had best speak to this, but I believe that it intends to add further safeguards on medical treatment for children who are being treated under parental consent. We agree with such a provision. Apart from that point, we feel that, broadly, the bill contains appropriate safeguards.

Mr McAllion: In its written submission to the committee, the Royal College of Psychiatrists says that it is extremely perturbed by the current practice of placing young people in highly disturbed adult wards. It wants the bill to include a duty of care on local authorities to ensure that young people are not placed in such inappropriate circumstances.

Dr Dyer: That is an interesting point. We certainly share the college's concern about placing young people in adult wards. That is contrary to the policy that is stated in the framework for mental health services, which was published five years ago.

Mr McAllion: But it happens.

Dr Dyer: Yes, it does. In our previous annual report, we examined compulsory admissions of people under 16. In the year that we were reporting—2000-01—there were 30 such admissions, 21 of which happened in adult wards instead of age-appropriate accommodation. The matter is very serious.

The Millan committee suggested that there should be a duty on health boards to provide age-appropriate accommodation. However, the Executive argued against that recommendation and said that the National Health Service (Scotland) Act 1978 contained a general duty to provide an appropriate range of accommodation. On that basis, we accepted that the bill was probably not the best way in which to secure such accommodation.

We are pressing the Executive in other ways. For example, we wrote to the chief medical officer, saying that there should be a national strategy for child and adolescent psychiatric services. At the moment, a Scottish needs assessment report on services for children and adolescents is nearing completion and we hope that a national strategy will be produced on the back of it. Although we did not continue to press for a legal duty to admit patients to age-appropriate accommodation, that does not mean that we think that the issue should not be addressed as firmly as possible in every other appropriate way.

Mr McAllion: You mentioned that there is some concern in England and Wales about whether the gateway to compulsion is too wide. Do you think that the criteria for detention in this bill are appropriate?

Dr Dyer: Yes, we do. It is particularly important that we have the criterion of impaired decision making. There are two justifications for compulsion. The first is the risk to other people, which is heavily emphasised in the English and Welsh proposals and is the predominant influence on the proposed criteria there. In Scotland, the risk aspect is rightly balanced by the question of giving treatment to people who are not in a position to realise that they are ill and to make a decision about their own treatment. That is dealt with through the criterion that the illness significantly impairs people's ability to make their own decisions, which helps to narrow things down. It also reassures people who might be worried about the idea of compulsion in the community that the provision would apply not because people were reluctant to take medication, but only if their decision-making capacity was significantly impaired by their mental disorder.

Mr McAllion: Is it possible for a patient to have a severe mental disorder and yet still be capable of making a rational decision about their treatment? If so, what are the implications for people who pose a significant risk to themselves and to the community but who are capable of making decisions? They would not come under the criteria.

Dr Dyer: If they were capable of making decisions, under the principle of non-discrimination they would be in the same position as someone with a physical illness.

Mr McAllion: So even if they were a risk to the community or to themselves, they would not be sectioned because they were capable of making a decision.

Dr Dyer: If they had the capacity to understand the situation and to make their own decision, they would have to live with the consequences of that decision. There would be no ethical justification for intervention. The English proposals envisage preventive detention for people who might have been considered likely to act dangerously in future. Such an approach contains huge civil liberties dangers. The bill's approach is quite right.

The situation would be different if somebody had committed an offence—the bill recognises that—because that would weaken the argument for their making their own decisions, as they would have offended against society and might have presented a risk to other people. If somebody had committed an offence or had an impaired decision-making capability, their decision could be overruled.

Mr McAllion: Someone who was a danger to the community would not be sent to prison just because they were capable of making decisions. Their decisions would be overruled.

Dr Dyer: Such people's decisions could be overruled. Through the courts, society could insist that such people had treatment if they had committed an offence, even if they were capable of making a decision. That is right.

Mr McAllion: One criterion is that treatment that will benefit the patient must be available. What are the implications of that criterion for patients who have a personality disorder for which no treatment is available?

Dr Dyer: Provision will be made for carefully assessing the situation, either under an interim hospital order, which allows the courts to send somebody to hospital for a limited time to have their treatability assessed, or under a hospital direction, which combines a hospital disposal with a prison disposal, so that people can go to hospital for a trial of treatment and, after that is completed or found inappropriate, go to prison to serve out the rest of their sentence.

First, the situation would have more careful assessment. Secondly, the provision is designed to ensure that hospitals are not used for custodial purposes. If treatment is unavailable, it is right that hospital is not the correct disposal. If there is no treatment likely to benefit a person, prison would be a more appropriate disposal. That follows the principle of benefit.

Mr McAllion: I would like to be clear about that. If we include personality disorder in the definition of mental disorder, that will mean that people with personality disorders can end up in prison.

Dr Dyer: That is so.

Mr McAllion: The bill would not protect such people.

Dr Dyer: It would be wrong to use hospital for a purely custodial purpose. If there is no possibility of treatment, hospital is not the right place to send somebody.

Mr McAllion: Are people who suffer from mental disorder, are incapable of making decisions and will not take treatment, but who are not a risk to the community—although they are deeply unhappy in the community—to be abandoned and left out in the community without treatment or assistance, to live lives that are often miserable?

Dr Dyer: That is an important point. The humanitarian function and not just the social control function of the legislation must be recognised.

The criteria say that a risk must be posed

"to the health, safety or welfare"

of the person, so not just purely physical risk is considered. The criteria cover not only danger to the self or to others, but risk to the person's health, safety or welfare. If the person's health would suffer seriously through untreated mental disorder, compulsion could be used, even if that person did not present a danger to other people.

However, a barrier would be placed to treatment for treatment's sake. People could not say, "You're ill and we think that you need treatment so we will give you treatment." Some risk would have to be posed to a person's health, safety or welfare.

Mary Scanlon (Highlands and Islands) (Con): My question is along the lines of appropriate treatment. I was delighted with Professor Cheetham's introduction; having sat through consideration of the Community Care and Health (Scotland) Bill, the committee is concerned about the workings between local authorities and the national health service. Should patients in the state hospital at Carstairs have the right to appeal on their level of detention?

Dr Dyer: We strongly support the Millan recommendation of a right of appeal for people who feel that they are being detained in conditions of excessive security. That problem is not theoretical, but real. At any time, there are 30 or so patients in the high-security state hospital at

Carstairs who everybody—the people in the state hospital and the people in the local service to which those patients would move if a place were available for them—agrees no longer need high-security care, but who cannot move, because suitable facilities are not available. Sometimes, people stay in those circumstances for one or two years or more.

That is wrong in human rights terms and could infringe the principle of proportionality in the European convention on human rights, which says that the state should take a proportionate approach to depriving people of their liberty. We do not believe that keeping people in high-security care for years after it is no longer necessary constitutes proportionality.

The Millan committee suggested that there should be a statutory right of appeal for people in high-security and medium-security care in such circumstances. Initially, the Executive was not inclined to accept that recommendation, but it is now considering it, although the bill does not provide for such a right. The Executive faces a difficulty in that the facilities do not yet exist and cannot be provided overnight. There is a nimby syndrome, whereby local communities and sometimes local medical communities do not want such facilities on their patch. That must be overcome if we are to have proper provision. We have suggested that there could be delayed implementation of such a right of appeal, so that services could catch up. That would act as a powerful driver for the appropriate development of services.

10:45

Mary Scanlon: That answers my next question. You suggest that the Executive might want to consider delaying implementation of the bill until service provision catches up. Last week, we heard from representatives of Stobhill about the proposed medium-secure unit, which is no further forward. We do not seem to be providing services locally.

Let us move on to the joint working agenda—

The Convener: Shona Robison wanted to come in on that point.

Shona Robison: At the state hospital at Carstairs, 54 patients await transfer including patients who are waiting for a local assessment. The situation is pretty grim. You may be aware of the current legal case of Wilma McGee, a woman from Dundee who has taken her case to the sheriff court. Interestingly, the sheriff has said that, if Tayside Primary Care NHS Trust does not find a bed at Murray royal hospital, it will be called before the court to account for itself. That is similar to the tribunal system that you propose.

You are talking about delaying implementation of the bill to allow resources to be allocated. However, if people have to take their case to the courts to try to get services, is there not an argument for moving ahead and putting pressure on the system to provide the places? The system is obviously not fair if people have to take their case to court; a tribunal system would be much easier to access. Surely, people deserve that now.

Dr Dyer: Yes. We were trying to be reasonable in suggesting delayed implementation, recognising the potential embarrassment for the Executive. We were talking not about delaying the whole bill—we would not want to do that—but about delaying that aspect of it. Events may drive things forward. The case that you mention is interesting, as it is the intention to bring managers before the sheriff. We are aware of other cases in which people have gone to prison despite the fact that doctors, the sheriff and everybody else thought that hospital was the appropriate place for them. Quite wrongly, people have gone to prison because of a lack of facilities.

It appears that the system of accountability for health boards has not adequately addressed the problem. It has been obvious for years that the facilities are not available, and an accountability review has not been effective in bringing that issue up the agenda of health boards. We are told that the new performance assessment framework will be more robust in that respect, but we await evidence of that.

Publicity could be another important lever, if sheriffs are going to do what Millan envisaged that tribunals would do. It was envisaged that, following a successful appeal to a tribunal, the tribunal would allow three months for the provision of the bed or service. If that did not happen, but there was a good reason for that, the tribunal might allow a further three months. It would then order the local service to produce an appropriate facility for the patient within 14 days. Presumably, the newspapers would be interested in such developments and that would help the development of services.

Whether or not the resources are introduced right away, we have no objection to the relevant provisions being introduced together with the rest of the bill's provisions. We are aware that not all the services will be available at first. The question whether to delay implementation of the relevant provisions to allow services to catch up with the new requirements, or to implement them sooner, which would act as a lever, is open to argument.

Professor Cheetham: A strength in having a statutory requirement is that it would relieve boards and trusts of the pressure that they feel. Every year we visit boards and trusts throughout Scotland. They feel pressure not to give great priority to mental health services in general, and particularly to services for the sort of patients that we have been talking about. It is typical to hear senior managers say in meetings that, although they know what the policy imperative is and what they would like to do, there are other local political pressures that lead them to support expenditure in other areas.

If something has to be provided by statute, managers are relieved of such decisions. It is sad that we have to resort to such measures, but it may be necessary. It is important that local authorities are told that they shall provide the range of services. If they have to provide them, that protects authorities from the pressures that may exist not to provide them. We have reached the stage with mental health services in Scotland where I think there has to be a statutory requirement.

Mr McAllion: I have been involved in discussions on the situation in Dundee. There is a perception that this is a matter of the courts deciding that there should be a place in a medium-secure unit at Murray royal hospital in Perth. That unit is not there, partly because the local authorities are not making provision for people to move to their areas from the Murray royal. Tayside NHS Board, which was recently allocated an extra £1 million to provide space at Murray royal, has had to be pressed.

Does not a duty have to be placed not just on health boards but on local authorities—and, ultimately, on the Executive, as it funds health boards and local authorities—so that they start to make provision? The Executive is skirting round the matter. It does not want to place a duty on health boards and local authorities, because, in the end, it will have to pay and it does not want to.

Dr Dyer: We would absolutely agree with that. That would be consistent with the national strategy document, "Health, Social Work and Related Services for Mentally Disordered Offenders in Scotland", which the Scottish Office produced in January 1999, following pressure from us, among other organisations. That document stressed the need for a comprehensive service. It is no good providing beds in medium-secure units to take people out of the state hospital. Unless community services are provided, to allow people to move on, they will just get stuck in those units. A comprehensive service is required, without barriers between the different bits of the service.

Mary Scanlon: That leads nicely to the point that I was going to develop. I understand that between 29 and 37 people were waiting for discharge from Carstairs over the summer—there are no medium-secure unit facilities elsewhere. In NHS hospitals, we often say that bedblocking is for the elderly, but there are many people with a mental illness or disorder who are bedblocked because of a lack of services in the community.

I cannot put my concerns any better than you expressed them in your written submission, so I will quote a few of the statements that you made about health board and local authority functions. You said:

> "there is an unfortunate perpetuation of out of date thinking in how some of the proposals are expressed … We would simply point out that mental health has not achieved priority in local authority services to date … We know of many people whose discharge is delayed because of lack of community facilities for them … To take one indication of this, in 2001-2002 over 50% of Social Circumstances Reports which were mandatory under the Mental Health (Scotland) Act 1984 were not provided."

That hardly amounts to a vote of confidence in local authority provision of mental health care in the community. Would you like to respond to that?

Professor Cheetham: As we indicated, there have been serious shortfalls in the provision of local authority mental health services. It is not clear why that is the case, as mental health problems are so widespread throughout the community.

Priorities have been focused on children's services and on criminal justice services, and it is clear why that should be the case. However, for reasons that we have not been able to understand, local authorities have not given similar priority to or focused similar energy or concern on mental health services. The possible exception is statutory duties. That is not necessarily reflected in the bill because of the problem over the provision of SCRs.

There are local authorities that provide very efficient mental health officer services and which are dealing well with the various procedures that are required under the Mental Health (Scotland) Act 1984. However, mental health service issues are much wider than detention. Most people are detained only briefly and, as we have said, services in the community are essential for their well-being, health and treatment.

I do not know why such services have been given low priority. The situation has deteriorated in the past few years. That is why it is so important that the bill should provide an opportunity for services to be re-energised and given more priority.

It is not that we do not know which services are appropriate or effective. There are well-researched services. We know that the range of mental health services in the community, and those that bridge hospital and community, can have good outcomes for people. We know what people find valuable from hearing about their personal experiences. It is not for want of knowing nor for want of skill that, for some curious reason, mental health services have not been given priority. After all, mental health problems can affect every one of us directly or indirectly.

Mary Scanlon: I think that you talked about a seamless transfer, but you also think that the bill could make local authorities disinclined to provide assistance for people who are in hospital. Rather than the bill addressing the problem and encouraging a seamless transfer from hospital to community, you state that the bill could make the situation worse, because it has different sections for local authority and health board responsibility. Is that your case?

Professor Cheetham: Sadly, I think that it could, which is quite contrary to the joint future agenda.

I understand that there are problems about the legislation affecting the provision of health services. Ministers have to provide a health service and it is not stated in detail what that should consist of. I would like that to be overcome so that there is detailed expression of the obligations on trusts and health authorities.

Equally, it should be recognised that social work does not just start when someone leaves hospital. That is nonsense—we all know that it is nonsense. Social work has to extend into hospitals. That is key to people's assessment and treatment in hospital. The planning of services has to start when people are in hospital. There is something curiously old-fashioned about the separation between social work and hospitals.

I fear that the bill could open up the possibility of quarrels in those areas where seamless services have not yet been established. Although parts of the bill refer to local authorities being able to request services and contributions from health boards, there is also a let-out clause—I cannot remember the precise wording—which says that boards must accept such requests unless they are contrary to other obligations that they have. I can imagine people thinking of all the other obligations that they have which might mean that they could gracefully decline the invitation to contribute to mental health services in the community.

Mary Scanlon: The financial memorandum states that local authorities will receive £13 million per year and the NHS will receive £6 million. Given that local authorities spend 8 per cent of the total on mental health services at the moment, how should the committee recommend that the emphasis be on patient care rather than on turf wars and divided budgets? What amendments to the bill would address the problems that you have outlined? Is ring fencing the money for local authorities one of the solutions?

Professor Cheetham: Ring fencing is a solution, but, as you know, it is unpopular with local government. However, in some areas the situation in respect of local authority and health service provision is dire, so there is a case for some ring fencing. The dire situation that occurred in respect of cancer treatment seems to have been quickly addressed. Resources were found and Executive and local action was taken. That does not happen with mental health services.

Those of us who attended the Holyrood conference on the bill heard that there are 14 vacant psychiatrist posts in Lanarkshire, compared with four vacant consultant posts in cancer care. How many people care about the 14 vacant psychiatrist posts in Lanarkshire? It is essential that direct action be taken to protect and promote funds for mental health services. Perhaps that will mean ring fencing, although that is easy for me to say, as I am not in the thick of a local authority.

11:00

Dr Dyer: Members may remember that Sir Roy Griffith did the original report on community care around 1990. He felt strongly about the matter and said that if local authority financing for community care was not ring fenced, it would always be a three-wheeled wagon. I suggest that it is a three-wheeled wagon. The Convention of Scottish Local Authorities or the ADSW should be closely questioned about the adequacy of the funds in the financial memorandum.

Professor Cheetham: Audit Scotland has been very helpful in its analysis of expenditure.

Brian Adam (North-East Scotland) (SNP): Will you expand on the views on advocacy services in your written submission? In particular, why did you choose to support the Executive's view in its policy memorandum, rather than the direction that the Millan report pointed to?

Dr Dyer: We think that advocacy is important and, in a sense, we have been doing it for some time in strengthening the voice of the patient by taking up issues with services. We warmly welcome the moves towards independent advocacy provision throughout Scotland. In our annual reports, we have noted that such provision is helpful where it is provided, but is currently patchy and is not always available where it should be.

We think that the Executive has taken the issue seriously in the bill and has made a significant effort to try to improve the situation and ensure that independent advocacy services are available where they are needed. We understand the Millan committee's original argument that there should be a right to advocacy services. The Executive's proposals express that right by putting a duty on the statutory providers to ensure that services are provided. We do not think that there is an important distinction in practice. We understand the argument that others have made that there is an important distinction, but the right can be enjoyed by service users only if the service is provided. Therefore, placing a duty on providers to ensure that services are available indirectly expresses the right of users to have an advocacy service. We understand that discussions are taking place between the Executive and the main advocacy organisations to ensure that, as far as possible, advocacy is built into various provisions in the bill. Broadly, we think that the approach is right.

Brian Adam: We are dealing with the bill's general principles. You are suggesting that the Executive has trimmed a little in respect of advocacy services. I am not convinced by your argument. Why should something that should be a right not be written into the bill? Why should it be diluted?

In addition, will you comment on the provision of finance? The financial memorandum says that about £3 million has been set aside for advocacy services and that it will be split equally between local government and the NHS. Would having the individual right written into the bill involve greater expense? How should services be delivered?

Dr Dyer: The crucial point is that advocacy services are fostered, encouraged and funded so that they are available when people want to make use of them. It is no good giving people a right unless the services that they require exist. People can wave their right about, but if the services do not exist, it is rather empty. It seems to us that the most important thing is to focus on ensuring that the providers ensure that the services are in place and are available. It is for others to comment in more detail on the adequacy of the financial provision, which, in broad terms, seems significant. A witness who is to give evidence to the committee later today may have more to say about that.

The Convener: I am interested in your views on the practical implications of advance statements, including those that specify treatments and those that refuse treatments. The bill appears to say that an advance statement would not be legally binding but that people should have regard to the wishes that are specified in the statement. What is your view on the use of advance statements?

Dr Dyer: We think that the bill takes the right approach. It is right that the bill acknowledges advance statements, which will generally be advance refusals. People will be able to specify the treatments that they do not want in future, but it is not legally possible for people to issue a mandate for a particular treatment. For example, services cannot be obliged to offer people particular treatments in hypothetical situations. The statements strengthen the patient's voice and allow people who are capable of considering treatment to express their views about future treatments, including treatments that they do not want.

It would be wrong for the statement to be legally binding because circumstances and treatments can change. New treatments can come along that were not considered when the statement was made and which are less invasive than those that existed before. A person may feel differently when they are in a situation that they had only imagined before and are not technically able to consent to or refuse treatment. It is right that the statements are not absolutely legally binding but must be seriously considered by people who offer treatment and by the tribunal when it approves a care plan.

Professor Cheetham: The commission has experience of working with patients—often people with manic depressive illness—who stated, in consultation with their families and the people responsible for their care, that they wished serious attention to be given to detaining them earlier rather than later during subsequent periods of illness. Those people were not able to make advance statements because such statements did not exist. It may sound unusual, but in at least three of the cases that I have worked on, where someone has resisted the idea of going into hospital and where they have not been detained, it has been argued that perhaps more attention could have been paid to the grounds for detention and to the fact that the protection offered by care and treatment in hospital would have helped that person for a brief period. In those three cases, a statement was discussed and agreed by all parties and inserted in the patient's records. The statements influenced later care and decisions and people have reflected that they were useful.

People do not always want to opt out of treatment—they do not always say that they do not want electroconvulsive therapy or other treatment. Some people say, "You cannot detain me if there are no grounds to do so, but examine carefully what I do and the state that I get into when I am in a certain phase of my illness." I have been very impressed by that.

Bill Butler (Glasgow Anniesland) (Lab): In your view, does the bill omit anything that would strengthen the commission's role in protecting individual patients?

Dr Dyer: We are broadly content with the bill's provisions on the commission and with the way in which it extends our role and powers. In our submission, we said that we would have preferred the bill to include a clear statement that our fundamental role is to protect the individual patient. That idea comes across through the duty to investigate situations in which people's welfare is at risk and so on, but it would help to distinguish the commission from other organisations if the bill contained a clear statement that the commission's role is to protect the welfare of people who might be vulnerable due to mental disorder and to promote good practice.

I have already said that that we would have welcomed the inclusion in the bill of the Millan recommendation that the commission should promote the principles of the legislation and that we should be able to bring matters to people's attention if interventions have not adhered to those principles. The Millan committee made another suggestion—on broadening the accountability of the commission—that is not in the bill. At present, we are accountable to Scottish ministers, but Millan suggested that we should also be accountable to Parliament. We suggest that the Scottish Parliament should be added to the list of bodies to whose attention we can draw matters of concern—for example, we could draw the attention of the Health and Community Care Committee to such concerns.

The Convener: It is probably good to end on a suggestion that the committee should have more work. Do members have any other questions? Do the witnesses want to come back on any points, bearing in mind the fact that we will hear again from the commission, or its representatives, in due course?

Dr Dyer: One can always say more, but we have had a good go at the bill this morning. We should give way to other witnesses who have opinions to express.

Professor Cheetham: In most respects, the bill is good. It is important that it is enacted before Parliament is dissolved.

The Convener: We will certainly do our best to play our part in that process. Thank you.

I suspend the meeting for a short comfort break.

11:11

Meeting suspended.

11:16

On resuming—

The Convener: We will now take evidence from Bruce Millan and Jim Kiddie, respectively the chairman and a member of the Millan committee, which produced "New Directions: Report on the Review of the Mental Health (Scotland) Act 1984". The report was influential in shaping the draft bill and the bill that we now have before us.

Good morning, gentlemen. I thank Mr Kiddie for his written submission. Bruce Millan has given us an incredible written submission in the "New Directions" report. We will touch on many aspects of that report.

We will start with short introductory statements and then go on to questions, just as you saw our previous victims being subjected to questions.

Bruce Millan (Millan Committee): Thank you. I found the invitation to condense 500 pages into a four-page memorandum rather difficult to fulfil. I would like to say one or two things at the start of my evidence.

Like Jim Dyer, I am pleased about the bill as it stands. It has followed, sometimes in remarkable detail, the recommendations that my committee made. I think that the bill will make very good legislation. Anything that I say that sounds as if it is critical of the bill should be considered against that background.

The matter of resources was not in our terms of reference, but in the introduction to our report we made what I think was a strong statement about the necessity for provision of the resources to implement the bill and I stand by that. I understand the committee's worries about whether the resources will be available. The bill—or act, as it will become—will not work unless sufficient resources are made available. We dealt with the detail of the question of resources in relation to only one matter. Mr McAllion raised points about children. The only time that we mentioned an inadequacy of resources that we thought had to be addressed was in relation to children and young people. Otherwise, resources were not a matter for my committee.

I will comment on three issues. First, I will discuss principles. I am not very happy with the way in which the principles are stated in the bill. We laid down 10 principles and we hoped—it was perhaps a bit optimistic of us—that they would all appear in one place in the bill and, if possible, in language that everyone could understand. That has not happened.

As far as I can see, almost all the principles that we suggested for the bill—detailed on page 23 of "New Directions: Report on the Review of the Mental Health (Scotland) Act 1984"—are included in one form or another, but they are not included in an understandable way. We made the point that, if at all possible, we would like a bill that ordinary people, including patients, could understand and use. That is difficult to achieve, particularly in a complicated subject such as mental health.

I hope that the committee will examine how the principles are expressed in the bill. In looking in particular at section 1, one might come to the conclusion that certain important principles have not been incorporated into the bill. However, later on in the bill, one might find that that is not quite accurate, because those principles are incorporated in a section.

That is all that I have to say about the principles. Everybody agreed that we needed a statement of principles in the bill; the evidence to the Millan committee on that was unanimous and I confess to a certain amount of disappointment that such a statement is not absolutely clear in the bill as introduced. We did not expect that all our individual principles would be drafted in the bill in exactly the way that we prepared them, but the principles need to be reconsidered. A certain amount of redrafting would improve the bill considerably.

My second point is on the grounds for compulsion. I am a bit unhappy about how the bill now expresses those grounds. We provided what have been described as six hurdles or gateways to compulsion. They are listed on page 63 of the report. I understood from the policy statement that the Executive issued in October last year that the Executive had accepted those conditions—all of which had to be fulfilled before compulsion could be imposed—with the minor, or perhaps not so minor, variation that our formulation, “impaired judgment”, would be changed to “impaired decision-making ability”.

I believe that “impaired judgment” is a better way in which to express the difficulty of judging whether a patient can make the kind of decisions about his treatment that it would be desirable for him to make. It might be that replacing “impaired judgment” with “impaired decision-making ability” will not make much practical difference. We discussed that in committee, but the matter ought to be investigated. Perhaps the committee’s professional witnesses today or later would give a view on that.

However, that is not what concerns me about section 53, which is about the powers of the mental health tribunal for Scotland, and when compulsion will be justified. Two of the hurdles that we included in our report seem for some reason to have been omitted. As far as I can see, there is no explanation in the policy memorandum or the explanatory notes as to why that has happened.

The first condition that has been omitted is:

> “it has been established that the necessary care and treatment cannot be provided by agreement with the patient”.

In other words, that means that the patient cannot be treated as a voluntary patient. That has been omitted from the section that deals with medical recommendations and from section 53.

The second recommendation that has been omitted is that

> “The care and treatment proposed under compulsory measures should be the least restrictive and invasive alternative available, compatible with the delivery of safe and effective care.”

It is to be admitted that the use of the least restrictive alternative is one of the general principles in section 1, but I feel strongly that all the conditions under which a long-term compulsory treatment order can be imposed should be included in one place in the bill. We recommended that and I have seen no satisfactory explanation for why that has not happened. That situation is not what I expected from reading the policy statement, which appears to show that the Executive accepted our recommendations on the grounds for compulsion. I assume that the Executive still accepts them; if so, they ought to appear in the relevant sections on medical recommendations and the power of the tribunal.

The Convener: You say that the two recommendations are not in those sections. By implication, do you accept that they are included elsewhere in the bill?

Bruce Millan: By implication, it might be that people will use compulsion only when agreement cannot be obtained from a patient. However, it is important that that should be stated in the bill.

The two omissions have been replaced by a vague provision that compulsory treatment orders must be necessary. Our report stated specifically that we did not like the provisions in the existing legislation that mention “appropriateness” and “necessity”, because we felt that those terms were too vague and should be replaced by something much more precise. The new condition that compulsory treatment orders must be necessary—I am not sure what that means—suddenly appeared in the bill without any notice that the Executive had had second thoughts about our recommendations on the grounds for compulsion.

I hope that the committee and the Parliament will consider the matter of grounds for compulsion. Our report states that that is the most important part of the bill, because it involves taking away a person’s liberty against his or her will. It is important that we get that right. We spent a lot of time discussing the grounds for compulsion and we felt that we had got the matter right. The minor adjustment to one of the conditions that the Executive intended to make is not a major concern for me, although others might want to speak about that, but the omissions are a major concern. I hope that the issue will be considered.

My third point, which may sound slightly less fundamental, is about the tribunal. I make this point against the background that the Executive has accepted in considerable detail our recommendation that there should be a mental health tribunal. I am happy about that. However, I am not happy about one matter that we considered closely. The tribunal is to have three members, one of whom will have a medical background. That person need not necessarily be a psychiatrist, but I imagine that in most cases he or she will be. We recommended that that member of the tribunal should examine the patient before the tribunal met to discuss a patient's case. One major fault in the present system is that only a minority of patients—28 per cent—appear before the sheriff, so their fate is decided without their being present.

I am very keen that patients should appear before the tribunal. In the English system of tribunals, there is an implicit assumption that the patient will appear. The patient does not always appear—he may refuse to, or may be too ill to appear—but the patient should always be represented. The assumption, however, is that it is desirable for the patient to appear. In the policy memorandum, the Executive has said that it would like more participation by patients at tribunals. To make that participation effective, there is considerable advantage in the medical member of the tribunal's having seen the patient beforehand, rather than relying on a piece of paper.

11:30

A psychiatrist, whose name I will not mention but whose judgment I very much respect, told me during our deliberations about the vast difference between judging a patient on the basis of a piece of paper and seeing that patient face to face. Unfortunately, the failure of the bill as drafted to accept our recommendation that the medical member should see the patient means that most decisions could be taken without anybody's having seeing the patient face to face in a medical context. The reasons that are given for that in the policy memorandum are not at all convincing.

The real difficulty is not mentioned in the policy memorandum. There is an ECHR difficulty regarding the medical member who sees the patient also being a part of the decision-making body. We were anxious to deal with that difficulty. If members examine the chapter in our report on the tribunal, they will see that although we acknowledged that there was a problem, we felt that it could be dealt with by providing—either in the rules of procedure or in some other way—that the medical member, having seen the patient, could be quizzed on his view by the patient or the patient's representative. That would prevent tidy, cosy decisions being made just for tribunal members.

We have seen tribunals working in England—not as many as we would have liked, because we did not have time—and I was impressed by the way in which the medical member could quiz the responsible medical officer on why he had taken a particular view. Our chapter on the tribunal gives figures for England, showing that a significant proportion of tribunal decisions in England go against the responsible medical officers. Under the present system in Scotland, it is virtually impossible to make a successful appeal to the sheriff. It is very important that we have the tribunal, that it acts independently, and that it does not always accept the view of the professionals who are dealing with the patient.

We need the patient to be at the tribunal, if possible, and we need the patient to be represented legally, or in another way. We need a named person to be able to come before the tribunal. However, unless the medical member of the tribunal can see the patient beforehand—whatever the ECHR difficulties—the patient will be disadvantaged. I am sorry that that is the position at the moment.

I suggest that the Health and Community Care Committee and the Parliament will have to get a clearer indication from the Executive as to why that recommendation of ours—to which I attach considerable importance—has not been followed. If the reason is to do with the ECHR, the Executive should come clean and should say to the committee, "We would like to do this, but unfortunately we would be vulnerable."

That would be fair enough—I would accept that. One would have to consider other possibilities, such as including the proposal in the bill that there should be an independent medical examination, if the tribunal were not happy; however, that would add to the time scale, to the uncertainty and to the distress of the patient. I repeat that I saw only a few tribunal sessions in England, but I was impressed by the way in which patients spoke up for themselves. The patients were put at ease and were not as intimidated as I might feel if I appeared before a tribunal. It is extremely important that patients should attend tribunals and that they are able to have their say, if possible. That is not a detailed point, but it is a detailed point in the context of the tribunal arrangements, which are recommendations that I welcome.

The Convener: Would you like to make a statement, Mr Kiddie? We have your written statement. We could move straight to questions.

Jim Kiddie (Millan Committee): I will be brief. I am conscious that the committee has received my paper. I wish to say publicly, as I have not had the chance to do so, what a pleasure and a privilege it was to serve under Mr Millan. His report, which has been widely commended throughout Scotland, provides a good basis on which to work.

I was on holiday last week, so my paper was rushed. It is perhaps an irony that, before I prepared my paper yesterday afternoon, I was preparing a submission to Aberdeen City Council for funding for the project that I manage. If funding is not secured, that project is likely to go to the wall. Later on, we can address the community care issues, which have already been mentioned. I hope that my paper is not too rushed.

I endorse everything that is being proposed. The main areas of concern to me and to service users are principles, advocacy services and the name of the bill, to which we can perhaps return.

The Convener: Let us hope that your application is successful. We wish that godspeed. Shona Robison will begin the questioning on the bill's principles.

Shona Robison: Mr Millan has given us food for thought this morning. I share his disappointment that the principles are not stated explicitly in the bill. What did you think of the Mental Welfare Commission's idea that there could be a way of including the principles in the bill by giving the commission the role of promoting the principles, which would mean that the principles would have to be listed? Is that suggestion worth considering?

Bruce Millan: The principles should be stated in their own right at the start of the bill. We recommended in our report that the Mental Welfare Commission for Scotland should have the responsibility of promoting the bill's principles. If that is not made explicit in the bill, I recommend that it should be. However, that is not a substitute for having a separate section for the principles, which everyone—not just the Mental Welfare Commission, but patients, voluntary organisations and so on—can look at.

Shona Robison: That is a clear answer.

You have both mentioned resources. You will have seen the financial memorandum. I take it from your comments that you have concerns about the level of resources that is outlined in that memorandum. Before you comment on that, I refer you to the statement in your report that any extension of compulsion through the introduction of compulsory treatment orders must go hand in hand with reciprocity. If the resources were not available to develop the required services, would you begin to doubt the wisdom of introducing compulsory treatment orders?

Bruce Millan: No, because we will have to have compulsion whether we like it or not, although it should be kept to a minimum. We said in the introduction to our report that it would be wrong for the new act to introduce more compulsion than is used in existing legislation. Some 90 per cent of patients are admitted voluntarily to hospital and compulsion is used only for cases that cannot be dealt with on that basis. That takes me back to what I said earlier about the grounds for compulsion.

The question of resources concerns not only those who might be subject to compulsion; it is very important for all patients, including informal incapable patients in the community and in hospitals. I cannot judge the financial memorandum, which deals only with the direct effects of the bill. Our concern was not so much whether the financial memorandum would be adequate; that is a matter for the Parliament, if I may say so. We were concerned more about the overall level of resources for mental health. The Mental Welfare Commission for Scotland and Audit Scotland are concerned about the resources and the fact that there is hardly an area in Scotland that has a comprehensive mental health service. We are very concerned about that.

I cannot really judge whether 45 or 55 additional mental health officers would be needed to meet the additional requirements on mental health officers in the bill. Such matters need to be considered, but they were not really matters for us, because they were not within our terms of reference. We were worried, however, about the overall level of resources for mental health.

Shona Robison: If the issues around existing resources and new resources are not addressed, will that undermine the intention of the bill?

Bruce Millan: Our report and the bill are designed to give patients, their relatives, named persons and so on a better deal. They can get a better deal only if more resources are available. That is what we said. The bill, as it stands, can represent a considerable improvement in the rights of patients and the services that are available to them, but it can do that only if the resources are available.

Jim Kiddie: It could be argued that there is already compulsory treatment in the community under section 18 of the Mental Health (Scotland) Act 1984. Indeed concern has been expressed about the increasing use of section 18 orders. That might draw attention to the fact that new appropriate legislation for community care is needed. The expectation among service users was made clear from the various consultations that took place. If we are introducing community treatment orders, there should, with regard to reciprocity, be access to the mental health tribunal for Scotland and the right to have an advocate present. I emphasise the word "right"—the committee might want to return to that.

On resources, I have brought with me an article that I wrote some months ago called, "Community Care—Bridging the Credibility Gap". There is a real credibility gap. Various projects that are run by voluntary organisations and others are dependent on making what I call Mickey Mouse money, such as from short-term initiatives from the

National Lottery and European social funds. If we are really taking community care seriously, the Parliament needs to take the lead and ensure that the package includes properly funded community care services that vulnerable people who have mental problems have a right to access. They also have a right to expect that those services will not suddenly come to a halt when the money runs out, but will continue with proper funding.

I do not have up-to-date figures, but I used to be involved with learning disabilities. Some time ago, Renfrewshire Council pointed out that 10 per cent of its social work budget was spent on people who have learning disabilities, whereas only 1 per cent was spent on people who have mental health problems. However, many more people have mental health problems than have learning disabilities. I am drawing attention to the need for investigation to ensure that we get to grips with the real, inevitable and necessary costs of providing effective community care, as well as the inevitable costs of implementing the legislation. At the moment, many people in both the statutory and voluntary sectors are wasting energy chasing illusory finance.

11:45

Shona Robison: Could you provide us with a copy of the article, so that it can be circulated to members?

Jim Kiddie: Yes.

Bruce Millan: Chapter 13 of our report deals with service users' rights to assessment and services, including reciprocity rights. We were aware of the issue, but our task was to consider what should be included in the bill, not how much money should be available. However, as Jim Dyer and Juliet Cheetham said, if a right to assessment and services is included, certain things must follow from that—as local authorities and the health service know.

Bill Butler: Why did the committee decide that personality disorders should be included in the definition of mental disorder?

Bruce Millan: Our report contains a very long passage on the issue that I cannot easily summarise. This morning, Jim Dyer commented on the matter from a professional point of view.

The term personality disorder is currently on the statute books. It was introduced by the Parliament in the first act that it passed, the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, following the Ruddle case. Everyone agrees that the term was introduced inaccurately, as it appeared under the heading of mental illness. If it is used at all, it should appear separately.

Because the term personality disorder was not mentioned in legislation before the 1999 act, and people seemed to get along quite happily without it, there is a case for saying that it is not necessary. That argument weighs strongly with me, but for the reasons that Jim Dyer has given this morning—for example, concerning access to services—we decided that the term personality disorder should be included in the bill.

The Royal College of Psychiatrists may be best equipped to deal with this point, but we do not expect that personality disorder as a primary diagnosis will often lead to compulsion. In our report we indicate that personality disorder was mentioned as the primary diagnosis in only two out of more than 1,000 cases in the year considered by the research project on section 18, which relates to long-term detention. That is explained partly by the way in which psychiatrists in Scotland regard personality disorder, although I am not able to deal with that issue from a professional point of view. However, we felt that it would be wrong for personality disorder to be left out of the bill.

The 1984 act contained a roundabout reference to personality disorder. In 1999 the Parliament decided to include the term specifically in legislation.

Jim Kiddie: In my day-to-day work, I am conscious of the increasing problem of people with a diagnosis of borderline personality disorder and their demands. They are very distressed people with complex needs who are not getting the services that they require from the statutory sector. We require much more intensive psychological support and intervention. The matter needs national attention.

Bruce Millan: I might add that—

The Convener: I am sorry, Mr Millan. We are going to be strapped for time, as we have to hear from the Royal College of Psychiatrists as well and we still have several questions. I will give you a chance at the end of the session to wrap up anything that we have not touched on, but I would like us to make some progress at this stage.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Bruce Millan may be able to address his point in answer to this question. Why did the Millan committee decide that people with learning disabilities should be included in the bill?

Bruce Millan: We deal with that point fairly extensively in our report, and Jim Dyer mentioned it this morning. Ideally, we would like learning disability out of mental health legislation, and we received strong representations to that effect. The Executive has accepted our recommendation that that should be considered further.

We were worried that if learning disability were left out of the bill, there could be a big gap, which could be to the detriment of people who suffer from learning disability. In New Zealand, learning disability was taken out of the legislation and there was found to be a big gap. Comprehensive and, to some extent, repetitious legislation then had to be introduced to deal with learning disability. I hope that the Executive will follow up the issue of learning disability. We ask that it does so urgently, to see whether there are ways of dealing with learning disability that are more appropriate than what is contained in the bill. A complication is the fact that people with a learning disability often have mental illness as well, and it is sometimes difficult to diagnose their problems easily.

Margaret Jamieson: You also recommended that certain types of behaviour and personality should be specifically excluded from being a mental disorder. However, the Executive appears not to have taken that up, on the grounds that it is probably not legally necessary. Are you satisfied with the Executive's position?

Bruce Millan: No, I am not. I think that the Executive has agreed to reconsider the matter. We examined the issue closely, as there are exclusions in the existing legislation. Although it may not be legally necessary to have exclusions, there is a pertinent point to be made. If there are exclusions in the existing legislation and then a bill is introduced that does not contain exclusions, the implication is that some of the previous exclusions are no longer to be considered as exclusions. We wanted the definitions to be brought up to date and we felt strongly—as Jim Dyer said—that there should be exclusions in the bill, especially given the current emphasis on alcohol and drug problems, which may accompany some kind of mental disorder but which should not, by themselves, bring anyone within the scope of compulsion under the bill.

Mr McAllion: We heard from the Mental Welfare Commission for Scotland and from you that there are not enough resources in the system to protect the rights of young people and children. The Mental Welfare Commission's view is that we should deal with that not through the bill, but by allowing the Executive to go ahead with a national strategy and a Scottish needs assessment programme. However, the view of the Royal College of Psychiatrists is that we should write into the bill a duty on health boards and local authorities not to put young people in circumstances that are inappropriate for them. What is your view?

Bruce Millan: I would welcome such a duty. We considered such facilities as single-sex wards. It is wrong that people are inappropriately placed. However, there is no point in putting that in the legislation unless the facilities will be provided. If an obligation were placed on a health authority or local authority, it would perhaps not be an obligation to provide services directly. Obviously, that would be desirable where it could be done. However, the obligation for small authorities might be to see whether services were available, even if they were not obligated to provide the services directly.

Mr McAllion: It seemed to me that the Mental Welfare Commission witnesses contradicted their written submission when, in reply to a question about giving users rights rather than placing duties on providers, they said that it would be best to put a duty on providers to ensure that services would be available. However, that did not seem to be their position in relation to young children, because they were not in favour of putting a duty on health boards and local authorities to make the services available.

The Scottish needs assessment programme sets all kinds of conditions across the whole health service, but the services are not there on the ground. Is it not the case that the bill must place a duty on providers to ensure that services appear?

Bruce Millan: Such a duty would certainly help. However, it can be argued—as Dr Dyer did—that at the end of the day it does not make much difference whether there is a duty or a right. If someone has a right but is unable to exercise it, then—

Mr McAllion: In an earlier bill, we gave to carers an independent right to have a separate assessment of their needs. However, no duty was placed on local authorities to provide for assessed needs.

Bruce Millan: My committee recommended a right to advocacy, but I would be happy if rights were applied elsewhere in the bill.

Dorothy-Grace Elder (Glasgow) (Ind): What is the reasoning behind the proposal for the creation of mental health tribunals?

Bruce Millan: Again, we dealt with that matter in considerable detail. We felt that the system of using sheriff courts does not work in the interests of the patients in the way that it should. We decided that there were two ways of remedying that. There could be a sheriff with professional assessors or there could be a separate tribunal. We decided that either of those systems could work, but that if we were changing the system, it would be preferable to go right over to the tribunal option.

We decided that having a tribunal would be better than having a sheriff with assessors. All sorts of difficulties would emerge with the latter system. Apart from anything else, sheriffs do not like sitting with assessors, as sheriffs like to decide everything independently. The Executive has taken the same view as we did.

Of course, introducing a tribunal system will be a major change and we did not underestimate the difficulty or scale of the change. We made it clear that the tribunal system will not work unless it is properly resourced. One argument against the English system is that it is not properly resourced. Tribunals in England have terrible delays that are obviously detrimental to the patients.

One advantage of the sheriff system is that there are no delays, because sheriffs are always in place—whatever they are doing. Our report states that if the delays that there are in England are incorporated into the system in Scotland, that will be a disaster. The tribunal system is another area in which resources are essential.

Dorothy-Grace Elder: You are referring not just to monetary resources, because there is the major problem of the severe shortage of general psychiatrists and health professionals. Who will serve on the tribunals? In view of the current shortage—never mind the position in future—who will have the time to be a doctor member or, indeed, a witness? Do we need to start training more psychiatrists now?

Bruce Millan: Previous witnesses made that general point about the shortage of consultant psychiatrists. Some tribunals in England use retired psychiatrists who, obviously, have more spare time. I have nothing against using retired psychiatrists—of course, the bill does not provide that medical members necessarily have to be psychiatrists—but I am not terribly happy about everything being done by retired people. I speak as a retired person. Retired people can do a good job, but it is important that medical members are professionally up to date with medical and psychiatric thinking. The membership of the tribunal is a significant issue. Again, if I may say so, it would be useful if the Health and Community Care Committee could get assurances from the Executive on how the Executive will meet the additional demands on the medical profession, which is already under much stress and strain.

Dorothy-Grace Elder: You referred to the obvious ECHR problem to do with having a doctor on the tribunal examining patients. However, you expressed strongly your view that patients should not only be present at a tribunal, but be allowed to participate. You did not expand on why you were against an independent doctor being appointed, apart from saying that you thought that it would delay matters. Why would that cause more of a delay, if it were allowed by the ECHR?

12:00

Bruce Millan: I am not against that idea. If we have a system in which the medical member does not examine the patient, there will have to be a provision whereby the tribunal, if it is unhappy about anything, can get an independent view. That takes time, though, and would delay the tribunal hearing, which is not desirable. At the moment, the patient can ask for an independent medical assessment and often does, which leads to a delay before the sheriff court.

Dorothy-Grace Elder: The ability for the tribunal to seek an independent view would be a way around the ECHR problem, would it not?

Bruce Millan: Yes. I wish that the Executive had been a wee bit more forthcoming on the issue. The policy memorandum does not mention the ECHR but, as I understand it, that is the basic difficulty. We mention that in our report.

If the Executive said that it would like to do what is suggested but is worried that it might not be able to because of the ECHR and that another way of getting the independent view would have to be found, that would be fair enough and we could judge that on its merits. However, the Executive has produced what I consider to be rather spurious reasons for turning down a recommendation, such as the view that if the medical member examined the patient, the patient would be distressed. Well, given that it is distressing to the patient to have to appear before the tribunal, that explanation is rather inadequate. The Executive also said that it would add more to the time and cost of the tribunals. I take the opposite view because I think that the arrangement that the Executive is suggesting will add to the time and cost. I did not find the arguments for turning down our recommendation convincing. Perhaps you would like to investigate that further. I accept, however, that there might be an ECHR obstacle that cannot be overcome.

Janis Hughes: Should patients in the state hospital at Carstairs have a right of appeal on the level of detention under which they are detained?

Bruce Millan: Yes, we recommended that, although in a fairly—how shall I put it—leisurely way. The problem is a lack of facilities. There is no point in saying that the bill should state that a patient's case should be considered immediately and that the patient will be transferred immediately. We suggested that the tribunal give the state hospital, the authority or whoever an initial three months and then a further three months before insisting that action be taken within 14 days.

We recognise the difficulties, but the situation at the moment is quite offensive. Everybody knows that there are patients in the state hospital and elsewhere who should not be there. I visited the state hospital and met some of those patients, who seemed to accept their position far more calmly than I would have done. They should not be there and that has been a scandal for years.

We know the nimby problems relating to

medium-secure facilities and so on and I have noticed that even MSPs have complained occasionally about a new medium-secure unit. However, we need a range of different types of accommodation and it is just wrong that people should be kept in secure units if they do not need to be. That is an infringement of their liberty.

Janis Hughes: You mentioned nimbyism. Do you think that there is a lack of understanding among the public about the fact that people are being kept in conditions that are unsuitable for their needs?

Bruce Millan: It is easy for the press to build up a campaign on the back of that lack of understanding.

Jim Kiddie and I were board members of the Scottish Association for Mental Health, which is why I got involved with the committee. I remember a local campaign—Jim Kiddie will be more familiar with it than I am—that prevented the provision not just of secure services, but of services for mentally ill people. The local press claimed that it was dreadful that we were putting dangerous people into the community. We have to resist such attitudes; indeed, I believe that the Scottish Executive has launched a campaign on stigma and public understanding. I understand why it is difficult for health or local authorities to proceed with something if there is hostility.

On the other hand, there are plenty of places with some kind of facility that seem to cause no trouble at all. I am still waiting to see the same thing happen in mental health as happened with the prison at Peterhead. The local community there said, “You mustn’t close our prison”; it would be great if the public were able to say, “We want a secure unit for mentally disordered people and you mustn’t close it once we’ve got it”. However, I think that such a day has still to come.

Mary Scanlon: You have made your position on advocacy quite clear. I believe that advocacy underpins the whole ethos of patients’ rights. A couple of sentences in your submission express your sentiments as strongly as you have expressed them today. For example, you say that

> “there must be a right provided. If there is not a right then some authorities and individual consultants will continue to ignore central guidance on the matter and block progress.”

You also claim that

> “there is a lack of commitment by many authorities.”

Although section 182 of the bill deals with advocacy, it focuses on the duty of authorities rather than on the right of patients. I want to tie that in with your central point in your introduction about the grounds for compulsion and the necessity for compulsory treatment after not receiving the patient’s agreement. The problem in Carstairs, for example, is that no one represents the patients in the blocked beds. Who will represent patients who are being compulsorily treated against their will if the bill does not contain a right to advocacy? Does that not underpin many of the issues that we have raised today?

Jim Kiddie: That is a good question. Let me deal first with Carstairs. Although I am by no means an expert on the state hospital, I understand that a very good advocacy project has been developed at Carstairs over some years, and I would be surprised if any resident of Carstairs did not have access to it.

On the general situation, I was interested to hear Mr McAllion pursuing the point about duty and rights. I was glad to hear Mr Millan say that he would be very happy if the right to advocacy were implemented. However, on the train down this morning, I was re-reading the consultation document that was produced by SAMH at the Millan committee’s request and issued to service users to find out what they wanted in the bill. The two things that service users wanted were the principles and the right to advocacy. For five years, I ran a successful collective advocacy project with individual advocacy elements at the Royal Edinburgh hospital. Since 1988, the hospital has had a patients’ council, which is successful and still continues. We had two individual advocacy workers; if we had had three, we could have covered the whole hospital. This is not rocket science; it is quite straightforward.

I hope that the bill will provide a right to advocacy. Without that, service users the length and breadth of Scotland will feel let down, if not angry. The fact that the Millan committee came to a consensus after two years of hard work and excellent consultation led to the expectation that the bill would provide such a right. Advocacy and access to tribunals should be part and parcel of the community treatment orders so as to protect people who are subject to compulsion.

I am not a lawyer, but if people in Holland have the right, I do not see why we cannot have it in Scotland. If the right is embedded in the legislation, the cost could easily be worked out—I would do it for a small fee. I notice that about £3 million is estimated as what is currently set aside for advocacy. Some of us worked out on the back of something—these days, I would not say that it was a cigarette packet—that it would cost between £3 million and £4 million to provide emergency advocacy within all the psychiatric hospitals.

Everyone who experiences secondary psychiatric care under a community treatment order should have the right to advocacy. If the bill provided such a right, one need only spell out what would be required to implement that and everyone would be happy. Members have a challenge ahead of them and I hope that they will rise to it.

Mary Scanlon: Next week, the committee will visit the state hospital at Carstairs. I am a wee bit concerned that you say that Carstairs has quite an advanced system of advocacy. Are you really saying that we could have the best advocacy system—which would best represent the rights of patients by ensuring that someone was there to shout for them—but that, unless we have the facilities such as a medium-secure unit and care in the community, such a system does not guarantee that patients will have the right to the treatment that they need?

Jim Kiddie: That is so, of course, but people need an advocate when they are unable to speak. I assure you that it is possible to recover from a mental breakdown. Eleven years ago, I could not write my name or brush my teeth, yet here I am today. That process can be helped if people have an advocate when they are in a situation of extreme vulnerability. For example, when I was about to have ECT, it would have been great to have had somebody to explain to me what it was all about. At that time, I would have agreed to anything that a consultant psychiatrist said.

I think that R D Laing said that he was more frightened by the fearless pursuit of power by his fellow psychiatrists than by the powerless fear in the eyes of his patients. Now, I have good relations with the Royal College of Psychiatrists and with individual psychiatrists, but I make the point that people lose all power and are extremely vulnerable when they experience a mental breakdown. In order to redress that power imbalance, the provision of advocacy is essential. It would also enable people to say what they really need. We might then be able to get it across that some of the treatment that is on offer is inappropriate. Psychological therapies and talking are sometimes just as important as medication.

As you can see, I am quite impassioned when I speak about advocacy. Finally, let me say that I know that certain parts of Scotland—they are known to me because I live in them—

The Convener: Is that a hint, then?

Jim Kiddie: In certain parts of Scotland, there have been struggles to secure advocacy. The attitude of the statutory authorities is that they will not provide advocacy because they are not required to do so and do not believe in it anyway. That kind of attitude must be overcome. One way of doing so would be to provide a right to advocacy in the bill. Otherwise, authorities will opt out, as they do at present.

Mary Scanlon: My final point is about joint working between national health service bodies and local authorities. That was mentioned in the Royal College of Psychiatrists evidence, which talked about out-of-date thinking. Does the bill perpetuate the divisions between the NHS and local authorities? Given the fact that the responsibilities that are placed on local authorities are quite separate from those placed on the NHS, does the bill place the emphasis on the provider rather than on the user of the service?

12:15

Bruce Millan: That can be argued, but the bill imposes duties on both sides of the divide—it is not, or should not be, a divide—to co-operate with each other. There is a legal duty to co-operate unless another responsibility does not allow it. Those are strong statements in the bill. They must be considered in detail.

We must look behind the bill. We must ask the Executive what it will mean in practice. What is the care plan? That has not been mentioned this morning—I do not think that the phrase has passed anyone's lips. Will the plan be a genuine care plan—all authorities have to be involved in it—or will it be a series of bland, generalised statements that could apply to all sorts of patients and not only to the individual with whom it is meant to be concerned? That must be examined, as it is not clear from the bill. I am not saying that the bill is defective, but we must look behind what the bill says about the care plan. We must get some assurances about how it will work in practice. The same applies to advocacy: how will it work in practice?

The care plan is an important new element. The tribunal must have the care plan in relation to compulsion; it cannot decide on compulsory detention or compulsory treatment without examining the care plan to determine whether it is adequate for the patient's needs. How do we decide whether it is adequate? Will there be guidance on that? Even on points on which the bill is okay—I am not criticising it; it is a good bill in many ways—we must look behind it and ask how it will work in practice.

The Convener: We will have to wind up at that point, simply because we are running out of time and we have another witness to hear from. If you have anything that you are burning to say to us, say it now. You have about a minute and a half.

Jim Kiddie: I made a submission about the name of the bill, on which others have commented. Scotland has a chance to give a lead to the rest of Europe. I commend to you the statement made by Gregor Henderson, whom the Scottish Executive appointed to develop positive mental health and well-being initiatives. He was asked:

> "So with a new Mental *Health* Bill imminent which is

essentially about the treatment of people who have reached a certain stage in their illness is there a contradiction at the heart of health policy?"

He replied:

> "I think the danger with the Bill is one of language. People continue to associate mental health with illness, risk and dangerousness. I think we need to stop doing things in policy and implementation terms that could be seen to be perpetuating those mythologies. We would like to see some further discussion about the name of the Act."

So would I and I hope that the committee would, too. I commend to you the "mental disorder bill".

The Convener: Thank you for that. I thank you for your written and oral submissions.

Our next witness is Dr Coia from the Royal College of Psychiatrists. Good morning—is it still morning? I mean good afternoon; sorry, we have dipped over into the afternoon. If Dr Coia will make a short statement, that will be helpful. We will ask questions afterwards.

Dr Denise Coia (Royal College of Psychiatrists): I will be brief, because I am in the unusual position of agreeing with most of what people have said today. I will probably reiterate some comments, because they are important.

The Royal College of Psychiatrists strongly welcomes the Mental Health (Scotland) Bill. It is based on sound principles from the Millan committee, particularly those of safeguarding patients' rights and increasing the flexibility to manage people who are detained, which is the important principle for us.

Along with everyone else, I make a plea that the bill is so important and so excellent that we would hate it to run out of time before enactment because of disagreements on specific matters. The European Commission recently commissioned a survey of all mental health legislation in Europe, which the Central Institute of Mental Health in Germany completed. The proposed Scottish bill is so far ahead of most European legislation that it is important that we implement it.

I will reiterate what my predecessors said. One of our key concerns about the bill is that it does not contain the three key principles of non-discrimination, least restrictive alternative and reciprocity. The reasons for putting those principles in the bill are important. The principle of non-discrimination allows people to retain the same rights and entitlements as people with other health needs have. The bill should not become a public order act—that is the major problem with the proposed English mental health bill.

We urge the committee to include a reference in the bill to the principle of the least restrictive alternative, because in the past 15 years psychiatry has reduced its beds and moved patients into the community. About 98 per cent of our acute services are managed in the community and it is appropriate that we develop proper community care.

We are concerned that the bill does not deal with entrapped patients in Carstairs. We caution the committee that, as has been said, allowing for legal action to move patients out of Carstairs will mean only that beds are taken away from non-detained patients. Last week, 10 patients from south Glasgow were boarded throughout Scotland. They are non-detained patients, so that service will be removed from them if we cannot manage patients in the community.

Reciprocity is a vital principle, because it protects patients' autonomy. It is vital in preventing the misuse of psychiatry to control social problems.

For those reasons, it is important that those principles are in the bill. They put down a commissioning marker to health boards and local authorities to provide resources and services.

We support the definition of mental disorder but would like the exclusion criteria that were in the draft bill—particularly those on alcohol, sexual orientation and deviance, and political and religious beliefs—to be in the bill, because those matters do not fall within the remit of psychiatric services.

We support the introduction of compulsory treatment orders because community services are the main locus for treating our patients. As part of the shift towards that direction of care, there has been a sharp reduction in the number of in-patient beds throughout Scotland, without the resources from those in-patient beds going to community services. The shift was appropriate because we can manage to treat and maintain most patients in the community.

I commend to members the idea of thinking of a four-tiered system when mental health services are commissioned, which involves primary care mental health services, community mental health teams treating the more severe end of the spectrum, intermediate services that provide crisis teams and assertive outreach, and in-patient beds. For each locality in the Glasgow area with a population of 40,000, those services are in place and include five in-patient beds.

We are talking about a small number of in-patient beds, which is why we think it important that we should have the tools at our disposal to allow us to manage a large number of patients—who would otherwise come under detention orders—with treatment orders in the community. If we do not go down that route, we will have to consider opening up additional in-patient beds, as the current level would not be able to cope with pressure.

People have talked about resources ad nauseam. I re-emphasise that the detention process will greatly increase the work load for doctors and mental health officers. We will have to think cleverly about ways of managing that work load. As has been said, we will not just grow new consultant psychiatrists. However, there are many processes that would allow us to manage things in a way that will deliver what the bill intends. If the financial memorandum allowed some flexibility, we could have consultants who, by giving up other things, would be able to focus on delivering what the bill intends. That is a short-term answer; in the longer term, we will have to increase the number of general adult psychiatrists.

We support the idea of mental health tribunals. We feel that we have a responsibility to make them work, despite some of the problems that will arise. The funding mentioned in the financial memorandum is for revenue costs of the tribunals; it is not for any kind of capital funding. We are unclear about where such funding will come from. Where will the money for buildings or offices come from? Acute in-patient services for psychiatry have wards, but they do not have any other facilities. All other assets have been stripped.

We find it puzzling that the health board and local authority functions are laid out separately, because we have been moving towards joint funding, joint commissioning and joint delivery by health services and local authorities. Although there is a statement about local authorities, we are concerned about the assumption that health boards will fulfil and finance their responsibilities under national health service legislation. We would like the bill to spell that out much more clearly, because there is a long history of mental health moneys in health boards being diverted into acute care.

We will have to take into account the impact of the joint future agenda. The agenda is excellent—it joins health boards and local authorities—but it has caused problems in mental health services. There has been a lack of understanding that, in psychiatry, we are delivering acute services in the community. Some of the joint future agenda has not allowed us to do that.

We strongly support advocacy services. As Jim Kiddie says, they are extremely important in enabling vulnerable people to make choices at a difficult and distressing time. However, although we have no particular view about there being a right to such services, we would caution that any such right should not detract from the development of advocacy services for non-detained patients. My concern is not about resources; it is about providing the work force to man advocacy services.

The Royal College of Psychiatrists is concerned that the bill provides for no specific duty of care for adolescents. Over the past two months in the Glasgow area, we have admitted adolescent in-patients to adult wards. I will give two examples. One young lady, having taken too many substances over the weekend, and having become psychotic and developed paranoid delusions, found herself, at the age of 18, in an adult in-patient unit in Glasgow. We think that that is a frightening and distressing experience. Similarly, when young people who suffer from schizophrenia experience the first episode in their life of what is a serious mental illness, they are frightened, distressed and concerned. A very disturbed adult unit, often with violent and aggressive male patients, is not the place to be at that point in time. We would very much welcome a duty of care.

12:30

The Convener: I concur with that. Bill Butler, Dorothy-Grace Elder and I were at Parkhead hospital last week. The issue of adolescents—I think that a 15-year old was in an adult ward—was raised with us.

You have answered some of the questions, so I may bounce about a little bit more than I have previously. We will start with Bill Butler.

Bill Butler: Dr Coia, in general terms what do you think the implications of the bill are for psychiatrists' practice and work load? You said that, in the short term, you will have to think cleverly and use lateral thinking about ways of managing the work load, as it will not be possible to meet immediately the need for the 18 to 28 additional psychiatrists that you mention in paragraph 5 of your submission. You also mention space, funding and personnel for tribunals. Will you elucidate?

Dr Coia: We must consider a number of issues. Time scales are mentioned throughout the bill. Members will notice that the time scale is often "as soon as practicable". The time scale must be much more clearly spelled out. For example, if it is a 24-hour period, that will bring into play doctors' terms and conditions in respect of the European working time directive and the new consultant contract under which consultants must, for example, take time off the next day. That will mean cancelling patient clinics at short notice.

I talked about being clever about managing the work load. I think that in large conurbations, it would be sensible to have one or two psychiatrists pulled out week on week to deal with tribunals and give second opinions. That will be possible in Glasgow and Edinburgh, but it will not be possible in the Highlands and Islands. There are major implications for the work force in the rural areas of Scotland in relation to the provision of back-up cover.

Psychiatrists are currently split between hospitals and the community. There is increasing concern—which is why adult psychiatry is currently not a popular option—that perhaps we are being dragged by the joint future agenda into a number of areas where our skills are not required and where the job could be done better by voluntary organisations or by lower-skilled community teams. We feel that we need a forum to discuss much more openly what community care we can deliver at the same time as trying to deliver the bill.

The other point on being clever about the work force is that, often, simple matters such as providing modern technology, back-up administration and good medical records departments can take hours off people's working days. The bill will have major implications in terms of the working time directive.

Janis Hughes: In your submission, you mention detention. Could the proposals in the bill whereby emergency detention is not necessary and people can go straight to short-term detention lead to people being in hospital or in care for longer?

Dr Coia: It is difficult to tell, but I think that, on balance, the answer is yes. In theory, that should not be the case—if someone is brought in for 28 days, rather than three days, one would think that they could be taken off the detention. However, in practice, the proposals could lead to people being kept in for longer. There is a world of difference between waiting for three days and seeing that someone is getting better—at which point the section is finished anyway—and a 28-day section, during which the psychiatrist would have to say that they were actively taking the person off the section. If the person leaves the hospital and kills themselves or someone else, the psychiatrist who took them off the section might fear the comeback, although that is not a good reason not to act. The Millan committee firmly pushed psychiatrists to use the 28-day section rather than the three-day section. We support that, although there will be some tendency towards caution and safety, which, in the practical world, may lead to increased time in hospital.

Janis Hughes: But you still support the proposal.

Dr Coia: Yes, we still support the proposal.

Mary Scanlon: Do you think that the bill's provisions for the duties of health boards are adequate? I am looking at the issue from the joint-working point of view. You say in your submission that you find it puzzling that health board and local authority functions are laid out separately.

Dr Coia: We have grave concerns about the fact that the bill does not include a duty of care for health boards. Without a duty of care, health boards will not be pushed towards commissioning community services. The bill states that local authorities will provide social care and housing but it does not talk about the acute psychiatric services that we are delivering. We deliver those jointly, with social workers in the teams, but health boards have a responsibility for putting the crisis teams, assertive outreach teams and home support teams into the community. At present, with the exception of some health boards, we are not seeing a great deal of evidence of that, as Jim Kiddie pointed out.

Mary Scanlon: I wondered whether the bill addresses that. You also say:

> "there is a long history of mental health monies in Health Boards being diverted into acute sector care".

You raise concerns about local authorities providing services. What should the committee do to ensure that local authorities and health boards provide the requisite and appropriate amount of money for services for people with mental illness?

Dr Coia: There is only so little that one can do about that.

Mary Scanlon: But money has been allocated.

Dr Coia: Allocating money is fine, but establishing a duty of care that commissioners will take notice of is much more important. It is difficult to ring fence or hypothecate money; it is easier to put money into programmes, as some health boards have started to do. There might be a programme for acute services and a programme for community and mental health services. Although money could be moved from one programme to the other at times, that would be difficult. We have found that health boards that have moved to programme commissioning have provided more resources.

Mary Scanlon: Is the bill a bit out of date and old-fashioned, given that the responsibilities of local authorities and health boards are still separate? Should more have been done to merge those responsibilities?

Dr Coia: It is old-fashioned. In several health board areas there is now a joint commissioner for mental health services, who jointly commissions both community and in-patient services. In some parts of Scotland, there are also joint managers who manage both health and social work staff. Through the joint future initiative, that is the way in which we are moving, and the college feels that that is the way in which mental health services should be moving.

Mary Scanlon: So, the bill could be a retrograde step from what is being developed on the ground.

Dr Coia: Yes. Unfortunately, it goes in the opposite direction at some points.

Mary Scanlon: That is sad.

Mr McAllion: We have heard one of the criteria for compulsion described as extremely vague, and there have been complaints that other criteria that were recommended by the Millan committee are missing completely from the bill. What is the view of the Royal College of Psychiatrists?

Dr Coia: Sorry, I do not understand your question.

Mr McAllion: I am asking about the criteria for compulsion in the bill. We have heard various views about the inadequacy of those criteria. What is the view of the Royal College of Psychiatrists?

Dr Coia: We feel that the criteria for compulsion are adequate. Impairment to the making of decisions is an important criterion. It is also important that personality disorder, which has been mentioned this morning, is included among the mental disorders that are listed in the bill. A sub-group of personality disorder is borderline personality disorder, and many people who have borderline personality disorders add to them a combination of alcohol and other drugs, and develop temporary psychotic disorders. Often, they develop paranoid delusions and have to be admitted to hospital, usually to be detained. We feel that such disorders should be included in the criteria.

Mr McAllion: Do all the criteria that are listed in the bill have to be met before compulsion can be used against a patient?

Dr Coia: The only criterion that would not have to be met all of the time is risk. Risk to oneself is important, but not always risk to others. That said, psychiatrists want to ensure that all the criteria are met.

Mr McAllion: Can someone who suffers from a mental disorder and who is a risk to either himself or herself or others make decisions?

Dr Coia: The answer is yes and no.

Mr McAllion: Surely it cannot be both.

Dr Coia: The issue is complex and difficult. Most psychiatrists would say that people who have severe mental illnesses of the sort that Mr McAllion mentioned have a degree of cognitive impairment. For that reason, they are not able to make competent decisions at that point.

That view is backed up by a lot of recently published neuroscientific research, which shows that there is a great deal of cognitive impairment in those with neurological and psychiatric conditions. The research has spawned a whole field of bioethics. Three years down the line, we may be able to answer your question much more competently than we can at present.

Mr McAllion: The bill will become an act in six months' time. It will affect people in the community.

Dr Coia: Yes.

Mr McAllion: I want to be clear. Someone who suffers from a mental disorder and who is a threat to themselves or to other people, but who has insight and is able to make decisions, cannot be detained compulsorily?

Dr Coia: I would think that the vast majority of psychiatrists in the real world—the practical world—would say that that person had a degree of cognitive impairment. They would therefore say—

Mr McAllion: Given the provisions of the bill, would the mental health tribunal agree?

Dr Coia: I do not know.

Mr McAllion: So we are taking that risk.

Dr Coia: It is a risk.

Dorothy-Grace Elder: How does the principle that compulsory treatment can be administered only if it is likely to confer a benefit on the patient fit in with the inclusion of personality disorder and learning disability in the definition?

Dr Coia: The research evidence on personality disorder shows that there are no appropriate treatments for a large number of those people. However, a number of treatments confer benefit for groups of patients who have anti-social personality disorders. For example, long-term psychoanalytical therapy has some benefit, although that treatment is not available widely in Scotland.

I agree with Jim Kiddie that, for the vast majority of people with personality disorders, social support and psychological interventions that reduce their harm-seeking behaviour can be enormously effective. Long-term support and a range of psychological interventions can take away the distress and the self-harming behaviour of many people who are treated by the psychiatric services. The treatment may not provide a cure, but it certainly alleviates some of the problems and leads to less destructive behaviour. I think that there is a role for compulsory treatment for those with personality disorders.

Dorothy-Grace Elder: People with a learning disability may also have other problems. I assume that that co-morbidity would mean that their learning disability would not be taken in isolation.

Dr Coia: No, not at all. About 50 per cent of people with a learning disability might develop a psychiatric disorder at some point in their lives.

Compulsory treatment for those people would attach to the co-existing psychiatric disorder.

Dorothy-Grace Elder: Members of the public should not be misled about that.

Do you agree with the strong views expressed by Jim Kiddie and others that there should be a right to advocacy?

Dr Coia: I do not have a passionate view on that. We would welcome a right to advocacy. However, I echo what Jim Dyer said at the beginning of the meeting. The most effective approach is to persuade local authorities and health boards to provide advocacy services by making strongly worded recommendations to that effect.

12:45

Dorothy-Grace Elder: That is not the same as saying that patients have a right to advocacy.

Dr Coia: No, it is very different from that.

Dorothy-Grace Elder: Why do you take that line?

Dr Coia: I do not feel strongly one way or the other about patients' having a right to advocacy. I would not be unhappy if the bill gave patients a right to advocacy services. However, I am keen that such services should actually be provided.

Dorothy-Grace Elder: Do you not think that giving patients a right to advocacy services would impel bodies to create those services?

Dr Coia: I hope that it would.

Mary Scanlon: Should patients in the state hospital have the right to appeal against their level of detention?

Dr Coia: Yes. We have grave concerns about patients' being entrapped within the state hospital. Such patients should have a right of appeal.

Mary Scanlon: Over many years we have heard about bedblockers and entrapped patients in the state hospital. Could we insert a provision in the bill to alleviate those problems? Is there something missing from the bill?

Dr Coia: I am not sure that there is anything further that could be added to the bill. It is important that the principle of the least restrictive alternative should be enshrined in the bill. That would make it possible for the college, when arguing against entrapment in the state hospital, to point out that the term "least restrictive alternative" appears in the bill. That is the way forward.

Mary Scanlon: Is it just a matter of time before one of the patients in Carstairs launches a challenge under the ECHR, along the lines of the Ruddle challenge?

Dr Coia: That is probably the case.

Brian Adam: Does the college foresee concerns arising from cross-border issues, if the proposed English bill is passed in its current form?

Dr Coia: Yes. There are grave difficulties. Someone of Scottish descent who has a personality disorder but no co-existing difficulties—for example, with alcohol or drugs—could be detained in England and transferred back to Scotland. At that point the person could be released from detention, because they would not meet our criteria.

Brian Adam: Do you suggest remedies that ought to be considered?

Dr Coia: The college has suggested many remedies to the Department of Health.

The Convener: So the remedy is not in our hands. For once, it is not our fault.

Dr Coia: No.

The Convener: Mr Kiddie made a point about the title of the bill. Do you have any burning feelings about that?

Dr Coia: Mr Kiddie made an important point about the need to understand that the bill is about mental disorder and mental illness. There is a great deal of confusion between the bill and the public mental health initiative in Scotland, which is excellent, but which is about social inclusion, social justice and supporting communities in Scotland. As psychiatrists, we are part of the consortium that is responsible for the initiative, but we see that work as very different from treating mental illness in the community. As I said, there is confusion in the joint future agenda. I support what Mr Kiddie said.

The Convener: Thank you for your written and oral evidence. That brings this evidence session on the Mental Health (Scotland) Bill to a close.

Chronic Pain

The Convener: The next item on our agenda is consideration of the Scottish health boards' response to our questionnaire on chronic pain. I suggest that we postpone that until a later meeting.

Dorothy-Grace Elder: When you made that suggestion earlier, I rashly agreed with you and thought that it was perfectly sensible. However, I have just checked and next week we must finish by 11.40 at the latest because of our hospital visit in the afternoon. The following week, there are four sets of witnesses and, unfortunately, I must leave that meeting slightly early, as there is a family engagement that I cannot avoid. The recess is approaching and health professionals are meeting the minister again in mid-October. It would be beneficial if we could discuss the matter before they meet the minister. Is there any way round that? The discussion will not take long—perhaps only 10 or 15 minutes. I crave the committee's indulgence.

The Convener: Let us discuss the matter for 10 minutes and that will be that.

Dorothy-Grace Elder: Thank you—I appreciate that.

I speak on behalf of the cross-party group in the Scottish Parliament on chronic pain, which I convene, and on behalf of some members of the committee. Kathleen Robson has produced a fine piece of research, which confirms in detail what we knew. Chronic pain services are short-changed and some things that happen are scandalous.

As we know, roughly 550,000 people suffer from chronic pain in one form or another. They may have spasmodic, regular, constant chronic pain or another form of it. We now know that only 47 whole-time equivalent health professionals in the whole of Scotland work with chronic pain. Only three of the 14 boards that responded to the questionnaire have a pain management programme, which is the yardstick. Roughly speaking, if the boards have not said that they have a pain management programme, that means that they do not have a proper pain service at all.

That patients are being shunted around the country is utterly unacceptable and borders on the inhumane. Boards admit that they send patients to England. Argyll and Clyde NHS Board sends more than 120 patients a year to Glasgow and England. Eleven out of 14 boards said that they send people to other areas. Borders NHS Board sends patients to Liverpool; Grampian NHS Board sent patients to England and Glasgow; and Tayside NHS Board sends patients to England. Tayside has good services, as does Lothian. Greater Glasgow NHS Board has 215 pained travellers, including patients from the Highlands, Ayrshire and Arran and Dumfries and Galloway.

Waiting times are outrageous at Glasgow southern general hospital—55 weeks is quoted. Someone in pain must wait one year and three weeks to see a consultant for the first time. The average Scottish waiting time is 16 weeks. The few services of excellence in Scotland are being overstrained and dragged down by the number of patients that they must take from other areas.

Had we existed half a century ago, many board attitudes might have been referred to us. No board had carried out a needs assessment of people with chronic pain in their area or could supply figures that would give us an estimate of total chronic pain funding in Scotland.

The paper states:

> "Very few of the Board areas provided funding specifically for professional training in chronic pain."

Many nurses and physios must pay for such training themselves. Only Greater Glasgow NHS Board has a substantial programme, and it has been confirmed again that Highland NHS Board has absolutely nothing, even for young people.

The boards are exceptionally mean with the voluntary sector, which has only around £13,000—

The Convener: Other members want to speak.

Shona Robison: What are the recommendations?

The Convener: The paper that pulls together the health boards' responses does not include a set of recommendations or proposals. I recommend that we send the paper to the Executive for its response. Bear in mind that we have said in our budget proposals that the issue should be considered. We can return to it during the next part of the budget process.

With respect, the points that Dorothy-Grace Elder is making are contained within the paper. The paper is good, but it does not include a set of recommendations or proposals. At this stage, we have to send it to the Executive for comment. When we receive those comments, we can make recommendations and proposals. They could form part of our budget proposals.

Dorothy-Grace Elder: May I also submit a paper that I have done that pulls together some of the information? Would you consider referring to the decision that the committee made in mid-May, which was to ask the Finance Committee for funding for comprehensive chronic pain services throughout Scotland? It would be excellent if you could state that in the letter to the Executive.

The Convener: That is the point that I have just made. We can state that in the letter and return to the issue. Are members agreed?

Members *indicated agreement*.

Shona Robison: Can we put a short item on the agenda for the next meeting of the Health and Community Care Committee for an update on the interim report on the expert group on hepatitis C?

The Convener: I have spoken to the clerks. A letter is being sent from me to the minister asking what is happening. I understand that the report will go to the Cabinet in the next week or week and a half.

Shona Robison: Can we have a short response to that at our next meeting?

The Convener: Yes.

Dorothy-Grace Elder: Is it all right for me to send the questionnaire returns that Kathleen Robson has compiled to some of the doctors and health professionals who have a special interest?

The Convener: Yes, it is a public document.

Dorothy-Grace Elder: They could also give us their comments.

The Convener: Yes.

Meeting closed at 12:56.

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