HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 2 October 2002
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
24th 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)
Mr Tom McCabe (Hamilton South) (Lab)
Ben Wallace (North-East Scotland) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Dr Jacqueline Atkinson (Adviser)

WITNESSES

David Hewitson (British Association of Social Workers)
Dr David Love (British Medical Association)
Dr Donny Lyons (Royal College of Psychiatrists)
Ruth Stark (British Association of Social Workers)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

LOCATION

Chamber

Scottish Parliament

Health and Community Care Committee

Wednesday 2 October 2002

(*Morning*)

[THE CONVENER *opened the meeting at 09:32*]

Item in Private

Convener (Mrs Margaret Smith): Good morning and welcome to this morning's Health and Community Care Committee meeting. We have received apologies from Bill Butler.

Item 1 is to consider whether to discuss in private item 5, which relates to witness expenses. Do members agree to take item 5 in private?

Members *indicated agreement*.

Subordinate Legislation

Nursing and Midwifery Student Allowances (Scotland) Amendment Regulations 2002 (SSI 2002/423)

Food (Figs, Hazelnuts and Pistachios from Turkey) (Emergency Control) (Scotland) (No 2) Regulations 2002 (SSI 2002/424)

The Food (Peanuts from China) (Emergency Control) (Scotland) (No 2) Regulations 2002 (2002/425)

The Convener: There are three pieces of subordinate legislation for our consideration this morning. They are subject to negative procedure.

No members' comments have been received on the regulations and the Subordinate Legislation Committee had no comments. No motions to annul the regulations have been lodged. The recommendation is that the committee does not wish to make any recommendations on the instruments. Is that agreed?

Members *indicated agreement*.

Mental Health (Scotland) Bill: Stage 1

The Convener: We move on to the substantial part of the meeting in which we will take evidence on the Mental Health (Scotland) Bill. Our first witness is Dr David Love, who is the joint chairman of the Scottish general practitioners committee of the British Medical Association. I welcome Dr Love to the meeting. Do you want to make a short statement, after which we will ask you questions, or will you move straight to questions?

Dr David Love (British Medical Association): I am content to proceed straight to questions.

Janis Hughes (Glasgow Rutherglen) (Lab): Does the general practitioners committee agree with the general principles of the bill? Has there been adequate consultation of your organisation on the content of the bill?

Dr Love: Yes. We agree with the principles of the bill and feel that there has been adequate consultation.

Janis Hughes: Is it acceptable for the principles of the bill to be set out as they are at present or would you rather see them included in the bill?

Dr Love: We feel that it would be preferable for the principles to be included in the bill. That would set the bill in context.

Nicola Sturgeon (Glasgow) (SNP): Do you think that the section 31 provisions for emergency detention are appropriate?

Dr Love: Yes. They mirror fairly well what happens at the moment and describe satisfactorily the situation in which the power might be used appropriately.

Nicola Sturgeon: Are the provisions in section 31 reasonably understandable?

Dr Love: As a general practitioner, I am quite happy with the description that is given in the bill.

Shona Robison (North-East Scotland) (SNP): On page 2 of your submission you talk about your concerns about getting access to mental health officers, especially in an emergency and specifically outwith normal working hours. Do you have any suggestions, other than having more mental health officers, of ways in which that problem could be addressed? The Royal College of Psychiatrists has suggested that a code of practice should require that local authorities provide a simple mechanism for medical practitioners to find and consult mental health officers. Do you agree with that view?

Dr Love: GPs are not familiar with the means of getting in touch with mental health officers as they rarely use the procedure, so the process can take a lot of time and several phone calls. It would be helpful to have clear guidance in each area that would detail how to contact a mental health officer efficiently. Once the mental health officer has been contacted, there are problems with getting speedy attendance, due to the mental health officer work force provision. That is a particular problem in rural areas, where there are long travel times, and in any area if the mental health officer is required in an emergency situation out of hours. Often, patients are sectioned without the consent of the mental health officer, not through the choice of the GP, but because of the constraints inherent in the system.

Mary Scanlon (Highlands and Islands) (Con): Section 32 places a requirement on GPs to notify a number of people about various matters after authorising emergency detention. Do you think that a seven-day deadline for doing that is realistic?

Dr Love: We would prefer it if all the information required as a result of the emergency detention were gathered at the time. Obviously, we are concerned about paperwork and bureaucracy and would like to keep that to a minimum, but we accept that depriving someone of their liberty by means of an emergency detention order requires justification. If the information were collected at the time, there would be no need for a subsequent report. That is particularly important if you consider out-of-hours situations, in which patients are often attended by out-of-hours co-operatives, which may well be employing locums who are not the patient's GP. Locums, by their nature, are mobile and difficult to track down. In those situations, it might be quite difficult for locums to comply with the requirements in the bill.

Mary Scanlon: Page 2 of the submission from the Royal College of Psychiatrists talks about bureaucratic responsibilities and issues of confidentiality. How could the administrative burden be simplified? Could a standard form that captures all the relevant information be created? Should hospital managers issue to the GP who has granted the certificate a form that they must return to the hospital and which would then be passed to the Mental Welfare Commission for Scotland? Is either of those suggestions helpful?

Dr Love: On the issue of confidentiality, as I said, GPs will not use the procedure often and will therefore not know to whom in the local authority to send the form. The instruction is vague. Further, in rural areas, where everyone knows everyone else, there would be great concern about informing a local authority that someone has been subject to an emergency detention order.

We would prefer all the required information to be on the form that accompanies patients during

the emergency detention process. Hospital authorities could copy that form and pass it on to interested parties. That would solve the problem of that task being expected of a locum, who might move out of the area after a couple of days.

Mary Scanlon: Are you saying that, under the General Medical Council's rules and guidance, you would not be allowed to pass on patient information to a local authority, or that that would not be good practice?

Dr Love: If that were required by law, the GMC would be understanding, but such a task would still cause GPs discomfort. The simple way around that is to pass the information on to hospital authorities, which can pass it on under their obligations.

Nicola Sturgeon: I was struck by the view in your submission that part 5, which contains the emergency detention provisions, might be used as

"a portal for assessment under Part 6",

which deals with short-term detention. Why do you have that fear?

Dr Love: Emergency detention and short-term detention are such important measures that patients should be fully assessed and, ideally, assessed by a psychiatrist before those measures are taken. In an ideal world, we would not use emergency detention—we would use only short-term detention, which involves assessment by a psychiatrist.

Emergency detention procedures are used because of the lack of capacity in the psychiatry service to respond quickly in emergencies. GPs are left with no alternative but to use the emergency detention procedures, rather than the ideal, which would be having a patient assessed by a psychiatrist before compulsory detention.

Nicola Sturgeon: That is a worry about resources, rather than a fear that the bill might exacerbate the over-reliance on emergency detention.

Dr Love: It would help if the code of practice said that when compulsory detention is being considered, ideally part 6 procedures should be used and that part 5 is less preferable. However, the choice of which part to use is often dictated by service provision considerations.

Mr John McAllion (Dundee East) (Lab): You suggest that when GPs cannot have a patient seen by a psychiatrist, they use the emergency procedure to deal with a crisis. After a patient has been detained for 72 hours under the emergency procedure, could they still not have seen a psychiatrist and be released back into the community or discharged?

Dr Love: I hope that that situation is unusual. I have never come across it. If the emergency detention procedure is used, the patient is usually removed to a psychiatric hospital within a few hours. It is almost unheard of for such a patient not to see a psychiatrist within the 72 hours once they are in a hospital. The problem is getting a psychiatrist to see a patient in an emergency in the community, before that person goes to hospital.

Mr McAllion: Is there no possibility of a psychiatrist in a hospital being overwhelmed by, and unable to cope with, the emergency admissions that GPs have sent?

Dr Love: I hope not. GPs use emergency detention procedures infrequently. The average volume of patients admitted each week under section 24 of the Mental Health (Scotland) Act 1984 is small.

Dorothy-Grace Elder (Glasgow) (Ind): At least in theory, section 19 leaves the door open to non-psychiatrists, including GPs, authorising short-term detention. Do you expect that to happen frequently? If so, would that be appropriate?

Dr Love: I am sorry—which section are you referring to?

09:45

Dorothy-Grace Elder: Section 19, which is in part 4 on page 10 of the bill, under the heading "Approved medical practitioners".

Dr Love: Approved medical practitioners will generally be psychiatrists, not GPs.

Dorothy-Grace Elder: But section 19 does not make that clear, does it? Furthermore, section 35 says that the person carrying out the medical examination must be an "approved medical practitioner", but it does not spell out that the practitioner must be a psychiatrist. Do you interpret section 19 as meaning that the practitioner must be a psychiatrist?

Dr Love: Yes, certainly. I think that, somewhere, it says that special training is required before someone is approved. The average GP will not be an approved medical practitioner.

Dorothy-Grace Elder: Is there much special training for GPs at present?

Dr Love: Very few GPs would meet the criteria in the bill to be an approved medical practitioner.

Dorothy-Grace Elder: Should section 19 of the bill be made more specific and include the word "psychiatrist"? At present, section 19(1) begins:

"A Health Board shall compile and maintain for its area a list of medical practitioners who—

(a) have such qualifications and experience".

However, it does not specify that those practitioners must be psychiatrists.

Dr Love: It would be helpful to have that explained and clarified. That could be done in the code of practice. However, very few GPs will be approved medical practitioners. There may be value in leaving some flexibility to cover the situation in rural areas, where it may be sensible for a GP to undertake appropriate training to become an approved medical practitioner. That could well ease the problem of service delivery in remote areas.

Dorothy-Grace Elder: When we visited a hospital in Glasgow, we heard about the severe shortage of general psychiatrists. In your view, is the shortage of psychiatrists in Scotland severe or moderate?

Dr Love: The shortage is significant. The latest figures show that there are 30 consultant vacancies at present and that 20 per cent of those have been vacant for more than six months. The additional number of psychiatrists that will be required to meet the additional work load caused by the new tribunals has been estimated at between 18 and 28. However, the Royal College of Psychiatrists will be in a better position to inform the committee.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I would like to ask Dr Love for some clarification on his submission. On page 2, the first paragraph on short-term detention indicates that, at present, patients who are periodically reviewed for a short-term detention are not necessarily reviewed by a psychiatrist. You say that that

"does not allow the patient sufficient protection."

What do you mean by that?

Dr Love: The paragraph refers to the sort of situation where, for example, a patient has taken an overdose and has required medical treatment for the effects of that overdose. The patient would obviously require psychiatric assessment and supervision. At present, the procedure is that the non-psychiatrist consultant in charge of the patient is designated as the responsible medical officer. We feel that it would be preferable for a psychiatrist, working in association with the medical unit, to be so designated. That would give the patient the benefit of having expert assessment of their problems.

Margaret Jamieson: In my area, we have psychiatrists on call for accident and emergency. Does that not happen elsewhere in Scotland?

Dr Love: It happens variably throughout Scotland, although it should be the norm. The point is that the designated responsible medical officer should be an on-call psychiatrist who can give an expert assessment of a patient's mental disorder, not a consultant who does not have psychiatric expertise.

The Convener: During our visit to Parkhead hospital in Glasgow, we heard anecdotal evidence that there is a difficulty in detaining or compelling homeless people or people who live in hostels who exhibit mental health problems that require treatment. Such people usually do not have a GP. Do you agree that that is a problem, or do GPs deal with it at present? Will the bill address that problem and, if not, how might it be addressed?

Dr Love: The bill will be a huge advance on the present situation. The present problem is that we have to use the procedures of section 18 of the Mental Health (Scotland) Act 1984, under which, as a default, the patient's GP should be involved. The new proposals on compulsory treatment orders in part 7 of the bill make it clear that two psychiatrists can carry out the procedure. There is an option for the patient's GP to be involved, but that is not a necessity. At present, problems can arise in out-of-hours situations when locums are involved, if the GP does not know the patient, or if the patient has recently arrived in an area and does not have a registered GP. Those situations have been a barrier to providing care and treatment for some patients. The proposals in part 7 will be extremely helpful.

Mary Scanlon: Page 3 of your submission states:

"In the context of emergency or immediate care, we are concerned by … Section 198 and the powers of the police to remove a person to a place of safety that might be an undefined hospital. This should be more carefully considered and defined. It would be inappropriate, but it may not appear so to a police officer, to remove a person to a community hospital or even a paediatric hospital."

Will you clarify that?

Dr Love: If a police officer finds a person in a public place who is a danger to themselves or others, the officer will have an obligation and the authority to take that person to a place of safety, which is simply defined as a hospital. At present, disturbed patients are sometimes taken to hospitals such as long-stay geriatric hospitals and left there. Disturbed people often wander and must be supervised by staff while they await the appearance of a psychiatric team, which, in rural areas, can take a considerable time. During that time, a member of staff will often be tied up with the patient, who has been placed in an inappropriate hospital, which is to the detriment of the care of the patients in that hospital.

Our suggestion is that the definition of a place of safety should not be as open as simply a hospital. The explanatory notes to the bill describe a place of safety as a psychiatric hospital. It would be a good idea for each health board to produce a list

of suitable hospitals that the police can consult so that they do not take patients to inappropriate hospitals. That tends to be more of a problem in rural areas, but it is a major problem when it happens. Under the present legislation, the police have fulfilled their obligations by taking a patient to a hospital. Often, the police do not stay in attendance and it is up to the hospital staff to cope with the patient.

Mary Scanlon: The point is important. I was out with the police on Saturday night. They cannot make judgments about people's psychiatric condition. Do you feel that adequate guidance and protocol has been given to ensure that the police act correctly? The police are in a difficult situation because they have not been trained to deal with such people. Should we amend the bill to ensure that people are not taken to an inappropriate place?

Dr Love: Yes. Police officers have to make a judgment, and in taking a person to a place of safety, they have made, in effect, a judgment that they are not dealing simply with someone who has committed a criminal act. Rather, they suspect—as best they can, without having received special training—that the person may be suffering from a mental disorder. The officers rightly feel that, rather than put the person in the cells, they should take them to a more appropriate place. The bill at the moment refers simply to "a hospital", but we need to give guidance to the police on what is an appropriate hospital. The word "appropriate" should possibly be inserted in the bill. The code of practice could define more fully what is meant by an appropriate hospital.

Margaret Jamieson: I seek clarification of the second paragraph on page 3 of your submission, which refers to compulsory treatment orders in the community. You state that such orders are appropriate provided that, in the absence of a specific local agreement,

"GP involvement with patients who are subject to compulsory treatment orders is restricted to the provision of General Medical Services when the patient is living at home."

What do you mean by that?

Dr Love: There is a slight problem, in that "responsible medical officer" is not clearly defined in the bill. The explanatory notes describe the "responsible medical officer" as

"The doctor with primary responsibility for a patient's medical treatment".

In the case of somebody who is subject to a compulsory treatment order and who is being treated in the community, the intention is that the responsible medical officer will be a psychiatrist who will supervise the patient's compulsory psychiatric treatment.

The difficulty is that when somebody is living at home it could be argued that a GP is the responsible medical officer, because they are primarily responsible for the person's medical treatment. That is true in all respects, other than with regard to specialised compulsory psychiatric treatment, which is the responsibility of a psychiatrist.

The definition of "responsible medical officer" needs to be clarified, because it is not clear and it could be interpreted as referring to a GP. I do not think that the intention is for a GP to supervise compulsory treatment orders, because that should be a specialist function.

Margaret Jamieson: But a GP would provide all the other medical services that the individual required.

Dr Love: Absolutely. If the patient has an intercurrent illness of whatever nature, their GP would continue to treat them. We are trying to distinguish between the normal treatment that GPs provide to somebody who lives at home—of course, people who are subject to compulsory treatment orders would continue to receive that treatment—and the specialised, compulsory treatment that is authorised by the compulsory treatment order, which should be supervised by a psychiatrist. In that context, the psychiatrist should be the responsible medical officer.

Margaret Jamieson: Is that distinction clear enough currently?

Dr Love: It is reasonably clear. I am not sure that there is a huge amount of experience of compulsory treatment orders as they are at present. I do not think that they are used extensively but, undoubtedly, under the new bill their use will be much more common.

Margaret Jamieson: But with individuals who suffer from drug addiction, for example, is it not true that in dealing with their abuse, GPs refer them to drug addiction services for other medical services, rather than deal with them themselves?

Dr Love: Yes. Practice varies according to the training and expertise of the GP. The difference with drug addiction services is that the patient generally participates voluntarily in a management programme. We are talking about compulsory treatment orders, where the patient is allowed to be treated in the community under strict conditions. That does not apply to the treatment of drug misusers.

The Convener: Would there ever be appropriate circumstances under compulsory treatment orders in which a GP in the community could be responsible for a patient's psychiatric medication?

10:00

Dr Love: That would be very unusual. Unless the GP had had special training, such a situation would probably be unacceptable to the patient. Because a compulsory treatment order represents a considerable restriction of a patient's freedoms, treatment should be supervised by people who have had specialist training. GPs are not trained to carry out that role. In patients' best interests, treatment should be supervised by psychiatrists.

Mr McAllion: The bill makes provision for individuals to make advance statements about how they wish to be treated or not treated in the event of their suffering from a mental disorder. Do GPs think that that is a good idea? If so, do they think that GPs should assist individuals to draw up such statements?

Dr Love: We have not thought deeply about that issue. Advance statements are important and must be heeded, but I am not certain that GPs should have a role in the production of such statements. It would probably be best for the individuals concerned to produce them in consultation with their friends and relatives.

The Convener: Thank you for your evidence.

I welcome Dr Donny Lyons from the Royal College of Psychiatrists. Dorothy-Grace Elder and I met Dr Lyons when we visited Parkhead hospital. Would you like to speak to your written submission, or are you happy to move straight to questions?

Dr Donny Lyons (Royal College of Psychiatrists): I would like to make one or two points about the submission, which I had to put together quickly to meet the committee's timetable. Some of the statements that I make in the submission reflect a quick read of the bill.

The Convener: I am amazed that anyone can read the bill quickly.

Dr Lyons: The submission was as detailed as I could make it within the short time that I had. After consulting colleagues, I have picked up one or two points in the submission that either reflect my lack of understanding of the bill or relate to issues on which we are not unanimous.

I refer members to my comments on the criteria for emergency detention in part 5 of the bill. I misread that part of the bill, but its wording could be made clearer. I suggested that the conditions set out in subsections (4) and (5) of section 31 should be listed together. I did not notice that one set of conditions may be satisfied, whereas the other must be satisfied. If I missed that, other people may do so as well.

I can cover other issues in response to questions.

The Convener: We will return to the issue that you just raised.

Margaret Jamieson: Are the criteria for authorising short-term detention in section 35 appropriate?

Dr Lyons: Yes. The decision-making ground—that a person's mental disorder affects his or her decision-making capacity—forms a crucial aspect of the bill. If the disorder does not affect a person's decision-making capacity, it is abundantly clear that the person should not be subjected to compulsion. In cases of short-term detention, it is important not only to assess what medical treatment should be given, but to give that treatment.

There is a view that consent from the mental health officer should be in writing, unlike the situation under current law. There should be a signature from the mental health officer to confirm that he or she has consented to the short-term order. Otherwise, we are generally happy with the grounds in section 35.

Margaret Jamieson: On page 2 of your submission, you mention that one criterion that is not included in the bill is that

"application for a compulsory treatment order would cause undesirable delay."

You say that that is an error—will you elaborate?

Dr Lyons: Thank you for reminding me of that. On emergency detention, the bill says that application for either a short-term order or a compulsory treatment order "would involve undesirable delay." I expect that it should say that one would apply for a short-term detention certificate because applying for a compulsory treatment order "would involve unnecessary delay."

Margaret Jamieson: What does it mean to you that the granting of a short-term detention certificate is necessary?

Dr Lyons: Do you mean the general necessity for such a certificate or its necessity compared to a compulsory treatment order?

Margaret Jamieson: We want to know your view because you deal daily with such matters.

Dr Lyons: "Necessary" means that there are no other ways of managing a person without using detention and compulsory treatment; that is, that one cannot treat the person safely without the person's admission to hospital under such circumstances or that one cannot treat the person on a voluntary basis under such circumstances. That could be explained more clearly in the bill.

Nicola Sturgeon: I understand why one of the criteria for emergency detention is that it would

cause unnecessary delay to apply for short-term detention. Should the same reasoning—that a CTO would cause unnecessary delay—apply to short-term detention? Is not the purpose of a CTO slightly different from the purpose of short-term detention? A CTO is for treatment whereas assessment is one of the purposes of short-term detention. There might be merit in applying for a short-term detention certificate even if there would be no unnecessary delay. I am not sure that I agree with your point.

Dr Lyons: That is a valid argument. Under the present law, we would apply for emergency and short-term detentions only in a situation where going through the sheriff and section 18 of the Mental Health (Scotland) Act 1984 would take so long that goodness only knows what would happen to the person in the meantime. One could argue that point both ways.

Mental health services treat people with chronic illness with whom they are in contact; they need to intervene when those people need to be treated, as opposed to having to treat someone who turns up out of the blue. Let us take the example of someone who has a long-standing mental health problem, such as a long-term schizophrenic illness, who becomes less well and has to be admitted to hospital for treatment. The health professionals will know that that person is not going to agree voluntarily to treatment, so in that situation the criterion in the bill would be met. In such circumstances, we would not have to assess the person; we would know that we had to treat the person, so we would not have to hold them for a short-term assessment period. Perhaps we could have a situation in which the person required a period of assessment so that we could decide on the appropriate treatment. Alternatively, we might believe that applying for a CTO would involve unnecessary delay. There is no reason why both criteria could not be included in the bill.

Mr McAllion: I want to go back to the answer that you gave on short-term detention certificates' being "necessary". You interpreted that to mean that you would not be able to get a voluntary agreement from the patient. I understand that Millan recommended that that be put in the bill explicitly as one of the criteria. Would you support that, rather than the vague wording that the certificate is "necessary"?

Dr Lyons: I would support that.

The Convener: Do you generally support the main Millan principles' inclusion in the bill?

Dr Lyons: As I have said, it is an unfortunate omission that the bill's principles are not set out clearly at the beginning, as they are at the beginning of the Adults with Incapacity (Scotland) Act 2000. There were problems with previous drafts of the bill and, because the principles were not clearly spelled out, some of the bill was a bit muddled. The latest version is much better, but it would read better if the principles that underpin the bill were set out clearly. I support thoroughly the Millan principles' inclusion.

Janis Hughes: One of the bill's aims is to move away from a situation in which the majority of patients are detained first through emergency detention, to a situation in which they are detained first through short-term orders. Is that a good policy and could one of the consequences of it be that people would end up being detained for longer?

Dr Lyons: It is a good policy. I have often had to detain people under emergency orders. Those orders must run for 72 hours before the person goes on to short-term certificates, which is silly. The real issue is getting the person on to a short-term certificate, under which they have the right to receive the treatment they need and to the act's protection in terms of treatments that require special safeguards. That right and the act's protection are not available under emergency certificates. I am firmly of the view—I think that my colleagues all agree—that emergency certificates should be used less and less. We welcome the opportunity to put people on to short-term detention certificates right away. We also think that when a person is detained under an emergency certificate, that should either be rescinded or the person moved to a short-term certificate at the earliest appropriate opportunity.

The question of whether somebody would be detained longer is difficult to answer, but I will give an example. We might admit to hospital somebody who has a mental illness and, during the 72 hours of the emergency certificate, we might hum and haw about whether we would detain them under a short-term order or let the detention lapse. In that sort of situation we must tailor our thinking and our intervention to artificial time scales that are set down in an artificial piece of legislation. The bill in its present form would not necessarily allow us to keep people detained for a longer or shorter period, but for a more appropriate length of time that could be reviewed regularly.

I would be concerned if people were worried that the new legislation was being used to detain people for longer. The period of detention should be appropriate to the individual. I worry sometimes about people detained under emergency certificates whose detention is allowed to become informal. Are they really undergoing treatment in a voluntary and participative way or is that situation just less hassle? The bill will allow us to be more flexible and to use the legislation in ways that are much more tailored to people's needs.

10:15

Dorothy-Grace Elder: It is good to see Dr Lyons again. One or two points in relation to my question have been covered, but is there anything else that Dr Lyons would like to mention about the arrangements for short-term detention? Might there be any difficulties in using short-term detention orders that would result in inappropriate use of emergency detention provisions?

Dr Lyons: If I am seeing somebody at home who is in fairly urgent need of psychiatric treatment, I would much rather use a short-term order than an emergency order. The only issue is the availability of mental health officers, which I have commented on in the section of my written submission that deals with emergency detention orders.

We all welcome the move away from consent from relatives towards consent from mental health officers, which is far more appropriate. I may have commented to committee members previously that I have often felt that the position that relatives are put in when they are asked for their consent to detention of a mentally ill person is harmful to their relationship with that person.

Mental health officers do a wonderful job—I do not say that simply because a couple of them are listening—but there is an issue in some parts of the country concerning early availability of mental health officers. My view is that the bill should insist that local authorities provide to medical professionals easy and quick access to mental health officers. That could perhaps be done under section 27, which deals with local authority duties. Medical professionals need to be able to contact mental health officers easily and quickly so that they can hear their expert input and advice. Availability of mental health officers is the only thing that might limit my use of short-term orders as opposed to emergency orders.

Dorothy-Grace Elder: You probably heard some of the previous evidence, which referred to the severe shortage of psychiatrists, which you mentioned when some of us visited you at Parkhead. The previous witness from the BMA stated that there are currently 30 consultant psychiatrist vacancies in Scotland, of which 20 per cent have been vacant for more than six months. The BMA estimates that between 18 and 28 new psychiatrists will be needed to help man the tribunals and so on. When we visited Parkhead, I think that we were given the statistic that about 50 per cent of mental health officer reports were not available or were delayed simply because of the shortage of staff.

Although we are dealing only with the legislative side today, perhaps Dr Lyons could comment on the shortages that were mentioned in the evidence that he heard this morning. We know that the Executive has the best of intentions, but the question is how they will work out.

Dr Lyons: I am sorry, but I did not hear the evidence from the previous person first, because I was slightly late as a result of the Edinburgh traffic and roadworks, which I am sure are there to prevent Weegies from getting into the city—

Dorothy-Grace Elder: They did not work, then.

Dr Lyons: No, but it was a nice try. Secondly, the sound system was not working where I was sitting.

It is important to separate out the principles from the practical arrangements. We all thoroughly support the principles of the bill and we thoroughly support much of its content.

However, the practical issue is not only that there is a shortage of psychiatrists. Some specialties are struggling; child and adolescent psychiatry and, in some parts of the country, learning disabilities psychiatry are having a rocky time. Provision tends to be patchy and some areas seem to have difficulty in recruiting and retaining consultant psychiatrists. In the long term, increased funding will be necessary, especially if we are going to have to sit on tribunals a lot of the time. However, I am confident that the need for more consultant posts will be acknowledged as part of this exercise and that funding will be made available.

That said, funding is one thing; bodies are another. It takes time to train a consultant psychiatrist and I imagine that over the next five years, that will become a problem. There is no easy answer.

Dorothy-Grace Elder: When we met in Glasgow, you said—tellingly—that you and your colleagues would prefer legislation that would make it easier to reduce restrictions but harder to increase them. Will you expand on that?

Dr Lyons: I have been working on that. I came up with the wording on the spur of the moment and I quite like it.

It should be appropriately difficult for us to increase the level of restriction for someone and easy for us to decrease it. The Millan principle of least restrictive intervention, which is outlined in the bill, fits in quite nicely with that.

I want to return briefly to emergency and short-term procedures. Although I have expressed anxieties about the mechanics of a doctor's completing an emergency certificate and then letting everyone know his or her reasons for doing so, I still believe that it is only appropriate that those reasons be recorded when a person is deprived of his or her liberty. That will make

doctors think about what they are doing and why they are doing it. We are to deprive people of their liberty, so we should not take our responsibilities to the individual lightly; we should clearly record, document and justify why we have done so.

The Convener: I will pass the questioning over to another Weegie representative who made it through the wire.

Nicola Sturgeon: Perhaps you answered this question earlier when you talked about the appropriateness of time scales. Do you foresee any problems with the time frames that are laid down in parts 5 and 6 of the bill? I am thinking in particular of periods of detention or obligations on doctors and mental health officers to report certain matters to various bodies.

Dr Lyons: One or two of the time scales are unreasonable not so much for doctors and mental health officers, but for hospital managers, who will have to report to the Mental Welfare Commission for Scotland within 12 hours. What will they do on a Friday night? Will they leave a message on the answering machine? Perhaps instead the bill should say that, if reporting on a detention cannot take place within 12 hours, it should take place within 12 working hours or whenever is reasonably practicable. The provision as drafted will not work.

Although the duty on medical practitioners who carry out emergency sections to report within seven days is not unreasonable, it will just not happen unless we find a very good mechanism.

Nicola Sturgeon: I think that the BMA suggested that such an obligation should be placed on hospital managers instead of on general practitioners. Do you have a view on that?

Dr Lyons: I agree with the suggestion. Hospital managers are used to dealing with such situations; they do so every day. They receive certificates and know automatically who to fire them to. However, because GPs carry out emergency detentions once in a blue moon, the chances that they will know or remember what to do are not high.

Either that information is captured on the prescribed form and, when the hospital manager receives the form, he or she circulates it as appropriate, or when the person is detained, the hospital manager sends the form to the GP—or whoever deals with the emergency—who returns it to the hospital manager, who subsequently distributes it. The mechanics are quite important. Placing the obligation on the medical practitioner will not work in practice.

Shona Robison: Let us return to the practical arrangements. It is always difficult to separate principles from practicalities, because the principles can be undermined if the resources are not there. There is a balance to be struck between ensuring that people who are subject to detention procedures get the professional attention that they require, and ensuring that the work of psychiatrists with non-detained patients is maintained and does not suffer as a consequence. Do parts 5 and 6 of the bill strike the right balance? More generally, do you share that concern? The BMA said that it is inevitable that the new work will take precedence over routine patient care, which could be to the detriment of patients. What are your views on that?

Dr Lyons: That is a danger, especially given psychiatrists' responsibility to sit on tribunals. However, only a tiny proportion of my work deals with people who are detained. The vast majority of my clinical work deals with people who are being treated co-operatively and voluntarily in a participative way. If the bill supports the principle of reciprocity—that with compulsion comes a duty to provide service—I will not disagree with that. However, I would have some difficulty with that reciprocity if it meant that people who were not detained received an inferior service. That is something to watch out for, generally.

There is nothing in parts 5 and 6 that gives me anxiety that an extra burden is being placed. My concern is more about the compulsory treatment orders and the work that goes along with them.

Mary Scanlon: The BMA's GPs committee says that it should be made clear that the medical officer who is responsible for a patient who is under short-term detention must be a psychiatrist, because that will help to protect the patient. The same committee says that, if no psychiatrist is present at the hospital, the bill should allow for a psychiatrist to come in from another hospital. Do you agree?

Dr Lyons: Yes. I have read the BMA's submission. A person may be detained in a general hospital ward, rather than a psychiatric ward. An example might be a person who is suffering from acute delirium, which is a mental disorder, although the underlying basis of it is a physical disorder, and therefore can be treated appropriately under the Mental Health (Scotland) Act 1984. In such a situation, the patient may be in a general hospital ward and there may be no psychiatrists in that hospital—in fact, that would almost certainly be the case. There must be some mechanism whereby, although the person who is in charge of the patient's day-to-day care may be a consultant physician, the responsible medical officer for the mental health side would have to be a psychiatrist. There is no question about it.

Mary Scanlon: In your submission, on section 32 on emergency detention, you say,

"we would doubt whether general practitioners, who will

presumably do most of this, will have sufficient knowledge of the Act".

I am an MSP for the Highlands and Islands, where psychiatrists will be expected to attend tribunals, write reports, go to people's homes and visit them in connection with CTOs, which means hundreds of miles and many ferry crossings. We have heard today that, with the implementation of the act, there could be up to 58 psychiatrists fewer than the number that is required. Can the act realistically be implemented with the acknowledged enormous shortage of key staff?

10:30

Dr Lyons: What you have said applies to CTOs, which is not what I came to the meeting to discuss; I came to discuss parts 5 and 6 of the bill.

Mary Scanlon: I was thinking of work loads.

Dr Lyons: You mention an anxiety that we all have about the potential work load that would ensue from CTOs.

Mary Scanlon: As Dorothy-Grace Elder said, 30 psychiatrists are needed at the moment. Implementation of the bill will mean that up to 28 more psychiatrists are needed, so another 58 psychiatrists will be needed if the bill is to be implemented as it should be. Last week, it was suggested that implementation should be delayed. Can the bill realistically be implemented when the key staff who are required to implement it properly are not there? Where can 58 new consultant psychiatrists be found in the next couple of years?

Dr Lyons: I mentioned that five years would be required to build up the work force. Perhaps the bill should be implemented on a phased basis and perhaps parts of it cannot be implemented until the manpower exists. That approach would not need to hold up the good and necessary emergency and short-term detention reforms, which is what I came here to discuss. CTOs may need more examination. That is to say not that CTOs are wrong in principle, but that implementation of the bill may need to be delayed or phased, given the manpower issue. Perhaps there are certain things that we cannot do.

Mary Scanlon: How will the shortage of manpower affect the implementation of the bill as it stands?

Dr Lyons: The shortage of manpower will not affect implementation of parts 5 and 6 of the bill.

Mary Scanlon: Will it affect your other patients?

Dr Lyons: As I said, I came to talk about parts 5 and 6 of the bill.

The Convener: From what you have said and what your colleagues said last week, it seems that a number of professions, as well as members of the committee, share the anxiety about trying to implement legislation that we cannot deliver in practice. We take that anxiety on board, although you are right to say that you have been invited specifically to discuss parts 5 and 6 of the bill. We will leave the matter there.

Janis Hughes: Section 32 deals with notification by a medical practitioner and lists who should be notified within seven days. Do you see any problems with that procedure?

Dr Lyons: As I said, I see problems with its mechanics. The list is perfectly reasonable, but the mechanics should not be the medical practitioner's duty; they should be the duty of the hospital managers.

Shona Robison: You approve of the removal of a relative's authority to consent to a person's being detained. However, many carers to whom I have spoken feel strongly that we are speaking about someone who knows that person best. Do you believe that it is still appropriate to consult the patient's named person or relative as part of the detention process?

Dr Lyons: Yes. That is mentioned in relation to short-term detention certificates. We feel strongly that the named person should be consulted. As the bill says,

"the approved medical practitioner shall have regard to any views expressed by the named person."

There is a question about whether that responsibility should belong to the medical practitioner or the mental health officer. That might be something to think about. We have mixed views.

Shona Robison: What do you think?

Dr Lyons: Personally, I think that the responsibility should be the practitioner's, whereas some of my colleagues think that it should be the MHO's. There is no reason why both should not have the responsibility.

My current practice is not to use relatives for consents unless I cannot get a MHO, which, in my experience, does not happen with short-term detention orders. The local authority that I work with is excellent at supplying MHOs. I take my hat off to East Renfrewshire Council.

I always consult the nearest relative and tell them what I am proposing to do. I tell them that I would be interested to hear their views. I say that I am not asking for their consent or permission because I believe that that would put them in a difficult position, but it is important for them to tell me what they think about the situation. I believe that that gets the balance right. It fits in with what I consider to be present best practice.

Dorothy-Grace Elder: Would it be appropriate to ask a question on your views on advocacy for

the patients? How strongly or how well or otherwise do you rate the presence of an advocate for the patient in appropriate circumstances?

Dr Lyons: As someone who battled long and hard to get advocacy services for older people in Glasgow and succeeded in doing so, I am a great supporter of advocacy and I am pleased that the bill contains proposals for advocacy.

A person has a right to advocacy or is entitled to appoint an advocate. However, one of the most difficult questions is what to do for the person who is not capable of appointing an advocate, given that the person who needs advocacy most is least able to appoint an advocate for himself or herself. That is a huge challenge and I do not have an easy answer. I might just leave that thought with you. I have been asked about the issue and have discussed it at great length at many advocacy conferences. Even people who are experts on advocacy do not have an easy answer.

The Convener: Thank you for your oral and written evidence, Dr Lyons. Do you have any other points to make or have we covered everything that you wanted to say?

Dr Lyons: I do not think that there is anything else. I will just ask Jacqueline Atkinson whether she thinks that I have missed anything.

Dr Jacqueline Atkinson (Adviser): No.

The Convener: She thinks that you have done all right. We will take up your earlier point of clarification. Thank you for your evidence and for meeting with us when we came to Parkhead. We appreciate that.

Dr Lyons: My pleasure. Thank you for having me.

The Convener: Our next witnesses are Ruth Stark and David Hewitson from the British Association of Social Workers. Welcome to you both and thank you for your written submission. If you would like to make a short statement before we go on to questions, we will be happy to hear it. If not, we will just go on to questions.

David Hewitson (British Association of Social Workers): Could I just begin by making a correction to our written submission? The opening statement, which says that we welcome the principles at the outset of the bill, was clearly a serious error on our part.

The Convener: Even I spotted that one.

David Hewitson: That came of using earlier drafts. We would be very pleased to see those principles clearly spelled out. We think that the Millan principles are excellent and should underpin the practice behind the legislation.

There are other issues that I want to address, particularly in connection with the duties of mental health officers. I am sure that those issues will come up in questioning. If they do not, I shall return to them at the end.

The Convener: That is fine. I shall kick off by asking whether you agree with the general principles of the bill and whether you consider that there has been adequate consultation.

David Hewitson: People have struggled hard to get the bill right. I know that some of the areas that we will cover today have been subject to debate and discussion. BASW has been very much involved in that. On the principles, we have learned much in practice since the draft proposals were issued and people have struggled to iron out the niggles in the bill as introduced. In general, I believe that the bill has the potential to become a very good mental health act.

Nicola Sturgeon: Could you outline in broad terms how you envisage the main role of the mental health officer in short-term detention? What does that add to the procedure?

David Hewitson: As officers of the local authority, we are one stage removed from the doctor and we are not answerable to the doctor as part of his or her clinical team. What I bring as a mental health officer is a view of the person in their social context. That is not to say that the doctors from whom you have heard this morning would not see the person in their social context, but that is the tint in my spectacles—protection of people's rights and liberties comes as part of social workers' core beliefs. That brings balance to the system and the stronger that voice is in the system, the better that check and balance will work.

Nicola Sturgeon: Do you think that the voice envisaged for MHOs in cases of short-term detention is strong enough?

David Hewitson: As I understand it, a consultant will not be able to go fishing around for a tame MHO. Under the bill, consultants certainly cannot go off to a desperate nearest relative to circumvent the procedure. If there are good reasons why people cannot be detained, that will be spelled out.

Shona Robison: We have just heard from the psychiatrist, Dr Lyons, that a psychiatrist is perhaps best placed to consult the nearest relative—although that was his personal opinion. What is your view?

David Hewitson: The important thing is that any information is brought into the discussion between the psychiatrist and the mental health officer. I take the point that was made about the issue being different in rural areas and in urban areas, where distances are much shorter. It is important

to see the person in their social context and to get the whole picture. The doctor and the MHO go in on a spot-check basis, if you like. They may know the person over a long period, but sometimes they will not. Getting information about the longer-term situation is as important for the medic as it is for the whole process of depriving people of their liberty. It is obviously important for that, too, but it is part of the overall assessment of the person.

10:45

The Convener: I will pick up on a point that Dr Lyons made about discussions with the nearest relative in respect of granting short-term detention certificates. Dr Lyons mentioned that there was some debate about whether that should be done by psychiatrists or mental health officers. What are your thoughts on that?

David Hewitson: Someone has to have a discussion with the nearest relative. I understand that there is a clear duty on the mental health officer to identify the named person. Although I looked through the bill, I could not find a provision under which we have to contact the nearest relative and discuss the situation with them. It would seem that we have to identify them, but that is not good enough. Am I missing something?

The Convener: I understand that the bill sets out that the medical practitioner should do that.

David Hewitson: Contact the nearest relative?

The Convener: Yes. The MHO has to identify the nearest relative, but the medical practitioner has to talk to them.

David Hewitson: Regardless of whether that is the duty of the mental health officer or of the doctor, the nearest relative has to be consulted. The information is not required solely for the discussion about whether the person should be detained; it is good medical practice for the doctor to have it.

Mary Scanlon: On page 1 of your submission, you say:

"One of the failings of the current system is the lack of insistence on the provision of such reports or the resources to provide the reports in the current recruitment crisis."

Are you saying that at the moment you do not have a duty to prepare social circumstances reports after short-term detention has been authorised?

David Hewitson: Under some circumstances, that is correct.

Mary Scanlon: I thought that the duty was a statutory duty.

David Hewitson: There are statutory and non-statutory reports. In the City of Edinburgh Council, we try to provide both such reports, but I understand that other local authorities provide only statutory reports. If a mental health officer is involved in the process of achieving consent, either at the emergency admission or the short-term detention stage, providing a social circumstances report is not a statutory requirement on the local authority. If the authority has a half-decent MHO service that is out in the community giving lots of consents, the statutory duty to provide social circumstances reports will apply relatively rarely. Nonetheless, good practice sets down that, where the report would add value to the whole process, the report should be provided.

I am sure that we will come to the issue of mental health officers saying, "I do not think that I will provide a report this time, thank you very much." Current legislation allows MHOs to do that. If I consent to somebody's detention, I do not have to provide a report. That said, I think that it is good practice for me to do so.

Mary Scanlon: In evidence last week from the Mental Welfare Commission for Scotland and the Royal College of Psychiatrists, we heard that only 50 per cent of the statutory social circumstances reports were being provided. Section 38 imposes a duty on mental health officers to prepare social circumstances reports after short-term detention has been authorised. Given the evidence that we heard last week, will MHOs have the resources to fulfil that role?

David Hewitson: The figure that you cite slightly hides the fact that some reports are done but appear late and that lots of non-statutory reports are prepared. Nonetheless, I accept that figure; I have no way of challenging it.

It is right that local authorities should be resourced to provide any service that is demanded of them. The mental health officer service is under strain in several local authorities. People are struggling to find the right way of working. There is a recruitment and retention problem in social work, as I am sure members are aware. We need to consider what payments are appropriate for mental health officers who take individual responsibility for decisions.

Section 38(3) of the bill states that a mental health officer need not produce a report where that would

"serve little, or no, practical purpose".

If MHOs are not given the resources to provide an adequate service in a local authority, I fear that they will be under pressure to use that get-out clause.

Mary Scanlon: Section 38(3) appears to give mental health officers wide discretion in deciding

whether to produce a social circumstances report. Given the acknowledged recruitment crisis and resource problem in social work, and the pressure that mental health officers are under, do you feel that many of them may choose not to produce reports? Might that not be a failing in the implementation of the bill?

David Hewitson: I know that section 38(3) has been struggled over. I was not part of that struggle and I do not want to betray colleagues who have sweated blood over the provision. However, I am concerned, although I do not think that my MHO colleagues will easily walk away from their responsibilities.

Mary Scanlon: They are doing so at the moment. Last week we heard that only 50 per cent of statutory reports are produced. If mental health officers are walking away from their responsibilities at the moment, what will they do when the bill is implemented?

David Hewitson: I repeat what I said a minute ago. Until a couple of weeks ago, I administered the MHO service in Edinburgh, so I know that efforts are being made to make clear to MHOs which reports are statutory.

Some of the reports that MHOs produce are statutory because a nearest relative gave consent; others are non-statutory because the mental health officer gave consent. MHOs regard the delivery of social circumstances reports as being about providing a service to patients—to people who are detained. The aim of the reports is to ensure that information about those people's circumstances is put before doctors and the Mental Welfare Commission.

I know that in the city of Edinburgh we have made efforts to ensure that mental health officers are aware which reports are statutory. You have claimed that 50 per cent of statutory reports are not produced and I have no way of challenging that figure. However, I know that often reports are provided late rather than not at all. That is my experience in Edinburgh. I do not know what the statistics are elsewhere.

Mary Scanlon: Would you be more comfortable if you had an absolute responsibility to fulfil the requirement to provide the report, rather than having the discretion to do so?

David Hewitson: No. Section 38(3) is good and useful, although you might want to have a backstop position. For example, if the Mental Welfare Commission felt that it wanted a report in a particular case, perhaps it should have the power to instruct that a report be provided. That would be reasonable. However, if a full social circumstances report—SCR—had been provided on someone who had been detained a month ago, there would be little or no point in my preparing a further report for everyone. If that information is available to the consultant and the mental health officer, why waste valuable social work time by going through the process of preparing another report?

Mary Scanlon: No one is asking you to reinvent the wheel every time. We are much more reasonable and professional than that. However, do you acknowledge that there are serious concerns?

David Hewitson: I acknowledge that. I would have concerns that the provision opens a large loophole.

The Convener: Are you suggesting that, given that the power of discretion in this section is wide, there should be a backstop position whereby somebody else's discretion could counteract the initial discretion? You suggested that the Mental Welfare Commission could fulfil that position, but could the approved medical practitioner or some such person also query an MHO's decision not to provide a report?

David Hewitson: A copy of the reasons goes to the responsible medical officer and the Mental Welfare Commission, and perhaps either of them could insist on a report. I do not think that mental health officers would do anything other than take their responsibility seriously, but they could be leant on and perhaps some sort of backstop could be facilitated.

Shona Robison: I share your concerns about resource-driven decisions being made. Should the bill contain any other safeguards? The tribunal system seems to be getting pulled into everything, but could it act as a safeguard or could an advocacy service be established? It strikes me that there must often be disadvantages for someone who does not have an SCR produced on them. It would be of great concern to me if, a year after implementation of the act, there was a huge drop-off in the number of SCRs produced. That would indicate to me either that all the SCRs that have been produced over the years had been a waste of time or, more likely, that a large number of people were at a disadvantage because of a lack of information.

I would not want us to rely on discretion, because that would seem to weaken the system, even if two people were making decisions based on their discretion. Can you think of any other safeguards?

David Hewitson: While I would see the production of the report as a professional service to the person who is detained, the report is sent to two specific places: the Mental Welfare Commission and the responsible medical officer. I think that they are the right people to provide a system of checks and balances. When the

treatment order is being applied for, appropriate social circumstances information must be provided to the tribunal.

Shona Robison: Is that information always provided? Are there any cases in which it would not be?

David Hewitson: No. That is part of the submission that the mental health officer must make when the application is made. If the detention is more than short term, social circumstances information must be provided. A care plan must also be provided, which will take into account the person's social circumstances.

11:00

Shona Robison: Is there a danger there as well? If that must be done, it will be the number 1 priority for resources and there could be a knock-on effect. If there is a priority list, people for whom an SCR is not provided will be disadvantaged.

David Hewitson: The justification must be that some things serve little or no practical purpose. Responsible medical officers and the Mental Welfare Commission value social circumstances reports greatly. Mental health officers are committed enough to their work to take SCRs at face value. They will only not want them when there is little or no practical purpose in having them. However, a resourcing issue arises.

Dorothy-Grace Elder: I have had to change the question that I was going to ask. Are you generally satisfied that MHOs will be consulted adequately for their consent before the authorisation of emergency detention or short-term detention?

David Hewitson: In the City of Edinburgh, we have standards that say we will phone back the doctor within 10 minutes, and that within an hour we will attend wherever the patient is. Sometimes one is rung at 11 o'clock in the morning and an appointment can be agreed for the afternoon—say, at 3 o'clock—to visit a patient when they are expected to be there and when it is convenient for all parties. If there is an emergency, we will deliver the MHO service to the standards that I described. However, sometimes that is not good enough. A patient may be about to storm out of a ward and the MHO—even when they are based in the hospital—cannot get to the ward before the patient hurtles out of the door.

I am pleased with the modification to a nurse's holding power, which will allow a doctor time to make an assessment. At the minute, as soon as the doctor appears, the nurse's holding power ceases; as soon as somebody with a medical qualification walks into the room, the patient is free to go or the doctor has to make an instant decision. That has been modified in the bill, which is good. It would be good if it were made explicit, either in the bill or in the code of practice, that that assessment should include the assessment of a mental health officer. I do not see such a provision at the moment; perhaps it will be in the code of practice.

With due deference to colleagues in rural areas, it is not possible to get an MHO to an island within an hour. MHOs work differently in such areas. However, in urban authorities, that is the sort of service that we can deliver. Giving the doctor the get-out of saying that something is impracticable has to be seen in that sort of context. However, the way that things are laid out in the bill is okay.

Dorothy-Grace Elder: How short is Scotland of MHOs? Can you estimate how many more might be needed?

David Hewitson: I am at a loss to answer that, I am afraid.

The Convener: I understand—that is not really what you came here to answer.

Dorothy-Grace Elder: Fair enough.

The Convener: Ruth Stark may want to pick up on the more general points.

Ruth Stark (British Association of Social Workers): Yes, I will.

About 200 MHOs are qualified and working in social work departments, but they are not practising—that is a wasted resource. We are about to enter a period in which the basic social work training will take longer. One has to be qualified for two years before one can begin the training to become an MHO. It then takes another 12 to 18 months to train. We are talking about people who, potentially, will have started out doing a three-year course, followed by two years of practice, then another 18 months to become an MHO. That is a huge time scale in which to train an MHO.

We are also losing MHOs, so retention is another concern. Theirs is a specialist task, which is recognised by its special training. We must take into account the fact that the problem cannot be solved immediately by throwing money at it. There is a question about what happens to the social worker's career structure, as well as the pay structure, which David Hewitson mentioned. One can do the job of an MHO as well as being a normal social worker and there is no financial recognition. Recruiting new MHOs is a big and complex problem.

Dorothy-Grace Elder: Let me understand this point, in case I misheard you. I think that you said that about 200 people are qualified MHOs.

Ruth Stark: Yes, they might be directors or social work assistant directors.

Dorothy-Grace Elder: In Scottish terms?

Ruth Stark: Yes.

Dorothy-Grace Elder: They might be working in social work, but they are not assigned as MHOs?

The Convener: Before Dorothy-Grace Elder continues, I want to ask a related question. From those 200 MHOs, how many people might we be able to channel into the extra duties that will result from the new legislation? You said that people must be retained in the service. Full training will take seven or eight years, so it is not realistic to think that the people who are just about to embark on social work degrees can be the MHOs that we need now. We must retain MHOs, transfer qualified people or persuade existing social workers who are without that final MHO qualification to switch to being MHOs. Do we need to put in place incentives for people to do that?

Ruth Stark: There are trained social workers who are not currently MHOs and who will not do the course because they foresee no benefit. They foresee more work for the same money and they do not want to take on that extra responsibility. There should be a financial incentive.

As soon as one hits management in social work, one ceases practical work. That is in contrast to the medical profession, in which there is a notion that one continues practising at whatever level one reaches. If the social work culture could be changed—it is a challenge for social work to consider changing—we might be able to access resources that already exist.

The Convener: I will come back to Dorothy-Grace Elder in a minute.

Janis Hughes: Sections 31 and 35 set out the criteria for emergency and short-term detention. Are those criteria appropriate?

David Hewitson: Yes. In particular, the condition that

"the patient's ability to make decisions … is significantly impaired"

is a major addition to the short-term detention criteria with which we work, and is right. However, we will struggle to take that on board, in comparison with our present practice. The principle is good, but ultimately the responsibilities that society places on MHOs and doctors will shift. If the patient has a major mental disorder but has the ability to make decisions about it, they will be able to take responsibility for the risks. That will be a change, but a good change.

Janis Hughes: Have any criteria been omitted?

David Hewitson: The other criteria are in line with present practice and I am happy with them.

Margaret Jamieson: The BMA's Scottish GPs committee and the Royal College of Psychiatrists suggested that, in practice, it will be hard to obtain an MHO's consent before emergency detention is authorised. What is your perspective on that? Can anything be added to the bill to make that less likely, or is that solely a resource issue?

David Hewitson: It is a resource issue and a matter of trust. The doctor must interview the patient—the doctor must be in the same place as the patient at some point. At times, in Edinburgh, we phone back in 10 minutes and will be anywhere in an hour. That is almost always good enough for emergency detentions and should invariably be good enough for short-term detentions under the present structure.

What the bill proposes is not dissimilar. In most circumstances, we should be able to get an MHO to the patient at the same time as the doctor is there, with the exception of rural communities. However, I have had robust telephone discussions with consultants about somebody's detainability, on the basis of what those consultants have told me. I am reasonably long in the tooth as an MHO and I have no difficulty in having such a spat and saying, "I am sorry—I am not willing to agree until I see the patient and decide for myself." At the moment, I do not have to sign anything. I just say, "I am David William Hewitson and I work here, and you can put that on the form."

Without doubt, it is good practice for me to see the patient. Such discussions can take place and MHOs can withhold their consent. However, when MHOs withhold consent, they withhold the patient's treatment and care, so they should not do that willy-nilly, because the patient deserves the best treatment and care that they can have.

Margaret Jamieson: Do you suggest that some MHOs do not do what you described?

David Hewitson: Some people take the principled view that they should always see and have a discussion with the patient, because the matter is of such import. That is their view, but that is not what the 1984 act demands of them. My normal practice is almost invariably to see patients, but at times that seems unnecessary. When someone is fed up to the back teeth of people locking them away in the blasted hospital, being bombarded with yet another person is an extra pain. I use my discretion.

Margaret Jamieson: Should that be contained in the code of practice? Should it be picked up in the continuing professional development of social work staff?

David Hewitson: I think so. Clear guidance should be provided on how consent can be obtained and on what is, and is not, acceptable.

Margaret Jamieson: Would patients' welfare be

compromised if doctors were unable to contact MHOs?

David Hewitson: It is much better that doctors have to accept the challenge and questioning of an MHO, and hear another opinion about the person's detention or detainability. As the previous witness said, GPs may have to use emergency detention orders once in a blue moon. Even as a manager—albeit a manager in a psychiatric hospital—I am regularly involved in detention. The MHO is the experienced partner in the pairing.

11:15

Margaret Jamieson: Is it important that you physically sign the order?

David Hewitson: Again, I would have to be in the same place as the piece of paper in order to do that, which might delay things. I swallowed hard when I thought that GPs were going to have to send a piece of paper to all those places. I wonder how that will work. Will self-copying forms be used and the bits sent to different places? It will be difficult. If we assume that a GP does the emergency detention, they will have to say why that person has to be deprived of their liberty. They must take it seriously.

Margaret Jamieson: I will impose on you, and ask you to consider that issue further and provide us with your thoughts at a later stage.

The Convener: We have a quick question from Dorothy-Grace Elder on advocacy.

Dorothy-Grace Elder: I tend to ask most witnesses this question. How do you rate the importance of advocacy services for patients, whether they are voluntary services, as they are in some areas, or paid professional services?

David Hewitson: Greater use of advocacy when people are disturbed and disordered in their own minds, so that they have somebody with a clear mind to say what they want to be said, is important. Advocates can not only speak on behalf of people, they can be there with them. For a while, I was on the medical committee of the state hospital, and often the advocate would come in alongside the patient. The patient would feel confident saying what they wanted to say, because they knew that they had somebody there who would take care of them and ensure that they did not miss things out.

Dorothy-Grace Elder: So there was an independent person, whether he or she was a volunteer or a paid professional.

David Hewitson: Today, on my first visit to the Parliament, I have an advocate sitting beside me. We all use advocates. Let us give the same sort of service to patients.

Mr McAllion: The two doctors from the BMA and the Royal College of Psychiatrists who gave evidence this morning were concerned not about disagreements with mental health officers, but about getting access to them. In fact, Dr Lyons said that we should insist that local authorities make available easy access to mental health officers. Would you object to the bill placing a duty on local authorities to provide a certain standard of MHO service, and for the standard to be set out in an accompanying code of conduct?

David Hewitson: That would be excellent. You would have to bite the bullet of providing the resources to local authorities to deliver that. You would have to think through the complex issues that arise when long distances are involved, what the standards will be, and how they will be drawn up.

The Convener: Thank you for your written submission and oral evidence.

Before we finish agenda item 3, I ask the committee to agree to take part of the evidence in private during Friday's meeting in Dundee—the committee is meeting four times in one week—because the witness, who is a patient, would prefer that. Is it agreed that we will take that evidence in private?

Members *indicated agreement*.

Hepatitis C (Compensation)

The Convener: For agenda item 4, members should have a copy of the response to my letter to the Minister for Health and Community Care, asking when we will receive a response on the work of the expert group on hepatitis C. There have been some developments on the back of that letter. I have spoken to the ministerial team and we have a date—30 October—for the minister to come to the committee. The date would have been earlier had it not been for the two weeks of recess. The ministerial team cannot come before the recess because of Cabinet timing, but the minister will tell us what is happening on the issue at the first meeting after the recess.

Members will notice from their work programme that the minister is scheduled to come the following week to talk about the Mental Health (Scotland) Bill and the budget process. However, it is important that the minister talks to us as soon as possible on hepatitis C and that we have a proper chance to question him on it. Rather than the minister having to deal with three issues at one meeting, it would be better for us to question him specifically about hepatitis C on 30 October. Are members happy with that suggestion?

Members *indicated agreement*.

The Convener: We will discuss agenda item 5, which is on witness expenses, in private.

11:20

Meeting continued in private until 11:21.

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