HEALTH AND COMMUNITY CARE COMMITTEE

Friday 4 October 2002

Session 1

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CONTENTS

Friday 4 October 2002

HEALTH AND COMMUNITY CARE COMMITTEE

25th 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

Shona Barcus (Scottish Association for Mental Health)
Lucille Crichton (Little Wing)
Bill Kerr (Hearing Voices)
Caroline Kerr (Hearing Voices)
Richard Norris (Scottish Association for Mental Health)
Dr Madeline Osborn (Mental Welfare Commission for Scotland)
Pat Webster (Hearing Voices)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

LOCATION

Dundee City Council Chamber

Scottish Parliament

Health and Community Care Committee

Friday 4 October 2002

[THE CONVENER *opened the meeting at 11:17*]

Mental Health (Scotland) Bill: Stage 1

The Convener (Mrs Margaret Smith): Good morning and welcome to this meeting of the Health and Community Care Committee. Unfortunately, Dundee is not sunny at the moment, but the welcome has been warm.

The committee will continue to take evidence on the Mental Health (Scotland) Bill. Dr Madeline Osborn, from the Mental Welfare Commission for Scotland, is our first witness. We will question her about the mental health tribunal for Scotland, which the bill will set up. Does Dr Osborn wish to make a short statement, after which we can ask questions, or proceed to questions immediately?

Dr Madeline Osborn (Mental Welfare Commission for Scotland): I would like to proceed to questions.

The Convener: Okay; I will kick off. What are the drawbacks of the current scheme, in which a sheriff who sits alone decides whether to allow compulsory treatment? Does the current set-up have any advantages over a tribunal?

Dr Osborn: From the patient's point of view, the current system's disadvantages include its extreme formality. Very few appeals take place in the hospital, let alone in another less formal setting. Most appeals involve a court setting, which many patients find daunting. Patients also associate seeing a sheriff with having done something wrong and getting into trouble, so the experience is uncomfortable. That is borne out by the small number of appeals to the sheriff. Of course, patients have no option when a detention order is imposed, but when they can vote with their feet in respect of appeals, they come to the Mental Welfare Commission for Scotland, which is a much less formal setting. From the patient's perspective, the current experience is daunting.

From a professional's point of view, sheriffs do not make consistent decisions. I came from south of the border, where detention is imposed after an application to a hospital manager, and I thought that the sheriff system would be far superior. I imagined that decision making would be more consistent, but my experience at the Mental Welfare Commission is that it is not. Different sheriffs have different views about the criteria for detention and for discharge from detention when patients appeal.

A sheriff does not take a collegiate approach to assessing professional evidence. He is always given a report by the patient's consultant, but the patient may commission independent reports through his or her solicitor. The sheriff weighs up the reports. In a tribunal system, a more collegiate approach is taken. Professional advisers sit on the tribunal and can reach a joint decision. I have experience of working in the mental health review tribunals in England and Wales. They always have a legal chair, but the three members' views are equal. A tribunal always has a lay member who has experience of alternatives to detention. Often, such evidence is not put to a sheriff under the current system.

The third member of a tribunal in England and Wales is explicitly a lay person and is often a social worker, who for some reason is called a lay person in that setting. Sometimes, the lay person has experience of voluntary services, of running community care services or of other mental health-related activities. The idea is that they know what services might be available as an alternative to detention. Under that system, the decision is based on a wider range of views and is made in a more collegiate way.

The Convener: You see no advantages to the present system over a tribunal system.

Dr Osborn: The problem that tribunals south of the border have run into is delay, which might be a problem here, too. That would be more of a problem than it is under the sheriff court system.

The Convener: We will ask about the English situation later.

Mr John McAllion (Dundee East) (Lab): The general understanding seems to be that a tribunal would consist of a president with a legal qualification, a consultant psychiatrist and a lay person who may have experience of social work or voluntary work, or who may be a mental health service user. Are you satisfied with that make-up?

Dr Osborn: May I correct one thing? I understand that the medical member would not necessarily be a consultant psychiatrist, but would be someone with a competency—a qualification—in mental health. That person might be a consultant psychiatrist, but need not be. For example, some general practitioners have membership of the Royal College of Psychiatrists and so have a higher qualification.

Mr McAllion: Is that a problem with the bill? Schedule 2 is vague about the make-up of tribunals. Are you happy with the vagueness of the schedule, or should it be tightened to specify the membership?

Dr Osborn: I assume—I may be wrong—that the composition of tribunals will be specified in regulations, but that might be unsatisfactory. It is important that one member has competency to decide whether someone has a mental disorder, because that is the basis of detention. It is essential to be able to judge against that criterion.

In determining care plans and reviewing whether they are appropriate for the patient, a member is needed who knows what treatment is appropriate and what constitutes good and poor treatment. I would go for competency in those matters. A consultant psychiatrist would often be the right person, but a basic qualification in psychiatry might be enough. I suggest that requiring a higher qualification such as membership of the Royal College of Psychiatrists, or a listing on the General Medical Council's specialist register as a psychiatrist, would be a reasonable way to approach the question whether someone is competent to make such decisions.

Mr McAllion: Is it the view of the commission that the bill should be amended to be more specific about who should sit on the tribunals?

Dr Osborn: The view of the commission is that one person should have demonstrable competency in psychiatry and the medical aspects of mental health.

Mr McAllion: When Bruce Millan gave evidence to the committee, he said that he thought that the medical person on the tribunal should always interview the patient. Do you agree with that?

Dr Osborn: On balance, probably not. I am persuaded by the argument, but it is difficult for the medical member of the tribunal to occupy several roles. If the medical member sees the person beforehand, they will be acting as an expert witness as well as acting in a judicial role. That does not fulfil the criteria of natural justice. Genevra Richardson, who chaired the scoping committee for the review of English and Welsh mental health legislation, wrote an interesting paper on the subject, pointing out the conflict. She said that the psychiatrist on the tribunal might relay in private to members of the tribunal evidence that they had elicited from the patient. Obviously, that evidence would not be open to scrutiny and would not be made available to the patient or their representatives.

That does not seem fair and I am persuaded by that argument. It is important that justice is not only done but seen to be done. If the medical member has an interview with the patient, that would interfere with the perception of justice being done and might lead to serious conflicts of interest.

Dorothy-Grace Elder (Glasgow) (Ind): You said that you have personal experience of the mental health review tribunals south of the border. What might we learn from the English experience? Are there any specific problems that we should be aware of?

Dr Osborn: The advantage of the system is that the tribunal goes to the patient and the meeting takes place in an informal setting. For example, the meeting to discuss an appeal against detention that was made by one of my patients, who had severe anorexia nervosa and was in an intensive care unit in a general hospital, took place in a side room in the unit.

The tribunal meetings are formal but are much less so than they would be if they took place in a sheriff court. That strikes the right balance. If I were a patient, I would need to be sure that people were taking my appeal seriously and so I would want the meeting to be formal, but I would not want the experience to be daunting.

A great range of representatives are allowed to come, such as relatives and legal representatives, and so the patient is well supported. All the evidence is available to the patient and their representative. They see the report and hear what the doctors, social workers and nurses have to say. The process is transparent.

Dorothy-Grace Elder: Could the meeting take place in a patient's home?

Dr Osborn: I have not known a meeting to take place in a patient's home. It might be difficult to set that up because quite a lot of people are involved: the patient; three members of the tribunal; the clerk; and the other attendees. However, I do not see why it could not be held in a day centre.

Dorothy-Grace Elder: In theory, it could.

You mentioned that one of the problems that is faced south of the border is delay. You said that there could be more delay in the sheriff court system. Will you give more details?

Dr Osborn: The delay is not a problem with short-term detention. I should just check that you are clear that tribunals in England and Wales do not impose detention; they simply hear appeals against short-term detention and they do so quickly. They are required to do that because short-term detention lasts for only 28 days.

For the equivalent of a section 18, there can be many weeks' delay. It is probably three years since I had experience of the process, but at that time the limiting factor was a shortage of appropriate medical members.

11:30

Dorothy-Grace Elder: We have heard consistent evidence about the severe shortage of psychiatrists. Is it your experience of the English system that delays are caused by a shortage of professionals?

Dr Osborn: Yes, that is probably the main limiting factor. The other problem was administrative. Resourcing the tribunals and providing clerking for them was often quite difficult.

Dorothy-Grace Elder: Have steps been taken in England to improve the training rates of psychiatrists?

Dr Osborn: I do not know. The recruitment process through the Lord Chancellor's Department is quite cumbersome. I was appointed as a medical member and the process was quite lengthy and slightly daunting. That might have something to do with it.

The tribunals are organised on a regional basis and I think that that helps. In a big geographical region such as Wales, if there are two appeals in the same week, and one is in the north and the other is in the south—a four-hour journey—it is difficult for the tribunal to hear both on the same day. Small geographical regions help the tribunal to organise itself flexibly.

Another problem that is becoming increasingly difficult is the adversarial nature of tribunal hearings. It has become standard for the patient to have a legal representative. Sometimes that is a legal executive, sometimes it is a solicitor's clerk but often it is a solicitor. The process is becoming increasingly adversarial, which takes up time, money and makes the process more cumbersome.

Dorothy-Grace Elder: Do you mean a qualified solicitor is almost always used? Is there someone acting for the unqualified advocacy service as well?

Dr Osborn: They might well be involved as well, but almost invariably, patients will have a legal representative of varying degrees of qualification. In hospitals I have worked in, it would be standard for the nursing staff to contact a solicitor for the patient if the patient did not have his or her solicitor and they were appealing to the tribunal.

Shona Robison (North-East Scotland) (SNP): Before I ask about the financial memorandum, I want to ask about what you said about the adversarial nature of the tribunals. How could that be changed? A person has a right to legal representation, and lawyers, being lawyers, are trained to be adversarial. How can we change that while maintaining patients' rights?

Dr Osborn: I am not a lawyer but surely there could be guidance, for example in the code of practice or from the Law Society of Scotland. There are ways in which the adversarial nature of the tribunals could be minimised. As you say, a lawyer's job is to ask questions and that is quite right, but I have seen situations in which it is clear that the patient is distressed by the process and is very unwell and there is a lot of cross-examination, which can take a very long time. That also contributes to delay.

Shona Robison: With a new system being developed in Scotland, there is an opportunity to ensure that the culture of the tribunals is correct from the start. I am not sure whether there will be a code of practice, but it strikes me that it would be sensible to have one.

On the financial memorandum to the bill, do you believe that the setting up and maintenance of the tribunals have been costed adequately?

Dr Osborn: I have not had a chance to see that. I came at rather short notice. I have been on leave.

Shona Robison: For example, £1 million is set aside to set up the tribunal system—to deal with administration and recruitment. You said that one of the problems in England has been providing clerking services and resources for the mental health review tribunals. It is hard to say whether £1 million is enough. Is your concern about the administration and recruitment? Is it about getting the staff or about having the resources to employ enough of them?

Dr Osborn: My concern is about employing enough staff. There will be a recruitment problem with psychiatrists. It will not be insuperable; its extent has been somewhat exaggerated, based on a misunderstanding. I do not know whether the committee has had evidence from the Royal College of Psychiatrists. Its figures were based on the assumption that a psychiatrist would have to sit through the whole of a tribunal hearing. The practice in England and Wales is that the psychiatrist gives his or her evidence and is then allowed to leave. Therefore, it does not take up the huge amount of time that the Royal College of Psychiatrists envisaged when it made the calculations.

Recruitment of psychiatrists will not be as difficult as some think, but it will be something of a problem. However, resourcing the day-to-day administration of the tribunal is extremely important. I do not know whether £1 million is enough. I guess that the Lord Chancellor's Department—

The Convener: I clarify that the £1 million is for the set-up costs. The running costs are £2.4 million, and there are members' fees and staffing costs. The £1 million is just for the set-up. After that, I guess that the continuing costs would be between £2 million and £4 million.

Dr Osborn: I do not know how much the tribunals cost to operate in England and Wales.

The Lord Chancellor's Department at Westminster would be the best place to get that information.

Shona Robison: We should do that. We should find out what the actual running costs are.

Dr Osborn: There are regions roughly the size of Scotland—in population, that is; not quite geographically—that could be used for comparison.

The Convener: We will check whether the Executive has used those as a benchmark for proper resourcing.

Mary Scanlon (Highlands and Islands) (Con): Does Dr Osborn anticipate any problems in finding consultant psychiatrists to staff tribunals? I put that question against the background of the 30 vacancies in Scotland and the fact that we would need up to another 28 psychiatrists to staff the tribunals. We heard that last week. Basically, we need 58 psychiatrists.

I return to the point that John McAllion made. Dr Osborn's choice is for the medical member not to see the patient but to depend on written evidence. Is that choice based on the shortage of psychiatrists and the cost or is it based on patients' best interests?

Also, Dr Osborn seems to feel that tribunals are adversarial. Is she shying away from the patient's interest because of the shortage of psychiatrists and the cost and time that are involved?

Dr Osborn: The fact that the psychiatrist will not interview the patient beforehand has nothing to do with the shortage of psychiatrists. As I explained, it would deny the patient natural justice if somebody interviewed them, made an opinion on whether they were detainable and then stepped out of the role of clinician and expert witness to sit and adjudicate. That does not seem fair to the patient. It has nothing to do with the shortage of psychiatrists. Until you said that, it had not occurred to me that it would save quite a lot of medical time if Scotland adopted a system in which the medical member of the tribunal does not see the patient.

Mary Scanlon: It will. Last week, Bruce Millan said that the consultant psychiatrist at the tribunal could not deviate from the written evidence unless they saw the patient, so it would be unlikely that they would make any further decisions.

Dr Osborn: In my experience, that is not the case—the psychiatrist or medical member can ask questions of the patient. The responsible medical officer and the social worker can assess the answers and weigh up the accuracy of what they say and the plausibility of the evidence. It is not true that the psychiatrist cannot talk to the patient, they do so in a transparent way, in that what they say to the patient and what the patient says to them is open and everyone knows about it. It is very much in the patient's interest that there are no secret medical examinations and that all the evidence is available.

Mary Scanlon: Will it be a problem to find consultant psychiatrists to staff the tribunal?

Dr Osborn: It will not be as much of a problem as some people envisage. I suspect that the job will be quite attractive for psychiatrists who have just retired or who are coming up to the age of retirement.

Mary Scanlon: That was mentioned when the committee visited Parkhead last week. You would be quite comfortable with such an arrangement.

Dr Osborn: Yes.

Mary Scanlon: Would the commission support having non-psychiatrists serving as the medical member of the tribunal?

Dr Osborn: The commission's position is that although it is not essential to have a psychiatrist, it must be someone who is competent. They must have demonstrable competency in assessing psychiatric issues such as medication and diagnosis. An example of a relevant person would be a doctor who is on the General Medical Council's specialist register as a specialist in psychiatry or who has a higher qualification in psychiatry, such as membership of the Royal College of Psychiatrists. There are general practitioners, public health physicians and various other doctors who have such competency.

Mary Scanlon: On the point about the adversarial nature of the process, are you happy about the patient and their named person being entitled to legal representation and legal aid?

Dr Osborn: I have said that I am unhappy about the adversarial nature of proceedings, which is not always in the patient's interest, but it would deny patients their right if they did not have legal representation. I would be very unhappy about a ban on legal representation.

Mary Scanlon: Does that proposal open up the way to a lawyers' paradise?

Dr Osborn: It does, but one must think about the patient's position. Not all patients have family, friends or advocates who can speak for them, help them to formulate their views and scrutinise the grounds given for their detention and any loopholes in those grounds.

Mary Scanlon: Would you welcome the presence of lawyers?

Dr Osborn: I would not welcome it, but I think that lawyers are necessary.

The Convener: Dorothy-Grace Elder has a suggestion about how we could keep the situation less adversarial.

Dorothy-Grace Elder: In Dr Osborn's opinion, would it be adequate for a patient to be represented by someone from an advocacy service who has had training in patient advocacy but is not a lawyer? Would not that remove some of the adversarial impact?

Dr Osborn: That could be the case, although it would depend on the training, experience and quality of the advocate. The patient should be free to choose.

Dorothy-Grace Elder: It could be argued that a person who is connected to a worthy group that has the aim of helping patients would have a genuine commitment to mental health welfare, whereas a hired lawyer could be just anyone—the first cab off the rank. The lawyer would make money out of it.

Dr Osborn: Most hospitals have a list of local solicitors or lawyers with mental health interests and experience. My experience south of the border was that the same three or four solicitors would usually represent patients in a particular hospital. Those solicitors had built up expertise and some of them had a high degree of compassion. We might have disagreed about how they thought their compassion should be exercised, but they were genuinely committed to their clients. There were some very good lawyers. It would be hard to deny the patient the choice. There is an issue of liberty.

Dorothy-Grace Elder: Could an advocacy service that is not legally professional but which is better trained and has more facilities make up for the lack of 100 per cent legal input?

Dr Osborn: In some instances it could. Everything depends on the quality of the training and the legal understanding of the advocates. Advocacy is pretty thin on the ground and training is not yet of the required standard. Significant resources are needed to put that right.

11:45

Mr McAllion: We are all concerned about the adversarial nature of hearings. Because of the adversarial nature of court proceedings, what happens in the courts at the moment is not justice. If it is passed, the Mental Health (Scotland) Bill will become law. We are talking about people's legal rights, so they need proper representation.

Dr Osborn: If I had to choose between lawyers and advocates, I would opt for legal representation.

Mr McAllion: Under the bill, would it be possible for the Executive to have a code of conduct that applied to lawyers who represent patients?

Dr Osborn: I hope so. A tribunal is supposed to be consensual, but sometimes members disagree and there are majority judgments. However, the aim is to reach a consensus view, so it would be helpful if the ethos of everyone who participates in the tribunal was to try to achieve consensus.

The Convener: That is the ethos of the Health and Community Care Committee.

You suggested that newly retired psychiatrists should serve on the tribunal. The same point was made to us when we visited Parkhead hospital. Will not those who serve on tribunals be required to maintain their professional development?

Dr Osborn: Absolutely. I suspect that there would have to be a limit on how long doctors continued to do such work after retirement. No matter how many courses people attend, eventually they get out of practice.

The Convener: So we are talking about people who have been retired only for a few years.

Dr Osborn: Yes. I would set a limit of five years after retirement.

The Convener: That seems reasonable.

Shona Robison: The Mental Welfare Commission has made a good suggestion about the right of appeal against excessive security. That aside, do you think that the provisions for appeal against decisions of the tribunal as set out in part 18 of the bill are reasonable?

Dr Osborn: From my reading of the bill, it is not clear that the tribunal would have the authority to compel provision of adequate treatment. If a care package proves to be inadequate or is not fulfilled, it is not clear what sanction is available to the tribunal, except to rescind the order. That may not be appropriate. The person concerned may still be ill and at risk and may still need treatment. I would like the bill to make provision for the tribunal to hold authorities to account if a care plan is not delivered.

Shona Robison: I fear that out of reluctance to rescind orders—which would result in a delay in treatment—tribunals might end up accepting the services that happen to be offered, regardless of the needs of the people concerned. Do you share that fear?

Dr Osborn: The only real sanction that the tribunal has is to rescind an order. It could require an explanation of why a service is not being delivered, but that is a fairly soft sanction. I would like the tribunal to have the power to require service providers to account for non-delivery of a care plan.

Shona Robison: There is provision for service managers to be brought before the tribunal to answer for their actions.

Dr Osborn: I thought that I had seen that provision in the bill, but I could not find it when I looked for it again.

Shona Robison: That is perhaps a slightly different issue from the ability to compel an authority to provide a specified service. As far as I know, the tribunal does not have that power—I see that the committee adviser agrees. There seems to be a grey area in relation to how far the tribunal can insist on particular services, because it will end up as a service-led rather than a needs-led package.

Dr Osborn: Being hauled up before a tribunal to explain and justify decisions acts as a strong sanction for service providers. Instead, most people would try to provide the required care plan and avoid that happening. However, you are right. The authority might say that it cannot provide particular services because it does not have the resources. I return to the point about levels of security. Although the commission was very much in favour of that provision, one can imagine a scenario in which the tribunal concludes that a patient should be discharged from a state hospital. However, facilities might be—and might continue to be—unavailable in that patient’s home town. What would a tribunal do if a health authority then claimed that it did not have the resources to provide the facilities? One reaches a point at which, even if resources were to be made available, services might not be provided until the next year or the year after that. After all, it takes a while to develop services.

Shona Robison: The MWC has suggested that implementation of part 3 of the bill should be delayed as a fall-back position to allow health authorities to get their acts together. However, we all know that mental health services are not the top priority and there is concern that if the provision is not strong enough to compel health authorities to provide services, the required services might not be developed.

On the other hand, when we visited the Orchard clinic, we heard concerns about the possible knock-on effect of services. The introduction of a duty to provide medium-secure units for people coming out of the state hospital might make it difficult to provide community services for people who leave medium-secure units. As a result, there is a problem with resourcing at all levels.

It was suggested that the school of forensic psychiatry, which is about to be established, might give us an opportunity to take a global look at all the services that are required down the line. What is your view on that?

Dr Osborn: I do not know about any proposals for a school of forensic psychiatry. However, I have heard of proposals for a forensic psychiatry board to co-ordinate services throughout Scotland.

In my heart, I agree that there should be some sanction to compel service providers to provide the care that people need. As the Millan report pointed out, if a patient is deprived of his or her liberty, it is only proper that there is a reciprocal duty on service providers to give them appropriate treatment. One of the great anxieties about making that compulsory in the way that Shona Robison suggests is that service providers might switch resources from patients who are not detained, which will disadvantage people who might be just as ill but who are prepared to be treated informally. That would be a lamentable state of affairs. I have no simple answers to the question and the issue is not easy to deal with, given that there are limited resources.

Mary Scanlon: The compulsory treatment order is linked to the care plan, which would be approved by the tribunal and reviewed every two years. In your submission, you say:

> “The Tribunal will have the power to revoke or modify the order.”

Would it do so because a local authority did not have adequate staff or resources? How would you balance such a decision in the patient’s interest? If Dundee City Council told you that it did not have adequate trained staff and resources to support the patient in the community under a compulsory treatment order, would you be forced to modify the order in line with the council’s inability to provide the service, knowing that that would not be in the patient’s best interest?

Dr Osborn: We might be, but there might also be alternatives that could be investigated and put in place by the tribunal.

Mary Scanlon: That is what I am worried about. What kind of alternatives would there be? Your written submission on compulsory treatment states:

> “The Tribunal will have the power to revoke or modify the order.”

I am worried that an agreed treatment order and care plan might have to be watered down to suit the levels of available resources and staffing. Do you share that concern?

Dr Osborn: Yes. That is of great concern, but it is no different from the current situation.

Mary Scanlon: We were hoping that the situation might be different—we all hope that the bill will make a difference, but we seem to have identified a loophole. Would you be forced to modify orders to suit the resources held by the council?

Dr Osborn: It might be possible to modify an order so that a voluntary organisation or private provider could provide the service. It is not always the case that a service is not available if one given provider is unable to deliver it. There may be opportunities to make other modifications. It is a problem, however.

Mary Scanlon: The option that you describe would be the second-best option.

Dr Osborn: That is possible, but things might change. If an order is reviewed two years after having been imposed, there might have been considerable changes in provision.

Mary Scanlon: The bill requires high levels of staffing and training; that will require huge increases in the number of key staff and the amount of resources. Resources are already stretched, given the introduction of free personal care for the elderly and so on. It is worrying to hear your view of things at this time, given the paucity of existing services for people in the community who suffer from mental illness. It is also worrying to hear how you would be willing at this stage to water down a care plan to suit a lack of resources, rather than to suit what is in the best—

Dr Osborn: I am not saying that I would be prepared to do that.

Mary Scanlon: I appreciate that.

Dr Osborn: I am saying that there is an obvious danger—

Mary Scanlon: That you may have no alternative.

Dr Osborn: Community services are excellent in some parts of the country. Only in certain areas are they not as well resourced as they might be.

Mr McAllion: It is not always a question of resources. A number of health boards are struggling to get medium-secure units established. Communities will not have them and are fighting against proposals. Surely one of the ways in which the Mental Health (Scotland) Bill could make a difference is by placing a duty on health boards and local authorities to provide age-appropriate environments, such as proper medium-secure units, for young people who have mental illness. Such moves are being resisted by the Executive, for obvious reasons. Do you believe that the committee should recommend that such a duty be placed on health boards and local authorities?

Dr Osborn: Yes, I do—it is the right of patients. Until now, we have been depriving people of their liberty and giving them treatment. No one specifies what that means; it is left to the discretion of the people who give the treatment. It is absolutely appropriate that, if someone is compelled to do something that they do not want to do, and if they are deprived of the freedom to behave as the rest of us may behave, there should be a reciprocal duty on authorities to provide appropriate treatment.

Mr McAllion: That is meant to be one of the principles that underpin the bill. Such a duty would therefore be appropriate.

Dr Osborn: Yes. One of my concerns about the bill—this might be developed in later evidence—is that its principles are not explicit and the MWC has been pressing for them to be made more explicit. The principle of the least restrictive alternative is now explicit, as is that of equality of opportunity, but other principles, such as reciprocity, are not.

Shona Robison: Given what we have been saying about the problem with resources, do you recommend to the committee that it push for the monies that are in the financial memorandum to be ring fenced?

Dr Osborn: My view is that legislation should not be driven by resources; it should aim for what is right, with resources then being sought to provide the necessary services. I would be in favour of anything that protected existing resources—I would, of course, would wish resources to be increased in future.

The Convener: So would you be generally in favour of ring fencing the money required?

Dr Osborn: I am not a politician or an accountant, but I am in favour of anything that safeguards resources.

The Convener: I thank everyone for the first evidence-taking session. We will adjourn for lunch.

12:00

Meeting suspended.

12:46

On resuming—

The Convener: I welcome Dr Osborn of the Mental Welfare Commission back to the committee. She has returned for a second bout—we are glad that she did not nip off at lunch. I also welcome Shona Barcus and Richard Norris of the Scottish Association for Mental Health, who are well known to the committee. Does either of the new witnesses want to make a short statement or would you prefer to move straight to questions?

Shona Barcus (Scottish Association for Mental Health): I will be brief. The committee has received our written submission; I will therefore not refer to it. We want to thank the committee for giving us the opportunity to influence the parliamentary process. As the bill represents possibly the biggest and most complex bill to come before the Parliament, the committee has an unenviable and challenging task.

The Convener: We think so.

Shona Barcus: The decisions that the committee will take over the next few months will affect the lives of many people for a great number of years. We are pleased to be in Dundee, because the city is home to a number of innovative groups and services, including the Corner—which deals with the issues that face young people—the Hearing Voices network and Little Wing. The committee will hear evidence from the last two groups later this afternoon. Those innovative organisations have an impressive focus on empowerment, involvement, self help and recovery.

Richard and I give evidence today as representatives of our staff and of the members of SAMH who use our many services throughout Scotland. We also represent 59 organisations and more than 600 individuals who are the signatories to our campaign. The signatories include the Scottish division of the Community Psychiatric Nurses Association, the British Psychological Society, many user and carer groups and voluntary organisations. Members may have seen our campaign publicity. We represent a significant weight of support for the positive elements of the bill, but we represent a similarly significant weight of concern about some of the elements with which we are not so comfortable. We hope that the committee will accord those concerns serious consideration in its scrutiny of the bill. I will stop there, because the committee has our submission. Thank you for the opportunity to say those few words.

The Convener: I will kick off the questions. Does the Scottish Association for Mental Health support the general principles of the bill? Do you consider that there has been adequate consultation on the bill?

Shona Barcus: We support the general principles absolutely, but we share the disappointment that many people have expressed, including Bruce Millan in his evidence last week, about the way in which the principles appear in the bill. We hope that the committee will be able to amend that.

Richard Norris (Scottish Association for Mental Health): As to whether there has been adequate consultation, we were aware that three events were organised by the Scottish Executive to consult on the bill, but that user and carer groups in particular were seriously underrepresented at those events. We suggested that there should be a fourth consultation event, which we organised at short notice at one of our projects in Edinburgh, but it was rushed, so there could have been better consultation on the bill, in particular of patient groups and user and carer groups.

The Convener: So, you are happy with the general principles, but you would have liked the principles of the Millan committee report to be in the bill.

Shona Barcus: Absolutely.

Shona Robison: I will address compulsory treatment. Your submission highlights the growing trend in compulsory treatment, which has seen a large increase of about 300 per cent over the past few years. Why do you think that that is so?

Shona Barcus: At the moment, it is possible only to speculate, because as far as I am aware, nobody has researched that, which highlights the great need for research. We are a bit concerned about the potential to extend the scope of compulsion when we do not know why its use is increasing.

That said, I will speculate. Part of the difficulty might be the failure of community care services to develop in the way that we hoped in light of the "Framework for Mental Health Services in Scotland", which was launched five years ago last month. We hear often from people who say, "When I want a service I can't get one. When I begin to feel ill and seek help, I'm told I'm not ill enough and when I end up needing a service, I'm still going to end up being sectioned. I don't want it any more." There is difficulty for people in accessing services.

The other element that is worth exploring is one that I raised previously. I had the opportunity to meet the president of the Royal College of Psychiatrists a couple of weeks ago in England. England has seen a similar rise in compulsion, only it is slightly ahead of Scotland. I asked him what he thought was behind that. Although what he said was anecdotal, he was fairly certain that an element of defensive psychiatry is at play. That assertion is held out by the experience of SAMH. When we first set up community-based residential services for people coming out of hospital because of the hospital closure programme, we often took people into those houses as tenants and residents as discharges from hospital under leave of absence. Some of my staff have said that it is interesting that many of the people who came out under leave of absence were meek and compliant with care. Their view was that there was a protective element among the people who were responsible for the medical care, which extended to releasing patients under leave of absence rather than as voluntary patients?

Shona Robison: By defensive psychiatry do you mean that those psychiatrists have used the precautionary principle and applied compulsory treatment to people when perhaps that was not the best course of action.

Shona Barcus: Yes. Dr Denise Coia alluded to that in her evidence last week.

Shona Robison: Will the bill lead to more or less compulsion?

Shona Barcus: We are afraid that it will lead to more compulsion. In the absence of research as to why compulsion has increased so dramatically, nobody can reassure us that it will not increase more. We understand that in other parts of the world where involuntary outpatient commitment—as it is sometimes known—is in place, there have been increases. We have only anecdotal evidence. We are trying to gain more concrete evidence about sections—or clauses—that have been applied elsewhere that restrict the amount of time that a community order can be in place; we have heard of things called sunset clauses that are used in north America. In some Australian states, orders expire after a time limit. We have been in touch with other organisations but we have nothing more than anecdotal evidence at present.

Shona Robison: You realise that it will be hard to amend the bill to remove compulsory treatment orders because they are a fundamental part of it. You seem to be suggesting that there should be some kind of safeguard, with monitoring to show whether levels of compulsion increase after enactment of the bill.

Shona Barcus: I am not sure that that is what I am suggesting, but because of the absence of research, we have general concerns about extension of compulsory treatment orders. Our other main concern about the extension of compulsory measures is that we do not have the range of community-based services that help people to get treatment early and avoid the need for detention.

I may be straying into evidence on the community-based part of compulsory treatment orders, but there is a ceiling on the number of possible detentions in psychiatric hospitals, which is the finite number of beds that are available. Once you start applying detentions to people in the community, how will you put a ceiling on the number? I am not sure that we have heard a satisfactory answer to that question.

The Convener: Has the increase in the number of episodes occurred since the 1980s or 1990s, or has it been a fairly recent thing?

Shona Barcus: The changes have taken place over the past 16 years. The rise in Scotland has been fairly steady and has been similar to the rise in England and Wales.

The Convener: Could that have anything to do with changes that were introduced in the Mental Health (Scotland) Act 1984? Were things handled differently before 1984? What about defensive psychiatry and legal challenges?

Richard Norris: It is difficult to speculate because no research has been done.

Dr Osborn: I would like to add to what Shona Barcus said. The increase in detentions is complex. It has been marked throughout the United Kingdom, and more marked in inner city areas than in rural areas. Central London and the bigger cities in England have a severe problem. Another factor, apart from unavailability of the range of community services, is that drug and alcohol misuse has increased hugely. Between one third and one half of people who are admitted to hospital have such problems. We know that drug and alcohol misuse makes people more disinhibited; they are more likely to do irresponsible things if they are irritable or aggressive.

As a result of the closure of hospital beds, hospital wards have become much nastier places, and much more disturbed places. Members will be able to imagine that if only the most disturbed people are admitted to hospital, there will be a lot of disturbance in the wards, which can be very difficult and disturbing for new people coming into those wards. People sometimes become more disturbed after being admitted, and then have to be detained to keep them in hospital.

Shona Barcus was right to talk about community services. There can be a delay before people are admitted to hospital, which might be partly because there are insufficient beds and partly because community services might not be available, although it is difficult to know that. People are therefore that much more ill before they come in, which means that they might require detention. Had those people been treated earlier, they might not have required detention. There is a range of interacting factors at work, and the phenomenon is pervasive.

Shona Robison: It strikes me that there is a crying need for research into what lies beyond that. Some of your suggestions are logical, but there seems to be a marked variation in the levels of compulsion from one area to the next, in rural and urban areas and in different parts of Scotland. Is that down to the practice of the local psychiatrists? I do not know. We need to press the Executive on what research it has done to inform its deliberations on the bill. Nothing has been presented to us that looks behind why the levels of compulsion are rising steadily.

13:00

The Convener: We could also ask whether there is regional variation across the country.

Shona Robison: Absolutely.

Mr McAllion: One of the conditions that have to be satisfied before a compulsory treatment order is granted is that the patient's ability to make decisions about medical treatment must be significantly impaired. Are you happy with that?

Shona Barcus: Not especially. We would like to know how that is defined. There is confusion between the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Scotland) Bill, in that two different gateways are being applied. In the Mental Health (Scotland) Bill, the capacity test comes in for special treatments as well. For some of those treatments, there is an issue about resisting or objecting to treatment, so the situation is not clear.

Richard Norris: During the consultation process, we maintained that it would be better to have one gateway to compulsion, which would be incapacity, rather than setting out two separate distinctions. The tests that need to be met for impaired decision making do not seem to be much different from the tests for incapacity, other than that one is meant to be a lower threshold than the other. We would like more detail about what is meant by impaired decision-making ability and how that will be measured in practice.

Mr McAllion: My reading of the bill is that significant impairment concerns a very narrow area of decision making: the ability to make decisions about medical treatment. Patients may be capable in other ways but unable to make a decision about medical treatment. Is not that a fair system? There are people who, for whatever reason, are unable to make a judgment about the necessity of their receiving medical treatment, and they could be at risk if they did not get that treatment.

Richard Norris: We would not argue with the idea that there must be such a category. We are not saying that there would not sometimes be a need for intervention if someone were unable to give consent. Our problem is that we are not clear how, in practice, impaired decision making will be different from incapacity. We assume that it will be different, but we would have preferred to see one test for whether somebody has the capacity to make an informed decision about their care, rather than two pieces of legislation with different tests.

Mr McAllion: So you are concerned that there are two legal ways in which that decision can be made?

Richard Norris: Yes. We would like more clarity about the difference between the two tests.

Mr McAllion: You spoke about defensive psychiatry. Is not there a danger that psychiatrists, afraid that somebody might damage or hurt themselves or someone else, might decide that somebody has impaired judgment in order to protect themselves from the risk of letting that person out into the community?

Richard Norris: There is a balance to be struck between making an intervention on the basis that someone is genuinely unable to make decisions for themselves and making an assessment of risk. As we understand it, the emphasis in the bill is meant to be on whether a person has the capacity or decision-making ability to consent to treatment. I do not think that anyone would argue about the fact that that could be a difficult decision to make in practice. We would like to be a bit clearer about the difference between decision-making ability and capacity. We argued that it would be clearer for everyone if we just had the concept of capacity in operation, rather than setting up a two-track system for considering whether people can make decisions in their own best interests.

The Convener: The Millan committee recommended that one of the conditions for compulsion should be that

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

That recommendation seems to have been replaced in the bill with the proposal that the making of the CTO in respect of the patient is necessary. Are you happy with that change?

Richard Norris: We prefer the original wording.

Shona Barcus: All the principles are important, but if one is thinking about using compulsory measures to deprive someone of their liberty, one must first consider informal care and ask whether it is possible to treat the person without resorting to compulsion. We are far from satisfied with that provision.

The Convener: Are you saying that the Millan committee's recommendation should be made explicit in the bill?

Shona Barcus: Absolutely.

The Convener: Do you have a view, Dr Osborn?

Dr Osborn: I assume that compulsion implies that there is no alternative and that informal care is not appropriate or possible. I suppose that that could be made explicit in the bill, or it could be contained in a code of practice. In principle, I agree that every avenue should be explored before compulsion is used.

The Convener: The Millan committee also suggested that the proposed care and treatment should be the least restrictive alternative compatible with the delivery of safe and effective care. That proposal has been omitted from section 53, although it makes a slightly modified appearance in section 1(9) and section 1(10). Should that proposal also be made explicit in the bill?

Shona Barcus: Yes—my view is the same. As I said, all the principles are critical, and the bill stands on the basis that principles such as the example that you gave are made explicit, as well as appearing elsewhere in the bill.

Mr McAllion: The bill allows the responsible medical officer to apply to the tribunal for a variation of a compulsory treatment order, but it does not seem to make a procedural distinction between applications to make an order less restrictive and applications to make an order more restrictive. Should such a distinction exist? Should the bill accelerate the procedure for an application to make an order less restrictive, so that it would go through almost on the nod?

Shona Barcus: I am not sure that I understand the question. We have some concerns about the potential to suspend the order and about the fact that tribunals seem to have less power in respect of the general authority to treat. We are also concerned about the role of advance statements in tribunal decision making.

Mr McAllion: I am talking about the responsible medical officer's right to apply to the tribunal to vary the CTO. The responsible medical officer can apply to have the CTO made less restrictive, or they can apply to have it made more restrictive. Should there be different procedures for each type of application? Should the procedure that covers applications that seek to make an order less restrictive be accelerated? Should those applications go through almost without opposition?

Shona Barcus: That is a good point.

The Convener: We have had so many meetings that I have lost track of them, but I think that it was only on Wednesday that we took evidence from Dr Lyons, who is from the Royal College of Psychiatrists. He said—I paraphrase—that it should be as difficult as possible to detain someone and that it should be as easy as possible to remove an order. That is what we are trying to get at.

Shona Barcus: We could not have put that better.

Dr Osborn: I agree.

Shona Robison: Are you generally content with the definition of "medical treatment" in section 228? Let me elaborate. The definition seems to be quite wide: it includes care, training for work and social and independent living skills. There could be a danger that people with learning disabilities might be made subject to a CTO when community care provided by a local authority might be a more appropriate alternative.

Shona Barcus: We are certainly concerned about the breadth of that definition. We believe that the bill should include some of the areas that have been excluded from it. We have argued that medical treatment, on its own, can be defined too narrowly. We have considered using treatments such as anger management and therapeutic approaches under medical treatment.

Dorothy-Grace Elder: Do the provisions on time scales, which appear in part 7, seem reasonable? I do not know whether you want to refer to that part, but I shall cite a couple of instances to save time. In section 45(6), there is a 14-day provision, whereby when

> "a mental health officer is required by subsection (1) above to make an application for a compulsory treatment order, the mental health officer shall make the application before the expiry of the period of 14 days beginning with—"

and so on. Then, section 46(3), on medical examination requirements, states:

> "Where the medical examinations are carried out separately, the second shall be completed no more than five days after the first."

I could go on, but I shall spare you. Those are fairly strict time scales. Do you think that they can be adhered to in everyday experience, given the shortage of staff—psychiatrists and so forth—that has been mentioned?

Shona Barcus: I do not know whether we have received any feedback from the people who use our services on whether that is a difficulty. We have concerns about the time scale that is set for the social circumstance report element. We think that 21 days is a long time to wait for an SCR. The impact of someone's social circumstances—their domestic and family life—can be crucial to their condition and if that is not taken into account early on, the decision-making process might not be fully informed.

Richard Norris: We do not have an informed take on how realistic those time scales are, so it is difficult for us to comment on that aspect.

Dr Osborn: The time scales are not dissimilar from those in the current legislation. By and large, there seems to be no problem with services' acting within those time scales.

Dorothy-Grace Elder: You will have heard of delays in the issuing of mental health officers' reports and so on, but you are not over-concerned about the inclusion of such time scales—14 days for the first report and five days for the second—in the bill. You think that the services could cope with them.

Shona Barcus: As Dr Osborn said, if those time scales are working at present and are contained in the current legislation, they would pose no difficulty if they were included in the bill. The danger of not including time scales is that things can slip. I would favour there being a time limit in the bill.

Dorothy-Grace Elder: I have an advocacy question for the SAMH representatives. How highly do you rate the advocacy that is provided by advocacy groups for the patient? Do you have any comments about the taking over of that role by legal representatives such as solicitors?

Richard Norris: We have a high opinion of the advocacy services. We do not provide advocacy services, but we know, from speaking to service users and carers, how highly those services are valued. We therefore support any attempt to ensure that there is improved access to advocacy services. My general impression is that it is not a question of choosing between an advocate and a legal adviser. It would not be a good thing for the choice to be seen as such. In some cases, a person may need to have good legal advice and a good advocacy service working for them.

Dorothy-Grace Elder: We heard from Dr Osborn of an adversarial, quite aggressive approach in the English mental health review tribunals, as solicitors are used in almost every case. Do you think that that is advisable, or could a compromise be reached if the independent advocacy services that exist were given a bit more legal training?

Shona Barcus: The line that it is not an either/or situation, as Richard Norris said, is the line that people would prefer to take. Independent advocacy of a non-legal kind is quite different and distinct. It is about helping people to express their needs, views and aspirations who might have difficulty in doing so themselves.

Likewise, collective advocacy has a very important role and perhaps you will hear more about that from your witnesses this afternoon. At the same time, legal representation is absolutely important. It should not be an either/or situation; people should have the opportunity to have both.

13:15

Dorothy-Grace Elder: The question of patient examination has been raised. We could be in trouble with the European convention on human rights if a member of the tribunal were the psychiatrist who might examine the patient. Is it possible or advisable to get round that by providing for an independent psychiatric examination as well as written evidence concerning the patient, telling the patient's story?

Shona Barcus: We expressed concern about the psychiatrist on the tribunal's being the same person who examines the patient, because of the independence of that individual and their rights. Having said that, it is important that the individual in question has the opportunity to speak to the tribunal, or to be represented by their named person or relative. I echo the point that Dr Osborn made earlier today that written evidence does not convey someone's full experience. It is important that the tribunal has the opportunity to ask questions of a number of people who are involved in the care of the individual and of the individual.

Shona Robison: You mentioned the social circumstance report. In recent evidence, we heard concerns about the changes to social circumstance reports, which would allow more discretion about whether they are completed. We all know that there is a problem at the moment, because 50 per cent of those reports are not completed, although it is mandatory that they be completed. Are you concerned that a far higher degree of discretion is creeping in?

Shona Barcus: Yes. I have expressed that concern as a representative of SAMH on the mental health legislation reference group and other members of the group have shared it, because they consider the social circumstance report to be an essential part of the assessment of the individual.

Shona Robison: Is it your concern that decisions might become resource driven, given time constraints?

Shona Barcus: There is concern that decisions could become resource driven anyway, but yes.

The Convener: We heard that evidence this week. Although concerns were raised about discretion, it was suggested that the Mental Welfare Commission for Scotland might have a role in overseeing the process and deciding whether a social circumstance report was necessary and whether a second opinion was necessary. Do you recall that that suggestion was made?

Shona Robison: Yes. I recollect that that was suggested as a possible safeguard. I do not know whether the representatives of SAMH feel that that would go far enough.

The Convener: Rather than it being down to the mental health officer to say that they did not feel that a social circumstance report was necessary, someone in the Mental Welfare Commission for Scotland could say that they felt that it was necessary. That would be a safeguard against decisions being totally resource driven.

Shona Barcus: Our view would still be that social circumstance reports ought to be made as a matter of course. That sounds a slightly cumbersome arrangement, but we cannot assess someone as a whole person in the absence of all the factors that influence them.

Shona Robison: I share your concern.

At our meeting on 9 October, we will go in great detail into the issue of community-based compulsory treatment orders. Representatives of SAMH are coming to that meeting, but Dr Osborn will not be there. I want to take the opportunity to hear whether the Mental Welfare Commission for Scotland supports community-based CTOs and what difficulties you anticipate arising from their introduction.

Dr Osborn: We strongly support community-based CTOs, because we see them as a less restrictive alternative to being in hospital. Admission to hospital is a hugely disruptive event in anyone’s life and can lead to stigma that disrupts their work, their family life and their experience with their children and has all sorts of knock-on effects.

We think that anything that would either prevent admission or shorten the time in hospital would be helpful. If I had to have treatment against my will for mental illness I would hate it, but I would hate going into a psychiatric hospital more. If I had to have treatment, I would regard it as preferable to have it while carrying on with my normal life.

Shona Barcus from SAMH elegantly described the dangers of CTOs, which may be unduly prolonged and may be imposed when there are no community resources to give people adequate treatment packages. The bill has attempted to provide safeguards against that. There will be mandatory reviews by the RMO and regular visits from the commission to people who are on CTOs. There is also provision for those people to appeal to a tribunal.

If I understand it right, people can appeal twice during a period of detention, which is 100 per cent more than they can do now. They can also have a review every two years. Again, I may have got this wrong but my understanding is that the tribunal will not do an automatic review after two years; the review must be requested by the mental health officer. I would regard it as a strong safeguard for people on CTOs that there should be an automatic review regardless of whether anyone requests it.

The Convener: We thought that the review was automatic.

Dr Osborn: I thought that a review was done at the request of the mental health officer.

The Convener: We will check on that, but my memory, which is not the best, is that the review is to be automatic.

Dr Osborn: The review is an extraordinarily important safeguard.

The Convener: We, too, think that and will check on the matter. However, it is not surprising that during our consideration of the bill we find a point of whose meaning we are unsure. If the review is the only such point that we find, we will be doing well.

Shona Robison: Are there other safeguards that could be introduced?

Dr Osborn: The care package has to be scrutinised and approved. We had a discussion earlier about whether the delivery of appropriate care should be compelled. Notwithstanding what we said this morning, it is a strong sanction that service providers must undertake to a tribunal to scrutinise the care package. If they do not do that, they would have to explain to the tribunal, even via the MHO or the RMO, why they have not done so.

Shona Robison: I want to explore one of the potential dangers a bit more. Someone could be put on a community-based CTO, but there could be triggers for their illness within their home environment. There is likely to be a reduction in available hospital beds because more people will become subject to community-based CTOs rather than being taken into hospital. Is there a danger that someone who would be better off outwith their home environment because that triggers their illness will no longer get access to a hospital bed because of the reduction in those beds? Have you considered that possibility?

Dr Osborn: It is not a substantial danger. There is little evidence about what triggers people’s illnesses. The only trigger that is well researched is that a high level of criticism in families can trigger relapses in schizophrenia, but treatment programmes are available for that. I would envisage such a programme being an element of the care package if someone on a CTO had such a relapse.

Shona Robison: Will a person’s home environment be looked at carefully before a community-based CTO is issued to assess whether the home environment would exacerbate the person’s particular problem?

Dr Osborn: I am talking theoretically about what would be good practice, but I think that most psychiatrists would want to do what you suggested. The SCR would be important in enabling the treatment team to make a judgment.

Shona Robison: So the SCR, which may become discretionary, could be critical in identifying whether it is wrong for a person to be located in the home environment. That takes us back to the SCR’s importance.

The Convener: I presume that access to legal and illegal drugs and to alcohol would be considered. There seems to be a co-morbidity issue in many cases—we have heard about that. I presume that such access would form part of the report, too.

Dr Osborn: It would have to do so. If a person is treated in the community and has access to drugs and alcohol, that would not help their mental health, although access to drugs and alcohol is not unknown in most psychiatric hospitals, unless they are very secure.

Dorothy-Grace Elder: If the bill is passed, will Scotland be out of step with the rest of the world in potentially allowing neurosurgery for mental disorders—NMD—on patients who cannot legally consent? The written evidence refers to practice in other countries. Any witness may respond.

Shona Barcus: Richard Norris will lead in answering the question for SAMH.

Dr Osborn: The 1991 United Nations resolution in respect of NMD suggests that that approach is not proper, although there are exceptions. How out of step we would be with the rest of the world is a complex issue. Members will have seen the Mental Welfare Commission for Scotland's written submission, which deals with the issue.

Dorothy-Grace Elder: We say "the rest of the world", but we are probably thinking more about practices in western Europe. The submission makes it clear that

> "mental health legislation is not intended to operate as a means of social control."

That is important. It continues:

> "We believe that the exclusions should be incorporated at stage 2."

Will you expand on that in relation to the protection of patients?

Dr Osborn: Did you mention stage 2?

Dorothy-Grace Elder: Yes—I assume that stage 2 of Parliament's consideration of the bill is meant.

Dr Osborn: Will you go through the question again, please?

Dorothy-Grace Elder: Yes. The submission states:

> "mental health legislation is not intended to operate as a means of social control. We believe that the exclusions should be incorporated at stage 2."

I think that "exclusions" refers to the types of person and condition that should be firmly and obviously excluded.

Dr Osborn: Are you talking about special treatments?

Dorothy-Grace Elder: Yes.

Dr Osborn: Will you tell me where you are quoting from in the submission?

Dorothy-Grace Elder: I am quoting from your submission.

Dr Osborn: Is that in the submission on neurosurgery for mental disorder?

Dorothy-Grace Elder: It is from the submission entitled "Neurosurgery for Mental Disorder: Submission to Health and Community Care Committee", which is from the Mental Welfare Commission for Scotland, I think; your submission refers to criteria for compulsory treatment orders.

The Convener: Hold on.

Dorothy-Grace Elder: Are we mixed up?

The Convener: What submission are you looking at? We have probably become confused by my asking you to ask a question three questions ahead of when you should have asked a question.

Dorothy-Grace Elder: I am asking question 19.

The Convener: What document are you reading from? Are we all looking at the same document?

Dorothy-Grace Elder: I am quoting from SAMH's submission.

The Convener: If I may be brutal here, Dorothy-Grace, you confused Dr Osborn and everyone else in the room, as you asked her to comment on SAMH's submission.

Dorothy-Grace Elder: I wanted SAMH to answer, but Dr Osborn volunteered to answer.

The Convener: The question is directed at Shona Barcus and Richard Norris. I will ask about specific treatments.

Dorothy-Grace Elder: My question is: if the bill is passed, will Scotland be out of step with the rest of the world in potentially allowing NMD on patients who cannot legally consent?

Richard Norris: In a word, yes. We will be out of step. It is important to note that, in many countries, NMD is either banned or not given. However, we have tried to find out what the legal situation is around the use of NMD in those few countries that allow the procedure to be performed. For example, in the Australian states where it is used, it cannot be given without consent. That also seems to be the case in the American states that I have managed to consider.

My research has not been exhaustive. At times, it is difficult to find the information. The recent Royal College of Psychiatrists report, for example, shows that that body, too, had difficulties in trying to ascertain the exact legal constraints governing NMD, where it is given.

The United Nations resolution that we quoted in our submission and the Council of Europe guidelines in the more recent white paper both state that NMD should not be given without consent. There cannot be much doubt but that Scotland would be out of step with a significant amount of international opinion.

13:30

Dorothy-Grace Elder: Your submission also states:

> "We are therefore very disappointed that the tribunal will not have the power to exclude specific treatments from being given, regardless of an individual's wishes and feelings."

For example, you mention an individual wishing not to have electroconvulsive therapy. Why do you think that those exclusions have not been made? What is the thinking behind that?

Richard Norris: We are not clear. I take it that you are referring to the power of the tribunal to make an order. Earlier, we understood that the tribunal would have powers to specify what sort of treatments it was authorising. That is how we understood terms such as "tailored order"—the order would be tailored to the individual's needs.

We are disappointed that the tribunal will not have that power. We believe that it is right and proper that the tribunal should know some things, but it does not have to make a decision based on every aspect of someone's medical care. The fact that it has the power only to authorise treatment or not and cannot make any comment means that it cannot say, for example, that an individual has made an advance statement that they do not want to be given ECT.

That is just an example to show that the tribunal would not have the power to say that it wanted the order to honour a certain condition. All that the tribunal can say is that it gives general authority to treat under part 13 of the bill. We believe that it is wrong that the tribunal will not have any more power than that.

Dorothy-Grace Elder: Does that fit in with your fears that the powers could be used as some form of social control and that people are being done unto?

Richard Norris: Where someone makes an advance statement about what sort of treatment they do not want to be given, they might also use that statement to say how they could be treated. However, we know that demanding a particular treatment is a slightly more complex issue than saying that one does not want a particular treatment.

That is clearly in line with the Millan committee principles on informal care, participation and the least restrictive alternative. The issue is all about empowering the patient to make a decision when they are well about how they want to be treated when they are ill. I know that giving patients the ability to say that they do not want to be given a particular treatment again—ECT or a particular form of drug treatment, for example—is a popular idea.

As we understand it, the problem is that the tribunal would not be able to do anything about that, even if it wished to. Even if the tribunal wanted to say that an advance statement should be honoured, it would not have the power to do so.

Dr Osborn: I have two points. One is about disregarding the patient's wishes and compelling them to have particular treatments. The other is about the safeguards surrounding special treatments such as ECT.

The Convener: Force feeding was another issue that was raised.

Dr Osborn: The point is that those treatments might be used only when a patient is not in a position to consent or to refuse consent because they are so severely ill. For example, I have seen patients in such a situation who think that the devil has entered their body and that they are so wicked that they deserve to die and do not deserve any treatment. Such a patient might stop eating, drinking and speaking. They might not be in a position to consent, if they are not speaking, or they might refuse consent to some treatments.

It seems invidious that a person who is less severely ill and is in a position to consent to treatment should be given it, while a person who is more severely ill, and, it might be argued, needs a certain treatment more, should not be given it because they are not in a position to consent to it—they are too ill to consent and their thinking is too disordered. I think that that would be the commission's position.

However, we believe that neurosurgery should never be given to anyone who demonstrates by resisting it or physically objecting to it that they do not want it. Simply because a patient cannot consent should not necessarily be a reason for depriving them of the treatment if that is the only option left that might make them better. The situation is likely to be extraordinarily rare, but we are concerned about protecting the rights of people who cannot consent. I see exactly where SAMH is coming from, but we must consider the rights of people who are so ill that they cannot consent. Are they to be deprived of treatment that might help them?

The inability of the tribunal to make directions about treatments was mentioned. That relates to the fact that safeguards, such as second opinions, are built into the bill to ensure that those treatments are not given unnecessarily. As the committee knows, in the case of neurosurgery, a complex set of safeguards with regard to second opinions and consent are built into the bill.

The Convener: How medically effective do you all believe NMD to be? Dr Osborn said that everything else might have been tried and that NMD might be the only option left. One of the submissions—I hesitate to say which one—said that the treatment was only 50 per cent effective, even for the small number of people who get to that point. The grounds for compulsion would seem a little clearer if you could say to us that it is 75 per cent or 85 per cent effective rather than 50 per cent effective. How medically effective is it?

Dr Osborn: Many treatments are only a third effective. It is sometimes said—this is perhaps a parody—that many treatments make a third of people better, leave a third of people much the same and perhaps make a third of people worse. That is the bottom line, so 50 per cent is better than that. You have to ask yourself whether, if you were so ill that you were tormented by the idea that you were evil and that you were going to destroy the people around, you had tried everything else and there was a 50 per cent chance of the treatment working, you would wish to try it. I take the convener's point that we cannot say that the treatment is effective on everyone. However, like most treatments, it is effective on a significant proportion of people. Very few treatments are effective for everybody.

Richard Norris: One of the problems with understanding the effectiveness of the treatment is the fact that it is rarely given. It is difficult to set up standard random control trials to measure its efficacy. The other issue about the treatment is the potential for something to go wrong and the fact that it involves a process that is irreversible—the destruction of brain tissue. The NMD unit in Dundee report puts the matter succinctly and appears to agree with the view that the treatment should not be given to someone unless they can give consent. It states that one of the essential elements of the treatments is its irreversibility and the potential for serious adverse consequences. For that reason, the situation is not the same as for some other treatments.

I appreciate that saying that anyone who resists or refuses treatment should not receive it is intended to build in an extra safeguard. However, that leads to a degree of illogicality in the criteria for provision of NMD. Under the bill, if someone is suffering from disordered thinking that leads them to say that they want the treatment—which is not the same as informed consent—they may be given it. However, if someone is suffering from disordered thinking that leads them to say that they do not want the treatment, they will not receive it—even though their thinking may be just as disordered as the thinking of the person who says that they want it. The danger of making such a provision is that it takes us away from the central issue—whether someone understands the treatment, what it is intended to do and the risks associated with it, and says that they are prepared to take that risk. The provision takes us away from the issue of consent.

The Convener: Jim Dyer gave the example of someone who had consented to treatment but whose consent was not accepted, because it was seen as the product of disordered thinking. Clinicians must make a difficult judgment. That is why a range of safeguards has been put in place. Shona, do you want to pursue the issue?

Shona Robison: Some of my questions about the new safeguards and whether you regard them as appropriate have already been answered. Do you have anything to add on the issue?

Richard Norris: Are you talking about the safeguards relating to NMD in particular?

Shona Robison: Yes.

Richard Norris: Our position is that the existing safeguards should be retained. At the moment someone is given treatment only if they are able to given informed consent.

The Convener: Dr Osborn, you mentioned in passing the various safeguards that exist. Cases may be taken as far as the Court of Session.

Dr Osborn: Safeguards are built into the system. We are concerned about people who are so ill that they cannot consent. It is illogical and invidious to be able to give treatment to someone who is not so ill that they cannot give consent, but not to someone who is so ill that they cannot give consent, even though the person whose illness is worse may need the treatment more.

The Convener: We had hoped to have an opportunity to question the clinicians at the NMD unit in Dundee. However, it is not the role of the Health and Community Care Committee of the Parliament to take clinicians away from the much-needed clinics that they are holding today. We hope that we will be able to question them about the issue at another time.

Mr McAllion: SAMH's position is that NMD should never be allowed without the patient's informed consent. However, Dr Osborn has spoken about the case of someone who is so severely ill that they are unable to give informed consent. Would not SAMH's position mean denying those people the chance of treatment?

Shona Barcus: There is another illogicality in the provision. If someone is incapable of consenting but resists treatment, they will not receive it. There are two elements of discrimination at play.

Our concerns are based on the evidence, which is not robust in respect of NMD. Although I support whole-heartedly the contention that NMD's 50 per cent success rate might be higher than that of other treatments, we are concerned that there is not more research into other treatments that might have higher success rates and fewer side effects.

NMD is a fraught issue. It is a controversial and irreversible treatment. SAMH has invited the Health Technology Board for Scotland to subject the issue of giving NMD to an incapable patient to an assessment. At the moment the HTBS is considering that request. We have made it because we believe that it is essential for an independent panel of experts to scrutinise the issue. If the HTBS comes back with a decision that is counter to ours, we will have to go back to our members on the issue. However, from the evidence of the report of the NMD unit in Dundee and, the year before that, of the report of the Royal College of Psychiatrists, we would be surprised if it came to a different conclusion.

Mr McAllion: There are many checks before the treatment can go ahead: every other possible treatment has to have been tried and failed; if the patient shows any resistance or has any objections, the treatment cannot go ahead; the Mental Welfare Commission has to appoint two independent people who have to give their approval; and the Court of Session has to hear all the evidence before saying yes or no. Are those not safeguards enough? Does their existence not justify, in the rare cases where it may be needed, the treatment going ahead?

13:45

Shona Barcus: Because it is not possible before the operation to predict the likely outcome, benefits and side effects, the surgeons at the unit in Dundee say in their report that they would not recommend it. It is important to listen to people with expertise.

The protocol that people have to go through in the period before neurosurgery—which can be up to two years—includes a number of the treatments that we will discuss next week. I am thinking about drugs prescribed in excess of the recommended limits, drugs used in different combinations, drugs used for purposes other than those for which they are normally prescribed, and two courses of ECT. What on earth is the impact of all that on an individual? It is hard to come to any kind of objective conclusion based on research and evidence. The evidence is not robust.

Mr McAllion: The Dundee unit may not be prepared to use the treatment but, in evidence to the committee, the Mental Welfare Commission said that it did not believe that the unit should be able to decide for the whole nation. The commission says that the issue has to be decided by the Parliament and by informed opinion. Do you agree with that?

Shona Barcus: Yes, I agree with that.

Richard Norris: Absolutely—which is why we say that it should be for the Parliament and not for the Court of Session to make the decision. The Parliament should decide whether the treatment can be given without consent.

Mr McAllion: You mentioned that the United Nations had outlawed the treatment, but a limitation was put on that UN position. The treatment can be carried out if it is to protect a person's health and well-being.

Richard Norris: We do not believe that that limitation is intended to mean that people can do the opposite of what the resolution demands and still be in accordance with the resolution. The purpose of the limitation is to cope with a situation where two different parts of the UN resolution may come into conflict in a particular country. However, the limitation does not mean that people can ignore the precise and clear wording of the resolution.

Mr McAllion: We have spoken about the different stages before NMD is reached. Do you feel that the kind of person about whom Dr Osborn spoke will not benefit from NMD?

Shona Barcus: The evidence is far from clear. If the kind of person whom we are discussing gets surgery and does not benefit, where does that leave everyone?

Mr McAllion: What about the kind of person who does benefit? You would be denying them the chance of getting better.

Shona Barcus: The lack of evidence is a real issue. People can always wheel out someone who has been helped by a procedure, but others can then wheel out someone who has not been helped. The problems with evidence on NMD have already been highlighted but, in addition to that, no long-term follow-ups have been done on people who have had surgery. We know of someone—who had the operation and who used SAMH's services—for whom the benefit was very short lived. The depression disappeared, but so did all his other feelings as well. Those other feelings have still not come back.

To our knowledge, there have been no long-term studies in this country on people who have had the operation. Many doctors say that such studies are needed. We support that. We have to have evidence on whether the treatment should or should not be used. We do not have that evidence.

The Convener: Are you against NMD on principle or could you support it in certain circumstances if you saw evidence of its benefits?

Shona Barcus: Through consultation with members of SAMH, our position is that we are opposed to NMD if a person cannot consent. If the HTBS comes back and says that it thinks that NMD should be given whether people are capable of consenting or not, we will have to go back to our members.

The Convener: So consent is the issue, not NMD itself.

Shona Barcus: That is what we are discussing.

Richard Norris: When the clinical resource and audit group—CRAG—produced a report on the issue in the 1990s, a representative from SAMH was on the committee that examined the matter. It was agreed that further research would be done on NMD along the lines that Shona Barcus mentioned. At the time, strong views were expressed that the treatment should not be given. Research must be done to justify the continuing use of the treatment. No new evidence has appeared in the past 10 years to prove that it is okay to relax the safeguards on NMD.

Shona Robison: The outcome of the HTBS assessment will be important for the part of the bill that relates to NMD. If the HTBS assessment comes out against the use of that procedure, there will be implications for the bill. The HTBS has not said that it will definitely go ahead with the assessment, but the committee should keep an eye on the matter. If the assessment goes ahead, we should find out about the time scale.

The Convener: Whatever we say about the issue in our stage 1 report, given what we have heard, it would be reasonable to suggest that more research should be done on the issue, whether that is through the HTBS or some other mechanism.

Mary Scanlon: The Mental Welfare Commission for Scotland's submission mentions

> "the CRAG Good Practice Working Group Report on Neurosurgery for Mental Disorder (1996) and the Neurosurgery for Mental Disorder in Dundee Report by Matthews and Eljamel (2001)".

Before we jump on the bandwagon of complaining about delay by the HTBS, we should consider the evidence from that research.

The Convener: Richard Norris pointed out that SAMH has tried to find out about the use of NMD elsewhere in the world. Given that NMD is so rare, it must be difficult to produce a definitive answer on its efficacy. Because everyone is different, each of the few cases has its own set of circumstances. Even if we suggest that research ought to be done, only a relatively small sample will be available at any one time. Is that a fair comment?

Dr Osborn: Yes. Often, different procedures are used. It is difficult to find a group of people who have undergone the same procedure for the same mental illness. It is also difficult to follow up on that for long enough to discover the adverse and positive effects.

The Convener: What kind of on-going follow-up is normally undertaken with people who have such treatment in Scotland?

Dr Osborn: The unit in Dundee follows up on its group of patients. I might be wrong, but I think that the longest follow-up period is three years. A follow-up period must be long enough for the last person who is treated to be followed up for a substantial length of time. At present, the figures from the unit in Dundee are tentative.

Mr McAllion: How often are people given NMD with informed consent?

Dr Osborn: Do you mean in Britain?

Mr McAllion: In Scotland.

Dr Osborn: We have figures, but I cannot remember them off the top of my head.

Mr McAllion: Are there hundreds of people?

Dr Osborn: All the cases that the Mental Welfare Commission has seen involved consent. I do not know of any cases in which there has not been consent.

Richard Norris: I think that the Dundee report mentions 28 patients from 1992 to 2000.

Dr Osborn: The number is not large.

The Convener: That is about three or four a year.

Dr Osborn: Of course, under existing legislation, people must give consent.

Dorothy-Grace Elder: It has come through clearly from the witnesses that even when people can be ticked as giving informed consent, they might be in a state of disordered thinking. Indeed, some people's wish to self-punish has been mentioned. That issue applies to the question that Shona Robison raised about people remaining in the community and in their home. Professionals might not think that that is suitable in some cases even though the people involved seem keen to remain at home. There could be pressures in such people's minds or a wish for self-punishment. Is that a fair summation?

Shona Barcus: Yes. That can apply to people whose thinking operates in that way in any situation, including those that involve compulsion. However, it is remarkable what can be achieved through an effort to work with someone who has disordered thinking without resorting to compulsory measures.

The Convener: The witnesses from SAMH are back with us next week. I confess that I am losing track—not the will to live—of exactly when we will see witnesses. We are taking evidence in a way that is slightly different from normal. I believe that next week we will see the witnesses from SAMH to discuss compulsory treatment orders.

We have probably exhausted you, Dr Osborn, but is there anything you want to say that we have not covered?

Dr Osborn: No.

The Convener: I thank the witnesses for their written and oral evidence. We will now have a five-minute suspension to allow a comfort break for the convener.

13:56

Meeting suspended.

14:04

On resuming—

The Convener: In our final evidence-taking session, we will deal with a collection of issues—general views on the bill, compulsory treatment orders, NMD, and anything that the witnesses want to say about the bill.

We are joined by Bill Kerr, Caroline Kerr and Pat Webster from Hearing Voices and Lucille Crichton from Little Wing—[*Interruption*]—and a mobile phone. Whoever has the mobile phone, please switch it off. There is always one, and it is usually Mary Scanlon. You wait until you get your report at the end of the session, Mary.

I ask the witnesses to tell the committee a little about their organisations and about their general views on the bill and why it is necessary. Those are the starting points. What are your views on services and what are the big issues that the bill should address? I ask for an introduction to your approach to the bill.

Lucille Crichton (Little Wing): I am a member of Little Wing, which supports carers and users and is actively involved in planning—[*Interruption.*]

Dorothy-Grace Elder: I am sorry. That is my mobile phone.

The Convener: I am going to start something like a swear box to make money when that happens.

Lucille Crichton: The committee will have to bear with me. My husband was meant to do the talking and I am a wee bit nervous.

The Convener: Do not worry; you have seen what the MSPs are like—there is no need to be nervous. Just wait until you see what I do to the MSPs after the meeting. You have no need to be nervous—they, on the other hand, do.

Lucille Crichton: Little Wing is a member of the Tayside mental health strategy accountability steering group.

The Convener: How did Little Wing start? What was the thinking behind it? What are its services?

Lucille Crichton: I was not involved at the start; I came along later. I assume that Little Wing's purpose was to give people—particularly service users—a voice.

The Convener: Does Little Wing deal with service users across the spectrum of mental health services?

Lucille Crichton: Yes. The organisation is wide ranging.

The Convener: Does Little Wing work with service users and carers?

Lucille Crichton: Yes.

The Convener: Is the organisation in continuing dialogue with the Tayside health authorities? Are you involved in that?

Lucille Crichton: My husband has attended the steering group, along with Ron Lindsay, who is Little Wing's development officer. I am not involved personally.

The Convener: Am I right in saying that you brought your personal circumstances to the Parliament's attention through a petition about your son, Darren?

Lucille Crichton: Yes. He is here today.

The Convener: We welcome him. Will you tell us a little about those circumstances and how they might have coloured your view on the services that are available?

Lucille Crichton: When Darren first became ill, he was only 13 or 14 years old. That was when we saw a deterioration in his health. When he was 15, his illness had become apparent to us from little pieces of his behaviour, before he was taken into hospital on an emergency section. Initially, we had problems even being believed. His illness became volatile and he was aggressive. He was also abusing alcohol and drugs and it was hard to distinguish what the problem was.

Things just got out of hand. He was hearing voices—he was in touch with God, so to speak. He was in no way able to make a judgment for himself. We phoned the emergency doctor and we had to take him to get seen. He was given tablets, but he was no better the next day. He was not sleeping. We took him back, and he was given more pills, but we ended up having to have him sectioned at Ninewells hospital.

There was no bed at the young persons' unit. My son spent about a week in the hospital. After he eventually got into the young person's unit, he was thrown out because he was caught with a small piece of cannabis. We had to endure another few sleepless nights. The service failed us, and I am not too sure how the Mental Health (Scotland) Bill will tackle a lot of the problems. At the same time, now that he is out, I can see the other side of the coin.

The Convener: How did your son end up in Carstairs? I think that that was the point of your petition.

Lucille Crichton: I will have to fast-forward a wee bit. When he turned 16, his section order was lifted, although the psychiatrist who was seeing him was not completely sure about it. In fact, she had grave reservations about lifting the section, but he was okay at that point. He came out and got in touch with his friends again. He started dabbling in cannabis, and that threw everything out the window. His medication just did not work. He ended up back in the Royal Dundee Liff hospital. Something happened at the Liff, and he was thrown out. That resulted in a court case, and he was sectioned and sent to the Murray royal hospital in Perth.

He had electro-convulsive therapy—ECT—at the Murray royal, which did not agree with him. It made him violent. He was okay one minute—we went to see him, and he was fine—but we got a phone call later the same day to say that he had turned round on the spur of the moment and attacked a nurse. Sending him to Carstairs had not been planned, but it had to be done. The Murray royal did not have the staff to cope with his situation. He went to Carstairs and the staff there sorted him out within six months. However, when he was told that he could get a transfer back, there were no staff and no beds available. It was like that for two and a half years.

The Convener: So how long was he in Carstairs?

Lucille Crichton: For more than three years in total.

The Convener: So you believe that the services failed your son at various points of his journey and that, ultimately, he was incarcerated in Carstairs, under a level of restriction that was possibly way beyond what was appropriate.

Lucille Crichton: That is correct.

The Convener: So your main cause for concern relates to the aspect of the bill that deals with least restrictive treatment. That is why you petitioned the Parliament.

Lucille Crichton: Yes.

The Convener: Thank you very much. It is good for us to receive the background to the work that you have been doing and to know where you are coming from. We will ask more questions about the bill in a minute.

I invite someone from Hearing Voices—I am not sure who has drawn the short straw—to give us a similar background: a wee bit about what Hearing Voices is all about. I know that you have consulted your service users about the bill and what they think are the main issues.

14:15

Pat Webster (Hearing Voices): I am a trained psychiatric nurse. I work as a carer to someone who hears voices saying "Devil, devil" and God-type voices—someone similar to the person about whom Dr Osborn talked earlier.

As I do not know where to start, I will start with my family history, which is set out in a slightly different format in our submission. I have traced my family history over three generations. My uncle was in and out of mental hospital for more than 20 years—he was detained on and off all through his life. He ended up hanging himself in his home from the back of a door.

Another member of my family, who will remain nameless, continues to go in and out of hospital on detentions. I went into psychiatric nursing as a mature student. While I was working in an acute psychiatric ward, my son began to tell me about the voices that he was hearing and what was happening to him. My son was presenting the signs and symptoms of mental illness and I realised that he could end up detained in a psychiatric hospital just like the other members of my family. Although the other psychiatric nurses were caring individuals, I did not have much—what is the word?

Bill Kerr (Hearing Voices): Faith.

Pat Webster: Yes—I did not have much faith in the psychiatric services.

As soon as my son told me of his symptoms, I began to look for a way to help him. I was not willing to hand him over to the psychiatric services, although I felt that further down the road they could perhaps help him. I allowed my son to speak about his voices and, by exploring what he said, tried to work out what I could do for him. My son was extremely disturbed—as acutely disturbed as patients under detention in hospital. He was also quite aggressive.

I found out that the Hearing Voices network believed in what I was doing with my son: listening to him; exploring his voices and thoughts with him;

and allowing him to talk about his experiences. My son did not want to touch medication of any kind. He saw what happened to other members of our family as a result of medication. For 18 months, we worked together, but after that I told him that I could not carry on counselling him. I knew that he needed someone else to talk to—someone who was independent and who had more experience. After all, there are some things that you cannot share with your mum.

The Convener: There are things that I would not share.

Pat Webster: That is what I mean. I spoke to my son and made the decision to go to psychiatric services. When he went for his first appointment, I stayed outside in the car, as I did not want to be seen as the critical, overbearing mother. We had waited a month for my son's appointment, which was at 9 am. Anyone who knows about people who are disturbed thinkers knows the problems of having an early appointment, but I got him up and got him there.

When he came out after the appointment, he told me that the voices were saying to him, "Escaping loony." He had been told that, because he would not take medication, there must be nothing wrong with him. After 10 minutes, the psychiatrist felt able to state that my son needed medication and that he could not have the counselling that he had gone in for. The service did not address that need.

Further down the road, I managed to persuade my son that medication might relax him. To roll things on a bit further, he accepted the need to take medication, but, strangely, his counsellor was never forthcoming, so I decided to see the psychiatrist myself and say "My son took your medication. What about giving him a counsellor?"

The Convener: Your own version of reciprocity.

Pat Webster: That is right—reciprocity.

We are a self-help organisation. In my opinion, psychiatrists often take away people's responsibility for themselves and attempt to control their symptoms through medication. Marius Romme, who conducted research on voice hearing in Maastricht, has stated:

> "What the research shows is that the voices exist. We must also accept that we cannot change the voices. They are not curable, just as you cannot cure left handed-ness or dyslexia – human variations are not open to cure – only to coping. Therefore, to assist people to cope, we should not give therapy that does not work. We should let people decide for themselves what helps or not. It takes time for people to accept that hearing voices is something that belongs to them."

Another question has never been answered for me. Voice hearers are often diagnosed as being schizophrenic. If schizophrenics' recovery rate in western society has not changed in the past 100 years, before and after the use of medication, why do we continue to use medication even though it is not effective? I recently found out that a third of patients who are on medication recover. Dr Osborn referred to that as well. However, before medication, a third of patients recovered. Where are the third of patients who recovered before medication? I think that the answer is that we do not have good community care.

The Convener: Let me stop you there. We will move on to our questions for you. At the end of our questions, we will give you all a chance to talk through anything that you feel we have not addressed.

I shall begin with some fairly general questions. Are you in favour of the general principles of the bill, as far as you understand them? I would be interested to know whether you think that the underlying principles should be included in the bill—as many people have suggested—and whether you feel that there has been sufficient consultation on the bill by the Scottish Executive and the Parliament.

Bill Kerr: The bill is impressive and I am in favour of what is being done. However, I am reticent about certain areas, especially the compulsory treatment orders. I was under a six-month section six or seven years ago, when I became ill. The crime I committed was to walk from Forfar to Aberdeen. I had no money and did not get myself together to sign on—my thinking was too abstracted. What I was going through was like an LSD experience. My sister picked me up on the way to Aberdeen and took me to Sunnyside. Then I was sectioned. The result of the court case was a foregone conclusion, because I was not consulted, although I was perceptive enough to understand what was going on around me. I may have been having hallucinations and hearing voices, but I was sufficiently perceptive to know that I was not being represented in the court case.

I am concerned that, in a tribunal situation, individuals may not be sufficiently understood to be represented. I am also concerned that the psychiatrists say that they will not interview patients beforehand. I know that there are problems with that, but I suggest that a named advocate could play quite an important part in the process. They could develop the person's personal story. Like Phil Barker, who is a prominent individual in mental health services, I maintain that the person's story, as told by them, is important, because it gives them an identity and helps them to put across what they perceive in their illness in a way that the psychiatrist can understand.

The availability of such information would mean that psychiatrists had much more of a personal touch, as in the Victorian era, when the notes that doctors made were all written out in longhand in beautiful script. The doctor took in every detail. Now patients get three minutes with the GP and six or maybe even 10 minutes with the psychiatrist. That is it—a snap decision is taken. What concerns me about snap decisions is that they do not enter into the humanity of dealing with the individual.

The Convener: You will have heard the comments that earlier witnesses made about tribunals and the fact that, because the tribunal would be a legal entity, people would have the right to be legally represented. We were all a bit disconcerted about the idea of an adversarial situation. There must be proper advocacy, which could be a mix of legal representation and advocacy services. The role of a person's advocate will be to ensure that the person gets the best legal representation. You are suggesting that, like doctors and politicians for example, lawyers sometimes do not go beyond the legalese and might not consider the individual. An advocate who was a member of a more professional and properly trained advocacy service, for example, would take that aspect into account. Would that be a fair paraphrasing?

Bill Kerr: As a movement, Hearing Voices is more involved with people who come out of hospital than it is with people who go into hospital—we are more involved with rehabilitation. I am schizophrenic and have been under a section; I was in hospital about six or seven years ago and I returned for a few weeks about two or three years ago during a slight relapse. I understand where I am coming from in dealing with the problems of people who are more ill than I am. I can counsel them and speak with them. That is known as befriending counselling, which is an area of expertise that is not practised at all in the national health service. Psychiatrists do not psychoanalyse or counsel; their primary role is to provide a medical diagnosis and to prescribe a medicine for the problem. The main orientation seems to be towards medicine.

In the Hearing Voices Network, we deal with people who come out of hospital and who go through a process of rehabilitation, which can take a long time. Some people who are ill, who have difficulties and who are on the edge of hospitalisation are in the community. The closures of hospitals in Tayside means that more people with schizophrenia, manic depression and other mental illnesses will be in the community. I am concerned that there is insufficient representation for services such as Little Wing and Hearing Voices. Funding is difficult to obtain.

The Convener: A couple of my colleagues are itching to ask questions.

Mary Scanlon: I intended to come to my question later, but since you have raised the matter I will ask it now. Section 182, which deals with advocacy, states that local authorities, in collaboration with the health boards, have the duty to provide independent advocacy services. Some members are concerned that the emphasis is on authorities' duty to provide such services, rather than on the patients' right to receive them. Is the emphasis wrong? Should there be more emphasis on patients' rights to advocacy?

Bill Kerr: Advocacy is much wider than your definition of it. From the legal point of view, advocacy relates to the person who comes to the hospital to deal with one's legal problems, one's wishes and so on. The bill refers to a care plan, which also involves advocacy. Advocacy is a wide area. We are doing arts advocacy that involves writing, photography and music. I am involved with groups on all those levels. In my view, advocacy has much wider scope than simply the negotiations in hospital situations. Advocacy in the community is essential for involving people and keeping them well.

Mary Scanlon: I understand that, but are you saying that everyone who has had to undergo experiences like yours should have a right to have an advocate represent them?

14:30

Pat Webster: Before becoming an advocate for a member of our group, I had to go to Dundee Independent Advocacy Service and get it to back me. Until I did that, I was not accepted as an advocate by the medical people.

The Convener: Why not?

Pat Webster: I do not know.

The Convener: Do they have to give you a reason why they would not accept you?

Pat Webster: I was not experienced enough to know what my rights were. I went to DIAS and agreed to do some training. I was told that I was the only citizen advocate who was involved with that organisation who had specific experience in mental health. That shows that it was ridiculous that the medical people did not accept me.

The Convener: Maybe that was why they did not. Perhaps that comment should be struck from the record.

Pat Webster: I do not know the technicalities related to rights and duties. However, if I am the only independent advocate in the Dundee area who is qualified to act as an advocate for people who have mental health issues, that is a poor situation. A man called George does it part time, but his time is taken up with other things and he cannot go to acute psychiatry. I do not know how we can ensure that there are loads of advocates, but that is what is needed, especially in relation to detention. That will be especially important if the named person is not recognised by the person whom the bill describes as the prescribed person.

It seems the prescribed person could object to the named person and get rid of them. If that happens, it is important that an independent person can be selected to go with the prescribed person when they make their case.

Mary Scanlon: You were your son's advocate, but we have to think about people who have no relatives or friends. Should everyone have the right to an advocate?

Pat Webster: Everyone should have a right to an advocate.

Mary Scanlon: That is not in the bill. The local authority has a duty to provide an advocate, but the patient does not have the right to have one. People have expressed concerns about that.

Dorothy-Grace Elder: Was Bill Kerr represented by a professional lawyer without the presence of an independent advocate?

Bill Kerr: Yes.

Dorothy-Grace Elder: How good, bad or indifferent was the service?

Bill Kerr: There was a foregone conclusion, basically. I was approached at the hospital and told that I was being taken to court that morning. The lawyer introduced himself and we had a wee chat. I did not know what was going on but I went to court anyway. The psychiatrist gave his report, after which the social worker gave her report. I was sufficiently perceptive to be able to remember what she said, which was that she felt that I was a danger to myself and therefore a danger to others in the community. I must stress that I had not done anything violent or criminal; I had walked from one place to another and I had no money. I felt very much that the lawyer saw the matter as a foregone conclusion and was there simply to gather his fees. He did not represent me sufficiently and my wishes were not made available to the judge. The hearing was merely a formality to ensure that I received a six-month section.

Dorothy-Grace Elder: So the matter was at the level of a car theft or a routine breach of the peace.

Bill Kerr: Yes—something like that.

Dorothy-Grace Elder: You said that you had not met the lawyer before that morning.

Bill Kerr: That is right.

Dorothy-Grace Elder: So the case went before the court briefly. Did the lawyer say just a few paragraphs or sentences?

Bill Kerr: He said only a few sentences. The report from the psychiatrist, whom I will not name, took up most of the hearing. As I had never met and therefore did not know the social worker, I have no idea how she was able to produce a report on me.

Dorothy-Grace Elder: When did this happen?

Bill Kerr: It happened about seven years ago.

Dorothy-Grace Elder: Are you in favour of an independent advocacy service?

Bill Kerr: Yes.

Dorothy-Grace Elder: Are you also in favour of legal representation being available at the time?

Bill Kerr: I am in favour of legal representation if it is necessary, although I do not know whether it is, because it means bringing in the lawyers. I am very concerned about their antipathy and ruthlessness.

Dorothy-Grace Elder: "First cab off the rank", as I said earlier. Although other witnesses have said that some lawyers specialise in doing that, I have not heard of that myself, but my experience is more limited than yours.

Do the witnesses agree that, whether or not there is a legal presence, there should be independent advocacy, by which I mean people who have a good picture of the client?

Pat Webster: Yes, definitely.

Dorothy-Grace Elder: Do you accept the principle that there should be compulsory medical treatment in certain cases? If so, when is it appropriate to provide such treatment?

Lucille Crichton: In our case, such treatment was necessary. However, I also see the other side of the coin.

The Convener: As far as other people are concerned?

Lucille Crichton: The bill needs to strike a balance between the two.

Dorothy-Grace Elder: Do you think that it does?

Lucille Crichton: No. It is too weighted against people who cannot manage their lives without medication. If such people are in hospital, they can be compelled to take their medication. However, Pat Webster's son can manage quite well without it.

Dorothy-Grace Elder: Are there any circumstances that justify compulsory treatment?

Bill Kerr: Sometimes such treatment is necessary. If I had not been taken by my sister to Sunnyside royal hospital and been put under section or whatever, I would have got worse. However, we in Hearing Voices feel that some people are not made better by going into hospital. For example, if someone goes to the doctor with a medical ailment such as appendicitis and comes out in a rash because of the medication, he can go back to the doctor who might say, "That doesn't work; let's try this". It is a process of experimentation.

However, in mental health, there is a much greater process of experimentation. Doctors do not know what the drugs do or how they work, they just know that they work. Indeed, they do not know how they work in each case; they can only experiment to find that out. I was on the wrong medication for 14 years. As a result, I had depression, anxiety and paranoia. I ran a business that went to the wall. I had a very difficult time for 14 years simply because the doctor put me in hospital, put me on medication and left it at that. There was no provision in the community.

What concerns me is how we operate compulsory medication in the community. A doctor could give someone a bottle of pills and say, "You have to take three tonight". That person could put them down the toilet but say "Oh yeah, I took them faithfully." How do we enforce compulsory medication in the community? Such treatment lends itself much more towards depot medication, which is an injection. I get an injection once every three weeks and if I do not turn up for my depot, everybody runs around like headless chickens. They chase me up and can follow me up. Tablet medication cannot be enforced in the community.

Dorothy-Grace Elder: Given the background, care in the community does not have the most fortunate of connotations. In the past, it was not backed by sufficient funding. Is there a danger that many of the best intentions in the bill will simply result in more ill people being on the streets? Bill Kerr referred to his own journey—walking from Forfar further north. Are such situations a danger? Is there any way of getting round that? Is it a matter of funding?

Caroline Kerr (Hearing Voices): My concerns are that a lot of what has been spoken about today will take up a lot of resources, and that the measures seem to include a high measure of control.

I have made a written statement. I am concerned about how care in the community comes about. My husband went through the system, as he explained to you. If he had had a legal representative and had not been placed under a compulsory treatment order, he would still have come back to a situation at home that was already broken due to mental health difficulties, which came from social difficulties. As I said in my statement, neither the psychiatrist, the doctor nor the medication relieved any of those problems. They offered a measure of stabilisation, but they did not offer a recovery model. They did not offer any basic change to the social problems. I am finding that Little Wing and the Hearing Voices Network offer a model for basic changes.

I have not been in a compulsory situation, but I have been in a mental hospital twice because of psychosis. Of course, once someone has suffered from psychosis, they are much more at risk of its happening again, so it is possible that I could face being put in a compulsory situation. The problem is in relieving that.

I have lost the thread of what I am saying a little.

Pat Webster: Could you talk about antidepressants and when the episode of psychosis first started?

Caroline Kerr: I had my first episode of psychosis after I had been on antidepressants for a brief time. That was after Bill had been on medication that was prescribed by his doctor for 14 years. I went to the doctor several times to say that there were problems, but the doctor said that he could speak only to my husband. However, my husband did not think that there was any problem. I am one of many people who are in the same circumstances.

I made a point in my written statement about medical practitioners' assessments of the needs of patients. I spent only a minimal amount of time with a medical practitioner and it is not fair that practitioners make decisions on that basis. Now the Executive is speaking about tribunals at which a psychiatrist will make a decision, but it was mentioned that the psychiatrist might not be at the full meeting—the psychiatrist might not be there for questions. It might be that there is so much pressure on the number of psychiatrists—

The Convener: My understanding is that the individual psychiatrist would be at the meeting to be questioned in much the same way as you are here to be questioned for part of the day. Witnesses who come to give us evidence do not have to sit for the entire time that we are taking evidence; they can come only to give their evidence and be questioned. The same will be true of the tribunal. I do not think that the earlier witnesses meant to say that the psychiatrist on the tribunal would not be at the whole meeting. I think that that referred to the psychiatrist who was coming to give evidence.

I will pick up on another point. I am aware that other committee members want to get in. To some extent, what you say about the community basis of mental health services and some of the difficulties that you have had point to the social circumstances reports that mental health officers produce being particularly important. Is that a fair comment?

Pat Webster: Yes.

Bill Kerr: That is where the advocate comes in.

The Convener: We heard evidence last week that in many cases SCRs are not completed and that the bill will give mental health officers discretion not to complete or supply them. I take it from your evidence that the reports are very important.

14:45

Bill Kerr: They are vital.

The Convener: Bill Kerr made the point that all patients are sometimes with a GP or consultant for only a few minutes. Given that a mental health officer must complete the social circumstances report, I hope that they would have to spend more time thinking about the total circumstances of somebody's life, rather than just the three or four minutes that they spend with them.

Shona Robison: I have a couple of questions. You talked about your experience in court. Was the social worker whom you mentioned a mental health officer?

Bill Kerr: I think that the person was a social worker, but I do not know.

Shona Robison: Do you know whether a social circumstance report was written about you for that court case?

Bill Kerr: Yes, one must have been written, but I was not consulted.

Shona Robison: What I am trying to get at is that social circumstance reports are important, but if the mental health officer had not had much contact with you, the report would only be as good as the information that they obtained from you. In your case it sounded like there was not an awful lot of—

Bill Kerr: I think she wrote the report in her dinner hour.

Shona Robison: This comes back to the importance of the advocate. We want an advocacy service that goes under the surface and tries to garner from the person some of the background and triggers and tries to find out what the person is about and why they have ended up where they are. That is really what you are saying. The advocacy service has to be in-depth.

Bill Kerr: We are talking about counselling in a way, because many authorities agree that schizophrenia is caused by some kind of trauma in early childhood or adolescence. If the advocate can isolate that trauma and spend time with the person developing their story, that person will start to have the confidence to trust the advocate with information about themselves and the advocate will be able to build up a picture of the person. A person's story is valid and tells psychiatrists all sorts of things about where the person is coming from.

Shona Robison: Is that what the Hearing Voices Network does?

Bill Kerr: Yes.

Shona Robison: Is there much interest from psychiatrists in the work that you do?

Bill Kerr: I have never met one.

Pat Webster: I have approached psychiatrists to see whether we can have joint working or some sort of alliance. I had a meeting with a psychiatrist, which was very traumatic so I never went near another one. One psychiatrist approached us recently after Caroline Kerr had approached her. That psychiatrist will come and speak to us, which I am pleased about. We very much believe in joint working and in training professionals to know what we are doing. It is important that professionals know what hearing voices is about.

I want to go back to what Bill Kerr was said about appendicitis. If a person goes into a GP's surgery and says that they have a pain in the left-hand side of their abdomen, the GP would not give them medication, because he would have to find out what the underlying cause of the pain was. He could not give the patient medication until he knew whether that person had appendicitis.

If the doctor gave the patient medication he would cover up the pain, and the patient might die from septicaemia as a result of a burst appendix. We in the Hearing Voices Network feel that voice hearing is due to trauma in childhood, so why are psychiatrists simply giving people medication and nothing else? They often give too much medication, which covers up the voices, but the voices are the way to find out what the underlying problem is and how to deal with it. Many people in psychiatric treatment today are walking about with septicaemia of the mind. They are in and out of hospitals constantly.

Because I have the mike, I would also like to say—

The Convener: We are running out of time.

Pat Webster: My final point is on detention. A person came to my office last year in crisis. I phoned the services and asked whether he could be admitted, but they said that there were no beds. Because I could not get a place in hospital for him, he ended up having to be sectioned a few weeks later. He came back to me this year, in crisis again. No work had been done in the interim, other than detention in hospital. When he came back, he sat in my office and pleaded with me to be hospitalised because he needed to be stabilised again. He had been taught over 15 years that that was the coping strategy—when you are in crisis, you go and get detained in hospital. I phoned the services and asked them whether he could be put into hospital, because he really needed it, and that was the way he had always coped. They came and sectioned him. I asked the community psychiatric nurse why he was put under section, and I was told that that was the only way in which they could get a bed for him. I have seen that a lot of times in psychiatry. I only cite that case because I dealt with it personally.

Shona Robison: Your service offers a different type of treatment—that is not the right word, but you know what I mean. With compulsory treatment orders tribunals will recommend a number of services as part of a care package. How would the Hearing Voices Network feel about being one of the recommended services in such packages? Would you be comfortable with that? Would you be worried that you would become part of the medical establishment, or do you feel that you would be of such benefit that you would be happy to be part of a package of care?

Pat Webster: I have not considered that, but I will tell you of a recent experience. A patient was being detained and had been in hospital for several months. He requested that he be allowed out to come to a self-help group, and was refused. When his package of care was put together, it cited his care for the week in the day hospitals in Dundee but did not mention that he wanted to go to the Hearing Voices Network. I can see how voluntary services could be involved in some way, but I would be frightened that we would not have the necessary resources.

Shona Robison: So the resources to enable you to carry out that function would be important.

Pat Webster: Resources would be involved.

Bill Kerr: If the national health service funded us, it would dictate what we should do and we would not have the freedom to be what we are.

Shona Robison: So although you are looking for resources to be able to provide the services, you also want to maintain your independence.

Bill Kerr: That is right.

Mr McAllion: You make a tremendous case for alternatives to the regime that the national health service offers. Unfortunately, the bill extends the idea of compulsion. In addition to the provisions that will make it possible to detain someone in hospital and force them to accept medicine, the bill proposes compulsory treatment orders that insist that someone stays at a specific address, asks for permission if they want to change address, attends a specific place to take medicine and submits themselves to monitoring. Do you go along with that regime?

Pat Webster: By the very nature of our organisation, we cannot go along with that. Our vision is for voice hearers to find a place in a society that knows of and understands their plight. In our view, it would not give people a good message about normalisation if someone were to remove them from their home. That would breach their civil liberties. In all honesty, we cannot say that we go along with those proposals.

Lucille Crichton: The present regime is that most people go to different parts of the city for medication and check-ups, although my son goes twice a week to the Murray royal hospital, where everything is given to him under one roof, including checks for lithium and clozapine. If he had those checks in Dundee, he would have to go to different parts of the city, which would not be a good idea. When people go for checks and so on, they should be able to have everything under one roof. It is not right that my son has to go back and forward to Perth twice a week. He should be able to get everything in Dundee. However, the Murray royal hospital is the only place where he can get his care package under one roof.

Mr McAllion: We are back to the availability of services on the ground, and they are not available at present.

You were speaking about GPs giving patients only three or five minutes, or psychiatrists giving patients only 10 minutes at best. I know that the NHS homeopathic clinic insists on half-hour sessions with patients but, because of that, patients cannot get an appointment for six months. That brings us back to the issue of resources. If GPs and other doctors are to be allowed more time to spend listening to their patients and taking on board what they say, we will need more doctors and psychiatrists.

Pat Webster: The first question to ask is whether a patient needs to see a doctor at all. In my son’s case, he spent 10 minutes with a psychiatrist. Would it have been better for him to spend an hour with a nurse?

Mr McAllion: Possibly, but I suspect that psychiatrists favour medication as the answer to everything because of the time pressure—they simply do not have time to sit down and talk.

Pat Webster: That is my point. Nursing services and advocacy workers, in addition to psychiatry, should be available to patients as a right when they walk through the door of mental health services. That might allow people to get things right from the beginning, which might mean that they would not need such intensive treatment and care for the rest of their lives. My son has not been in a hospital, yet he has the same symptoms as two other members of our family, both of whom were in and out of hospital throughout their lives. Hospital treatment is used as a coping strategy—it is like a learned behaviour.

Mr McAllion: Dr Osborn told us earlier about one of her concerns. Fewer beds are available in the NHS and patients on wards are becoming more highly disturbed than ever before. Someone who is detained in a ward will have a much more traumatic experience than would have been the case previously. We should be trying our best to keep as many people as possible out of hospital. That means that we have to find a system to treat them in the community. Do you think that CTOs, with the compulsion that lies behind them, are a good idea?

The Convener: I suppose that CTOs are part of the reciprocity bargain that Millan suggested. The other side of buying into compulsion in the community is that the community will make available the range of services that people need if they are to exist within the community. As Pat Webster said, a person can be guaranteed services—although the circumstances might be difficult—if they are put into a hospital. We know that that person is not only taken out of a particular situation but put into one in which they may get access to services. If we leave them out in the community, the services are not there. The bottom line is that if there were services in the community, compulsory treatment in the community would be regarded as part of the bargain.

15:00

Bill Kerr: The CTO deals not just with people in hospital but with people in the community. Rehabilitation takes a long time. For example, it took me two or three years to come to terms physically with my medication. I was going about looking and feeling wiped out. I was on a higher dose then. I have since negotiated a reduction in the dose, so I am much more alert. Rehabilitation in the community must be part of a person's treatment under the CTO. The question is how that is negotiated.

Mr McAllion: What you are saying is that it cannot all be one way. The psychiatrist can require a person to live at a particular address and attend a particular location to submit to medication, but something must be given back to the person.

Pat Webster: As Bill Kerr said, it is about negotiation. Yesterday, we spoke to someone who has done a report in Aberdeen; he said that reciprocity is for equals and that negotiation is needed. I agree that if there is no negotiation, there is no reciprocity.

Mr McAllion: Meaningful negotiation is what you mean and not just someone sitting down and listening to you but then ignoring you.

Pat Webster: Yes—meaningful negotiation.

The Convener: I have a question that will probably interest Lucille Crichton particularly. One of the Millan committee's recommendations was that proposed care and treatment should be the least restrictive alternative

"compatible with the delivery of safe and effective care."

That condition has been omitted from a particular section of the bill. Obviously, a least restrictive alternative would have meant that your son Darren would not have ended up in Carstairs. A least restrictive alternative for someone else might mean that they would not be detained in hospital but would be treated in the community. Should that condition be included clearly in the bill?

Lucille Crichton: Yes.

The Convener: That would have made a big difference to you.

Lucille Crichton: Yes.

The Convener: Does anyone else have a view on that? The situation is that everybody agrees that there are people in Carstairs state hospital—which we will visit on Monday—who should not be there. However, people also agree that there are not enough medium-secure unit places for those people to be taken out of Carstairs and put into a less restrictive environment. We recently visited a medium-secure unit in Edinburgh. However, a few weeks ago petitioners who gave evidence to us did not want a medium-secure unit sited in Glasgow.

If I may speak on behalf of my colleagues, I say that it is obvious to us that medium-secure unit places are needed. Should a duty be imposed on the Executive to make available medium-secure unit places? Should the bill place a duty on local authorities, health organisations and the Executive to make available such places?

Bill Kerr: Carstairs is for the criminally insane and you will be more aware than are we of the number of people who are criminally insane. However, I have relevant evidence about a friend whom we will call Jim, although that is not his name. Jim was in hospital and was disturbed by voices, so he went through to his ward. The television was on and the staff were watching a match. Jim asked them to turn off the television because it was disturbing him. The staff said no and told him to get back to bed. They put him back to bed. Jim came through at 2 in the morning and put the television out of the window. They put him in Carstairs for nine months. He was not criminally insane, but they considered his act to be a criminal act.

The Convener: The point that I am trying to make is that at the moment we are putting people into Carstairs who have no business being there.

Pat Webster: Compulsion depends on the will and intent of the professionals. I remember visiting a patient who was becoming a bother at Liff hospital but had not been admitted. I phoned his CPN and psychiatrist to ask why he had not been admitted, because he was obviously in need. He had been returned to the community, but there was no support there for him. He kept returning to the hospital because that was his coping strategy. He had been taught to come to the hospital, because that was the place where he was safe. However, he could not be readmitted to the hospital. When I challenged the psychiatrist and the nurse on that, they said that he was not medically unfit. I asked them why they were giving him antipsychotics if he was not psychiatrically ill and could not be readmitted. Three weeks later the patient was in Carstairs.

It is good to have a medium-secure unit if people in Carstairs need it. However, the issue is how people end up in Carstairs. Do they end up there because of compulsion and the great power of the psychiatric profession?

Lucille Crichton: More than a week ago a woman was incarcerated in Carstairs by the sheriff officer because the Murray royal hospital said that it did not have the staff to look after her—even though there was a bed for her. The female patient who took up the bed is still in the Murray royal hospital, but in a different area. There is still only one female bed in Carstairs. That is not right.

The sheriff officer stated that, if the woman were not given a bed within six months, he wanted to know about it. The introduction of a medium-secure unit is a real necessity. If we do not sort out the problem, it will get worse. Forensic patients are the forgotten in society. As my husband puts it, "Forensic patients are mice and the mental health service is a Cinderella". Forensic services receive very little help.

The Convener: You mean that, in a Cinderella service, they are treated even worse then others. We knew where you were going with that analogy.

Lucille Crichton: I always put the cart before the horse.

The Convener: We got the gist of what you were saying, which is the important thing. Do members have any further questions? I want to give the witnesses a chance to deal with any issues that they have not yet covered.

Dorothy-Grace Elder: The location of medium-secure units is important. We cannot plonk them down anywhere. The unit that we saw in Edinburgh was ideal. Is it important for patients to be near normal facilities, such as shops and libraries, to which they can be taken on outings? Other sites may be nearer to home, but located in a void.

Lucille Crichton: Much of the land around the Murray royal has been sold off, so the facility has been reduced in size. The word is going around that in a couple of years the facility will be no more. I do not know where the new one will be situated. I see Perth as ideal, because it has a wide catchment area. At issue is where the facility should be sited in Perth.

The Convener: Do you wish to make any further points? We have received your written submission and have covered a large number of issues. However, you are welcome to make a final comment before we finish.

Pat Webster: The bill does not have a very good title.

The Convener: A few people have mentioned that.

Pat Webster: In the meeting that we had, we thought that mental health was not the right title.

The Convener: Would you prefer the bill to be a mental illness bill?

Pat Webster: Yes, because the current name is not really right.

The Convener: We did not name the bill.

Pat Webster: Do you want us to give you some names?

The Convener: It is just our job to check and amend the bill as we see fit. Even then, the Executive can still override our amendments. We will certainly consider what you say carefully.

Pat Webster: Could I talk about the staff and client relationship and compulsion?

The Convener: I can give you a couple of minutes.

Pat Webster: I believe that CPNs will be monitoring compulsions rather than using their time for therapy. That is a worry for us. It came across clearly that the CPNs will be coming in to see whether we have taken our medication and it will not be about building up a therapeutic relationship and moving us on to recovery.

One of the quotes in our submission is:

> "I want to recover and I want to work."

The bill is not a way of achieving that.

The Convener: Thank you very much for coming in and for the written submissions from the Hearing Voices Network.

Bill Kerr: Could we have more time in which to make written submissions?

The Convener: Yes. We are happy to take further written submissions from you.

Pat Webster: Could we make a submission in a video form? Some people might like to speak.

The Convener: Yes. We are happy to do that. As I explained to some of you over a nice lunch of soup and stovies, there have been time constraints on the committee because of the bill. We have been waiting for it since February and now that we have it we have to work to a tight timetable.

We are taking evidence in the committee rooms in Edinburgh and are also trying to get out and about to places such as Dundee. We are also trying to organise visits to see what is happening on the ground. We are up against time, but we are happy to accept any further evidence, written submissions or comments from you, or any other individuals or organisations you know that work with carers and service users. We want to know their views of the services and the bill. Please pass that on.

Pat Webster: What is the time limit?

The Convener: Mid-November, but that would be absolutely last minute. We would prefer to see something coming in earlier than that so that we could add it to what will be a fairly substantial report.

Meeting closed at 15:12.

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