HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 9 October 2002
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE

26th 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:

Mrs Mary Mulligan (Deputy Minister for Health and Community Care)

WITNESSES

Shona Barcus (Scottish Association for Mental Health)
Dr Denise Coia (Royal College of Psychiatrists)
Dr Jeanette Gardner (National Schizophrenic Fellowship)
James Kennedy (Royal College of Nursing Scotland)
Christina Naismith (Association of Directors of Social Work)
Hilary Patrick (Millan Committee)
Willie Paxton (Association of Directors of Social Work)
Colin Poolman (Royal College of Nursing Scotland)
Professor Kevin Woods (Scottish Association for Mental Health)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

LOCATION

Committee Room 1

Scottish Parliament

Health and Community Care Committee

Wednesday 9 October 2002

(*Morning*)

[THE DEPUTY CONVENER *opened the meeting at 09:34*]

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 12) (Scotland) Order 2002 (SSI 2002/430)

The Deputy Convener (Margaret Jamieson): I welcome the Deputy Minister for Health and Community Care, who is here to speak about the order. Do you have anything to say to the committee, minister?

The Deputy Minister for Health and Community Care (Mrs Mary Mulligan): No, but I am more than happy to take questions.

The Deputy Convener: There are no questions. We are old hands at dealing with amnesic shellfish poisoning.

Motion moved,

That the Health and Community Care Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.12) (Scotland) Order 2002, (SSI 2002/430) be approved.—*[Mrs Mary Mulligan.]*

Motion agreed to.

Mental Health (Scotland) Bill

The Deputy Convener: We come to the evidence session on the Mental Health (Scotland) Bill. The first witness is Hilary Patrick, who is an honorary fellow of the University of Edinburgh's school of law and who was a member of the Millan committee. I understand that, like me, you have been pushed in at the last minute. We will bear with you if you will bear with me. Do you wish to make an opening statement?

Hilary Patrick (Millan Committee): No. I was asked to give evidence as some sort of expert on the legal issues in the hope that I might be able to clarify some of them. If the committee has questions, I hope that I can answer them.

The Deputy Convener: We have questions, but we always give witnesses the opportunity to make an opening statement.

Mr John McAllion (Dundee East) (Lab): Can you clarify the concept of legal capacity, especially the relationship between having capacity and being able to consent to or refuse treatment?

Hilary Patrick: I hope so. One of the difficulties of Scots law is that tests, such as the test of the legal capacity to take medical decisions, are not written down in old statute books.

There are different kinds of capacity. There is the capacity to get married or to sign a will. The test of having the capacity to take medical decisions is what the reasonable person on the number 23 omnibus would think is the capacity to take the decision, which is that the person understands the question and the treatment and is free to make a decision.

With mental illness there are issues about feeling that one has a choice, understanding that what doctors say is true and not thinking that doctors are trying to poison one. Some illnesses can compel people to refuse treatment. For example, anorexia might almost force people to refuse treatment. The test is the common sense one of whether the person understands the treatment and believes the information that they are given. A person must be quite ill not to have the capacity to take such a decision.

Mr McAllion: Section 53 states that a tribunal can authorise compulsory treatment where, among other criteria,

"the patient's ability to make decisions about the provision of such medical treatment is significantly impaired".

What would be the difference in practice if the bill, instead of using the phrase "significantly impaired", said that the patient must lack the capacity to make decisions?

Hilary Patrick: I think that there is a difference.

The Millan committee agonised over the matter and received from various organisations strong representations that we should have a capacity test rather than one that relates to impaired judgment or significant interference with decision making.

It is a question of degree. Members of the Millan committee looked at the capacity test and were concerned that some people might be refused treatment because they lacked capacity. The pressing example that came to us was particularly dear to me. That example involved a depressed, middle-aged housewife who has a ghastly life, a ghastly husband and all sorts of reasons for being depressed—in fact she wants to die. Please do not tell my husband about this—[*Laughter.*]

The Deputy Convener: It will all be written down.

Hilary Patrick: This is privileged information.

She refuses treatment for her depression, but we do not want the doctor to say, “You have the capacity to take that decision. Okay. We’re not going to treat you. Die.” She knows what she is saying when she refuses treatment—she has the capacity. We want the doctor to say, “Look, Hilary”—or whatever her name may be—“your capacity is impaired in this situation. Even though you are refusing treatment, we want to give you treatment.” The question of degree is subtle, but the feeling among members of the Millan committee was that that woman could benefit from the compulsory treatment provisions, despite the fact that she had capacity. In such situations, we felt that she should be treated against her will.

Mr McAllion: In part 13 of the bill, the Executive again introduces the concept of capacity, with reference to people who are capable, and those who are incapable, of consenting to treatments such as neurosurgery for mental disorder—NMD—or electroconvulsive therapy. Why did the Executive not simply reiterate the wording of section 53, which deals with impaired judgment? Why did it reintroduce the concept of capacity in part 13?

Hilary Patrick: In order to fall within the compulsory treatment regime of the Mental Health (Scotland) Bill, you have to suffer from impaired judgment—that is the test in the bill. You will not come under that umbrella unless the doctors say, when they are sectioning you, that you have impaired judgment. Thereafter, there are specific rules for specific treatments. For example, you can have NMD only if you consent to it, unless an application is made to the Court of Session on the ground that you do not have capacity. ECT is recognised as a controversial treatment and it was decided that if the person was able to make a decision and rejected ECT, they should not be given that treatment against their will. You may argue that those provisions are not easy to understand, but the idea behind them is that a pragmatic approach should be taken. Each of the treatments is considered and decisions are made about the appropriate tests that will allow those treatments to go ahead.

Mr McAllion: Part 13 of the bill deals with NMD and ECT. If a patient’s ability to make a decision was significantly impaired, would the provisions of part 13 not protect them because they had capacity?

Hilary Patrick: Are you asking about a patient who has been sectioned—

Mr McAllion: I am asking about a patient who does not meet the capacity test for NMD and ECT. In other words, the patient has capacity, but their judgment is significantly impaired. Could they be subjected to treatment?

Hilary Patrick: That is a good point that has also been made by the Scottish Association for Mental Health. I think that you were asking about a patient whose judgment was impaired when they were sectioned under the Mental Health (Scotland) Act 1984—that is why they became a detained patient. In fact, the NMD rules will also apply to people who are informal patients and who have not been subjected to that test. The simple answer to your question is “yes”. If NMD is to take place, patients will have to have the capacity to give their consent.

Nicola Sturgeon (Glasgow) (SNP): Are the provisions of part 13, which relate to medical treatment, an improvement on the Mental Health (Scotland) Act 1984? If so, in what ways are they an improvement?

09:45

Hilary Patrick: They are a dramatic improvement on the 1984 act.

The whole basis on which compulsory treatment is to take place is different. There was criticism of the way in which second opinion doctors had to operate under the previous act. They now have to take into account the principles of the treatment, the wishes and views of the patient and carers and any statement that the patient may have made in advance. Under the old act, second opinion doctors had to certify that the treatment would be of benefit to the patient. The proposed provisions include greater consultation, which is an improvement.

The rules on drug treatment have been tightened, so that drug treatment can go ahead for only two months without consent or a second opinion. New treatments are to be introduced on force-feeding and on medication in excess of the recommended dosage. The new rules on ECT, which we have mentioned, mean that a capable patient will be able to refuse such treatment. New rules on children and young people will mean that the second opinion will have to be given by a psychiatrist. The simple answer to the member's question is "yes"; the new provisions under part 13 are a dramatic improvement.

Shona Robison (North-East Scotland) (SNP): Do you have any comment on the human rights implications of the bill's provisions for medical treatments and compulsory treatment orders?

Hilary Patrick: I am sure that your own lawyers will examine the proposals. I have undertaken considerable study of the human rights aspects of mental health cases. As yet, none of the cases that have come before the European commission of human rights has led me to think that the provisions would be in breach of the European convention on human rights.

It has been argued that the NMD provisions, in particular the possibility of NMD being given to patients who are incapable of consent, could be in breach of the ECHR. That argument depends on whether the treatment is viewed as an invasion of the patient's human rights—it could also be proved that NMD is a beneficial treatment. I do not have a view on that, but the human rights argument could be put that to ban the treatment for people who are incapable of giving their consent could also be a breach of human rights.

If the bill contains adequate safeguards in respect of second opinions, if the views of the patient and carers are taken into account, and if evidence before a court proves that the operation could help a patient who is so ill that they cannot consent to it, there should be no such implications. As I said, it could be argued that, if the Parliament banned NMD it could be in breach of human rights.

Shona Robison: SAMH has said that patients who are incapable of giving their consent to NMD may give rise to a conflict with a 1991 resolution of the United Nations General Assembly. What would be the legal consequences of Scots law coming into conflict with a UN resolution?

Hilary Patrick: I do not think that there would be any such consequences.

Shona Robison: You do not.

Hilary Patrick: No. Although I think that you will probably find that we are in breach of an awful lot of UN conventions.

Shona Robison: Indeed.

Hilary Patrick: I am not sure whether it is possible to say such things—off the record.

Janis Hughes (Glasgow Rutherglen) (Lab): Do the safeguards in the bill in respect of neurosurgery provide adequate protection to patients who are incapable of giving their consent?

Hilary Patrick: The major change that is proposed is that informal patients will be brought within the ambit of the provisions. That happens at the moment as a matter of practice. Any patient for whom NMD is proposed at the moment, whether they are a detained patient or a voluntary one, must go through the procedure of being interviewed by Mental Welfare Commission for Scotland doctors and by lay people, who must certify that they consent and give a second opinion to the effect that the operation is appropriate. When I was involved with SAMH, we were keen to promote the extension of that protection to informal patients as well, as happens south of the border. It is a reform that I certainly welcome. NMD is a serious and irreversible procedure and patients are vulnerable, as they feel that it may be their last hope. Last week, I visited the centre in Dundee that does those operations. People are desperate and they will say, "Do anything to me, doctor." The protection for informal patients is an improvement.

On whether the safeguards are adequate, I cannot think what else we could have. There is one little thing that slightly concerns me about all the consent provisions. It is just a drafting matter, but the bill as currently drafted says that the patient must consent in writing to the treatment. My concern about that is that there are really two separate issues: whether the patient consents and whether there is written evidence to support that. Those two things should not be confused. I could be pressurised to sign a consent form, but I would not be giving real consent. Wording may not be your area, but it is a concern of mine that we separate out those two aspects of consent. The bill should be worded to the effect that the patient should consent and that, at a later stage, a form should be signed to evidence that she consents. We do not want people coming along and simply saying, "Ah, she's signed the form." That is a general concern about all the consent provisions as drafted.

Janis Hughes: Do you agree with the argument that it would be discriminatory if the law were to prohibit NMD from being carried out on patients who were incapable of giving consent?

Hilary Patrick: There is an argument to that effect. I know that the Mental Welfare Commission for Scotland has argued that it could be precisely the person who is so disabled by depression that he or she is unable to make a decision who might be refused treatment. There is an argument that to ban that treatment for a person who is so ill would not be proper, if there were evidence that that treatment could help them.

Janis Hughes: Might the phrase

"does not resist or object to the treatment"

be open to abuse and therefore be disadvantageous to the patient?

Hilary Patrick: That phrase is taken from the Adults with Incapacity (Scotland) Act 2000. It was intended to provide protection even to a person who had been judged incapable of taking a decision so that, if he or she showed any resistance—even if it were not what you or I would call an informed resistance—that could be taken into account. The intention was to provide protection to somebody who, even though they had been judged incapable by the law of making a decision, might be struggling in some way, so that that resistance could be taken into account. Having all those concepts makes the situation more confusing, but if the intention behind them is understood, perhaps the use of that wording can provide support.

Janis Hughes: Would you say overall that the wording is not open to abuse?

Hilary Patrick: Unless somebody explained to me how the wording was open to abuse, I would not immediately think that it was.

Mary Scanlon (Highlands and Islands) (Con): The Executive intends to add by regulation the authority to force-feed a patient who does not or cannot consent, provided that an expert, independent doctor from the Mental Welfare Commission for Scotland authorises that. The same will apply to medication above the recommended dosage and to drugs for reducing sex drive. Are you concerned that those provisions are not in the bill and that they will not be added to the bill by amendment, but will be in regulations?

Hilary Patrick: Yes. That has been the pattern of mental health legislation. However, if the Executive knows that it will make regulations on those subjects, I do not know why it does not put those provisions in the bill. I do not understand the reason for that.

Mary Scanlon: Should those provisions be in the bill and openly discussed in Parliament? Would such provisions be controversial if they were in the bill?

Hilary Patrick: Obviously, those treatments are controversial. That may be why the Executive does not want them to be debated. Those treatments are administered now under the Mental Health (Scotland) Act 1984, without proper regulation, and it would be better for them to be regulated. The proposed measures are an attempt to improve regulation. Those treatments are controversial. All that I can say is that I do not know why, if the Executive knows that it will put those provisions in regulations, it does not put them in the bill.

Mary Scanlon: It is a concern that those treatments fall under the liability to compulsory treatment. Non-compliance could mean that patients ended up in custody, were taken to a specified place or were admitted to hospital. We can tie that in with SAMH's submission, which says that non-compliance may involve force. Are you concerned that patients who require force-feeding or drugs that reduce sex drive may be subject to force?

Hilary Patrick: Obviously, nobody would be unconcerned about that. I find it upsetting and distressing that that happens. That is the sad nature of mental health law. We have had that system for a long time and will probably continue to have it.

That is the crux of the ethical issues that mental health legislation deals with. When is it appropriate to treat people against their will? That is a question of balance. Why do we do it? As the committee knows, mentally ill people are the only people who can be treated against their will. The reason why we do that—the Millan committee tried to grapple with that—is that we hope that treatment will help those people. We treat them because we feel that we have a duty to help people who are in distress. For example, force-feeding is generally linked to anorexia. There is controversy about whether that is the appropriate treatment.

Mary Scanlon: I do not want to take advantage of the convener, but I have another question. Did the Millan committee assume that force-feeding, drugs to reduce sex drive and higher dosages would be dealt with in the bill?

Hilary Patrick: Our main concern was that safeguards, such as second opinions, should be in place, unlike previously. I honestly do not remember what we said about those treatments. We would regard any legislation as an improvement. Under the 1984 act, no safeguards are provided in relation to those treatments. Under the new act, the second-opinion regime and other matters will be provided for. The situation will be clearer.

Mary Scanlon: What view does case law take of whether force-feeding counts as medical treatment? Would our defining force-feeding as medical treatment in regulations raise legal difficulties?

Hilary Patrick: The case law, which is from England, but would be persuasive in Scotland, is that force-feeding constitutes a medical treatment under mental health legislation. That is why any such treatment to date has been carried out under the Mental Health (Scotland) Act 1984. There is a very wide definition of medical treatment in the bill, so I do not think that the definition in regulations of force-feeding as medical treatment would cause difficulties. One would always prefer material to be in the bill rather than in regulations.

10:00

Mary Scanlon: On medical treatment, what are the differences and overlaps between the Mental Health (Scotland) Bill and the Adults with Incapacity (Scotland) Act 2000?

Hilary Patrick: I thought that you wanted me to finish at 10 o'clock.

It is going to be very difficult. I often say that three patients in a ward could all be in hospital with exactly the same severity of illness, but they could all have a different legal status. One could be a voluntary patient; one could be detained under the Mental Health (Scotland) Act 1984; and one could be detained under the Adults with Incapacity (Scotland) Act 2000 if he or she were so ill that they could not agree to be there. A patient could be brought to hospital passively because they were very ill, rather than having been sectioned because they were resisting being brought in. There will be a complex overlap between the Mental Health (Scotland) Bill and the Adults with Incapacity (Scotland) Act 2000. We recommended that the code of practice looks carefully at how the two pieces of legislation interact. If there was any question of the incapable person resisting treatment, he or she should be brought in under the eventual mental health act rather than under the Adults with Incapacity (Scotland) Act 2000.

It is terribly complicated. I could have disabling schizophrenia and I could agree to go to hospital, so it would not be appropriate to use the Mental Health (Scotland) Act 1984. I could be unable to agree, because my delusions were so serious, without expressing a view as to whether I went to hospital, and I could go to hospital passively under the Adults with Incapacity (Scotland) Act 2000. If I resisted in any way, it would be totally inappropriate to use the Adults with Incapacity (Scotland) Act 2000 and I should have the protections of the Mental Health (Scotland) Act 1984.

The Deputy Convener: Thank you for answering the committee's questions this morning. Do you want to add anything before you leave that we might have missed out?

Hilary Patrick: I mentioned the protections for children and young people, which are important. The Executive will introduce additional safeguards for children and young people if they are unable to consent and we will consider those with interest. I emphasise the importance of the role of the Mental Welfare Commission for Scotland. It will appoint the independent second-opinion doctors and it can stop a treatment if it thinks that it is inappropriate. There will be oversight of the rules.

The Deputy Convener: Thanks very much. We now have Dr Coia, Shona Barcus and Professor Woods.

There are two separate organisations on this panel, so will both command the same amount of time or will one organisation take the lead?

As none of the witnesses seems to have a view, they will have to hold their own. Do you have opening comments to make?

Dr Denise Coia (Royal College of Psychiatrists): I would like to make a brief comment about compulsory treatment orders. I want to make the same point as I made at last week's meeting about community services and psychiatry being the main locus of treatment for our patients. There has been a shift towards that direction of care—which we have supported—with the sharp reduction in in-patient beds in Scotland.

We believe that the bill modernises our approach to involuntary treatment and gives psychiatrists the tools that can allow people who have serious mental illness to remain in the community, if that is appropriate.

In addition, I have to make the comment that I made at last week's meeting about children and young people. I emphasise our concern that specific services should be available for children and young people in the community and through in-patient services.

Finally, with regard to medical treatments, we support the safeguards that are contained in the bill.

Professor Kevin Woods (Scottish Association for Mental Health): I would like to make one or two comments, principally about compulsion.

We are concerned that the proposals in relation to community-based CTOs might lead to an unintended increase in the use of compulsion. We acknowledge that everyone believes that compulsion should be a last resort, but we are a bit concerned that the bill might result in an unintended increase in compulsion because of the absence of appropriate alternative community resources.

We are also concerned about the amount of uncertainty about whether such orders will work as intended. If members consider the evidence—the committee's adviser has produced a very helpful literature review—there seems to be considerable uncertainty about whether the orders will do what their designers intended that they should do. Since the literature review was prepared, there have been other important studies published on the topic and, if I may, I will refer to them. One was conducted by the RAND organisation in the United States. It asked whether involuntary compulsion works. Its conclusion was that

> "There is no evidence that a court order is necessary to achieve compliance and good outcomes, or that a court order, in and of itself, has any independent effect on outcomes."

A similar paper that was published in the British Medical Journal about a study in Australia reached a broadly similar conclusion. We would be happy to let members have those papers.

A third and final point is that because of our concern about resources, we believe that the principle of reciprocity is vital and we have already registered our concern that there is not in the bill a clear statement of that principle. That is the point that Mr Millan made when he appeared before the committee. We believe that such a statement is vital if community-based services are to be properly resourced.

The Deputy Convener: We will take the evidence in two parts. In the first instance we will concentrate on medical treatment. What are your views on how effective neurosurgery for mental disorder, electroconvulsive therapy and treatments to reduce sex drive have been in improving mental health? How will they continue to be effective? How often are such treatments administered each year? Dr Coia might like to go first.

Dr Coia: I will start with NMD, which is controversial. Our feeling is that the bill contains good safeguards. We believe that people who are incapable of consenting but who agree to treatment should not be denied a final opportunity for treatment, provided that all the appropriate safeguards are in place. Although we acknowledge that situation in principle, we do not expect to encounter it in practice. However, the fact that we would be lucky to come across one such case in a population of 5 million during the next 10 years is not a reason not to include such a provision in the bill. The principle is extremely important.

The evidence base in relation to NMD is highly variable. The Millan committee considered a number of reports from a range of organisations on the evidence base for NMD, which were found to be equivocal. The most successful outcome rate that one can expect is 50 per cent. The Royal College of Psychiatrists is not saying that there is a strong evidence base for the treatment. We support the deliberations of the Millan committee and of a range of other groups that were consulted, which have concluded that it might, on balance, be worth offering NMD to people.

Similar neurosurgery is carried out for stage 2 and stage 3 brain tumours. The evidence base indicates that the success rate for such surgery is 10 per cent for stage 2 tumours and 5 per cent for stage 3 tumours. For intractable epilepsy, the evidence base shows a success rate of about 10 to 15 per cent. We should put NMD in that sort of context. The evidence is not in its favour.

We support the ECT safeguards. The statement that one cannot give a patient ECT if he or she is able to make a competent decision to refuse treatment is particularly important. Although there is a strong evidence base for ECT, the way that people feel about it makes it a controversial treatment. That is why we support the proposal. The introduction of advance statements—which will allow someone to opt out of having ECT—is important because it will provide an additional safeguard.

Shona Barcus (Scottish Association for Mental Health): Although we do not have much to add to the evidence on NMD that we gave on Friday, I have several points to make.

On Friday, I said that we had written to the Health Technology Board for Scotland to invite it to assess NMD for incapable patients. Yesterday, I received a response that said that such an assessment did not fit the HTBS criteria. The HTBS acknowledged that SAMH would be unhappy with its decision.

In its letter, the HTBS states that the first criterion of

> "Clear health benefit anticipated, or evident, from the technology"

has not been met,

> "because, on a population basis, the health benefits are very small."

On cost-effectiveness, it said that

> "HTBS is not aware of an evidence base".

The third criterion of

> "Wide variation in provision or outcome across Scotland"

is not answerable

> "because of the very small number of cases involved."

In relation to the criterion of the treatment's having a

> "Major impact on NHS resources (consuming or releasing)",

the HTBS states:

> "following from the above, this criteria has not been met."

Therefore, the HTBS will not accept our invitation.

I heard what the Royal College of Psychiatrists in Scotland said about Millan's considerations, but I reiterate the point that we made last week, which is that two pieces of quite significant evidence have subsequently emerged—the report of the neurosurgery unit in Dundee and the report of the

Royal College of Psychiatrists in the UK—that caution against the procedure.

The report from the neurosurgery unit in Dundee recommends that the procedure should not be carried out on people who cannot consent to it. That is because of the uncertainty about predicting outcomes and because of the uncertainty of knowing in advance who will benefit from the treatment. The neurosurgery unit in Dundee is trying to build up an evidence base, but it is not in favour of the procedure at the moment because of the mixed evidence.

The Royal College of Psychiatrists in the UK carried out a piece of research under the chairmanship of Professor Chris Freeman, who practises in Scotland. That report talked about resisting Crown pressure to follow the way things are going in Scotland. The UK college is about to embark on re-examination of the matter because it is a few years since it last considered the matter.

10:15

One more point on NMD is that, although it is easy to discuss surgery for physical conditions such as brain tumours, the medical profession is not in agreement about the cause of mental illness. Although some people have produced evidence to suggest that the causes are physical, others suggest that there are a variety of causes, some of which are situational and social, as to why people develop depression and some of the other things that are treated with NMD.

On ECT, we are concerned about the provision to give ECT to people who are incapable of consenting to it. It is probably not necessary to revisit all the detail in our written submission, but I am not sure that the evidence base in favour of ECT is so strong. The evidence in favour needs to be balanced against the evidence against ECT. Many of the trials that support the provision of ECT have been carried out on very small numbers of patients.

I want also to acknowledge the role of advance statements. Even if an advance statement says that the patient does not want ECT, the tribunal will have no power to vary a plan of care that includes ECT unless it decides not to give the general authority to treat. There is concern about that.

SAMH's position on ECT reflects a Council of Europe white paper, which I can quote from if the committee wishes.

Mr McAllion: I am not clear about what you were asking the Health Technology Board for Scotland to do. As I understand it, the issue is whether the bill should allow NMD to be given to patients without their consent.

Shona Barcus: Yes.

Mr McAllion: Given the fact that NMD has never previously been given to patients without their consent, how could the Health Technology Board research the issue when there is no evidence to research? What were you asking the board to research into?

Shona Barcus: We asked the Health Technology Board to evaluate the evidence on NMD—

Mr McAllion: Did you ask the board to evaluate the evidence on NMD as such or did you ask it to evaluate NMD as a treatment given without consent?

Shona Barcus: We asked the board to evaluate the evidence on NMD in light of the recommendation that that treatment be given to people who cannot consent. We asked the board to make a judgment on that.

Mr McAllion: For the strict purposes of research, the board would have had to deal with two different types of patients. Evidence that it might have from patients who had given consent could not strictly be applied to patients who might not give consent. I know that you are trying to make a link, but is not that why the Health Technology Board said that it did not see the point in doing such research?

Professor Woods: I am not sure about that. We asked the Health Technology Board to investigate whether there was more up-to-date worldwide evidence on the clinical effectiveness of NMD, irrespective of whether the treatment was given with or without consent. Part of our case is that it is doubtful whether this irreversible, unpredictable and—at best—partially effective treatment should be available.

Mr McAllion: Did you want to test the accuracy of the figure of 50 per cent that is used by Dr Coia?

Professor Woods: We wanted to see whether there was more evidence. As I think the convener pointed out last Friday, if NMD was a treatment that everyone agreed was highly effective, we might not be having this debate. However, there are doubts about its effectiveness. The fact that the treatment is irreversible and that its effects on individual patients are difficult to predict means that we should be cautious about using it. The issue should be decided by the Parliament, rather than by the courts. It is the question of clinical effectiveness that we are asking the committee to consider.

Mr McAllion: Do you mean the clinical effectiveness of the treatment itself?

Professor Woods: Yes.

The Deputy Convener: Do you wish to come back on any of those points, Dr Coia?

Dr Coia: Not particularly, although I reiterate that there is an issue about the evidence base, which it is important that we understand clearly. On the other hand, the evidence base is sufficient to the extent that it would be reasonable to offer NMD to a select group of people. The principle of discriminating against people because they are incapable is wrong.

Nicola Sturgeon: You have answered the question that I was about to ask, but I want to be sure about your view and SAMH's view. Your evidence raises this question, but is it the view of the Royal College of Psychiatrists that people who are incapable of consenting should still have the option of neurosurgery?

Dr Coia: Yes.

Nicola Sturgeon: Given that, do you think that the safeguards that are outlined in the bill—the three steps—are adequate?

Dr Coia: Yes.

Mr McAllion: One of the controversial treatments that we have heard about this morning, other than NMD, is the authority to force-feed a patient who does not, or cannot, consent to that, provided that a doctor who has been appointed by the Mental Welfare Commission for Scotland authorises it. What do you think about the authority to treat a patient in that way? Secondly, what do you think about the fact that the Government intends to introduce that authority by regulation, rather than in the bill?

Dr Coia: I will echo what Hilary Patrick said this morning, which is that force-feeding someone is an extremely unpleasant experience that nobody would relish. The activity diminishes the people who are carrying it out as much as it diminishes the person to whom it is being done, particularly when it concerns young people who are suffering from anorexia.

It is an extremely rare procedure, and I cannot honestly say that I have ever seen it done in my clinical practice. We do, however, admit into adolescent in-patient units young girls whose weight has gone down to 3 or 3.5 stone, and who, at that point, are really at death's door. Under those circumstances, where some benefit might be achieved from force-feeding, and if the measure has been discussed with the family who are around the person and who will be frantic with worry at that stage, there is a rationale for it. I do not think that there is any rationale for force-feeding being carried out in the community. There must be appropriate adolescent in-patient facilities.

I do not see any objection to force-feeding's being covered in the bill as opposed to under the regulations. It is an unpalatable treatment, but it is important to have a discussion in the public domain about the fact that it happens. Such things should not go on behind closed doors and I urge the committee to take a view on the matter.

The Deputy Convener: You mentioned adolescent in-patient units, but we have very few NHS facilities in Scotland specifically to treat anorexia.

Dr Coia: Our facilities for adolescent in-patients in Scotland are a national disgrace. There are currently 34 such beds for a country that has a population of 5 million. The recommendation is that there be a minimum of 80 to 100 beds for adolescent in-patients for a total population of 5 million. We have complained repeatedly—including last week—to the chief medical officer. We have told him that we, as adult psychiatrists, will not be comfortable treating adolescent patients in adult in-patient units.

It was mentioned when I was last before the committee that

"a 15-year old was in an adult ward"—[*Official Report*, *Health and Community Care Committee*, 25 September 2002; c 3096.]

at Parkhead hospital. We found that to be completely disgraceful. I have major concerns about the lack of facilities for adolescents.

The Deputy Convener: Do you think that the amount of money stipulated in the financial memorandum is sufficient to ensure that we can provide such facilities throughout Scotland, particularly for adolescents?

Dr Coia: That is the golden question. The financial memorandum is extremely short on detail and the funding is insufficient to provide for such facilities.

Professor Woods: I will comment on the question whether force-feeding should be provided for by regulation. We are not clear why provisions on force-feeding have not been included in the bill, which we would prefer. Perhaps the committee should ask the Executive about that, because we do not know why it has chosen to deal with the matter by regulation.

Shona Barcus: We support many of Dr Coia's comments and would like the matter to be covered in the bill. Members may recall that David Davidson spoke about his anorexic daughter during the debate on mental health law. We need to reflect on the reciprocity issue. As Dr Coia said, there is a paucity of early-intervention services for people who suffer from anorexia. Force-feeding ought to be a last resort but, unfortunately, that is not the case for the vast majority of young people with anorexia, despite the fact that the incidence of the condition is increasing.

The Deputy Convener: Some of us had an opportunity to visit some of the facilities that are available in Scotland and were quite surprised by the long waiting list.

Mr McAllion: The Executive intends to issue regulations on the use of drug treatments to reduce sex drive and the administration of medication for mental disorder above normally recommended doses. What does the Royal College of Psychiatrists make of that proposal?

Dr Coia: We support the strong safeguards in the bill on the use of drugs above normal limits. On the use of drugs to reduce sex drive, although we support the safeguards, we point out to the committee that those drugs are not widely or commonly used in Scotland. As Hilary Patrick said, they are referred to in the bill because of past experience, but the bill also makes it possible to look at new treatments.

Shona Barcus: SAMH is disappointed that the two-month time scale is the only safeguard in the bill. We would like the bill to have stronger safeguards for those treatments. Dr Coia and Hilary Patrick both mentioned the drugs that are used to reduce sex drive. We are also not particularly familiar with their use in Scotland, but we hear regularly from people who have been unhappy about receiving cocktails of drugs in excess of normal limits. We have assisted families to make inquiries in the circumstances in which someone who has been in receipt of such treatment has died.

Mary Scanlon: I have a supplementary question. The bill refers to patients who are subject to compulsory treatment in the community, but it also refers to absconding patients and non-compliance with the terms of compulsory treatment orders. The bill says that patients can be "taken into custody and"—

The Deputy Convener: We are talking about treatment, Mary.

Mary Scanlon: I know that, but I want to ask about SAMH's evidence, which says that

"Non-compliance—

with community treatment orders—

"may result in being taken to a specified place for treatment, or in admission to hospital."

Who will run after those absconding patients? Are you satisfied with the bill's provisions on taking them into custody?

The Deputy Convener: We are dealing with the issue of medical treatment now—we will come to compulsory treatment orders next. Mary Scanlon will get an opportunity to ask that question again.

Shona Robison: Are you generally content with the bill's definition of "medical treatment"? I ask because the definition seems quite wide—for example, it includes rehabilitation, education and training in work and social and independent living skills. Is the Royal College of Psychiatrists concerned that that wide definition might lead to people whose primary diagnosis is that they have a personality disorder being made subject to a compulsory treatment order and prescribed cognitive therapy, when a custodial sentence might be more appropriate?

Dr Coia: We were not concerned about that because we read the bill differently. Let us assume that compulsory treatment orders will be used to detain patients who have a serious and enduring mental illness. In psychiatry, medical treatment is not only about medication and the prescription of drugs. For many people—especially when they move back into the community—other social interventions and behaviour therapies such as cognitive behaviour therapies are important. There is a lot of evidence that, if medication and social interventions are put together, relapse rates are almost halved. We strongly welcome the emphasis on broadening the definition of medical treatment.

10:30

Shona Robison: I agree with you in principle, but how can things be enforced?

Dr Coia: Do you mean non-drug treatments?

Shona Robison: Yes.

Dr Coia: Compulsory treatment orders are useful in that social interventions and cognitive behaviour therapies can be provided in the community. People might have to attend weekly and, for many, ways in which they change their thinking can be just as helpful as medication. Shona Barcus spoke about the origins of mental illness, and social interventions can be helpful.

Shona Robison: Would non-compliance with the rehabilitation part of the treatment order be regarded as seriously as non-compliance with the medication part?

Dr Coia: That would have to be considered case by case. I cannot give a straight yes or no, because I would have to consider a practical example. However, for some people, the rehabilitation part can be more important than the medication part.

Shona Barcus: I agree, but there is concern about the lack of availability of treatments such as cognitive behavioural therapies and psychological therapies. There is increasing evidence that often people respond better to treatments when they have consented voluntarily, rather than when they have been coerced.

The Deputy Convener: We will now discuss compulsory treatment orders.

Mary Scanlon: Is the Royal College of Psychiatrists satisfied by section 53 of the bill, which sets out the conditions that must be satisfied before a compulsory treatment order can be authorised?

Dr Coia: Yes.

Mary Scanlon: Will the bill lead to more or less compulsion?

Dr Coia: That is difficult to predict, although I do not see why it would lead to more compulsion. I disagree with what Professor Woods said in his opening statement about community treatment leading to more compulsion. I feel that our ability to treat more people in the community will be strengthened.

Shona Robison: If you are sure that there will not be more compulsion, would it be wise to put safeguards into the bill? For example, a review could be triggered if the number of CTOs increased dramatically.

Dr Coia: It would certainly be useful to monitor regularly the number of CTOs. We have supported SAMH's call for an investigation into the fact that the number of detentions has increased dramatically over the past few years. There must be reasons for that and we should find out what they are. Trying to persuade people to do a national audit has not been easy. In future, it will be important to monitor the kind of people who are coming under CTOs and what sort of treatments they are getting. Any such national audit of that would be welcome.

Shona Robison: Who would carry out such an audit?

Dr Coia: A range of people could do it—it could be the Executive or it could be the Mental Welfare Commission.

The Deputy Convener: Section 46(2), which is on medical examination of patients, states:

> "examination … shall be carried out by an approved medical practitioner".

We assumed that that is someone with expertise in diagnosing or treating mental disorder, but section 46(4) states that the patient's general practitioner can carry out the medical examination. Given the publicity in the past few days about GPs who object to complying with the Adults with Incapacity (Scotland) Act 2000, does the Royal College of Psychiatrists believe that it is appropriate for GPs to be involved in that process?

Dr Coia: We think that it is appropriate for them to be involved, because a GP is a person's lifelong partner and should have a background knowledge of the person and their family. Psychiatrists might spend some time in a professional relationship with a patient, but that is episodic rather than over a lifetime. It is important that GPs are involved.

The Deputy Convener: They will be interested to hear that.

Mr McAllion: Section 51 places a duty on mental health officers to prepare a care plan before they apply to a tribunal for a compulsory treatment order. The section places a number of requirements on the mental health officer. For example, he must consult with medical practitioners and identify the patient's needs and the treatment. Are those provisions reasonable and adequate or should additional provisions be added to the section?

Dr Coia: I think that they are adequate. The duty is important because the mental health officer will set out the services in the community that are central to the package of care. The officer is probably best placed to do that. I support section 51.

The Deputy Convener: Does SAMH have a view on that?

Professor Woods: We are broadly content with the arrangements.

Mr McAllion: Should the tribunal have the power to vary care plans? It is not clear to the clerks or to members whether section 53 grants that power.

Professor Woods: We believe that the answer is yes. If I may say so, section 53(5) should be modified. The issue relates to a point that Mary Scanlon raised. We prefer the original Millan proposals, but they have been amended in the bill. We would prefer section 53(5) to make it clear that it must be established that the treatment cannot be provided by agreement and that the treatment should be the least restrictive alternative. The bill uses the formulation that the treatment must be necessary. I believe that Mr Millan also made that point in his evidence to the committee.

Dr Coia: I support the power of the tribunal to vary the care plan. There is an issue about the medical member of the tribunal. The bill says that the doctor must be a "medical practitioner", but we are concerned about that. For example, with children and adolescents, the doctor should be an expert in child and adolescent services.

Bill Butler (Glasgow Anniesland) (Lab): Do the witnesses feel that the measures that might be authorised under a compulsory treatment order, as described in section 54, are appropriate?

Dr Coia: Are you referring to the fact that someone can be removed to hospital if necessary?

Bill Butler: Yes.

Dr Coia: We support those measures.

Shona Barcus: SAMH has made its concerns known in its written submission. Mary Scanlon referred to our concern that force might be used to remove someone. We are also concerned that the requirements on the patient in section 54(1)(c) are broader than the ones that were in the draft bill. There are a number of requirements, but I pick out section 54(1)(c)(iii), which is

> "to allow monitoring of the patient in the patient's home, or visits there, by any person responsible for providing medical treatment, community care services, relevant services or other services to the patient".

How many people will have to be allowed entry to somebody's house?

Bill Butler: Do you think that the provision is too widely drawn?

Shona Barcus: I think so.

Bill Butler: What would you suggest?

Shona Barcus: I have not had an opportunity to consider that. The provision was narrower in the draft bill, which was better. I would like to have more time to think about it.

Janis Hughes: We heard some of your concerns about community-based compulsory treatment orders in principle. Under what circumstances do you think they would be acceptable and for whom do you think they would not be suitable?

Dr Coia: It may be useful to give practical examples. We envisage CTOs in the community as being useful for people who have serious mental illness, such as people with schizophrenia who are well on medication but often stop their medication and become unwell. At that point, they have little or no insight into their illness and how their behaviour is affecting other people, such as carers and family. They can become more of a danger to themselves, rather than to other people. Particularly in the past three or four years, that group has become increasingly vulnerable to the alcohol and drugs that are around in our society. It is important to pick up on that.

The other group would include those suffering from bipolar depressions—particularly rapid-cycling hypomanic episodes—who are extremely well and, in most cases, working. Those people may be on mood stabilisers, but might regularly stop taking them. Such people often do major financial damage, rather than anything else, to themselves and their families and are extremely distressed when they are well again.

It is important to say that there are people for whom we do not consider the orders appropriate. For example, it is not appropriate to use CTOs for the many people in Scotland who hear voices. There are many reasons for hearing voices that are to do not with mental illness, but with physical disorders such as hearing problems. In the past, such people often got caught up in psychiatric services, but we do not think that CTOs are appropriate for them.

Coming back to Janis Hughes's point, we would not use CTOs for people who have straightforward personality disorders, who have not offended and who are not psychotic. It is a different matter when people have borderline personality disorders, are psychotic, use alcohol and drugs, and reoffend.

Professor Woods: I asked myself a broadly similar question and turned to the review of literature that the Scottish Executive asked to be prepared in the context of the Millan report. Paragraph 4.20 asks:

> "Who are community treatments suitable for?"

The evidence presented in that review showed that guidance is generally unclear. With no clear guidelines as to who is suitable, it is difficult to assess whether CTOs are underused or overused. It seems that we will have to learn for whom they are suitable if the bill is enacted in its present form.

Janis Hughes: We heard that you think that there may be an unintended increase in the number of treatment orders. How many community-based orders do you think there may be—in terms of a percentage rise, perhaps?

Professor Woods: That is very difficult. Our concern is with the adequacy of comprehensive community mental health services in general against the background of an as yet unexplained increase in the incidence of hospital detention. We agree with the Royal College of Psychiatrists that we need to research that and understand what has been going on. Shona Barcus has heard from colleagues in Australia about their experience, which it might be helpful to share with the committee.

Shona Barcus: On Friday, we mentioned that, having heard about the soaring number of detentions, we had been in contact with an organisation called SANE Australia—I should point out that there is no relationship between SANE Australia and SANE UK.

The Australian group is a big and well-respected organisation for people with severe and enduring illnesses, mainly schizophrenia. Its chief executive, who is in between journeys abroad at the moment, has e-mailed a short note. She says:

> "yes there does seem to have been an increase in the use of CTOs (and I will try and locate some figures for you) and this almost certainly means an increase in the use of depot medication—which as we know means typical medication with dreadful side-effects.

> For all the wonders of Australia's mental health policies and plans, we still have a crisis-driven system so CTOs are one strategy to 'treat' people in the community who are very ill but deemed not ill enough for the number of in-patient beds available. We are pushing hard for more and better community services and supports so that crises are less likely to occur (not exactly rocket science—pretty homespun common sense!). I would say that it is highly unlikely that anyone on a CTO would have access to CBT for example as very few people have access in the public system here anyway."

She goes on to say that the organisation's website contains information that can be downloaded and she has referred us to a professor who is very much on top of the issue of depot medication and is also concerned about the CTO situation. We have e-mailed him, but have not had a response yet.

10:45

Janis Hughes: What is CBT?

Shona Barcus: Cognitive behavioural therapy. Dr Coia referred to it earlier. The concerns expressed in the e-mail from SANE Australia echo ours, but Australia is a bit further down the line, as it has had involuntary treatment for some years now.

Dr Coia: I caution the committee about taking evidence from countries where private medicine is paramount. Psychiatry in North America and Australia is what is known as programmed psychiatry. A patient gets six or eight weeks of care either as an in-patient or on an out-patient programme. The insurance runs out at the end of that.

In Scotland, we provide generic services, not programmed services. I hope that, in relation to generic services, we can support people over long periods of time. I do not think that the resource issue of acute in-patient beds comes into this discussion. The people whom we would be considering for compulsory treatment orders in the community are not those to whom we would be offering an in-patient bed.

The debate is not about the number of in-patient beds. It is about people who relapse. The rate of relapse in the community is higher because people there do not take medication, they add alcohol and drugs to their systems and so relapse more quickly. We believe that CTOs should be used to reduce the incidence of relapse, not as an alternative to acute in-patient admissions.

Nicola Sturgeon: You have described how the bill should work in an ideal world. I have heard concerns that community-based CTOs might be used inappropriately. There seem to be two strands to that concern. First, people who require in-patient care might find themselves on community-based orders because of a lack of beds. Secondly, people who would not require compulsion if they had the right support might find themselves on community-based orders because that support does not exist. How real are those concerns? Can they be dealt with in the bill or are they purely resource issues?

Dr Coia: There are two separate issues, as you say. There is a shortage of in-patient beds in some parts of Scotland and there is a shortage of community facilities in some parts of Scotland. However, there has been a willingness during the past year or two by the Scottish Parliament and the Executive to deal with some of the mental health service resource issues. Often the issue is not an overall lack of resources; it is about the redirection of resources that were intended to go into mental health services. Sometimes the overall pot of money is not the problem.

I disagreed with you when you said that if people had the right support, they would not get admitted to hospital. Those are what we call revolving-door patients. No amount of social support will prevent them from relapsing. They need medication and what we would call very sticky specialist services in the community. With the right support and services, such people will not relapse. People with schizophrenia who do not receive treatment relapse every 18 months to two years. With treatment, they relapse every eight to 10 years, on average. Social supports are important in providing improved social functioning. Unfortunately, they do not prevent hallucinations and delusions from happening in an acute episode. We are dealing with two separate issues.

Nicola Sturgeon: I want to ensure that I understand the concerns correctly. I understand that there is a group of people who require compulsion and that no amount of support will prevent that from being necessary. However, there is concern that the number of compulsory treatment orders will increase—perhaps inappropriately. Another group of people who could be supported in the community and do not need to be sectioned will end up being sectioned because that is easier when resources in the community are limited.

Dr Coia: I do not agree that that will happen. There is potential for it to happen if people who work in the health services, such as I, do not say robustly to the Scottish Executive that there are not enough services. I agree totally with what SAMH says about the lack of community services in some parts of Scotland, but that is not a reason for halting in its tracks an extremely good and modern bill. It is important that health service and social work professionals and voluntary organisations continue to knock on the Executive's door, to set up cross-party groups and to tell members what problems exist.

The new public mental health drive, which has received additional funding to the tune of £7 million, is evidence of a willingness to promote mental health. I would be surprised if the Executive did not match that by improving health services.

Professor Woods: Nicola Sturgeon put our concerns rather well. I would like to say more about services in the community. We are concerned about the potential unintended consequences of the orders. One of the papers quoted in paragraph 4.33 of the review of literature relating to mental health legislation, which summarises evidence gathered in preparation for the bill, makes the important point that

> "a CTO does not confer any advantage to the patient in comparison with a comprehensive community care"

package. The review continues:

> "Rather the reverse is suggested, that CTOs can alienate patients from services. The widespread use of CTOs in Australia and New Zealand to date, they point out, has produced little evidence to support their continued use."

There is uncertainty about the effect that CTOs will have. The issue of resources is crucial. The issue of reciprocity is dealt with in paragraph 90 of the policy memorandum, rather than in the bill. Paragraph 91 states:

> "The NHS and local authority will be expected to ensure that such services are made available. It is intended to add provisions to the Bill setting out that, if this turns out not to be the case, the responsible medical officer will be under a duty to report the matter to the Tribunal."

That sounds fine, but when I read it for the first time I wrote in the margin of the paper, "So what?" Resources and services may still not be available. We are concerned that CTOs may produce an unintended drift.

The Deputy Convener: Surely the argument needs to be different depending on whether CTOs are community based or hospital based. The support mechanisms for people in the community—social services, voluntary organisations and so on—will be different from the support mechanisms for those who continue to be detained in hospitals under CTOs. How do you differentiate between the two situations?

Professor Woods: I am not sure that I do. My point applies equally to both sets of circumstances. We want a general strengthening of comprehensive community-based services, as described in "A Framework for Mental Health Services in Scotland". The description of what should exist is right. We would like it to be delivered.

On community-based CTOs, the financial memorandum suggests that there should be an additional £2 million for local authorities and £2 million for health authorities. I hope that I remember that correctly. I do not know what justification is given for that or whether those figures will be enough.

Dr Coia: I will make a point about community-based CTOs and patients relapsing. One of the major problems when people with chronic mental illness relapse and are taken into hospital, as opposed to staying in the community, is that they lose some of their self-esteem and self-confidence. That is important. They often slide socially because their friends do not want to know them—they can lose all such social contacts. They also slide economically. Their jobs are put on hold and they usually lose them. Such people move themselves completely out of normal life. The Royal College of Psychiatrists is pleased that the bill will give us the tools to treat and manage that group in the community so that some of the slide does not happen. That is one of the things that we find positive about the bill.

Mary Scanlon: Paragraph 102 of the policy memorandum acknowledges that the case for community-based orders is unproven. Are not community-based compulsory treatment orders inherently contradictory in that they are based on compulsion but in practice require a great deal of co-operation to work successfully? Is that not a contradiction in terms?

Dr Coia: It is a contradiction in terms, but that has been the case for the past 50 years. In the past, people with mental illness may have been on leave of absence for their treatment. They were in the background, if you like. However, such people do not, by and large, refuse treatment daily. There is a contradiction, but in my clinical practice the approach has worked. We feel that having the CTO sanctions in the community will allow us to manage a group that traditionally may even have been in long-term care.

Mary Scanlon: I ask SAMH the same question.

Shona Barcus: Your question is well put. We share the concern. The issue is about services being available in the community and people agreeing to participate in those services.

However, there is another concern, which I think SAMH expressed in evidence to the committee—we certainly did so in evidence to the mental health legislation reference group. There is another group of patients who are not subject to compulsion but nonetheless feel coerced into agreeing to certain treatments for fear that they will just be compelled to undergo those treatments if they do not agree. The Millan committee considered that in chapter 12 of its report and there was reference to it in the policy statement. We would support amendments to the bill to deal with that issue.

Mary Scanlon: I have difficulties with the degree of force and compulsion, as I said at the conference on 3 September. I read from SAMH's written submission that non-compliance may involve being taken to a specific place for treatment and "may well involve force". I see that non-compliance can result in a person being taken into custody, a specified place or hospital. Are we talking about police intervention?

Shona Barcus: We could be, because that certainly happens at the moment.

Mary Scanlon: If patients are taken into custody by the police, they are falling out of any form of health care. Is that a concern?

11:00

Shona Barcus: That is a concern. I imagine that police might be involved in accompanying someone to a clinical setting rather than a custodial setting. Nevertheless, it is upsetting for people who are removed from their home and into hospital under police supervision, often handcuffed. We are concerned about that.

One of the service users who spoke on Friday made a point about medication. How can people be made to take medication orally four times a day? You cannot let someone into your house four times a day to stand over you while you swallow pills. He asked how that would be policed. How, for instance, would people be prevented from putting their medication down the toilet? If you are trying to persuade people to take medication that they do not want to take, things could get quite aggressive. The person involved may be feeling threatened and vulnerable. Often, angry situations arise because the person is defending himself or herself aggressively.

Mary Scanlon: That is my concern, and the police have raised it with me as well. How can you check that that patient is complying with a community-based compulsory treatment order? Newcraigs hospital in Inverness reports an average of three missing patients a week, which takes up a huge amount of police resources. Are we making provisions in the bill to deal with absconding and non-compliant patients? What sanctions—if that is the right word—should there be to help community psychiatric nurses? Will they have to go looking for patients? I cannot understand how the system will work—it is a bit like electronic tagging. How do you think that it will work?

The Deputy Convener: Dr Coia, would you like to respond to that?

Dr Coia: I could give you some practical examples, as I work in a community mental health team in the Gorbals. We have to detain patients in the community and try to persuade people to comply with their medication requirements to ensure that they are well. That is my day-to-day job.

In Glasgow, the community police are linked into our community mental health team. If we had to detain someone and take them to hospital, the community police might come with us. However, usually they do not and it is either the doctor or the community psychiatric nurse who discusses the matter with the patient.

If we had CTOs in the community, we would expect that group of patients to be visited regularly and come to our day services. Usually, we would be giving them the newer anti-psychotic medication, such as Clozapine. A weekly or monthly blood test would ensure that they were complying with the medication.

Using force with another human being is not a pleasant experience and is to be avoided at all costs. As I said before, it diminishes the people who are using violence as well. We do not use any force whatever, whether physical or verbal, with the vast majority of patients with whom we deal in secondary care. If we had to deal with them under a compulsory treatment order, the situation would be the same as it is just now: a number of nurses would sit with the patient until an ambulance arrived to take them to hospital.

Mary Scanlon: When a patient goes missing from a psychiatric hospital such as Newcraigs, they are reported to the police as a missing person. If a patient goes missing while under a community-based compulsory treatment order—if they have not turned up for treatment or have not been in when the community psychiatric nurse has visited—would they be reported to the police as a missing person?

Dr Coia: In the first instance, the community psychiatric nurse and the doctor would go out and look for them.

Mary Scanlon: They would go out and look for them?

Dr Coia: Yes. They would go to the patient's home, if they thought that they might be there. If they were not in, they would talk to the neighbours. The police would be informed, but they would usually be the community police, who would start to make inquiries in the area. A process is followed before the issue is about a missing person.

The Deputy Convener: The police service in Glasgow may be run significantly differently from that in Inverness.

Mary Scanlon: There is no doubt about that.

Shona Barcus: As a representative of a national organisation, I can say that Glasgow is better served in many respects than other parts of Scotland. In rural areas, there are huge concerns—

The Deputy Convener: I do not consider the city of Inverness to be a rural area.

Shona Barcus: As well as campaigning and working to influence policy, SAMH provides services to about 1,800 people throughout Scotland. If somebody goes missing from one of our services, we quickly follow a protocol that may involve informing the police. The intention is to help to find the person and to ensure that they are safe. When someone refuses or resists treatment, tension exists. That tension can escalate, particularly if somebody is unwell. We are concerned about how the provisions will be enforced.

The Community Psychiatric Nurses Association, which is one of our campaign signatories, has echoed our concern that its role will become to police, rather than to be a guest in someone's house. At present, people have the power to say, "Go away," if they so choose. The CPN will have a right of access and the function of their role will change dramatically.

Shona Robison: Will SAMH elaborate on its written evidence about service users' views on CTOs in the community? What the Scottish Executive says is the view of service users is different from what SAMH says.

Shona Barcus: We were a bit concerned about the responses to the Executive's consultation. During the consultation that SAMH and local associations for mental health were involved in organising, views were mixed. On balance, carers favoured community-based orders more than service users did. As I think I said to the committee last week, some service users saw orders as a blunt instrument and said, "Why not tag us and be done with it?"

To be fair, it is worth saying that the more that we consult on the developing bill, the more that service users begin to understand the issues. One bizarre aspect of the consultation is that people were asked to comment on a bill that was not fully understood even by the people who were working with it, so service users and their carers had a low starting point. They did not understand how it worked and found it inaccessible. Let us face it—the bill is not easy reading for most people, unless they have a legal background.

People did not understand all the issues on which they were being consulted. Somebody might be presented with a choice and asked, "If you were being forced to take treatment that you did not want, would you rather be forced in your own house or in hospital?" I know what I would answer. It is much less restrictive not to be forced, but to agree to accept treatment. That is the thrust of the concerns that we hear. It is fair to say that service users' concerns are increasing as they begin to understand elements of the bill.

Shona Robison: I understand that there is some dubiety about the figures for the number of responses. You have corresponded with the Executive about that. Will you say a word about that?

Shona Barcus: We heard the number of groups that had been consulted. We asked to see the responses, and when we received them, we found that 10 responses were from groups and the remainder were from individuals. It is alleged that we did not have access to all the responses, but we are still waiting for the responses that we did not receive.

It appears that the position of SAMH—which has hundreds of members and nearly 2,000 service users—was being weighed against the position of a single carer who had completed an anonymous questionnaire. That does not accord with the weight of concern that was being expressed.

Shona Robison: Are sections 60 to 64, which deal with a responsible medical officer's duty to review a CTO, adequate to ensure a patient's safety and welfare?

Dr Coia: We were pleased with those sections. A review will take place after six months, a second review will take place six months later, and thereafter reviews will take place yearly. We feel that the regulations that are in place are satisfactory. Moreover, the capacity to revoke an order is important, although it should be substantially easier to revoke or suspend it and substantially more difficult to detain someone. Apart from those comments, we are satisfied with the provisions.

Shona Robison: It strikes me that, unless we install closed-circuit television cameras in a person's house, the RMO will require to be in closer contact with someone under a community-based CTO. Should the RMO have an additional responsibility to review such an individual's treatment regularly—perhaps every week, fortnight or month?

Dr Coia: If we are going to introduce a community-based CTO, we must ensure that the care plan makes it clear how what are called intermediate services will be provided for patients. By intermediate services, I mean the involvement of not only community mental health teams, but much more active and assertive teams. Such teams would have a smaller case load and would review the patient's treatment regularly. However, I do not think that such provision needs to be written into the bill. Instead, the care plan should reflect a greater degree of supervision than we would perhaps have in a hospital environment.

Shona Robison: We heard earlier that the RMO should report to the tribunal if such services are not available. However, the question—and concern—is what happens then. Is that an even stronger argument for ensuring that the tribunal has the power to vary the care plan?

Dr Coia: Yes. That would be a useful role for the tribunal.

Shona Robison: I ask SAMH to respond to that question.

Professor Woods: We are content with the provisions in section 64.

Shona Barcus: We reinforce the points that we made last week and that Dr Coia has just highlighted. It should be easy to revoke or suspend orders and harder to increase their conditions.

The Deputy Convener: In its submission, SAMH argues that it is unacceptable that parents should be able to consent to long-term anti-psychotic medication on behalf of their children without a second opinion. How can the bill rectify such an anomaly, which has also been acknowledged by the Millan committee?

Shona Barcus: We suggest that a second opinion should be sought, and that one of the opinions should be supplied by a child and adolescent mental health specialist. Our concern is that parents do not always act in the best interests of their children, even when they believe that they are. Indeed, Children in Scotland will be making a submission that highlights similar concerns.

The Deputy Convener: Should that issue also be addressed in the children's commissioner bill?

Shona Barcus: I am not sure that we have given the matter due consideration. On parental consent, the draft mental health bill indicated that one parent would be named as the child's named person or primary carer. We are concerned about families in which the parents are separated or divorced, or disagree about the best interests of the child. I have not yet found the section of the bill that addresses that concern.

The Deputy Convener: Well, you have several weeks to do so. You can probably come back to us later. Thank you for your evidence. We will now have a short comfort break.

11:13

Meeting suspended.

11:21

On resuming—

The Deputy Convener: Our next set of witnesses represent the National Schizophrenic Fellowship, the Royal College of Nursing Scotland and the Association of Directors of Social Work. We have to be organised—I ask members to indicate to whom they are addressing their question. I thank the witnesses for attending the committee meeting and ask whether anyone has a statement to make.

Dr Jeanette Gardner (National Schizophrenic Fellowship): I will make a brief statement, which is also to be found in our submission. The Millan report said a lot about respect for carers, but that is not fully reflected in the bill. The named person is included, but primary carers, informal carers and other members of the family who are carers are not. If they were included, the MHO would have to consult more than one carer when undertaking their social circumstances report. Although MHOs may do that at the moment, they should be required to do so.

We are also concerned about patients who should be sent to a place of lesser security but, owing to a shortage of places, are entrapped in the state hospital. The bill should include a right for them to be sent to a place of lesser security; it is a question of human rights.

James Kennedy (Royal College of Nursing Scotland): The RCN welcomes many aspects of the bill. We believe that the process to date has involved a high level of consultation. However, we are disappointed that not all of the Millan principles have been included on the face of the bill. The RCN consulted nurses in Scotland widely. Although we accept that compulsory treatment orders are a highly contentious issue, we believe that, on balance and provided that adequate safeguards are put in place, there is a place for them. We endorse totally the comments that earlier witnesses made about the limited spectrum of services that are available in Scotland. That fundamental issue requires to be addressed.

Christina Naismith (Association of Directors of Social Work): We welcome the opportunity to answer the committee's questions.

The Deputy Convener: The first question is about support for the general principles of the bill. The RCN has indicated its support, so I ask Dr Gardner and the ADSW representatives whether they support the general principles of the bill and whether adequate consultation has taken place.

Dr Gardner: Yes. We are a family organisation. In the survey that we did, families came out in favour of compulsory treatment—which I had not expected—but only after everything else has been tried. People thought that treatment should be compulsory only if someone is known to have stopped their medication and relapsed and to have had possibly several emergency admissions to hospital. Nobody likes compulsion, but we think that it is better than people spending their lives in a remote ward in a psychiatric hospital. People should at least have the opportunity to go into the community.

I noticed that the previous set of witnesses talked about the widespread use of compulsory treatment. I thought that the Mental Welfare Commission existed to monitor the use of such treatment. Compulsory treatment should be restricted to people who have had frequent relapses. There should be stringent safeguards to ensure that it is used only if there is no other way to treat and care for people and only for people who could have a reasonable life in the community.

The Deputy Convener: Did the Executive consult adequately in preparing the bill? Do the organisations that the witnesses represent agree with the bill's general principles?

Dr Gardner: Yes. We very much support the bill's general principles. Our corresponding body in England and Wales used the Millan committee report in its arguments for better treatment and better care.

Christina Naismith: As we mention in our submission, we wish to see the full inclusion of the Millan committee principles as laid out in the Millan committee's final report. As the bill stands, those principles have been somewhat watered down and obscured. Some of them are missing entirely. We want the full Millan committee principles to be stated on the face of the bill.

The Deputy Convener: Did the Executive undertake adequate consultation on the bill?

Christina Naismith: I think that the consultation was adequate. The consultation was not only around the bill. The bill developed on the back of the Millan committee proposals, on which wide and extensive consultation took place over a number of years.

Mary Scanlon: Some of my questions have been answered. I notice that the financial memorandum estimates that community-based compulsory treatment will be applied to around 200 people. Are you in favour of compulsory treatment? Do you support the introduction of community-based CTOs?

Christina Naismith: In principle, we are in favour of compulsory treatment within the community, principally for the kind of people whom Dr Coia referred to. From our direct experience, we believe that some people who are confined to a life in hospital could have their quality of life improved if they were given the opportunity to have a more normal life experience. Such opportunities would be enhanced by the measures that are suggested in the bill. The issue goes beyond treatment. I say clearly that the issue is not simply about giving medication but about the wider social and psychological support that people need to provide quality of life.

Mary Scanlon: Does the bill sufficiently protect the rights of patients for whom compulsory treatment is being sought? If not, how could the bill strengthen patients' rights in respect of compulsory treatment?

The Deputy Convener: Mary, please indicate to whom the question is directed.

Mary Scanlon: That question is for the RCN.

James Kennedy: Our position is that we support the use of compulsory treatment orders, but we believe that the implementation of such treatment must be tight and must be closely monitored. If compulsory treatment orders happen, we will need to know whom they happen to and when, why and where they happen. We believe that such information will itself reveal the pattern of the existence or absence of mental health services across Scotland.

Colin Poolman (Royal College of Nursing Scotland): The bill contains sufficient safeguards if it is implemented in the right way. As James Kennedy said, we will find out how the situation pans out only when the bill is implemented.

Mary Scanlon: I ask the same question of Dr Gardner. In your submission, you say that there was worry that the order could be used as a cross-cutting measure. Will you elaborate on your concerns?

Dr Gardner: Yes. Hospitals are an expensive way of caring for people, so hospital managers might say that they need to get rid of a certain number of patients. The most awkward and difficult patients would be put out to grass, as it were. Having been put out there, would they have enough resources allocated to them? If so, would those resources have been taken away from other mentally ill people who do not have enough resources?

11:30

Mary Scanlon: If there are alternatives to in-patient treatment and treatment orders in the community, whether those are based on compulsion or non-compulsion, do you believe that we use compulsion too much under the current law? I ask that question of all the witnesses. The bill does not cover non-compliance, and you will have heard my previous questions on the subject. Someone said that CPNs would be used as community policemen. Is that an exaggeration? Do the witnesses, in particular the RCN, have concerns about that?

Colin Poolman: When we consulted our members, we discovered that there is a fear that that could happen and that CPNs could go from patient to patient, monitoring compulsory treatment orders in the community. It was felt that the therapeutic interventions ought to be considered. CPNs should not only supervise orders; there should be a therapeutic relationship, directed by the care plan. The CPN's role in monitoring the compulsory treatment orders should be part of that therapeutic relationship with individuals.

Mary Scanlon: I am asking about your members' concerns about looking for missing persons and how orders can be policed. What sanctions would be available? That is a special concern given the fact that you cover the Highlands and Islands.

Colin Poolman: Yes, that is definitely an issue. When someone goes missing who is under an order—be it an in-patient order or a community order of any type—procedures must be in place that professionals can follow. Decisions should be made more formally by a clinical team, based on a risk assessment. We heard how people check with neighbours, and so on. At that point, people would need to decide whether the order was appropriate. They would need to take into consideration the last time that they saw the individual and which other professionals were in contact with the individual.

I do not have a fear that CPNs will be running about Inverness, hunting for patients. When there is significant concern for somebody's safety—and the issue is safety—there is a role for the police, who should be involved in filing a report for a missing person and the appropriate procedures that are followed thereafter.

Mary Scanlon: I ask Dr Gardner the same question. My concern is that, neither in the financial memorandum nor in the 168 pages of the bill is there any protocol that takes in the role of the police. A lot of Northern constabulary's time is taken up in looking for missing psychiatric patients, and the police are worried that more time will be taken up. There are no resources and there seems to be no protocol. I accept what you are saying—it sounds good—and I appreciate the fact that there is good practice in Glasgow, but that is not the case throughout Scotland, and I am concerned that many patients will be taken into custody during compulsory mental health treatment. That is a genuine concern.

Colin Poolman: We would share your concern if police resources were being misused. However, it is for other people to decide what resources to allocate to such things and whether resourcing is a key component in the implementation of the bill.

Dr Gardner: It is a concern, especially for users, that police will be involved in the CTO, which is all about compulsion. As we have just heard, CPNs will and should form a therapeutic relationship with the patient. That relationship should never be hostile, but that is not the case in practice and, in practice, the police are not involved with missing patients unless they are known to relapse quickly and to need prompt psychiatric help. With someone who is relatively stable, the police might be informed, but they do not necessarily search for them.

Willie Paxton (Association of Directors of Social Work): There is no national protocol on involving the police; the matter is usually worked out locally. I acknowledge that the involvement of the police is the most unpleasant and difficult aspect of compulsion.

Mary Scanlon: That is true for the police as well.

Willie Paxton: Indeed; they are the people who ultimately must lay hands on patients.

Mary Scanlon: They are not trained to handle mentally ill patients.

Willie Paxton: Police officers are perhaps not trained specifically for that, but they are generally very good in such situations. Such interventions should be based on proper risk assessment and risk management. In my experience, we would ask for the police to be present only in the most extreme circumstances and when there is a perception among a group of professionals that a person might become violently resistant to being detained. That is the case at the moment in hospitals and it is likely to be the case in the future under the bill.

Shona Robison: I have a question for the RCN witnesses. Perhaps they heard the comment from SAMH that the Community Psychiatric Nurses Association has signed up to SAMH's campaign, which indicates concern about CPNs' changed role. The RCN evidence contains a number of views, some of which are supportive of the measures, but others express concerns that the new powers will damage the therapeutic relationship. What is the balance of views in the CPN work force? Do you have any figures for that?

James Kennedy: As part of our overall consultation process, we have talked to a network of nurses who work in mental health settings, including community psychiatric nurses. There is a spectrum of opinion, but we feel that our evidence balances those views. That is why we made strong comments on safeguards and resources. If one considers some of the issues that Mary Scanlon has highlighted this morning, it is evident that the system does not work well throughout

Scotland, although we have heard examples of things working well. The range of views depends on the philosophy of the nurses, where they work and the resources and staffing in those areas.

Shona Robison: So CPNs' views are coloured by the context of where they work.

James Kennedy: The fundamental issue for CPNs is to develop and work in a therapeutic environment with patients. That is the raison d'être for CPNs and mental health nurses. CPNs have anxieties about whether compulsory treatment in the community will have a detrimental effect on their relationship with clients. The relationship between a CPN and a client is often about exploring such issues. However, on balance, the view of the range of nurses whom we represent in Scotland is that there is a place for compulsory treatment.

The Deputy Convener: When you took that sounding from your membership, what was the view of CPNs who work with community care orders? Those people have hands-on and daily experience of dealing with such situations.

Colin Poolman: The responses that we received from our members were varied. As James Kennedy said, we have come back with balanced answers. Nurses have experienced difficulties in that they have found that some of the existing legislation in relation to the care programme approach is unworkable with patients. They feel that it is difficult to implement the care programme approach at the same time as building relationships with their patients. Some of the nurses who have said that they are not in favour of compulsory treatment in the community feel that it would place too much strain on the therapeutic relationship. Other nurses have a more balanced view; they believe that it is necessary to have the least restrictive practice for the individual. That form of treatment would be a far better way of helping the group of patients that we discussed earlier to maintain their mental health than making them return to hospital on a regular basis would be.

Bill Butler: I have a question for the RCN, but other witnesses might want to express a view. Does the bill provide adequate safeguards to ensure that community-based CTOs are not used inappropriately—for example, to ease the pressure on patient beds? If the bill does not provide adequate safeguards, how could it be amended to prevent such inappropriate use?

Colin Poolman: There needs to be monitoring of how the compulsory treatment orders are used. There must be an audit of how many orders are proposed and implemented. As Professor Woods said, we will find out how effective and how widely used the CTOs are only when the bill is enacted. We hope that they will not be used instead of appropriate services. If someone is unwell and requires hospital treatment, they should have such treatment. Treatment should not be done on the cheap in the community. Safeguards need to be implemented to ensure that that does not happen, because such abuse should not take place.

Willie Paxton: It is worth emphasising that a series of checks and balances have been built into the bill, which requires a significant amount of scrutiny of an application for a compulsory treatment order. That process begins with an independent and objective assessment by a mental health officer. We train mental health officers on the understanding that their core business is to provide an objective assessment across a range of criteria.

Bill Butler: You feel that the safeguards are adequate.

Willie Paxton: Yes. There is also a tribunal. The care plan that is envisaged as part of a multidisciplinary process must stand up to the scrutiny of the tribunal. The person who is the subject of an application has the opportunity to bring in an advocate to speak on their behalf and to make the professionals concerned justify the plan against a set of principles, which include the need to prove that the plan will be of benefit. That represents a big advance on the present system.

Dr Gardner: One of the basic safeguards is that a compulsory treatment order is to prevent a relapse or deterioration in the health of the patient. Compulsory treatment in the community should not be seen as depot medication. Medication is not the central part—the whole care plan is what matters. In some cases, that holistic approach has been missing because of a lack of resources. A person should not be made the subject of a CTO unless all the safeguards are met. A CTO should not be issued early on. As well as being seen to reject the care of the people who care for them and the medical treatment that is being supplied, someone must relapse before one could even consider a compulsory treatment order.

Bill Butler: Do you feel that the safeguards are adequate?

Dr Gardner: I am not sure that they are—I am not sure that they are clear enough. It might be possible to emphasise them in the code of practice.

Mr McAllion: Before a mental health officer applies to a tribunal for a compulsory treatment order, he or she must draw up a care plan. Under the principle of reciprocity, he or she should try to ensure that all the social, psychological and mental support that a person requires is present in the community. What happens when a local authority does not have the budget to meet a patient's needs? Will the mental health officer be under pressure to include in the plan what is available, rather than what is required?

Willie Paxton: I am not sure what the outcome for the person in the case that Mr McAllion cites would be. However, mental health officers' assessments are objective and independent.

Mr McAllion: Independent of local authorities and the NHS?

Willie Paxton: Yes. MHOs are accountable to local authorities as regards good practice and professional behaviour. However, as long as their assessments are objective and based on good practice, those assessments will stand.

11:45

Mr McAllion: What happens if a mental health officer believes that a patient who could be subjected to compulsion needs certain services to be available, but those services are not present? What does an MHO do in such a situation?

Willie Paxton: I find it difficult to envisage what sort of services the member is referring to.

Mr McAllion: I am referring to services such as halfway houses, which should be present in the community but may not be available in an area because the local authority is strapped for cash or the health board is short of money. Do you recommend that in such cases compulsion should not be applied?

Willie Paxton: Decisions must be based on the merits of individual cases. If an MHO says in their assessment that a person needs a service that does not exist, I do not see how they would be justified in compelling that person to accept it.

Mr McAllion: So the principle of reciprocity would apply in that situation. If the services that are required are not present in the community, compulsion should not be applied.

Willie Paxton: There is a wider issue of resourcing that we intended to cover.

Mr McAllion: Often local authorities assess people in terms of what they can afford to give them, rather than in terms of what they need. I have seen that happen time and again in a range of services. The system begins to break down because of a lack of resources. I do not blame local authorities, as they have no other option.

Willie Paxton: I understand that the bill does not give local authorities the option of proceeding as Mr McAllion describes. Mental health officers are expected to offer an independent, objective assessment that is based on a person's needs.

Mr McAllion: Earlier, a witness said that if the responsible medical health officer, the patient or the named person believed that the care plan that was set out in the treatment order would not be met, they could take the case back to the tribunal. However, the tribunal cannot force a local authority to provide something that it does not have the money to provide. Therefore, is there not a gap in the legislation?

Willie Paxton: I am not sure that what you describe is a gap. In my view, it is just part of life. We do not live in an ideal world in which everyone can have everything. Have I misunderstood what you are driving at?

Mr McAllion: You seem to be saying that there is a limit to reciprocity. You are saying that it relates to what local authorities and health boards can afford, rather than to what people need or what is desirable.

Christina Naismith: I would like to make a point about the resources that are being allocated under the financial memorandum to the bill. We are concerned that there may not be sufficient resources to fund the kind of services that will be required to supply the care plans that we hope will be developed for people who are compulsorily detained, either in the community or in hospitals.

At the moment, none of us would dispute that there is a paucity of community services. It is in everyone's interest that the provision of services is increased. However, it is difficult to relate the measures aimed at doing that to the bill. Some of those measures relate to prevention and to ensuring that people do not come within the ambit of the bill or require mental health services. Earlier, we spoke about children and adolescents. We hope that not all early interventions will be of a medical nature and that they will not involve addressing people's mental distress only through the kind of means that we have discussed. We are talking about working with people at different levels. Some of that work belongs in the bill, but some of it falls outwith the bill.

We are concerned that provision of services is at such a low level. The bill imposes additional duties and responsibilities. We need to bridge the gap between what is required by law and what authorities are able to provide. I am talking about health provision as well as local authority provision. The health service and local authorities must work together.

There are other policy agendas that we have to ensure that the bill supports. For example, the joint future agenda will ensure that there is integration between health services, housing and social work and that we can provide an holistic service.

Nicola Sturgeon: I direct my first question to the RCN. Your written submission points to your concern about the impact on resources of the nurses' role in monitoring CTOs. Can you quantify that impact? Are the additional resources that are earmarked in the financial memorandum sufficient? There is no specific mention of any additional resources for nursing.

James Kennedy: The estimates in the financial memorandum are fairly modest if we are trying to create a significant, well-resourced spectrum of community-based services, including the provision of assertive services. From a community health point of view, as Professor Woods and others have already indicated, we already have a framework for mental health services in Scotland. It is clear, and it has been exhibited in today's questioning and evidence, that there are not enough resources associated with that framework, which covers the spectrum from people who might be well and who might require prevention and early treatment, to those who require compulsion.

The nurses to whom we have spoken are concerned that the bill will have a greater impact on their case load and work load at a time when the case loads of community psychiatric nurses are particularly high and intense. Although there are more CPNs, the nature of their work has changed radically and become more intense over the past five to 10 years. We have some significant anxieties about the funding in the financial memorandum.

Nicola Sturgeon: You point to an increasing vacancy rate among psychiatric nurses. Are you concerned about a growing recruitment and retention problem?

James Kennedy: We have serious concerns about recruitment and retention across all nursing groups, but it is emerging clearly that that is a particular issue in mental health. When there are a relatively small number of community psychiatric nurses in a community mental health team, all that is needed to create a serious problem is for one vacancy to be held for a long time to balance the books in the trust or because someone cannot be found. We know that that happens in some areas and we believe that that issue has to be considered.

We have to break the cycle of an increasing work load and fewer people to do the work.

Nicola Sturgeon: My final question is to the ADSW. The financial memorandum provides funding for 45 new MHOs. Is that sufficient to meet the increased demands that the bill will generate?

Christina Naismith: I confess that we contributed to that calculation. It is based on the purely statutory work that MHOs would be expected to carry out. It also considers the populations that we are currently working with. It was a difficult calculation to make and it does not take into account any other duties that MHOs might have. It is about resolving problems and not compelling people—

Nicola Sturgeon: I am sorry to interrupt but that suggests to me that the financial memorandum is not at all realistic.

Christina Naismith: Additional work has to be done. At the moment, an issue is the number of MHOs in the country who are not involved solely in MHO work. MHOs carry out a range of duties. They are normally social workers working in a team and MHO duties are done in addition to their other work as social workers.

We will have to consider redeploying MHOs and redesigning the services so that MHOs do MHO work full-time and do not diverge into other kinds of work. At the moment, because MHO work is only a part of a social worker's case load, it can be difficult to juggle. For example, a social worker might be in a children and families team that deals with child protection issues and might be allocated a child protection case, as well as being on a rota for undertaking MHO duties. It can be difficult to balance those responsibilities. That is an unintended consequence of the current rota arrangements.

Nicola Sturgeon: Again, that suggests to me that if people are doing more than one job or are going to become full-time MHOs, a problem will be created elsewhere within the social work service, given the current recruitment problems. We are focusing on the bill, but do you envisage any problems occurring in other areas as a result of the bill, which may not adequately have been thought about?

Christina Naismith: Not as a result of the bill, but as a result of the range of duties that are placed on social workers across the board. There is a general difficulty with the recruitment and retention of social workers, to which you have referred. One of the consequences is that it is not clear how people will take on specialisms, for example in child protection, as an MHO, in criminal justice work or whatever else they might have to get involved in.

We are having difficulty recruiting social workers into the profession. We have to address that problem, but the difficulty of that challenge is not an argument against having social workers acting as mental health officers and bringing their professional expertise and insight to people with mental health problems and needs. There is a different argument there, which needs to be unpicked.

Nicola Sturgeon: Do you share the concern that others have expressed that the financial memorandum as a whole is unrealistic?

Christina Naismith: Yes—the amounts that it specifies are inadequate.

Janis Hughes: Let me pick up on a point that the ADSW made in its written submission. It states:

> "the Bill does little to further the policy direction promoted through the Joint Future agenda which is attempting to secure integrated health and social care provision."

Could you elaborate on that?

Christina Naismith: We are concerned that the bill draws a distinction between what local authorities will provide, which is most of the community bits, and what the NHS will provide, which is the hospital bits along with some treatment in the community. That is not how things currently work, nor is it how we would intend them to work in the future. We would like the relevant areas of the bill to be reframed, so that it is not at the behest of local authorities to request health boards to help them out with cases. That is not current practice; we want to build on existing best practice.

I acknowledge the paucity of resources and the fact that different places have varying levels of resource, but if we build into legislation distinctions as to who does what, we must be clear that social work has a distinct role in the care and support of people undergoing treatment in hospital, as well as in the community. Likewise, we must give regard to the particularly intensive role that CPNs and other psychiatric colleagues play in the community. It is a matter of understanding the multidisciplinary nature of our work. It is not necessarily an either/or matter.

Janis Hughes: So there is a contradiction between the bill and the Community Care and Health (Scotland) Act 2002, which advanced joint working.

Christina Naismith: Yes.

Bill Butler: Dr Gardner, does your experience of the Mental Health (Scotland) Act 1984 Act and your reading of the bill lead you to believe that the bill will benefit service users and carers?

Dr Gardner: Yes, on quite a lot of points. To begin with the carers' point of view, there is often hostility between the carer or family and the service user. That may be because of the illness or long-term hostility, or it may be because users can now name a person who is to represent their interests, which I think is a very good thing.

I mentioned the advance statements in my submission. As well as saying what kind of care and treatment they want, users can say to what extent they want intervention, help or involvement from their family or from certain individuals. There is no doubt that some people do not want certain members of their family near them in hospital, although they might get on quite well with them at other times. The advance statements for when people are very ill and the duty to identify a named person represent a very good advance. The MHO will normally get hold of other members of the family to find out what the social circumstances are. Connected with that, primary carers should be specified rather more often in the bill, or certainly in the code of practice.

The rights of people in the state hospital to go to a place of medium or lesser security are missed out of the bill. At present, they may go back to their local hospital—but that is why some of them often find themselves trapped. Except for the Orchard clinic in Edinburgh, there is a lack of medium-secure units, which are very much needed.

People can be rehabilitated. They may have committed a crime or have been very aggressive for a very short time in their lives, but they should not be punished again and again or for years and years by being stuck in places such as the state hospital.

Shona Robison: You have answered one of the questions that I was about to ask, but I have a question about respect for carers, which you covered in your written evidence. How do you suggest that that principle should be covered in the bill? Do you want it to be a stated principle in the bill? Would that be enough or are you looking for more than that?

Dr Gardner: If it were a stated principle in the bill, that would cover most things. There are places in the bill where I think the primary carer ought to be mentioned along with the named person. Stating a principle about carers in the bill is essential.

The Deputy Convener: Thank you all for providing your evidence this morning.

Meeting closed at 12:00.

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