HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 30 October 2002
(*Morning*)

Session 1

£5.00

Produced and published in Scotland on behalf of the Scottish Parliamentary Corporate Body by The Stationery Office Ltd.

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Scottish Parliamentary Corporate Body publications.

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HEALTH AND COMMUNITY CARE COMMITTEE

27th Meeting 2002, Session 1

CONVENER

*Mrs Margaret Smith (Edinburgh West) (LD)

DEPUTY CONVENER

*Margaret Jamieson (Kilmarnock and Loudoun) (Lab)

COMMITTEE MEMBERS

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

COMMITTEE SUBSTITUTES

Brian Adam (North-East Scotland) (SNP)
Ian Jenkins (Tweeddale, Ettrick and Lauderdale) (LD)
Mr Tom McCabe (Hamilton South) (Lab)
Ben Wallace (North-East Scotland) (Con)

*attended

THE FOLLOWING ALSO ATTENDED:

Dr Jacqueline Atkinson (Adviser)

WITNESSES

Rachel Annand (Scottish Independent Advocacy Alliance)
Chris Evans (Highland Users Group)
Helen Garner (University of Glasgow)
Maggie Keppie (Edinburgh Users Forum)
Chris Mackie (Scottish Independent Advocacy Alliance)
Keith Maloney (Consultation and Advocacy Promotion Service)
Graham Morgan (Highland Users Group)
Professor David Owens (Royal Edinburgh Hospital)
Hilary Patrick (Law Society of Scotland)
Tony Rattray (Advocacy Safeguards Agency)
Marcia Reid (Highland Users Group)
Adrienne Sinclair Chalmers (Advocacy Safeguards Agency)
Willie Twyman (Edinburgh Users Forum)
Adrian Ward (Law Society of Scotland)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Graeme Elliot

LOCATION

Committee Room 2

Scottish Parliament

Health and Community Care Committee

Wednesday 30 October 2002

(*Morning*)

[THE CONVENER *opened the meeting at 09:39*]

The Convener (Mrs Margaret Smith): Good morning and welcome to the Health and Community Care Committee. The first item on the agenda is consideration of a negative instrument. No comments have been received from committee members, the Subordinate Legislation Committee has no comments to make and no motion to annul has been lodged. The recommendation is that the committee does not wish to make any recommendation in relation to the instrument. Are we agreed?

Members *indicated agreement.*

Mental Health (Scotland) Bill: Stage 1

The Convener: Item 2 is further consideration of the Mental Health (Scotland) Bill. This morning, we are considering in particular advance statements, advocacy and the rights and protection of patients.

Our first witnesses are Hilary Patrick and Adrian Ward from the Law Society of Scotland. You may begin by making a short statement and we will then move on to questions. I will try at the end of the questioning to give you an opportunity to pick up on anything that we have not covered.

Adrian Ward (Law Society of Scotland): Thank you for having us. In my brief opening comments, I will delineate what Hilary Patrick and I can cover to assist you. I have three specific points of evidence that I would like to give at the outset, and I have two concerns of a general nature and overriding importance to the discussion.

The Law Society of Scotland's mental health committee is a small committee, which operates in our own time. We prioritise. In the past three years, I have been more involved with the Adults with Incapacity (Scotland) Act 2000. Hilary Patrick has been our lead person on the Mental Health (Scotland) Bill. I have dealt with it too, but Hilary is probably better equipped than I am to deal with more detailed questions.

The Convener: That was neatly done.

Adrian Ward: Unlike Hilary Patrick and many of your other witnesses, I was not on the Millan committee, yet I have in the past had quite a lot of involvement with the subject, including internationally. Because of that, I can make one important point. By the best standards of international work on mental health issues—which is basically three-cornered and concerns a balance of the rights of the patient, the needs of clinical effectiveness and the interests of society—the Millan committee's work is outstanding.

My first concern is that I do not see that work fully carried over into the bill. The Millan committee, with great care and much consultation, set out a list of general principles. The Scottish Executive assured us that they would be carried into the bill, but they are not there.

My experience of the Adults with Incapacity (Scotland) Act 2000 is relevant. That act commences with a list of principles. The Parliament did an excellent job and those principles work well in practice. They assist those who apply the act and benefit the people whom the act is about. The fact that there is no such list of principles in the bill is a major worry, which carries through to the other provisions, such as the rights of the patient or the effect of advance statements. If those provisions are set in the context of the Millan principles stated clearly in the first section of the bill and overarching everything in it, we can be comfortable. If the bill contains only the detailed provisions, we have concerns.

My first point of evidence is that the Millan committee's work—viewed objectively with knowledge of what is being done internationally—is excellent. The second is that the Adults with Incapacity (Scotland) Act 2000 is working well.

My third point of evidence is on the structure and drafting of the bill. I have seen some of our best lawyers with expertise in the area struggle to follow it.

The Convener: I am glad that you said that.

Adrian Ward: I have seen those lawyers go to and fro through the bill to follow the cross-references and cope with the terminology. The patient is referred to as the "patient", the "individual", the "relevant person" and the "specified person". Sometimes the "relevant person" is somebody else. In almost every section, we have to go to and fro, like in a paper chase.

The Mental Health (Scotland) Act 1984 is on the desk, in the briefcase or in the pocket of almost every psychiatrist, mental health officer and advocacy worker. People use it. It is about basic, fundamental human rights. As a representative of my profession, I know that it is probably not in my interest to say this; nonetheless, those people should be able to read it and understand it without having to have a lawyer sitting beside them all the time. When an expert lawyer is struggling, that should not be the case. That is a point of evidence. I have seen the difficulties and have experienced them myself, and I have seen how the 1984 act needs to be accessible and usable.

09:45

As you will understand, regarding all these issues about patients' rights and so on, if we have clear, accessible legislation that is governed by clearly stated principles—the Millan principles—we can be more comfortable. First, I recommend that you ask the Executive to undertake, early during stage 2 of the bill, to replace section 1 with a section that does what the Executive said that it would do and that sets out clearly the Millan principles—not only as they apply to some people or some situations, but as they apply to anyone who is exercising functions under the bill and to all those functions. That happened with the 2000 act and it is working.

Secondly, I ask the Executive to take a bit more time. I can see a parliamentary draftsman who has been put under pressure to do a lot in a short time. A bit more time is needed to straighten out and clarify the drafting of the rest of the bill. I recommend that you seek that undertaking because it will be difficult for you and your colleagues to build that in as you go through stage 2. It will be much better if that restructuring is done first; then you can address specific matters as you go on.

I am sorry that you have heard from me for longer than I intended.

The Convener: No, those were interesting comments. Without wanting to speak on behalf of my colleagues before we have discussed our stage 1 report, I can say that some of the issues that you raise have been raised privately among ourselves in our work on the bill so far. We echo your comments about how difficult it is to follow what is meant in some places in the bill, which suggests that it is not well drafted.

I will kick off with the first question, which is fairly general. One of the things that we have to do at stage 1 is to say whether the committee thinks that the general principles of the bill are okay. I hear what you say about the need for the general principles to be laid out in the bill. That being the case, does the Law Society support the general principles of the bill? Do you think that there has been adequate consultation on the bill?

Adrian Ward: I think that the answers are yes and yes. I have been doing this job for many years. I have seen the huge change since the Parliament was established. Being close to the 2000 act, I was close to your first major piece of legislation. Consultation on that was good, and the Parliament was open to input from outside right through to stage 3. There has been good consultation so far. I hope that you will continue with the same degree of openness. Consultation is valuable and contributes to the quality of what is produced. It gives many people who are concerned about a certain topic a feeling of ownership of what is produced.

The problems with the content are those that I have outlined, broadly speaking. When you get to stage 2, the Law Society will propose amendments and pick up specific points. However, that is not a topic at this stage to any great extent. You are concerned with the principles. We support and welcome the principles in the broad sense.

Hilary Patrick (Law Society of Scotland): We accepted the principles that are stated in the Executive's document "Renewing Mental Health Law"; however, as Adrian said, we do not believe that what is set out in the bill adequately represents what is stated in that document. Various principles are missed out. There is the strange principle of equal opportunities, which does not seem the correct way of expressing the principle of respect for diversity that Millan recommended. We therefore support the principles that the Executive has stated, but not as they are set out in the bill. We have submitted written evidence that states our concern about the way in which the principles appear in the bill.

The Convener: We will take Adrian Ward's yes-yes answer with a caveat.

Adrian Ward: The answer is subject to what I said before it and what Hilary Patrick said after it.

Mary Scanlon (Highlands and Islands) (Con): Does the Law Society support the creation of mental health tribunals, or does it prefer the current model, in which a sheriff sits alone and decides cases in a courtroom?

Adrian Ward: That has been the subject of much debate on our part for years. We first addressed the issue in the context of consultation on incapacity legislation, which started in 1991 and asked all consultees what the forum should be. We answered that question at great length and with considerable care. As we were dealing with impinging on an individual's rights and because what the forum did at first instance might be subject to appeal, which would mean that the forum would have to state the reasons for its decisions in a way that an appellate court could consider, we favoured sheriffs. However, we recommended strongly that sheriffs should usually be designated to take all such work in a sheriffdom. We envisaged such a system extending to mental health work and sheriffs building up expertise. The traditional adversarial procedure before a sheriff who sits back does not work well in incapacity or mental health matters.

That was our view, which the Scottish Law Commission took up. Its draft bill on incapacity proceeded on that basis, but the 2000 act dropped that requirement, so that any sheriff could undertake the work. The first preference was for a designated sheriff and the next preference was for a form of specialist tribunal. We got neither. Given that the 2000 act went that way, we favour the tribunal. If we had experience of specialised designated sheriffs, I would hesitate. However, having examined the options—I need not rehearse them, as they are well covered in the paperwork—I support the tribunal.

Mary Scanlon: Over a period, you have concluded that the creation of mental health tribunals is acceptable.

Adrian Ward: I prefer designated sheriffs. If we take the route set out in the bill, we will have the strange situation in which jurisdiction under the 2000 act is with the sheriff and Mental Health (Scotland) Bill matters are with tribunals. I expect that someone will compare the performance of both and bring both jurisdictions to the same place—a tribunal or a sheriff. However, that is for the future.

Hilary Patrick: The Law Society's mental health and disability committee may have different views on that. With some experience of the tribunals down south, some of us greatly prefer tribunals, because of their greater informality and the input from people other than lawyers, such as psychiatrists and lay people. Some of us are excited about and welcome the prospect of mental health tribunals for mental health cases.

Mary Scanlon: We received a paper from someone who worked down south who said that the courtroom and the sheriff were better.

Hilary Patrick: Some people like the formality of the sheriff court, which they think gives the law dignity. I find even the layout of sheriff courts, which the committee may have seen, inappropriate in such cases. In people's minds, that makes a link with criminal procedures. The fact that the layout is aimed at intimidating people makes it inappropriate in mental health cases. As I have a little experience of tribunals down south, I strongly favour them.

Mary Scanlon: If the bill is passed and tribunals are established, will the lawyer's role of speaking for patients in the system wither away and pass more to patients' advocates or to patients themselves? Alternatively, given that paragraph 109 of the explanatory notes says that legal aid will be available, will tribunals be a lawyer's paradise?

Adrian Ward: That relates to what I said in my opening comments. If we get the clarity of the act right, people will find it accessible and they will need lawyers less. That is an important point. The difference may be that if somebody is looking at a particular section of the act and if they can confidently find their own way through it or their voluntary advocate can do so, they may not need a lawyer. They should not have to go to and fro through the act and refer to other acts—members will notice that even in the very first section it is necessary to go to another piece of legislation to find out what it means.

Mary Scanlon: So you are saying that if the advocacy services are not up to the standard, more people may opt for lawyers.

Adrian Ward: No. I am saying that if the draftsmanship of the act is helpful, lawyers will be needed less, but they will still be needed and in many cases rightly so. We are talking about a very strange concept. If I break my leg, it is up to me whether I accept treatment, how I am treated and where I go. It is up to me whether I suffer it and do not seek treatment at all, if I am daft enough take that decision. We are applying different standards, in many cases rightly so, because my broken leg does not impair my judgment about how I want it to be dealt with, but sadly my mental illness may do so. The illness that I am there to be treated for may impair my judgment about the treatment. That is a difficult area. Working that through in individual cases will in some cases require legal input. There is a case for reviewing how the legal aid regime interacts with mental health law and incapacity law generally. That is probably generally acknowledged. There will be cases where legal representation is needed and, when legal aid is required, it will help if there are quick procedures that do not lead to a delay in matters that need to be dealt with promptly so that the tribunal can get to the heart of the matter quickly.

An experienced tribunal will be able to operate more efficiently and when lawyers are involved it will not have to be told things that it already knows. It will be possible to get to the heart of the matter quicker, which is important as lawyers charge by time—if you use up a quarter of my time you will get a quarter of the bill, whether it is funded by legal aid or by another means.

Mary Scanlon: Will there be more or less legal input? I know that it is difficult to project forward.

Hilary Patrick: It is difficult to project forward. We should consider the experience of the employment tribunals. I do not know what the figures are for those, but that would be a model to work on. I would be reluctant to advise somebody not to have legal representation. Most people have legal representation in cases before the sheriff, because of the fundamental human rights provisions. There is no doubt that if a non-legally qualified advocate or representative wanted to train themselves up to represent people, they could do it, but I do not know whether they would want that role. My feeling is that generally people would have legal representation at the tribunal, to ensure that the various points were put forward.

Dorothy-Grace Elder (Glasgow) (Ind): Mr Ward remarked earlier in his informative address to us that he did not want to have a health professional sitting with a lawyer at his or her side while trying to plough through the act and other linked legislation. Before I move on to another question about advocacy, could Mr Ward clarify that he is saying that if the bill is redrafted to provide proper clarity, it will be much easier—this is aside from his other, moral considerations—for an untrained member of the public to represent a patient?

Adrian Ward: The main benefit for those engaging with the system—doctors, administrators and so on—will be that if the legislation is more clearly drawn, they will less frequently get into the situation where there is a conflict and they need advice, whoever provides it. That is important. If the principle of participation is included and as far as possible treatment is agreed rather than imposed, there will be agreement. If the act is difficult to interpret and somebody believes that somebody else has made a wrong interpretation because of that, there is more likely to be conflict. The concern is not so much the extent to which we need lawyers as whether we might needlessly generate situations of conflict and disagreement or doubt that would give rise to the need for a lawyer.

10:00

Dorothy-Grace Elder: Is the Law Society satisfied with the general arrangements for advocacy in the bill, which provides for a duty to provide advocacy services rather than for a right to advocacy? Does the existence of a duty imply a right?

Adrian Ward: I think that that is always so. There must always be access to advocacy, which is why there must be a duty to provide advocacy services that people can access if they want to. We need to be careful about the difference that can arise between what happens on paper and what happens in practice. If I have just been admitted and am confused and unwell, it will not help me to know that an act somewhere says that I have a right to an advocate. It is better if somebody can tell me, "We have an advocacy service. People from it are happy to come and talk to you. Why not have a word with them? You do not have to use them." I need someone to whom I can relate, who is independent of all the system that may seem to me to have put me where I am.

Dorothy-Grace Elder: So we must be proactive in approaching the patient, or any representative of the patient, to offer the advocacy service.

Adrian Ward: Having had a health care responsibility for about five years, I have some experience of advocacy services in a health care situation. Fostering an advocacy service was extremely helpful in dealing with mental health patients and learning disabled patients. It was helpful to everybody to have someone who could stand apart and articulate concerns.

Dorothy-Grace Elder: One part of the Law Society's submission seems to contradict another part, although I am sure that it will be pointed out to me that that is not so. On page 1, the submission states:

> "While the Millan Committee recommended a 'right to advocacy', the Bill proposes a legal duty on health boards to provide advocacy. Whilst not denying the legal differences, the MHD Committee believes that it is more important to ensure that advocacy is available to those who need it and is fully integrated into the process than to concentrate on these legal distinctions."

However, over the page, the second paragraph on page 2—

Hilary Patrick: Sorry, our pages are numbered slightly differently. Under which heading does this paragraph occur?

Dorothy-Grace Elder: After the subheading "Definition of 'advocacy'", the next subheading is "Integration into compulsion procedure". Under that subheading, the submission states:

> "The MHO should be under a legal duty to help the patient access advocacy."

At first, the submission seems to say that a legal duty is not really required, but it then says that the mental health officer should be under a legal duty.

Hilary Patrick: We simply wanted to say that the bill should spell out that the mental health officer must not only advise the patient about the existence of advocacy services but help the patient to get an advocate, if that is what the patient needs. The reference is to what the mental health officer should do, not to the more dramatic distinction between a health board's duty and a patient's right.

Adrian Ward: I envisage that the sentence to which Dorothy-Grace Elder referred would operate in the way that I described. When I am admitted to hospital as a patient, I would be told, "We have an advocacy service. Would you like people from it to come and see you? Why not have a chat with them? You do not have to use their services, but they are there." We need to make the actual link. That is the duty that we envisage.

Mr John McAllion (Dundee East) (Lab): I want to pick up on a small but important point from the earlier exchange with Mary Scanlon about the issue of tribunals versus sheriff courts. The evidence to which Mary Scanlon referred was from a professor of psychiatry who had 16 years of experience in England and Wales. That professor said that, although tribunals were in theory less intimidating and therefore easier for patients, the tribunals were in practice often held in cramped hospital rooms with an atmosphere that was claustrophobic, aggressive and adversarial, which caused distress to patients. Should standards not be set down in a code of practice about where tribunals should be held?

Hilary Patrick: Absolutely. When tribunals were recommended by Millan and by those of us in the Law Society who are in favour of them, we hoped that there would be set up a high-quality tribunal system rather than a pale imitation of the English system. A tribunal system must be properly resourced. Obviously, if tribunals are held in a broom cupboard, they will not work well.

There is a problem in England with delays and with clerking the tribunals. We do not want to have that in Scotland; we want a high-quality, well-resourced tribunal service. It is also true to say that the psychiatrists do not always like tribunals, because some people find them aggressive and they are fairly thorough in their questioning of the psychiatrists, who might not like that. Others think that that is helpful. The tribunal should not be aggressive or adversarial, but there should be an attempt to discover the facts of the situation and find out about the best alternatives. Those of us who have seen a tribunal believe that it is possible to do that round a table, a bit like in this meeting, because this is not intimidating either.

Mr McAllion: It should be.

The Convener: I am glad to hear that it is not intimidating.

Hilary Patrick: Tribunals can get to the truth in a way that is not possible with a sheriff who is sitting on a pedestal. I was at a sheriff court in which somebody who was sitting in the body of the kirk, as it were, knew something about the case but could not be asked a question unless she was brought back into the witness box and swore the oath. We think that the tribunal system is able to be much more thorough in its investigation and some professionals will find that intimidating.

Mr McAllion: In your evidence you indicated that you believe that the advocate should be able to attend the tribunal if the patient requests that. You also think that the code of practice should spell out the advocate's right to access to the documents to get information. With regard to the patient journey, will you spell out the points at which the advocate would have the right to access correspondence and to attend the tribunal to speak on behalf of the patient?

Hilary Patrick: The advocate would have that right if the patient wanted them to have it.

Mr McAllion: So it is conditional on the patient's asking for it.

Hilary Patrick: In my view it should always be conditional on the patient's wanting it. We do not want an army of aggressive advocates coming in. There is no risk of that happening at the moment, but the nature of advocacy is that the advocate reacts to what the patient wants and acts as the patient instructs. If the patient wants the advocate to see his or her correspondence, the advocate should be able to do so. That does not always happen at the moment. Nursing staff say, "No we can't let you see that because of patient confidentiality." There is a misunderstanding of the role of advocacy. Even if the person has a legal representative at the tribunal, they might still want their advocate to be present to offer them support.

Mr McAllion: And if they do, they should have the legal right to it.

Hilary Patrick: Yes. It should be made clear that that can happen.

Mr McAllion: In the bill or in the code of practice?

Hilary Patrick: Some of that could be in the code of practice.

Mr McAllion: The British Medical Association has made it clear that it wants the boundaries to be defined between doctors' right to withhold information and advocates' right to ask for information. Who is right?

Hilary Patrick: The whole confidentiality issue should be explored. I do not think that there is really an issue. In 99 cases out of 100 I would be entitled to see my medical records. If I wanted my advocate to see the records, it would not be for the doctor to say that they cannot seem them. The confidentiality is to protect me. If I were happy for a third person to see the records, the doctor should allow that. However, people need guidance on that. Advocacy is still quite new, so we need guidance for the BMA, nursing staff and social work staff so that these matters are understood. That can be included in the code of practice, rather than in the bill.

Mr McAllion: Is the BMA absolutely wrong to suggest that doctors should decide which information should be made available?

Hilary Patrick: I would not want to say that the BMA was wrong.

Mr McAllion: Go on.

Hilary Patrick: I would have some difficulty accepting that interpretation.

Adrian Ward: The problem is the BMA's starting point. As Hilary Patrick said, the principles of confidentiality, whether in the medical sphere or in any other, exist to protect the patient or client. For example, if my confidentiality is protected and I want to share it with someone, it is my right to do so. If I want to authorise someone else to have access to information that is confidential to me, that is my control of my information. The rules of confidentiality prevent people who happen to have confidential information about me from spreading it around in ways that I do not want them to. That is the purpose of the rules of confidentiality.

Shona Robison (North-East Scotland) (SNP): I want to move on to advance statements. In your submission, you say that you debated whether to recommend that only the tribunal could authorise the overruling of an advance statement but you decided that, on balance, you would not recommend that approach. Presumably, you do not think that advance statements should be legally binding. Why did you come to that conclusion?

Adrian Ward: We came to that conclusion with one important caveat: overrulings are acceptable only if the principles are clearly in place, so that any decisions about departing from the preferences that are expressed in an advance statement are made against the background of the Millan committee principles.

Hilary Patrick: That is one of the key ethical issues with which we grappled. The proposal that only the tribunal should be able to overrule an advance statement is attractive. When I am well, why should I not be allowed to say that I do not want electroconvulsive therapy should I become ill and be about to die? Why should I not be able to do that, just as I can say that I do not want a blood transfusion, even if I am going to die? Doctors have to respect those views. Millan did not recommend that an advance statement should not be that binding because of concerns that I raised in previous evidence to the committee: although I may have had legal capacity, what if my judgment was clouded when I made that advance statement? On balance, we went with protecting life, although we could be open to the accusation that, by not recognising the autonomy of the person, even if they have made a statement that they know what they are doing in refusing such treatment, we are taking a paternalistic approach. We felt that, if we were to make a different recommendation, we would need more experience of advance statements.

To say that advance statements do not have legal effect diminishes what is in the bill, which clearly says that they must be given regard to. That means that they cannot be ignored and legal cases have determined that they must be read and considered. The statements have some legal effect, but they are not so completely binding that the person is allowed to die.

Shona Robison: On a point of clarification, you said at the beginning of your answer that you would be happy with the proposal that only a tribunal would be able to overturn an advanced statement if a clear statement of general principles were included in the bill. If such a statement were not included, would you have a different view?

Adrian Ward: Yes, but I would not like to start from that point. It is so important to include the principles in the bill that I would be reluctant to get into a hypothetical debate on what such a statement would look like. In effect, if we did not put the principles in an overarching position at the beginning of the bill, we would have to restate them all the way down the line.

Shona Robison: Is it fair to say that most of your evidence is given with the caveat that the general principles be included in the bill?

Hilary Patrick: Yes.

Shona Robison: On advance statements, you mentioned that if the person's views were overturned by the tribunal, that should be reported to the Mental Welfare Commission for Scotland. Is that a safeguard? You seem to be saying that that would be done so that the commission could gain an understanding of the working of advance statements, which could be of interest to the wider medical field. Is that recommendation a safeguard or should such reports be made in the interests of research?

Adrian Ward: I will come in briefly on that point and ask Hilary Patrick to add some comments in a moment. We are getting into uncharted territory. Although it is right and proper that somebody monitors how things work out in practice, there might be a need to modify the codes of practice, if not the legislation. It is a useful discipline for somebody who is doing their very best in a difficult professional situation and who feels that they have to override an advance statement to know that they will have to report the fact that they have done so and explain why. I am not doing down whoever does that: in my professional practice, I know that I have to justify what I am doing in certain situations. For example, under the Adults with Incapacity (Scotland) Act 2000, if I let a client execute a power of attorney, I have to sign a certificate to say that they are able to do so. That discipline is valuable and important and it would apply in this instance.

10:15

Hilary Patrick: I agree absolutely. We also want the doctor on the ward to report any occasion on which he or she overrules the advance statement. We must both monitor how the new provisions work and have a safeguard in place.

Janis Hughes (Glasgow Rutherglen) (Lab): The bill would enable people to request to be treated in a particular way. Do you think that that is appropriate? Do you foresee any difficulties in that?

Hilary Patrick: Are you asking whether I foresee difficulties in the bill's referring to that?

Janis Hughes: Yes—in the context of advance statements.

Hilary Patrick: There is no reason why people should not make such requests, although they would never be able to use the bill's provisions to force doctors to treat them in a particular way. Legislation does not work like that. However, it is helpful for people to be able to express preferences. A current theme in psychiatry is that people should be helped to plan in advance—which they often want to do—and to state what kind of treatments work well for them. However, a doctor could never be bound to give such treatments.

Janis Hughes: Do you foresee that difficulties will arise if people indicate that they want to be treated in a particular way with which medical staff do not agree?

Hilary Patrick: I do not foresee such difficulties arising under the bill as drafted because staff would have to have regard to such requests. Let us imagine that I want psychoanalysis three times a week. Obviously, doctors could not be bound by my request, because the resources are not in place to meet it. If I wanted some sort of talking treatment, that would be borne in mind under the bill as introduced, and one would hope that staff would be able to reflect that in my treatment plan. However, we cannot have advance statements that bind doctors or health services to provide certain treatments on demand.

Janis Hughes: Do you think it appropriate in the mental health context for patients to have the right to refuse treatment?

Hilary Patrick: A lot of people refuse treatment. We have retreated a little by saying that such refusals should be given very serious consideration. We believe that if the refusals are overruled, that should be reported to the commission, and that the reasons for overriding the refusal should be recorded. We are not saying that refusals should just be ignored; we are saying that they should be given serious consideration. In the final analysis, if the person's life is at risk, or if no other treatment is available, we think it appropriate for doctors to carry on giving that treatment. However, we know that that view is unpopular with a lot of user groups.

The Convener: As we have a lot more questions to ask, I request that only one of the witnesses answers each question from now on—just pick which of you has the most expertise in the given field.

Nicola Sturgeon (Glasgow) (SNP): Your evidence indicates that you welcome the introduction of a patient's right to choose a named person. Does the bill make satisfactory arrangements for the appointment of a named person?

Hilary Patrick: We have concerns about children and young people, as we said in our submission—perhaps there is no point in my reiterating that. We are concerned that children who have the mental capacity to do so should be able to choose their named person. We have problems with parents automatically being the named person and said that there should be a mechanism to deal with situations in which parents do not agree who should be the named person.

There should be a procedure to remove an unsuitable named person and we were not terribly happy with the great long list of nearest relatives, which we thought was slightly over the top when it got to the husbands and wives of grandparents.

We suggest that the people at the bottom of that list are almost so remote that they will have little interest in representing the person. An alternative procedure would be to go back to the shorter list of fairly close relatives that was in the 1984 act. If no one on that list could be the named person, the mental health officer should suggest to the person that they should appoint their own named person. We were not totally happy with the provisions in the bill, but we welcome the general proposal that a person should be able to appoint their own named person.

Nicola Sturgeon: I have read what your written submission has to say about the procedure to remove a named person. Can you say a bit more about the circumstances in which you think that that would be appropriate? For example, where the conduct or effectiveness of a named person was in question, should the tribunal at that point be able to remove them? In addition, should a third party have the right to challenge the appointment of a named person at the outset if they believe that that person is not suitable?

Hilary Patrick: Given the principles of the bill, we hope that it would not happen often that a third person would be able to challenge the appointment of a person named by the patient, as that would be unfortunate. On the whole, the principles of participation and of respecting a patient's wishes mean that we would expect a patient's appointment to stand.

Although I cannot think of an example immediately, a situation could arise in which the named person in some way used undue influence to become appointed. In such cases, someone who was concerned should be able to challenge the appointment.

The situation that we have experienced in practice is that of a person's nearest relatives being unsuitable for appointment and, under the 1984 act, there is no procedure for the removal of an unsuitable person. For example, someone might be unsuitable to be appointed as a named person because they have abused the patient. Our experience is of nearest relatives who are in an abusive relationship with the patient and, at the moment, there is no provision for removing them, which must be nonsense.

Nicola Sturgeon: Do you want the bill to deal with such situations?

Hilary Patrick: Absolutely. I believe that that was an unintended omission.

The Convener: We will move on to questions from Mary Scanlon. The points that Dorothy-Grace Elder and Janis Hughes were to raise have been covered.

Dorothy-Grace Elder: My point was about the children's—

The Convener: No, Dorothy-Grace. You asked three questions earlier, which is part of the reason why we have no time left.

Mary Scanlon: In your submission, you said that section 215(6)(a) is not clear. I realise that quite a lot of the bill is not clear. Could you expand on your concerns? What wording would you prefer in that paragraph?

Because we are short of time, I will ask all my questions at once. The explanatory notes state that the bill will make it an offence for a paid carer to have a sexual relationship with a patient. However, that provision does not apply to an informal carer. Is that the type of clarification that you are seeking?

Hilary Patrick: The wording in section 215(6)(a), which is about defining sexual acts, is probably beyond me at this stage of the proceedings. The Executive should be asked to clear up what it intends to achieve with that paragraph. I think that it is about care workers who are working with profoundly learning disabled people, but I do not know what kind of acts the paragraph is supposed to cover.

Mary Scanlon: Section 215(6)(a) states that "sexual act"

> "does not include any activity which a reasonable person would regard as sexual only with knowledge of the intentions, motives or feelings of the parties".

Can you clarify what that means?

Hilary Patrick: No, I cannot. I find it almost impossible to envisage a sexual act that I would not regard as sexual because I knew something about the motives of the parties who were involved.

Mary Scanlon: Whatever the provision means, the offence is such that, although a paid carer can get two years in prison for it, an informal carer cannot be found guilty of it. Is that what we are saying?

Hilary Patrick: That is right. Clarification is necessary.

Mary Scanlon: I am sorry about that. I find the issue confusing.

Hilary Patrick: The provision is not clear. One cannot create a criminal offence without using clear language.

Mary Scanlon: Should the bill or the code of practice clarify whether patients in hospitals or accommodation for mentally ill people, including people with learning disabilities, should have a right to have sexual and emotional relationships with each other?

Hilary Patrick: Should the bill clarify that?

Mary Scanlon: Yes.

Hilary Patrick: Possibly.

Mary Scanlon: Do not such people have a right to sexual and emotional relationships with each other?

Hilary Patrick: In a way, the bill already provides for that. If one wanted, one could put in a principle to that effect. Some of the original principles almost make such a statement—they say that one should not interfere unnecessarily with people's lives.

The intention behind the new offences was to indicate that such people could have sexual relationships. Under current law, bona fide relationships are sometimes criminalised. The new provisions attempt to legitimise valid, free, consenting sexual relationships between two people. I suppose that the answer to your question is yes.

Mary Scanlon: The bill seems to make matters more confusing in that a paid carer can be sentenced to two years, whereas an informal carer cannot be found guilty of such a sexual offence. Does that cause you concern?

Hilary Patrick: People need to be protected. It is a question of where one draws the boundaries. If a relationship between a patient and their informal carer were abusive in some other way, other legislation would kick in. The offences with which we are dealing are specific offences that relate to paid carers. I do not know whether that helps.

The idea was that relationships between paid staff and clients should not be permitted. If a patient's informal carer were their father, other law would kick in to protect the patient. It might seem that the bill is inconsistent, but I do not think that that is the case.

Mary Scanlon: What about relationships between patients?

Hilary Patrick: If such a relationship were abusive or unequal—

Mary Scanlon: How would one decide whether it was abusive?

Hilary Patrick: That would be decided in the same way that the courts decide—

The Convener: I presume that the law would step in in the same way that it steps in with any abusive relationship. The same procedure would apply as with everyone else.

Hilary Patrick: Yes.

The Convener: We have a number of other questions on the criminal law aspects of the bill. We had expected that a member of the Justice 1 Committee might have been present to ask about those matters. We will give you those questions in writing, if that would be acceptable. We will check with our justice colleagues to find out whether there are any other issues that they would like us to cover. Are there any other points that you would like to make at this stage, or have we covered everything?

Adrian Ward: I want to make two points that arise from previous questions. The first, which concerns advance statements, is a code of practice issue rather than a legislative matter. The circumstances in which the advance statement is made are important. The BMA has produced general guidelines for advance statements, which I would commend. The guidelines advise people to discuss with a medical team what they want to do. Obviously, if an advance statement is made following such discussion, it is more likely to be helpful and effective.

Secondly, on the point about a right to sexual and emotional relationships, I have a problem in principle about defining the rights of people who happen to have mental health problems. They have the same rights as all of us, except where the law, for good reason, modifies those rights. That is an important principle.

The Convener: Thank you for your oral and written evidence. We will suspend the meeting for probably no more than five minutes before we take the next set of witnesses.

10:30

Meeting suspended.

10:38

On resuming—

The Convener: I welcome our next witnesses, who are from the Highland users group, to this meeting of the Health and Community Care Committee. I hope that you have seen from the evidence session with the Law Society how we take evidence. You can begin with a short statement if you want, after which we will go into questions.

All of you will probably want to answer all the questions. However, it will help us if perhaps only one or two of you do so. You should decide, using the criterion of relevant expertise or relevant opinion, who will answer a particular question. Do you want to begin by making a short statement?

Graham Morgan (Highland Users Group): Yes. I will begin with introductions. Marcia Reid, who is a member of HUG, is a hospital patient with valid experience of the Mental Health (Scotland) Act 1984 because she is currently detained under section 18 of the act. She has spoken previously about trying and failing to get advocacy. I am a worker with HUG and I, too, use mental health services. A long time ago, I experienced compulsory treatment but was not detained. Chris Evans also works in HUG and has experienced long periods of sometimes extremely serious mental illness. She has received advocacy on one occasion and has worked as a volunteer advocate.

Like the previous witnesses, we found the bill almost impossible to understand, although the explanatory notes were better. The principles of the Millan committee were important and their values should inform the legislation.

Community treatment orders cause us a lot of concern. People are worried about them. Some people think that they could be less restrictive than hospital treatment, but other people are frightened of them and are wary of how they might be enforced.

HUG is an advocacy group. We think that the good job that we do helps to challenge the exclusion that some people experience. We believe that ensuring that our unique experience is heard helps to make services much better. Representational advocacy is vital. People can feel bewildered when they are vulnerable and need representation on a range of issues relating to medication, the attitude of certain doctors and legal matters.

When HUG first talked about advance statements, many people thought that the statements could solve many of the problems that we face when action is taken on our behalf at times when we seem not to understand what we want to happen.

We like the idea of the named person. We can have a great deal of trust in people around us who are not necessarily relatives or next of kin, but who have a great deal of knowledge about our lives and provide a lot of care. We are keen to be able to name those people as representatives.

We need to ensure that mental health legislation is made in the context of the provision of resources. There needs to be sectioning, which we agree saves lives. However, we also think that sectioning should be a last resort and that there should be sufficient resources in the community to ensure that most of us can manage without resort to compulsion.

Janis Hughes: Was there adequate consultation on the bill?

Graham Morgan: I do not have a national perspective, so I will tell you what we did. When the Millan committee first started consulting on the review of the Mental Health (Scotland) Act 1984, we consulted about 70 HUG members and produced a report. After that exercise, members of the Millan committee met about 15 or 20 members of HUG, many of whom had experienced sectioning. Some time later—this summer and early autumn—we met a couple of MSPs and an MP and held a meeting of our round table, which involved about 40 people examining the later parts of the 1984 act. The paper that I sent to this committee was cleared with reference to previous statements by HUG members and by consulting our committee.

With such an important piece of legislation, you can never over-consult. However, the consultation must be made relevant and user friendly and people must be made to understand its importance. In the Highlands, we had a good experience with the consultation process, but, to be fair, that is because we created opportunities that ensured that we would.

Janis Hughes: You are to be commended for the breadth of your consultation. We are pleased that your members have had the opportunity to comment on the bill.

Can you outline some of your members' concerns about community-based compulsory treatment orders, which you mentioned in your opening statement? Assuming that you agree with the principle that the least restrictive form of treatment available should be used, do you agree that community-based orders are the logical outcome of that principle?

Graham Morgan: Our group is happy to give contradictory opinions.

The Convener: So are we.

Graham Morgan: Marcia Reid may want to speak about what is like to live in the community under a section 18 order. If a compulsory treatment order means that someone does not need to be in hospital and can live with friends, carrying out their usual activities but having a degree of control exercised over their life, that may be a good option. However, we do not know where the bill is leading. Is it the first step towards treating people more forcibly, more paternalistically and in a more authoritarian manner in the community, where normally people would see themselves as free, rather than in hospital, where they would expect to be subject to some control? That worries us.

In our written submission, I indicated that one person who phoned us anonymously was terrified by the idea of being treated in the community, as her friends and relatives might then find out that she had a mental health problem and was detained. To escape any proposed Big Brother actions, she has ceased her treatment.

I ask Marcia Reid to describe the balance between hospital and community care.

10:45

Marcia Reid (Highland Users Group): I am a hospital patient in Elgin in Morayshire. For the past 15 months, I have been subject to a section 18 order. I am allowed to go into the community, but as soon as a psychiatrist feels that something is going wrong, I am taken back to the ward. I do not have much say in that decision—I receive compulsory treatment.

While I am at home, I must receive services. If I do not, I am taken back to hospital. I am worried that psychiatrists may use the new compulsory treatment orders as a way of saving beds and money by treating people in the community. While I am under section, I have very little say in decisions about my care. I participate in a scheme called the care programme approach, which means that I have regular reviews with my psychiatrist and other people. If they believe that I should be treated in a particular way, I may argue against that. However, I am not listened to.

Last year, I tried to access advocacy services, but in Moray there is no such service at present. I featured in a video that Graham Morgan produced on the bill. I talked about my experiences of advocacy and how last year I was unable to obtain advocacy services when I really needed them. After seeking assistance throughout Scotland, I was able temporarily to engage someone from Fife. I had constant battles with my psychiatrist, who wanted to place me in a long-stay institution. I did not want to go, but my family could not support me because my mum is disabled and my sister is a single parent. People should have the right to access advocacy services.

Janis Hughes: Is one of the problems with community-based treatment orders that people like you do not have enough family support? Would you prefer not to receive treatment in the community?

Marcia Reid: I would prefer not to be treated compulsorily in the community. If people are ill enough to be sectioned, they are ill enough to be in hospital. They should not be treated in the community. I oppose ECT being carried out under compulsory treatment orders. People should not be compelled to receive ECT while they are under section. Ten years ago I received ECT while under section. As a result I have suffered considerable memory loss and have experienced other significant side effects. I was coerced to receive the treatment; if I had not agreed to it, I would have been forced to have it. People should be able to decide whether to have the treatment, as it is a very invasive procedure. I do not support compulsory treatment orders.

Janis Hughes: That was helpful.

Chris Evans (Highland Users Group): I wonder whether compulsory treatment orders are being used to sanction further losses of hospital beds. Beds will still be needed for people like Marcia Reid who feel that it is appropriate for them to be treated in hospital. Compulsory treatment orders might seem like a cheap—and not the most appropriate—option for an individual.

The other question is whether there are adequate community resources to provide the care and support that will be needed if compulsory treatment orders are going to be introduced, particularly in rural Highland areas. People who are not involved in mental health will be required to be involved. Although that might not be a bad thing, it raises training and resourcing issues. I am not sure whether the approach has been adequately thought through.

Marcia Reid: I agree with Chris Evans's point. If we are not able to get a community psychiatric nurse into the north-west of Scotland once a month, how will we be able to get one every day to ensure that people take their medication under compulsory treatment orders?

Janis Hughes: That is a good point. The issue of resources needs to be more closely considered.

Dorothy-Grace Elder: I congratulate your group on its achievement in pulling together 260 members from an area of 10,000 square miles.

On page 3 of your submission, you mention the

> "three main types of advocacy",

which are

> "Collective – where a group of people speak out
>
> Representational – where an individual is represented
>
> Citizens – where a partnership aimed at promoting inclusion is developed".

Can you expand on the main differences in those three services and the circumstances in which each might be appropriate?

Graham Morgan: Collective advocacy is provided by a group such as HUG, which discusses issues that affect us—almost as a community—and then campaigns for change to improve the lives of people who are either members of our group or are affected by mental illness. Such action is aimed at creating strategic change, influencing services by saying what we think of them, shifting attitudes and increasing our confidence in order to control our own lives. As a result, it is very much a mechanism of social justice for a group. We are like a campaigning group.

With representational advocacy, a person might raise a particular issue related to, for example, housing, medication or parts of mental health legislation, about which they feel that they do not have the skill to speak out. As a result, they might get in an advocacy worker or volunteer to help them to represent their position.

I have much less knowledge of citizens advocacy. It is often used with people who have learning disabilities and is aimed at involving very vulnerable people who might have been excluded from society for a fair time and might find it hard to be with other people. They would be linked with an unpaid person in order to be part of and have some contact with the community.

Dorothy-Grace Elder: You feel that that is separate from collective advocacy.

Graham Morgan: Yes. Collective advocacy is the action of a group or constituency of people, whereas representational advocacy and citizens advocacy are centred on one person.

Dorothy-Grace Elder: Should the bill or code of practice say more about the application of those three different types of advocacy instead of simply making vague mention of "advocacy services"?

Graham Morgan: I think so. Representational advocacy, which is the bill's main emphasis, is vital, especially for people who have been detained. However, collective advocacy is a mechanism for social justice that we need to be able to develop across Scotland. HUG is very fortunate to have received funding, but groups in other areas have received nothing like the funding that we have received.

Dorothy-Grace Elder: Would you say that those three types of advocacy should be included in the bill, or would it be sufficient to mention them in the code of practice?

Graham Morgan: I will give you an ignorant answer. I would like the bill to ensure that those forms of advocacy can exist in the different areas of Scotland. How that will be done I do not fully understand, so I do not want to make ill-informed comments, but I hope that the bill will promote those forms of advocacy and people's right to get them.

Dorothy-Grace Elder: You commented on ECT, but would anyone like to comment on psychosurgery? Do you think that it is applicable in some cases?

Graham Morgan: When we talked about that in HUG a couple of months ago, many people were alarmed that it still existed. For a time, it was thought that psychosurgery could be used without consent under the Adults with Incapacity (Scotland) Act 2000. People were horrified to hear that that could happen. However, a very small number of people—one at least—said that at times in their lives they had thought that, if that was their last option, with huge trepidation they might consider it. That is not as clear cut as saying that it is abysmal and barbaric, but a lot of people would be extremely alarmed to think that it could be used. Everyone would be against the idea that it could be used without consent.

Dorothy-Grace Elder: One set of witnesses described it as being like taking a hammer to the delicate mechanism of a watch. I do not know whether any of you have personal experience of psychosurgery.

Graham Morgan: It is a rarely used treatment.

Nicola Sturgeon: I want to ask a question that is related to advocacy. The bill confers on patients the right to choose a named person. First, are you satisfied with the procedures that are laid down in the bill for the appointment of the named person? Secondly, do you have any views on what the relationship should be between a named person and an advocate?

Graham Morgan: The process of choosing a person to be on our side who knows about our care should be informed by the people who surround us and whom we trust. The majority of members of HUG welcome the idea of a named person. We would like that to happen. It is a fairly obvious concept: if someone provides care for you, knows you and your wishes and how you would like to be treated when you are ill, and they are a part of your life but are not necessarily a relative, it would be sensible if they could be the named person whom you chose.

We do not want that to mean that all relatives are excluded from information about our treatment. Some need to be excluded because, as we said, they can be abusive, but most of our relatives have our interests at heart. They are part of our families and are loving, ordinary people, so they need to have the knowledge that they, too, will be involved in the decisions in some way. That fudges the issue a bit, but I would not like the question of named people to detract from our family relationships. Does that answer your question?

Nicola Sturgeon: Yes.

Chris Evans: With regard to the named person and advocates, it is important to remember that the advocate would be working for an individual or alongside them to support them. I hope that that will mean that they work with the named person, because the named person is someone whom the individual has selected as appropriate to be involved in their care. With representational advocacy, it is important that the advocate represents one person's wishes. There are issues. Advocates cannot represent the user and the carer, because the issues are separate. They may not be in conflict, but they are separate issues.

Nicola Sturgeon: The Advocacy Safeguards Agency, which is giving evidence later this morning, states in its written evidence that, in its view, for an independent advocate to be a named person would represent an absolute conflict of interest. Do you agree with that?

Graham Morgan: I do not know. There could be confusion if someone had a named person trying to represent him or her—or to represent their view of them—and an advocate also representing a view. However, I do not know what the solution would be.

The Convener: You will probably be able to think a bit more about the question when you hear what the advocacy services have to say.

Shona Robison: Let us turn to the bill's approach to advocacy. The bill will impose a duty on local authorities to secure advocacy services. Would HUG prefer the inclusion of a right to advocacy services in the bill? Is there a difference between the duty and the right?

Graham Morgan: I do not know what the difference is between the duty and the right—I was hoping that the committee might be able to tell us.

11:00

Shona Robison: Millan certainly wanted people to have a right to advocacy services so that there would be no ambiguity; the right to the service would lie with the person rather than the duty being placed on the service provider to provide it. That view vests the power in the person who would have the right. Many people who have given evidence feel that there is a big distinction, but others do not feel that so much. Has HUG considered the matter?

Graham Morgan: It is easy for people who have a mental health problem or a learning disability to become excluded and marginalised in society and to feel that they have—or actually to have—very little say in their treatment. We believe that any modern act of Parliament should ensure that people who are not being listened to or who are unable easily to express their views have the right to assistance in putting their views across or speaking for themselves. I suppose that my view is that there should be a right to advocacy. I do not know the resource implications of that, but the principle should apply.

Shona Robison: The resource issue is important. As Marcia Reid said, in rural areas where the provision of advocacy services will perhaps be more difficult, resource issues will be most problematic. It is, therefore, important that people have the right to such services, especially in rural areas.

Mary Scanlon: Your written comments on advance statements suggest that you seek a balance between respect for patients' future wishes and appreciation of practical considerations, bearing in mind the facts that patients' views might change and that the forms of treatment could become more effective. You say that you consulted widely and that you heard varying views. I draw your attention to two points on page 5 of your submission. You state:

> "Making informed decisions about future events where our views, the circumstances or the therapies on offer could be very different, is a situation where we cannot always rely on the views that we had in the past even though we were well then."

I understand that statement. However, you go on to say:

> "It may also be very hard for a user to overturn an advance directive when they are ill, maybe for a long time, and when their capacity to make decisions about some aspects of their lives is clearly affected"

at a point

> "when they … no longer agree with their previously expressed views."

Your group's faith in advance statements seems to be uncertain. Will you clarify that?

Graham Morgan: Yes. Most members of HUG think that advance statements are the solution, although some members think that there could be problems. Let us say that someone is ill for a long time and their capacity to make decisions is really affected. In the first of the points that you quoted, we say that our capacity to make decisions can be fluid. We can be completely ill informed about aspects of our lives that are influenced by our illness, while we are rational and able to make decisions in other areas. I am worried that people might be held to advance statements when much of their capacity is evident, despite the fact that it can be proved that some of it is not evident. I am worried that people will get stuck in limbo.

With advance statements about future events, I worry that a past view that was informed by the circumstances of the time might put a person into stasis if the statement cannot be changed. That is my opinion, but it has been checked against those of HUG members. Common sense should be used, although a great deal of emphasis should be put on advance statements as an effective method of presenting views.

I am not sure what HUG's opinion is on how binding advance statements should be. I guess that most people would say that advance statements should be listened to, but that there should be circumstances in which they may be overturned. Some HUG members would say that advance statements should be binding—just like statements that ordinary members of the community make—even though they seem later to be illogical. I cannot answer the question because our members have conflicting opinions on the matter.

Mary Scanlon: Marcia Reid said that she tried to make a verbal advance statement, but because the resources did not exist to support her in the community, she was sectioned and taken into hospital. Would advance statements help to tackle the problems that she mentioned in north-west Scotland? The policy memorandum states:

> "If successful, advance statements might in some cases reduce the need for compulsory measures."

Do you have such faith in them?

Marcia Reid: Yes. If people were consulted more on their care and if advance statements were listened to more, there would be less need for compulsory treatment. If people are consulted, their wishes and needs are heard more. The need for compulsory treatment orders will be reduced if what patients want as part of their care can be agreed to.

Mary Scanlon: I know that Chris Evans lives in Ardnamurchan, which is probably one of the most remote areas of Scotland. Is it a problem to make an advance statement there? Would it be binding and helpful in the long term if the service existed?

Chris Evans: In many instances, the issue would be the services. The answer to the question would depend on what the important elements in an individual's advance statement were. Like Marcia Reid, I would not want ECT under any circumstances because, despite what is being said and despite the results of the Scottish ECT audit network, I have not seen good scientific evidence that convinces me—when I am well—that ECT would not do me harm as well as good.

Mary Scanlon: I am not entirely sure about this complex bill, but the policy memorandum states:

> "the validity of a statement may be questioned if it is old, if it is ambiguous, or if the person may have been mentally unwell at the time of making the statement."

Should anyone have a right to challenge advance statements? New processes and therapies might become available or the psychiatrist might know better what is good for a person than the person did when he or she wrote the advance statement.

Chris Evans: Graham Morgan alluded to the fact that new measures, treatments and therapies will appear and it is important that one might amend one's view of possible future treatment in the light of such advances. However, I am not clear about the circumstances in which the advance statement will be made. The lawyers mentioned that issue earlier. We are not talking about someone sitting down and thinking, "This is what I want", putting that down on a piece of paper and giving it to his or her psychiatrist, GP or whatever. We are talking about a consultative collaborative statement. I say that based on the assumption that the person maintains contact with the services. However, if a person recovers fairly well, a gap could open up in their contact with services and I am not sure what would happen in that instance. I am theorising, but if a person loses touch and becomes unwell again, what he or she wanted 10 years ago could have become inappropriate for all sorts of reasons. This morning's session has raised for me more questions than answers.

Mary Scanlon: That is also the case for me.

Chris Evans: I want to focus on two aspects. The first is the philosophy or principle behind the use of advance statements, which is important. The second is the application or execution, which is equally important.

Mary Scanlon: Time is also important. None of us know whether we will have a mental illness. It can suddenly happen and we have no time to prepare for it.

You mentioned some of the practical, as opposed to legal, barriers that prevent people who have mental illness from enjoying the same rights as other people. What can the Scottish Parliament do to address some of those concerns?

Graham Morgan: I feel as if I should spend all day trying to answer that question—so many elements of our lives can be unpleasant. Mental illness is an unpleasant experience and its effects and society's reactions to it can be even more unpleasant. I will quote from our submission, which sets out that:

> "People experience high rates of unemployment".

I understand that 85 per cent of people who have a severe mental illness are unemployed, 40 per cent of homeless people have a mental illness, as do 40 per cent of the prison population. Those statistics send out a clear signal that something is wrong with the way in which society treats people who have a mental illness and about the situation of those who are vulnerable.

We need better employment opportunities and better work practices that cater for people who have mental illness, that deal with the effects of stress at work and that improve well-being. We need to do simple things, some of which are beginning to happen through campaigns to challenge the stigma of mental illness. Those campaigns can be extremely effective in helping young people to understand what it is they are going through. They can also help people to realise that they can access services without guilt or fear.

I do not want to carry on about the spectrum of our experiences, but most areas of our lives relate to marginalisation or exclusion. That is not to say that we are all desperately unhappy most of the time, but we can be put on the edges of society and we can be ashamed of what we are going through. Loads of things are needed to give us control of our lives and widen our opportunities.

I will highlight the matter of state benefits. Many of our members do not claim benefits—they are so depressed that they cannot bear to look at the disability living allowance application form and end up sticking it in a pile of papers. We need to tackle simple things such as the benefits system. We need to ensure that the system is accessible. If we cannot do paid work, we should be able to do voluntary work without feeling that our benefits status is at risk.

I will stop there—I am beginning to feel as though I am giving a lecture on the subject.

The Convener: As someone else took my last question, I will attempt to get in a question at this point. I am happy to let Mary Scanlon take over the work load on my desk.

Do you support the idea of mental health tribunals' replacing the existing sheriff-based system? In your submission, you raised a point about the independence of those who are called upon to sit on tribunals in rural areas. Could you set out the implications of that?

Graham Morgan: I will start, then Marcia Reid will mention her first experience of a sheriff court. In general, we are in favour of tribunals, although some people say that the seriousness of what we go through merits the formality of the justice system and the justice that it offers. Most of us say that we want an informal system; one that is fair and in which people's opinions are heard and in which they are not frightened.

One of our members is particularly concerned about tribunals in places such as the Highlands, where we all know each other really well. We worry that the composition of a tribunal could become so close and pally that we would not be sure of a fair hearing. The psychiatrist might know the social worker, or whoever is on the tribunal, and people might almost collude because they do not want to offend each other. Does that make sense?

11:15

The Convener: Yes.

Graham Morgan: It is important that the committee hear Marcia Reid's experience of the first time she went to a sheriff court.

Marcia Reid: The first time I went to the sheriff court was when I went to be sectioned in December 1992. I remained under section for the following five years. It seems funny now, but when I first went to the court I thought to myself, "I wonder how the sheriff will be dressed." I did not know whether he would have cowboy boots, a badge and a hat. I had never been to court before and I found it to be quite a terrifying experience. My mind was going round in circles as to what was going to happen next.

As Graham Morgan asked, would tribunals remain impartial in rural parts of the Highlands and other places where everybody knows one another? Perhaps the social worker would know the rest of the people on the tribunal and there might not be a fair hearing if the patient already knows them. Somebody might think, "I have known you for the past 10 years and I don't particularly like you", and the tribunal might then go against the patient.

The Convener: You found the sheriff court experience quite daunting.

Marcia Reid: Yes. I agree that tribunals in the hospital would be better and I said that to Graham Morgan a number of years ago when the Millan committee was meeting.

The Convener: Do you think that it would be reasonable for the people who sit on the tribunal to be brought in from outside? That might allay some of your concerns about the situation in small rural communities. Would your concerns be dealt with if the psychiatrist on the tribunal were from outside the area? Do not you think that we will have enough difficulty staffing the tribunals without adding more caveats?

Marcia Reid: The psychiatrist should be from outside the area, because in a small area the chances are that the psychiatrist will know the social worker and others and that they will collude. The patient might think that they are all in it together and that he or she does not have a chance if the members of the tribunal all know one another well. The tribunal would not be independent in such a case.

Graham Morgan: We agree with Marcia Reid, but there are practical difficulties in trying to get people in from outside the area. It would be hard to get people from outside the Highlands to hear a tribunal in Durness, for example. I am not sure whether that overturns the point that Marcia made; I do not think that it does. We need to be sure that we trust what happens at tribunals, even if it is difficult to bring in people from outside.

The Convener: Do you have any other comments to make on the bill? Would you like to see any other improvements to the bill? Are there any points that we have not covered in our questioning so far?

Marcia Reid: I am sure that many members of HUG feel that people should not be forced while they are under section to accept treatments that they really do not want, such as ECT and neurosurgery, which are invasive procedures. While I was under section 10 years ago, I was told that if I did not sign the form to accept ECT, another doctor would force me to accept it. Since then, for the past 10 years, I have had considerable memory problems. I did not want the treatment but I had to take it, and I have been left with bad side effects as a result. I do not feel that people should be forced while under section to take treatment that they do not want; they should not have treatment unless they decide that they want it.

Chris Evans: I would like the bill to be another mechanism for increasing resources for mental health in general. A lot of the measures in the bill will obviously require more resources. One could argue that measures such as the anti-stigma campaign might make people who are currently reluctant to approach their general practitioner more willing to access services. There will not be a decline in the need for help and support for people who have mental health problems, and it is vital that the bill be matched by resources so that it can be properly implemented.

Graham Morgan: I agree with much of what Chris Evans has said. We must acknowledge that the bill will need to contain means by which to detain people and to infringe our rights, but emphasis must be placed on the rights of people who suffer from mental illness, especially in regard to representation and speaking up. I am keen to stick to the principles of the Millan report, which were enlightening and positive. As Chris Evans said, there are two important things to consider, the first of which is resources. If we are to detain people, we must do so in the context of there being adequate resources that will give us quality lives in the community. Part of that involves challenging the stigma that is attached to mental illness and the attitudes not only of the community but of professionals and the friends of people who have mental illness.

The Convener: Thank you for your contribution this morning and for your written statement. I echo the comments that my colleagues have made. We know that you do a great deal of good work throughout the Highlands and it is clear that you have done a lot of work in consulting on this important bill. We share some of the concerns that you have expressed; other witnesses have expressed similar concerns. We welcome the fact that you have been able to take part in the process; it is important that we hear exactly how the bill will affect people who use the services, or who are trying to use services that do not, in some cases, exist. Thank you again for your evidence.

We welcome our next set of witnesses. I know that they have been sitting in the public gallery listening intently to the other witnesses, so they will know the form. I invite them to make a short statement before we ask questions. When we ask questions, I will ask one person from each group to answer. I do not think that we have enough time to hear individual responses from all the witnesses.

Adrienne Sinclair Chalmers (Advocacy Safeguards Agency): I am the director of the Advocacy Safeguards Agency. Tony Rattray, who is our senior evaluation worker, and Tilly the dog are with me—that is important.

I have just mentally slashed about three quarters of my presentation for the benefit of the committee. However, I want to say what advocacy is available and what is not available. We have already sent the committee a copy of the independent advocacy map, which was produced this year. The ASA has taken over production of the map, which shows the spend and resources that have been committed by health and local authorities to advocacy. The map shows clearly that, even at this late stage in the game and two years after the Executive said that everyone in Scotland who needs access to independent advocacy should have it, one local authority has as yet made no commitment—not one penny piece—to independent advocacy. There are health boards and authorities whose contributions are negligible and others whose commitment does not extend beyond the end of this financial year.

The Convener: Which council has not committed anything?

Adrienne Sinclair Chalmers: East Renfrewshire Council has made no commitment.

The Convener: That is fine—members have a name check.

Adrienne Sinclair Chalmers: I thought that members might ask about that, so I thought that I would provide an opportunity for them to do so.

I want to say something about independence, which is extremely important. I am sure that the committee is aware that independence is vital for good advocacy, yet time and again people think, “That independent stuff just applies to those guys over there and not to us.” Recently, a national health service trust—I am prepared to name it, too—said to us that a person’s key worker could be an advocate; however, in the face of national policy guidelines to the contrary, it said that it was perfectly capable of managing an independent advocacy organisation and employing independent advocacy workers in its own hospital. That is clearly not so.

Tony Rattray will briefly say something about standards, effectiveness and resourcing.

Tony Rattray (Advocacy Safeguards Agency): As Adrienne Sinclair Chalmers said, I am ASA's senior evaluation worker. One of my roles is to evaluate advocacy organisations throughout Scotland. We hope to evaluate approximately 20 organisations per year, including those for people with mental health problems.

We aim to consider advocacy organisations' principles. I do not know whether members are aware of "Principles and standards in Independent Advocacy organisations and groups"—it was produced by Advocacy 2000, which has been succeeded by the Scottish Independent Advocacy Alliance. We want to refer to that document to ensure that organisations throughout Scotland meet the agreed principles of advocacy.

The Convener: We believe that we have a copy of the document, but we will check.

Tony Rattray: We aim to consider the policies and procedures of organisations and to ensure that they are proactively reaching those who most need advocacy, which was discussed earlier. We aim to consider the difference that advocacy organisations make through outcomes for people and to ensure that they make a difference on the ground for people who have mental health problems.

We recommend that there should be a national code of practice for advocates and, obviously, that needs to be discussed. We are aware that many local organisations have local codes of practice, but we recommend bringing those together at national level. We recommend that there should be national core skills for advocates—all advocates should have such skills so that they can work. We also recommend further development of principles and standards, which I mentioned.

We are concerned about funding for evaluations, in which I am becoming involved. "Independent Advocacy: A Guide for Commissioners", which the Scottish Executive produced a while ago, said that all local authorities and NHS boards should make commitments in their funding agreements with advocacy organisations in respect of independent evaluations, but that has not happened in all areas. We would like the bill or the financial memorandum to include such a commitment, because we are concerned that such commitments will not be made.

Success has come from the change fund for people with learning disabilities. This financial year, about £370,000 has gone into developing advocacy through the planning process. In acknowledging that funding has gone into developing advocacy for people who have learning disabilities, we recommend that funding that becomes available for the Mental Health (Scotland) Bill should concentrate more on people who have mental health problems, dementia and acquired brain injuries.

The Convener: We will leave it at that point and if there is anything that we do not cover, we can come back to it at the end.

11:30

Chris Mackie (Scottish Independent Advocacy Alliance): I am from the Scottish Independent Advocacy Alliance, as is Rachel Annand. We are involved in different advocacy organisations. I will start by clarifying the role of the alliance. We are a membership organisation for advocacy projects, organisations and groups. We are in our infancy.

I welcome the bill. We believe that it represents a long overdue update of legislation. I echo some of the previous comments that the principles of the Millan committee report should be carried through to the bill.

To focus on advocacy, we question the definition that is contained in the bill. In our written submission, we suggest an alternative form of words. We emphasise—Adrienne Sinclair Chalmers touched on the matter—the nature of true independent advocacy, which means that it is not provided by health providers, local authorities or any other service provider.

Our submission states that we would like recognition for advocates and advocacy workers. However, we would also like to say that advocacy can be carried out by other people; we do not have a monopoly on providing advocacy. The Scottish Independent Advocacy Alliance is just what its name suggests—we look at independent advocacy, but we want there to be recognition of those who act as advocates informally.

Our submission states that we would like funding of advocacy organisations to last for a minimum of three years. That would help to secure the stability of the organisations and allow them to concentrate on delivering advocacy instead of on the constant search for funding. We suggest that funding for advocacy organisations should look not only at the provision, but at the development of projects and organisations so that they can grow and better meet the needs of the people with whom they are meant to be working.

In conclusion, I thank the committee for the opportunity to give evidence.

The Convener: Do you really mean that?

Chris Mackie: Absolutely.

Janis Hughes: Thank you for your introductory statements. Do you support the general principles of the bill? Were you offered enough opportunity to respond to consultation on the contents of the bill?

Adrienne Sinclair Chalmers: I thought that the principles were good—they are just not included in the bill any more.

Graham Morgan and the other witnesses from HUG talked about some of the efforts that they had made to express their opinions on the bill. That is largely what has happened. Where people have had access to good collective advocacy and have been able to access organisations that have the resources to help them to comment, they have been able to do so. However, as we said in our written evidence, we came across service users who were at a bit of a loss and had not realised that a lot of the consultation had been going on. That is not their fault. It is a good example of the benefits of collective advocacy. Where strong collective advocacy exists, people had the opportunity to comment.

Rachel Annand (Scottish Independent Advocacy Alliance): We do not have much to add to that, apart from to emphasise, as Chris Mackie did, that we supported the principles that were produced by the Millan committee. It would be nice to see them in the bill.

Janis Hughes: You have outlined the roles of your organisations. Do you interact? Do your roles differ in a more specific way than you have already mentioned?

Chris Mackie: Both organisations grew out of the national Advocacy 2000 project, which looked at the development of independent advocacy throughout Scotland. The two organisations perform slightly different roles. The Scottish Independent Advocacy Alliance aims to represent advocacy organisations and advocacy projects and to support those groups, whereas the Advocacy Safeguards Agency—its representatives will correct me if I am wrong—aims to support commissioners, the development of advocacy within local authorities and health boards, and the Executive in its thinking on advocacy.

The Convener: Is that a fair summary?

Adrienne Sinclair Chalmers: Yes, we do that. A lot of our work is done in co-operation with the Scottish Independent Advocacy Alliance and others who are involved in independent advocacy.

Shona Robison: The Scottish Independent Advocacy Alliance refers in its written submission to the bill's definition of advocacy. Specifically, the submission mentions the need to remove the word "advice". Will you say a little more about your reasoning on that?

Chris Mackie: Independent advocacy provides support for a person to express their opinions and, where necessary, expresses that person's opinions on their behalf. "Advice" implies that an advocate would direct the person. That is not the role that we consider independent advocacy to play.

Shona Robison: That is clear. Will Adrienne Sinclair Chalmers or Tony Rattray give their views on the definition?

Adrienne Sinclair Chalmers: The Advocacy Safeguards Agency had a meeting a couple of months ago with the Mental Health (Scotland) Bill team, during which we raised that point. The team was thinking of "advice" more in the way that the term is used in legal circles, which is not that different to the role of an advocate. However, considering that advocates do not give advice in the more general sense, we thought that it was unhelpful for that word to remain in the bill. Although we could understand why it had been used, we would rather see it away.

Shona Robison: So you agree with Chris Mackie.

Adrienne Sinclair Chalmers: Absolutely.

The Convener: Are you concerned that the Advocacy Safeguards Agency is not referred to in the bill? Tony Rattray mentioned that the bill sets out no framework for measuring and monitoring advocacy standards.

Adrienne Sinclair Chalmers: What do you mean by "concerned"?

The Convener: Do you have any concerns about it? We have considered bills in which new organisations are established to ensure that the framework of the bill and the services to which the bill refers are delivered. From what you have said, it seems to me that the Advocacy Safeguards Agency has been set up to do that. If the bill says that we should implement rights and/or duties—whichever we end up with—on advocacy for service users, why does it not refer to an organisation that has been set up to ensure that advocacy is available? Are you concerned about that?

I know that those questions put you in a difficult position in some ways. Would you consider it to be beneficial for the bill to contain provision for an organisation whose remit was to ensure that the right or duty to advocacy was implemented in the long term?

Adrienne Sinclair Chalmers: It is a bit difficult for us to say this, but we would have more clout if we were referred to in the bill. Any clout that we have is vicarious. I am convinced that we will be mentioned liberally in the code of practice, but, considering that we were set up to ensure that the type of commitments that are in the bill come to fruition—you are right in that assumption—it would be helpful for the bill to make some reference to us.

The Convener: Does anybody want to pick up on the monitoring and measuring of standards?

Chris Mackie: The SIAA's concern is for good-quality advocacy and high standards within advocacy. Whether a specific agency is named is not our concern.

Rachel Annand: The principles and standards took a long time to develop. They are about the standards of advocacy organisations and are clear that a lot of work needs to be done around collective advocacy. The SIAA's concerns are around matters such as a code of practice for individual advocates and basic skills for individual advocates in, for example, citizen advocacy.

I work in a citizen advocacy project. In such projects, an ordinary, responsible local citizen gets to know somebody with a learning disability. That person has two functions: one is representation and helping somebody in meetings or in making complaints; the other is about social inclusion and widening somebody's networks. The latter function is especially important in our case, when people who have lived in long-stay hospitals for 40 or 50 years move back into the community.

The worldwide citizen advocacy movement would be concerned about proposals to direct individual partnerships or to state that advocates must have a basic level of skills or conform to a code of practice, because the situation is about what two individuals want to do. I do not direct what the partnerships do, and I would not expect anybody else to be able to do that.

Dorothy-Grace Elder: If an individual—someone who is using the advocacy service or a carer, health professional, or whoever—has concerns about substandard advocacy services, whom should they approach and what can be done about that?

Adrienne Sinclair Chalmers: If an individual has a concern about the performance of advocates from a specific organisation, their first port of call would be that organisation. The organisation will have funders who will want to hear if people think that the service that they are paying for is substandard. There are all the other usual lines that people can take. The Advocacy Safeguards Agency would not be the body to approach to complain about substandard advocacy; nevertheless, we would be able to work with the commissioners to address any issues concerning the standards of certain organisations.

Dorothy-Grace Elder: The word "safeguards" seems to imply that you would be a body to which a member of the public could go.

You say that you are aiming for high standards, but your excellent document—thank you for compiling it—shows that the funding for advocacy is low and diverse. For instance, Edinburgh allocates three times as much funding to advocacy services as Glasgow does, yet Glasgow's population is a third greater and there is a higher incidence of mental ill health in Glasgow. How can the services in Scotland be of a high standard when the overall level of funding is low—some areas, such as the one that you mentioned, get none at all—and the funding is of such diversity?

Tony Rattray: That is why the agency has both roles. It will continue to support both the development of advocacy, through its two new development workers, and its evaluation. We will not just ensure that advocacy is of a good quality; we want to continue the impetus of the planning process. Funding for advocacy has risen by £1.75 million over the past two years, and we want the investment to continue to rise. That will be one of our key roles. In our watchdog role, we will continue to hound the areas that are not funding advocacy so that we can ensure that they reach the standard that we want to see and satisfy the Scottish Executive's statement that advocacy should be available to all people who require it.

Dorothy-Grace Elder: We heard from an earlier witness that, because there is no advocacy service in Moray—her area—eventually, after quite a struggle, an advocate had to be produced from Fife. Do you find that that happens quite often? Do advocates have to be sent around the country?

Tony Rattray: I have to correct that statement. A new organisation—Moray Advocacy—was set up a few months ago.

Dorothy-Grace Elder: She was talking about what happened in her time, when she was facing severe problems.

Tony Rattray: Yes. There is now an advocacy organisation in Moray.

Dorothy-Grace Elder: But do you still find that advocates are having to be sent great distances?

Tony Rattray: Judging from what I have heard from the advocacy organisations, I think that the problem is more about waiting lists and the fact that the demand for advocacy is just too high. The advocacy organisations are unable to cope. People who need an advocate on a certain day are having to wait for a few weeks, which makes the service almost irrelevant because they need the advocate there and then.

Nicola Sturgeon: The written submission from the Advocacy Safeguards Agency makes it abundantly clear that you do not think that advocates should also be named persons. Do you want to say any more about that? Do you think that that requires to be ruled out expressly in the bill, or could the issue be dealt with in another way?

Adrienne Sinclair Chalmers: The reasons for that view are stated pretty clearly in our written submission. The named person will have roles other than that of an advocate and will have an opinion about things from time to time. That is clearly at odds with the principles of independent advocacy. There will be circumstances in which the appointment of a named person may be influenced or rejected by persons other than that individual. Evidence was given on that issue earlier. There seems to be clear conflict between the two roles. What was the second part of your question?

11:45

Nicola Sturgeon: Do you think that the point needs to be made in the bill or are you happy for the issue to be dealt with informally?

Adrienne Sinclair Chalmers: It does not need to be made in the bill, but it should be instilled in independent advocacy organisations and referred to in the code of practice. However, it never does any harm to mention things in primary legislation.

Mr McAllion: Section 182 would place a duty on local authorities, in collaboration with the relevant health board, and on health boards, in collaboration with the relevant local authority, to secure the provision of independent advocacy services. Is it clear to you which of the two types of body is meant to be the main funder? By naming both, do we risk creating a loophole that will make it possible for each to blame the other for not securing the provision of independent advocacy services?

Adrienne Sinclair Chalmers: It is not clear to us that either local authorities or health boards are expected to play a leading role. They have a joint and several responsibility. Someone will have to stump up.

Tony Rattray: We seek joint funding agreements. Usually, there is a 50:50 split. Funding agreements should be joint, so that local authorities and health boards take joint responsibility. The aim of joint futures is that, where possible, funding agreements should be joint.

Rachel Annand: The organisation for which I work has a three-year plan from the local health board, which provides by far the majority of our funding, but applies yearly to the council for a section 10 grant that would not cover the rent for an office in Edinburgh. We are based in Dunfermline, where property is slightly cheaper, but the grant pays for no more than 15 hours of administration. There is a need to consider where funding comes from. However, it does not matter who provides it, as long as we get the sum that we need.

Adrienne Sinclair Chalmers: I refer members to a piece of work that is not covered by the contents of the bill. The Advocacy Safeguards Agency has been charged with ensuring that NHS boards, as lead organisations, make adequate advocacy provision within their boundaries. Advocacy services are supported by a combination of health board funding and local authority funding. There is already a mechanism to ensure that advocacy services are provided by both health boards and local authorities.

Mr McAllion: This morning all our witnesses have stressed the importance of independence in advocacy services. Bearing in mind the old adage that he who pays the piper calls the tune, is there not a danger that, because the core funding for advocacy services comes from health boards and local authorities, they will be able to pressure advocacy organisations?

Adrienne Sinclair Chalmers: Not if the Advocacy Safeguards Agency has anything to do with it.

Chris Mackie: Before undertaking any work using local authority and health board funding, the Scottish Independent Advocacy Alliance would demand that its independence be guaranteed. We would want our independence to be written into the contract. When receiving funding from statutory agencies, we would be duty bound to report on, monitor and evaluate certain things, but we would insist that there should be no conflict of interest.

Mr McAllion: Is there not a danger that the health board or the local authority could choose who they decide to contract with, and that that act could exclude people from providing advocacy services because the health board or local authority did not approve of them?

Adrienne Sinclair Chalmers: The main danger seems to be that those big glossy organisations that have lots of people to do nice packs that tender for providing advocacy services are those that tend to get the contract. Recently, a few contracts have been issued to Enable for advocacy for people with learning disabilities. We were not necessarily that overjoyed about those contracts. Attention will certainly need to be paid to the independence of that advocacy work. I am not saying that it cannot be done, but it will have to be questioned.

The local project that has come up from the ground and has the investment of local people in it tends to do less well in the tendering process than the big glossy national organisations. The Advocacy Safeguards Agency and the principles and standards that were published by Advocacy 2000 say that preference should be given to the local organisations that have local commitment, experience and involvement.

Mr McAllion: Does the Advocacy Safeguards Agency have any powers to intervene in the process under which health boards award contracts? Can you say, "No, you cannot do that"?

Adrienne Sinclair Chalmers: In an extreme situation, if the local authority or health board would not listen to us, we could go to the Scottish Executive health department and express our extreme dissatisfaction. That is the most that we could do.

Recently, we were involved in a tendering process in Glasgow for minority ethnic advocacy. I found that to be quite an interesting and valuable experience. We were there not to take part in making a decision on who got the contract, but to comment on the documentation, the plans and the standard of the advocacy that was being proposed. We were listened to and I believe that the commissioning process was improved by our presence.

Mr McAllion: If everything goes well, the bill will be enacted by March 2003. Are there sufficient advocacy services across Scotland to implement the legislation by March 2003?

Chris Mackie: In a word, no.

Mr McAllion: How much money is needed to provide adequate advocacy services?

Tony Rattray: The financial memorandum for the bill talks about increasing advocacy funding. At the moment, £3.7 million would be needed for advocacy for people who would qualify under the provisions of the bill. The financial memorandum proposes increasing that figure to £6.7 million, which is another £3 million.

Our concern with that is that there is £1.5 million of additional local authority funding, but the Executive is suggesting that the NHS funding will come from existing funding streams—that is, from the national health programme. We are concerned that the necessary funding will not become available because our experience is that a lot of NHS boards are struggling to find funding. They might have higher priorities and might not have the money. The Executive might need to consider ring fencing funding for advocacy services under the bill.

Mr McAllion: On the map that you provided for us, funding for Tayside NHS Board and Dundee City Council is static up to 2003-04. It is not increasing. In effect, it is diminishing.

Tony Rattray: Yes. Tayside NHS Board funding has not gone up, but funding in Dundee City Council has.

Mr McAllion: Has the figure gone up since you printed the map?

Tony Rattray: Yes, but Tayside NHS Board is still static.

Mary Scanlon: Section 182, which is a short section on advocacy, simply says that

> "'advocacy services' are services of support, advice and representation".

Would you like the bill to clarify the role of advocates throughout the patient's journey, perhaps through stages such as compulsory treatment, detention and appearances before the tribunal? Should the advocate have the right to be with the patient at all stages of the process?

Adrienne Sinclair Chalmers: I have been going through the bill line by line, which is an even lovelier experience than it might otherwise be given that I cannot see and I have to listen to a talking computer reading it. There are various points in the bill at which we believe that reference should be made to an independent advocate or independent advocacy. The named person is mentioned many times in the bill. If advocacy is to be real, it must be mentioned more often throughout the bill.

Parts of the bill—for example, section 74, on the mental health officer's duty to inform people about advocacy—need to be beefed up. It is not good enough for someone just to inform a person who is in a state—life is difficult enough for them—that there is an advocacy service, because they might need help to get that service. I referred in my written evidence to someone who was given the number of an advocacy service but was unable to use the ward pay-phone. That happened only a few months ago.

Various bits and pieces must be put in the bill. I can provide the committee with a full statement of those as soon as I manage to finish writing it.

Mary Scanlon: I am sure that you will also provide a few amendments at stage 2. Instead of the bill's general comment about advocacy, would you prefer an advocacy service to be available throughout all stages of compulsory treatment and detention?

Adrienne Sinclair Chalmers: Absolutely. Advocacy has to be mentioned at all stages or people will conveniently forget it.

Mary Scanlon: My second and final question is whether there are procedures in the bill in which it would be inappropriate for advocates to have a role.

Adrienne Sinclair Chalmers: They should not give people ECT. [*Laughter.*] I am sorry, that was terrible.

The Convener: Did that just slip out?

Adrienne Sinclair Chalmers: It did—sorry. That was shocking.

Mary Scanlon: Well, this is a democratic committee.

The Convener: Okay. It was a serious question. Is there any point at which advocates should not have a role?

Mary Scanlon: Or should not be participating.

Adrienne Sinclair Chalmers: When the patient does not want them. That is the only answer that I can think of.

Rachel Annand: I want to make a point about not being too prescriptive about what goes in the bill. One role of the advocacy alliance is to protect and celebrate the diversity of the movement. Therefore, concerns have been raised around the issues of collective and citizen advocacy. For example, if an advocate is to be present within two hours, they will probably have to be a paid person. That would lead us down the road of having only professional advocacy.

Members have probably heard and read people's views that they want a range of different types of advocacy. This is about what people want and need. There should be more about advocacy in the bill, but we must balance that with avoiding being too prescriptive because that could lead us down the road of just one type of advocacy.

The Convener: I must end this part of the session because we are getting tight for time. If we have not covered anything that you want to mention, please do so in writing. Thank you for your evidence today and your written submissions.

I welcome our next set of witnesses, who have been able to listen to what earlier witnesses said. Please begin with a short statement and introductions before we move to questions.

Keith Maloney (Consultation and Advocacy Promotion Service): I am Keith Maloney and I co-ordinate the Consultation and Advocacy Promotion Service. We have been around in the Lothian region for 11 years and have worked closely with the Edinburgh users forum. Maggie Keppie and Willie Twyman have experience of using mental health services and are active in the user movement in Edinburgh.

We are giving evidence at the end of a long morning and other people have covered most of the points that we wanted to raise. However, it will be useful if I reinforce some points and remind people of them.

We welcome the fact that service users have been given opportunities to become involved in the process of reviewing mental health legislation since Millan started his work back in 1999. Millan took on board several issues that service users felt were important, including the right of service users to access independent advocacy services. Service users welcomed that and are a little disappointed that it has been watered down to a duty to provide advocacy.

12:00

We reinforce the importance of including the principles in the bill. Others talked about that. The principle of reciprocity, which is a difficult word with which we are all struggling, is important for service users, as it tries to ensure that good services are available in the community and that compulsory orders are last-ditch measures for service users. Without reciprocity or a guarantee that good alternatives will exist in the community, service users feel that compulsory treatment orders in the community will be not a last, but a first resort, and will be used purely to make people take medication—treatment that they would refuse in other circumstances.

Service users feel that collective advocacy is important and must be included in the bill. Without collective advocacy, service users will be unable to organise themselves. They will have no view on and no influence over the services that are provided to them. It is all very well talking about people having choice, but if people are to have choice, services from which they can choose must exist. Collective advocacy is fundamental to allowing the service-user community to influence the services that it receives.

The committee has talked about how advocacy services are policed and how standards are kept up. It is important that service users are involved in checking how good the standards of the services that are provided to them are. Collective advocacy allows service users to be involved collectively in monitoring and evaluating the services that are provided to them.

I guess that we will be asked to answer questions about the named-person provisions. I support HUG's view. Service users in the Lothians have welcomed the inclusion of the named-person idea, because it gives them a choice of who should represent them. It is important that everybody knows that a named person is not independent. As Adrienne Sinclair Chalmers said, a named person will be expected to have a view. That is different from the advocate's position. Along with a named person, an advocate will remain necessary, to ensure that service users have somebody who can help them to speak up for themselves. An advocate will not make decisions in service users' best interests, but will purely represent service users' views and ensure that people take on board and respect those views when taking decisions about people's lives.

Mary Scanlon: The submission refers to a reduction in hospital bed availability and the fear of "a tidal wave of formal and 'hidden' compulsory treatment orders."

Will Maggie Keppie and Willie Twyman outline why that might happen?

Maggie Keppie (Edinburgh Users Forum): As everybody knows, in the past 10 years, the numbers of acute beds and other hospital beds have been cut, especially in the Royal Edinburgh hospital. We are concerned that, if a bed is not available, somebody will be put under a compulsory order instead of an attempt being made to work out the problem in another way.

For me, as for everybody else in the room, my house is my home. It is a place where I have fun with my nieces and nephews and to which, after a tough day at the office or whatever, I can go home, put the music on and sit on the couch. The fact that I would be required to let health professionals and social workers into my home if I was put under compulsion disturbs me. Within the user movement, I am quite a public figure, but my home is my home and that is different. If compulsion were to extend to my home, it would become not my home but a house. That is one reason why I would hate to be put under such an order.

There are other issues too. What about when, having been sectioned and put on medication, people feel better and want to come off medication? I found myself in that situation. Although it took only two seconds to decide to put me on an injection, it took three years of decreasing the medication before I could come off it.

Should somebody be able to tell me where I should live, whom I should see or what medication I should take? Lithium may work for some people, but for me, it reduced my quality of life to zero because of its side effects. It is bad enough that in 2002 we still have compulsion in hospital. Allowing compulsion in the community could be just the start. What would come next? Will we get tagged or get told when we can leave our houses?

Another issue is appearing in front of sheriffs. I did not have a parking ticket or a speeding fine, but the procedure I had to go through to be put under section was degrading. I went to the sheriff court once, but on the other occasions when section 18s were put on me, I felt so bad that I did not even go to court. We are people. Yes, we have an illness but, no, we are not criminals. Why treat us in such a way? Prisoners coming out of prison do not have such restrictions placed on them, so why are they placed on us?

Mary Scanlon: If the convener will allow me, I would like to consider the bill as a whole. One of its principles is that of the least restrictive alternative. Committee members like me are told that treating a patient in their own home, albeit compulsorily, is less restrictive than locking them in a hospital. Is that right or not?

Also, would the advance statement perhaps help to reduce the tidal wave of formal and hidden compulsory treatment orders? Would the ability to state in advance things to which you have previously objected give you more rights?

On the least restrictive alternative, are you saying that, if you were sectioned, you would prefer to be in a psychiatric hospital? Would you find that less restrictive than being in your own home?

Maggie Keppie: Yes, I would find that less restrictive for many reasons. I am manic-depressive. I have insight into the depressive part of my illness and I can handle it. When I know that I am going down, I can ask the doctor for anti-depressants or, if I am not sleeping, I can go to get sleeping tablets. The other part of the illness is when I go high. At that time, I go for walks at 4 o'clock in the morning and—this might sound daft—forget to feed myself for up to a week. I lose all sense of time and I lose road sense and so on. If a bus is passing and I want to walk out, I walk out. When I am ill and high I need 24/7 care for the sake of safety. I might be able to get that in my home, but I do not know whether every single person with a mental health condition could be given that amount of care.

You asked about advance statements. Making an advance statement that nobody will look at or follow would be a complete waste of my time. There should be rules. For example, if a tribunal or doctor overturns an advance statement, the reason for that should be recorded. At the same time, there should be a way to challenge that decision. If I said on my advance statement, "Don't put me on lithium because I get fed up waking up every morning to find that I have been incontinent," and somebody said, "Okay, but blah, blah, blah," I would want to know who had made the decision and whether I had the power to challenge it.

Keith Maloney: I will add something quickly about the least restrictive alternative. We need to talk about the least restrictive alternatives rather than about which treatments are less restrictive than others. At the moment we are talking about whether compulsory treatment in the community is less restrictive than compulsory treatment in hospital, but we are not talking about whether there are even less restrictive treatments than the compulsory order in the community. It is really important that people have access to alternatives in the community other than medication.

Mary Scanlon: I invite Willie Twyman to come in on the second part of my question. Do you think that giving advocates an increased role would decrease the risk of there being a tidal wave of compulsory treatment orders?

Willie Twyman (Edinburgh Users Forum): We have had a long talk about compulsory treatment orders with many users. It was once said that they were to be like a hospital without walls. People would be trapped in the community and would have no say. That is the problem with the orders. I believe that advocates are a necessity. There is no other way round the issue. When somebody is ill or on medication, they find it hard to talk. I asked Maggie Keppie a question once when she was on medication and she answered it 10 minutes later. That is the kind of problem that I am talking about.

It is hard to argue with experts when social workers, psychiatrists and community nurses are telling you what is best for you. The situation is intimidating. They can make decisions with which it is impossible to argue. Even an advocate would find it hard. At least we will have the chance to have someone put across our point of view. It is not easy. It is like appearing before the Health and Community Care Committee.

Maggie Keppie: It is all right; we have slipped out to the bar only twice.

The Convener: You are just like the rest of them—they have drink under their desks.

12:15

Willie Twyman: That is where advocacy comes in. Members must remember that individual advocacy is totally different from collective advocacy. We need both. Mention of both types of advocacy seems to have slipped out of the bill. At one time, both were mentioned; now there is mention only of advocacy. Individual advocacy is important for an individual, but collective advocacy helps us to put our point of view to the committee, for example. Without such support, we would be unable to do that.

Collective advocacy enables us to appear before committees and organisations such as CAPS to argue for them to give us a place. We are users and we have problems. That is where collective advocacy comes in. HUG has done an excellent job in the Highlands by bringing together people in a wide area. We have tried that approach in Edinburgh. Collective advocacy and individual advocacy are two different things.

Mary Scanlon: You are the judges of the service.

Shona Robison: Willie Twyman has answered my question about collective advocacy. It is safe to say that you believe that the bill should make specific reference to collective advocacy.

Willie Twyman: Yes.

Maggie Keppie: Some people think that if we fund individual advocacy, we do not need to fund collective advocacy. We had a situation in CAPS in which one of our funders turned round and said that we needed individual advocacy. We had been doing collective advocacy for years. CAPS got the contract for providing individual advocacy, but the contract for collective advocacy was dropped. The group that had been set up was strong enough to look elsewhere for funding. That group is still running. It is like most projects—once they are up and running, a new flavour appears. To get the funding, it might be necessary to change some aims to fit the new flavour.

Nicola Sturgeon: In your written submission, you comment that people who have a named person should still have the right to advocacy services. What would happen if the advocate and the named person had different viewpoints? One hopes that such situations would not arise very often. Do you have any practical suggestions about how those cases could be resolved?

Maggie Keppie: Someone who has a named person will have a relationship with them, somewhere along the line. They will not have a relationship with their advocate. In my opinion, it would be good if the named person and the advocate sometimes had different points of view, because then they could work together. The advocate might be able to show my named person that, even though their heart was in the right place and they were trying hard, they might not be acting according to my wishes.

The advocate will act on what I want, not on what my named person or my carer wants for me. There are three different relationships: with the carer, with the named person and with the advocate. Sometimes doctors can be very persuasive—we call it collusion. There have been many times when the professional has got my family to talk me into doing something that I did not want to do. I hope that, in future, that would not happen if I had an advocate.

The Convener: I think that you may already have answered the question that Dorothy-Grace Elder was going to ask.

Dorothy-Grace Elder: I shall abbreviate my question. Is it your general experience that Scottish mental health professionals tend to be institutionally opposed to patient autonomy and rights?

Willie Twyman: I think that they are frightened, to be honest with you. That is what it comes down to. They worry that the advocate will take power away from them and that they will not be able to make decisions, but it does not work that way.

Dorothy-Grace Elder: Is it a power thing?

Willie Twyman: Yes. When the advocacy services first started, there were a lot of problems. Now, you will find that a lot of professionals quite enjoy having an advocate, because that solves a lot of problems between them and the patients. However, I have heard of cases in which people wanted to take an advocate along and the psychiatrist turned round and said no, and then the person was moved out of Edinburgh to St John's. That does not happen so much now, but in the beginning the problems all stemmed from the worry that psychiatrists would not be able to do their job. They may have genuine reasons for thinking that their treatment is the right treatment. The patient may disagree, but someone who is ill may disagree with a lot of things. It all comes down to the question of what rights we have. If someone who is a Mormon has an accident and breaks an arm, they can say that they do not want a blood transfusion. If we were to say that, we would be sectioned and put in hospital.

Dorothy-Grace Elder: Correct me if I am wrong, but I think that you are also concerned about advocacy in relation to protecting the family relationships of people with mental health problems. Parents are often afraid of their children being taken away from them and, in some cases, they might not seek help. Will you explain more about that in relation to your own circumstances?

Willie Twyman: I can give you a perfect example. My wife and I have both suffered from mental health problems. We have two children, who are grown up now, so we no longer have that problem, but when they were younger, it was a constant fear. It was so bad that one of the doctors suggested that they could be taken into care, and my wife was so frightened that she was talking about moving down to England. That is the kind of fear that we are talking about—the fear that if your kids are taken off you, you will not get them back. One of my children is in Leeds at a dance school and he is doing really well, and my daughter is an aircraft engineer. We had mental health problems, but we brought them up.

That is the kind of intimidation that I am talking about. It does not sound like much if somebody says, "Oh, we'll just put them into care," but putting them in is not the problem; the fear is that you will not be able to get them back, and that has happened in some families. That kind of fear is also used to persuade people, by saying, "If you take your medication, we won't take a section out on you." A section may not have been taken out, but you have been threatened with a section so you take your medication. A lot of people take their medication rather than have a section on them.

Dorothy-Grace Elder: You have had a very successful child-rearing experience, but you had years when your children were young when you were afraid that they might be taken away just because, officially, you have a mental health problem.

Willie Twyman: Yes. My problem is not as bad as my wife's problem was. Fifteen or 16 years ago, they were almost going to take her into hospital. The situation reached the point when the doctor said, "I know you need to come into hospital, but if I bring you in, it will go on your records and the next time you take ill, it will be easier to bring you in. I can try to keep you out." That kept her out of hospital altogether, because it was never marked down. Although she was a day-patient, she was never taken in, which is what they would usually have done at the time.

Dorothy-Grace Elder: That shows an extremely judgmental attitude to who is thought to be fit to be parents.

Willie Twyman: Once the fact that you have been taken into hospital is stamped on your records, the doctor sees that you have been in hospital and thinks, "They're not well. Get them in." That is another problem.

The Convener: Let me play devil's advocate for a moment. Maggie Keppie has given us her opinion about the use of compulsory treatment orders in the community. You are suggesting that we need a flexible service. Although your wife could have gone into hospital, that might have been the worst thing for your family in the longer term. Instead, what was needed was the flexibility to allow family members to receive treatment while ensuring that the family could be maintained.

Maggie Keppie: We are all individuals and we all have the right to individual lives. I am not saying that every time that someone falls ill, they should be put into hospital. Instead, we should have the choice without any compulsion.

Janis Hughes: What mechanisms does Keith Maloney apply to ensure that his organisation offers adequate advocacy services? Does the Advocacy Safeguards Agency's remit adequately maintain those standards or should the bill contain a provision to enforce them?

Keith Maloney: We are very open about how our service is run and managed. We are funded through the mental illness specific grant, for which we have to reapply each year. As a result, each year, we have to report on what we have been doing, the number of people we have worked with, the issues that we have dealt with and so on. To support our application, we also have to get feedback both from the people whom we support and from professionals.

A couple of years ago, we used some of our grant to pay for an independent organisation to carry out an evaluation of us. We have tried to be as open and as critical as possible about our practice and, as I have said, we have involved the people for whom we provide a service and professionals in the process.

We welcome the introduction of the Advocacy Safeguards Agency. Having an arm's-length organisation with which we and our funders can work is a major step forward. Apparently, one of the reasons why health boards do not fund advocacy services is that they are frightened that they will influence our work. The presence of the Advocacy Safeguards Agency allows the funding process to go ahead and demonstrates that there are people around who can check the standards of the work that is provided. I am not sure about the legal need to mention the agency in the bill. As Adrian Ward said, it might be advantageous to do so to ensure that there is no danger that it will be removed from the funding process in future.

The Convener: I want to bring this section of evidence taking to a close because we have another set of witnesses to hear from. I thank the witnesses for attending this morning; I hope that we were not too intimidating. It is important that we get a sense of how the bill will affect people's lives, and your useful contributions have given us that.

Willie Twyman: I thank the committee for inviting us to the meeting. It is nice to feel that we have a voice.

The Convener: We are delighted to have you.

Maggie Keppie: On that last point, do not take another 40 years to change it, because I might not be around then.

12:30

The Convener: I hope that we will not have to, if we get it right.

We come to our final set of witnesses in what has been a fairly long morning. I thank them for sticking with us and for listening over the course of the morning. I welcome Helen Garner from the University of Glasgow, and Professor David Owens from the Royal Edinburgh hospital. You have looked in particular at advance statements, but I am aware that there may be other issues that you wish to bring up. We will focus first on advance statements because that is what we want to hear from you about and we are a bit tight for time. I aim to finish by 1 o'clock at the latest, if possible.

Do you want to make a short statement or do you want us just to go to questions?

Helen Garner (University of Glasgow): Perhaps I could pass on the short statement and pick up at the end any matter that has not been covered.

Janis Hughes: I want to ask Helen Garner about the scale of her research. How many people were involved and from what walks of life did they come?

Helen Garner: There were two stages to the research. The first was a sort of brainstorming stage, during which we went to many groups in Scotland—patient groups and staff groups—to ask for their general ideas. Thereafter, we did a postal survey of five groups of stakeholders including psychiatrists, mental health officers, managers in hospitals and user-services representatives. We could not go directly to service users because of confidentiality issues. The other group that we surveyed included professionals such as social workers, doctors, nurses, managers and voluntary organisations. The survey was of about 1,500 people in total but, as I say in the paper, it was not a referendum and it was not necessarily a representative sample. We tried to make the sample as broad as possible, but our research does not constitute a vote on advance statements.

Janis Hughes: The research paper provides an overview of the findings, but did you break down the views of patients, professionals, carers and so on?

Helen Garner: I am reluctant to quote the figures; in fact, I have not brought the figures from the questionnaires with me. It is a distortion to say, "This many people from this group were in favour and this many weren't", because the whole discussion is bedevilled by the terminology: what is meant by "advance directive", which is the term that we used in our research? A wide range of views was expressed—which I have outlined in the paper—from a positive desire for a change in law, to a desire for something that is not necessarily a change in law, to being altogether against the idea.

Janis Hughes: On page 2 of your paper you list reservations about advance directives that were made

"by people with the full range of views about the usefulness of advance directives."

What do you mean by

"people with the full range of views"?

Helen Garner: There were people who wanted advance directives and people who did not. All were concerned about the practicalities of implementing the directives and questions were asked including on how one would ensure that directives are up to date, how to change them and how they take into account new circumstances that the individual who made the directive did not know about.

Janis Hughes: So your findings are based on those opinions, irrespective of which side of the fence the people were on in relation to advance statements.

Helen Garner: Yes. There were big concerns expressed about the practicalities.

Mary Scanlon: After your research, what conclusions did you reach about the usefulness of advance statements?

Helen Garner: I am trying to be careful about representing both the research and my personal view, so I will introduce the answer by including my personal view. I was originally positive about advance directives and thought that they provided an opportunity to increase patient autonomy. However, during my research I learned about many of the practical difficulties and I now have major reservations about enshrining them in law. We put hypothetical models to people, so our research was not based empirically on the working and effects of certain models of advance directives. The research was useful, but it was not empirical and found out only opinions about what the different models of advance directives would achieve.

Mary Scanlon: Do you still have serious reservations?

Helen Garner: I have reservations about advance directives. The survey was very useful for me. On the first page of my report, I divided our respondents into two broad groups, because I think that people have two different ideas about what advance directives can achieve. A minority of people in the research—members should, however, bear in mind my reservations about the research's representativeness—wanted to change the law so that it would give patients the power to refuse or opt in to treatments. The larger group thought advance directives would have a useful role in improving communication and in getting people talking to one another. It is not clear to me how changing the law would improve that.

Mary Scanlon: I ask Professor Owens what, as a clinician, are his views on the usefulness of advance statements? You probably heard Marcia Reid and one or two others talking about how professionals in your position can be powerful and dictatorial in challenging advance statements. Would you find them useful or would they interfere in your judgment?

Professor David Owens (Royal Edinburgh Hospital): I have profound reservations about advance statements for several practical and theoretical reasons. The theoretical issues include the fact that advance statements place doctors in a difficult position with regard to their duty-of-care responsibilities, which are legally held. If doctors are unable to fulfil those responsibilities effectively, what position will we be in? Advance directives could also put us in a professional quandary. The Government and our professional bodies have been flogging the idea of evidence-based medicine for some years, and practice has shifted in that direction. There is a potential conflict between the evidence-based recommendations that we would make and what is contained in an advance directive, which obviously may not be evidence-based.

There are many practical problems of implementation, some of which have been touched on. They include knowing whether the directives are up to date and whether they are being seen in the light of full information, which the patient may have updated. We might, for example, not know when a statement was made. We know that patients who have major psychiatric disorders have a long run-in before they become unwell. Is competency an issue in such cases? We do not know. For example, some schizophrenia studies show that the run-in to a first episode can be up to four years, during which patients show symptoms, but not enough to have them brought to attention. If an advance statement were made in that context, would competency also have been considered? If a directive is made after an episode of illness, we know that people can suffer from residual symptomatology that can continue to cloud their judgment, even though they have recovered what we consider to be competency. All that sidesteps the issue of what competency is.

I often think that I would like the lawyers who draw up the test of competency to come and work in my ward for a couple of weeks; they would then realise what a difficult and arbitrary decision it is. There are many practical implications; I can mention others if members would like that.

Mary Scanlon: Paragraph 344 of the explanatory notes covers what is deemed to be "incapable". What is the power or mechanism under the bill that allows you to challenge or overturn an advance statement? I am not entirely clear about that.

Professor Owens: I will remind myself of the phrase that is used in the bill—it is a lovely phrase. It is "have regard to". I am not clear whether we should duly have regard to the statement, but then say, "Well, I'm sorry, but that's not what I'm going to do."

Mary Scanlon: When you talked about your duty of care, you implied that care of patients could be impeded by the advance statement.

Professor Owens: That is right.

Mary Scanlon: Under such circumstances, do you have the right or are you able under the bill to say to the patient, "I know something that's better for you," and tell them that you want to overturn the statement?

Professor Owens: As I understand it, we have that right, provided we have given the matter due regard. I am not, to be honest, sure; there seems also to be a question about calling for a tribunal or whatever.

The Convener: My understanding is that such matters might have to go to a tribunal.

We have lost our adviser, I am afraid.

Professor Owens: Just at the crucial moment.

The Convener: Technical questions are being asked when our technical expert is no longer here—that is unfortunate. The suggestion has been made that there would be a right of appeal to a tribunal to ascertain why a person had disregarded an advance statement. I could be wrong about that, so I will have to clarify that.

Mary Scanlon: Is there also a potential right that is to do with clinicians' duty to give the best possible care?

Professor Owens: The issue is about optimal treatment. I do not think that anyone in my business believes that we have the best treatments available. Anybody who is being honest will acknowledge that patients often pay a substantial price for the benefits—which may be debatable—that they receive. The worry is that, if we introduce measures that dilute what we already have, we will in effect reduce the effectiveness of the treatments that we are able to offer. That effectiveness can now be substantial. When I started off in this business, people would often say, "Let's just wait and see what happens", in relation to potentially psychotic patients. We now realise that that approach is totally wrong.

When psychosis is suspected, early and effective optimal treatment is absolutely crucial. The treatment affects not only the short-term outcome but the long-term outcome, as well as the relapse rate and so on. People's advance statements might be based on information of which the clinician is not aware; for example, on a "Panorama" programme that was slanted or one-sided, or on what a person heard from the local herbalist. The clinician might not have the knowledge to counteract the views that the patient has brought to his or her advance statement, and will end up treating sub-optimally in a situation in which they know that that will be detrimental.

Mary Scanlon: I know that we are short of time. How can we get the balance right to ensure that patients such as Marcia Reid are able to say that they do not want ECT, and that the level of treatment that could help is not reduced? Could you put that in writing, or in amendments? We would benefit from anything that would get that balance right.

Professor Owens: With all due respect, I think that the process has been moving forward. People think increasingly that quality of care is improved by guidelines, directives and so on. Enshrining it in legislation is not the way forward. It is not a practical option and it would lead to a top-heavy bureaucratic system of administration.

Mary Scanlon: Are you saying that advance statements are not a practical option?

Professor Owens: That is right. They are not practical if they are enshrined in legislation.

Mary Scanlon: Really?

Professor Owens: I think that the way forward is as recommended by the technology appraisal boards—the National Institute for Clinical Excellence, or NICE, and the Health Technology Board for Scotland which, in a recent review of atypical anti-psychotic drugs, pointed out that a key part of the management of patients who have major psychiatric disorders is "discussion" and "negotiation", to use their words. To enshrine advance statements in law will in effect make psychiatrists feel, and practise, as if they have one hand tied behind their backs. Ultimately, that will be detrimental to patients.

Mary Scanlon: Thank you. That was very helpful.

The Convener: I would like clarification on what you mean when you talk about enshrining advance statements in law. Do you mean the final legal word on a matter should come from somebody's having included in an advance statement treatment that a psychiatrist must carry out, or do you mean that we should not enshrine in law people's right to make advance statements—with consultation and agreement where possible—to which due regard should be paid, which would allow clinicians a get-out clause? Would you be happy with the second option being enshrined in law, rather than the first?

Professor Owens: I would be happy with the second option, but I do not look on it as a get-out clause.

The Convener: I am afraid that my ability to find the right words has left me after four hours in the chair.

Professor Owens: The process of discussion and negotiation should not be restricted or given special status; it should be practised across the board. When guidelines such as the Health Technology Board for Scotland's come into force and are widely used, we will be moving in the right direction.

12:45

Mr McAllion: You will have heard earlier that some patients who have deep reservations about compulsory treatment in the community might well make an advance statement saying that they do not want such treatment. Those patients made the point that the choice should not be between compulsory treatment in the community or compulsory treatment in hospital; they believe, rather, that the least restrictive available treatment, which might be neither, should be used. Is there a danger that psychiatrists will have to recommend compulsory treatment in the community because the least restrictive treatment is not available because of lack of resources?

Professor Owens: That is a potential risk, but I do not think that it will be a great risk in practice. Psychiatrists do not enjoy sectioning people; it is often a difficult and traumatic experience for us. We are aware of the issues and responsibilities that are involved in removing people's freedom of choice and liberty and psychiatrists are among the few people outwith the legal system who have the right to do that. I was surprised that some people might prefer to be treated compulsorily in hospital rather than at home. That came as a shock to me and I admit that I was not prepared for it.

Mr McAllion: Let us be clear. People who might receive a different package of treatment are sectioned, but they do not receive the different package because there are not sufficient resources to provide it.

Professor Owens: In my view and experience, that is uncommon. People are subjected to compulsory powers because of the medical issues that they present, such as their symptomatology, behaviour and insight. I do not think that people are compulsorily detained because there is no ready alternative.

The Convener: Helen Garner's written evidence mentions that many service users have no particular interest in or need for advance statements. Can Helen Garner give the committee an estimate of how many advance statements mental health tribunals in Scotland are likely to deal with in a year?

Helen Garner: Several witnesses have said that the bill is difficult to understand. I have read the part about advance statements several times and I still find it difficult to know what is intended. For example, I have not been able to establish who the person might be

> "who is within the class of persons prescribed by regulations for the purposes of this paragraph and who signs the statement as a witness to that subscription".

That issue will define the nature of advance statements. Will people be able to write the statements with their neighbour, or must the statement be discussed with the responsible medical officer? Those two possibilities would produce different types of document.

If a person's advance statement said, "On no account do I want anti-psychotic medication", but that person was admitted on emergency section, it is not clear to me from the bill whether that person could be treated with anti-psychotic medication or whether the case would have to go to tribunal. That concerns me because there is an issue about time. How long will the process take? A person who is brought into hospital in the middle of the night might be very ill and disturbed, but might also have an advance statement that says that he or she does not want anti-psychotic medication. How long would staff have to wait until they could do something?

That issue has arisen in America, where advance directives have status in some circumstances. At times, restraint has to be used instead of medication. By restraint I mean people having to be tied down, physically restrained or put into seclusion. Depending on what advance statements allow, their use will have consequences. As I say in my submission, if restraint were to be permitted under the bill it would have consequences not just for the patient, but for other people in the ward. I am not a clinician, but I think that it is important for us to remember how ill people can be. I have a little nursing experience and have seen people harm themselves in hospital. I would be anxious if the only thing that doctors could do to look after people was to restrain them physically.

The Convener: The only health-related occasion on which I have been asked for an advance directive concerned what I wanted to happen during pregnancy and at the point of delivery. The reality of the deliveries of both my children bore no resemblance to what I thought and hoped I would experience. I was in the hands of professionals. I had to compare what I had wanted in advance with what they were having to deal with, but I had no way of knowing that a particular set of circumstances would arise.

Helen Garner: The convener makes a valid comparison that was in my mind. However, in a birth plan you do not expect to change the relationship with, and the legal duties of, the people who are responsible for the medical well-being of you and your baby. You may say that you are the sort of person who wants to have her hot, wet, slithery baby on her tummy, or that you are the sort of person who wants the baby to be well wrapped up before it is given to her. A birth plan can be a useful way of conveying your values and experiences.

The Convener: People are asked to give their views on issues such as epidurals.

Helen Garner: Yes, but they are allowed to change their minds, which is crucial. Under the Mental Health (Scotland) Bill, that issue is unclear and may not have been thought through. I understand that people may withdraw an advance statement only if they are as competent as they were when they made it.

The Convener: Once I had had two children, all competence was out of the window.

Helen Garner: So—you would not have been allowed to change your advance statement.

Professor Owens: There is another practical problem. There is an assumption of predictability about episodes of psychiatric illness, but that assumption is not well founded. Many of the issues that we are discussing will arise in relation to schizophrenia. We know that the symptomatology of schizophrenia is very unstable; there is no predictability of symptoms for at least the first five years of the condition, and perhaps for the first 10.

The circumstances in which the illness occurs are also unpredictable. Patient's personal circumstances often change; a statement might be appropriate when a patient has a particularly prominent carer, but once that person is no longer around the statement might not reflect the patient's circumstances. Let us not forget that community care still often means family care.

In the long term, episodes of illness can have very unpredictable outcomes. One of my patients had a bipolar illness that was for 10 years absolutely predictable by the calendar. He had six weeks up and eight weeks down, with a very rapid switch between the two. On 1 November, the patient went into a down, as predicted, but he remained there until 7 July—for no reason. He came up only because we had to give him ECT. He was deteriorating rapidly and was in a health-threatening situation. Neither he nor I could have predicted that. The assumption that there is an element of predictability in both symptoms and circumstances is not valid.

Shona Robison: My question is about witnesses to advance statements. Helen Garner's submission says:

> "It is not clear who those people 'within the class of persons prescribed by regulations for the purposes of this paragraph' section 187 (2) (d) of the Bill are who may witness an advance directive."

To whom do you think the Executive is referring?

Helen Garner: I do not know but the matter is pretty critical. If I make a will, I can choose, as my uncoerced opinion, anyone in this room to sign it. People may make advance statements now; they exist in common law, but I do not think that they have been tested in the courts in Scotland. Such statements can be made, but can be overturned by the Mental Health (Scotland) Act 1984.

If the class of people making the advance directives were mental health professionals, you would probably get a softer sort of document that would ask, "If this illness occurs again, is this what you would like?" I presume that the directive would not then have to go to a tribunal to be changed. It would be the sort of advance directive that I call an aid to improved communication.

Shona Robison: Who do you think would be the best people to act as witnesses?

Helen Garner: As I say, I have done a volte-face on the matter. I started my research thinking that advance directives were a great idea. However, the more I think about them, the more my inclination is to leave the law as it stands so that although anyone can make an advance directive, mental health legislation can, in patients' best interests, kick in and overrule advance directives.

I would like to see patient autonomy and self-determination enhanced in lots of other ways such as advocacy services, self-management programmes and learning the early signs of relapse. I am in favour of the values that people want the advance directives to embody, but there are better and less problematic ways of embodying them. I am not sure that it is a job for the law.

The Convener: I am aware that time is getting on. We will have a quick question from Mary Scanlon. Shona Robison also has a final question for Professor Owens.

Mary Scanlon: I have a brief question for Professor Owens. It has been suggested that patients might be able to opt in to treatment through an advance statement rather than wait to be detained because they will refuse treatment when they become ill. Is that workable?

Professor Owens: I very much doubt that that is practical. Among the major criticisms that have been made by many patients and most families are criticisms relating to whether there is adequate and early access to services. The trouble is identifying problems specifically enough and in pointing people in the direction of psychiatric services rather than to other more appropriate support services. There are still problems with getting early access to services but, in practice, it is difficult to envisage an opt-in situation such as Mary Scanlon suggests.

Mary Scanlon: Is that because of the problem of availability of services?

Professor Owens: It is to some extent, but it is really about knowing what criteria are used to opt in. Would you use the normal ups and downs of life? Are you becoming over-concerned with getting engaged in psychiatric services or do you indeed have the prodromal or early symptoms of a major disorder? For example, do you have a strong family history of a disorder about which you are beginning to become concerned? Those are all major issues.

However, opting in would mean that a person would have to know the set of problems with which he or she was dealing, but people do not know those things. There are alternative services available such as counselling services or GP support services. Opting in to psychiatric services is not a trivial thing for most people to do and we acknowledge that. We do not want to encourage hordes of people to medicalise their problems and opt in to formal psychiatry.

Shona Robison: In your submission you lay out why you believe the tribunals system might not be in patients' best interests. That is fairly strong evidence and you obviously feel very strongly about it. If the tribunal system goes ahead, how could some of your concerns be allayed? An example might be a code of conduct for how the tribunals have to be conducted.

Professor Owens: Not all the trials that I attended during my time in England were bad; one or two senior legal figures chaired tribunals extremely effectively. I believe that tribunals lack—for want of a better term—the majesty of a court appearance. I was interested to hear comments to the effect that patients are not criminals, and I have taken that on board. However, the matter that is being decided is one of personal liberty.

13:00

It is wrong for any patient or patient group to think that doctors are not intimidated by appearing in court. A major issue is being decided at such times and the court brings to the process dignity and objectivity that are not brought by a tribunal.

The tribunals that I attended in England and Wales took place around a table and there was not the formality that is imparted by a court—the tribunals turned adversarial very readily. On one occasion I was sitting next to a legal representative who ended up wagging a finger at me very unpleasantly. I remember the occasion vividly.

It is the long-established dignity and objectivity of the court that would give the appropriate level of solemnity to what I think are very important decisions. It was a great relief to me to come north of the border and see how the system operates here. As I say in my submission, I believe that many of my colleagues who work south of the border will be surprised that we are opting for a tribunal arrangement here. I am sure that any tribunals that the committee visited that were working impressively could have been offset by many more that consultants and subsequently patients found to be very unpleasant.

The Convener: Thank you for that. Do you want to raise any other points?

Helen Garner: I have two points to make. On opting in, during my research an example occurred that demonstrates the difficulties of opting in to the service. A person had responded very well to ECT and seemed to have a very regular pattern. However, when he became ill, he was not competent to agree to ECT so he had to be detained under mental health legislation and then had to go through the proper procedure of getting a second opinion and so on. That person wanted an advance statement so that he could have ECT without getting the safeguards. Whatever one's position on ECT, that would give rise to concern and is a vivid illustration of the difficulties of opting in to treatment.

I will mention the other issue because we talked a bit about babies. I have said that I am not convinced that the law is the way to increase and improve patient autonomy and responsiveness. Resources are a key issue. I want to bring to the committee's attention the fact that, in Scotland, there are no dedicated mother-and-baby units. If a mother needs to be detained under the Mental Health (Scotland) Act 1984, she is separated from her baby and that is true even if she is a voluntary patient. That is a very important civil rights issue that will not be dealt with by the bill.

The Convener: If we get the chance, we might mention that to the minister next week.

Thank you for your written and oral contributions this morning.

Meeting closed at 13:02.

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ISBN 0 338 000003 ISSN 1467-0178