HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 6 November 2002
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE

28th 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)
Maureen Macmillan (Highlands and Islands) (Lab)

WITNESSES

John Aldridge (Scottish Executive Health Department)
James Brown (Scottish Executive Health Department)
Sarah Carpenter (ChildLine Scotland)
Malcolm Chisholm (Minister for Health and Community Care)
Sheriff Robert Dickson (Sheriffs Association)
Eddie Follan (Children in Scotland)
Colin McKay (Scottish Executive Health Department)
Sheriff Richard Scott (Sheriffs Association)
Kay Tisdall (Children in 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 6 November 2002

(*Morning*)

[THE CONVENER *opened the meeting at 09:33*]

Item in Private

The Convener (Mrs Margaret Smith): Good morning. I welcome everyone to this meeting of the Health and Community Care Committee. Agenda item 1 is the suggestion that we take item 5 in private because, as a matter of courtesy to the committee, the Minister for Health and Community Care has offered to brief us on the forthcoming expert group's report on hepatitis C prior to its publication. Are there any comments?

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Agreed.

Nicola Sturgeon (Glasgow) (SNP): I am opposed to the suggestion. I do not want to make a big deal about it, but there is an issue of principle here. The report has been eagerly anticipated by a lot of people, especially those who have been infected with hepatitis C. There is already some frustration that there has been a three-month delay. I know that there are people here today who want to hear what the minister has to say. I think that it would be wrong to exclude them from a discussion that affects their lives. Holding the briefing in private would do nothing to enhance the Parliament's reputation for openness. I know that the report is being published later today, but this morning's meeting will provide the first opportunity to question the minister and probe the thinking behind his response. People have a right to hear today's discussion.

In general, committees should not go into private session without good reason, and I am not convinced that there is a good reason in this case. The only reason that has been given is that the minister does not want to pre-empt the publication of the report, but we would do so only by a few hours. That would not be the end of the world. Had the minister been worried about that, I am not sure whether there was anything to stop him putting the report into the public domain in advance of this morning's meeting and allowing us to have an open discussion.

Margaret Jamieson: Nicola Sturgeon is simply at it this morning. The report is not the minister's report, but he is prepared to discuss his views on it. If we are briefed prior to publication, that must always be done in private, otherwise what is the point in having dates and times of publication? I propose that the item be taken in private.

Mr John McAllion (Dundee East) (Lab): I understand that the committee's involvement was inspired by petitions that were forwarded to it. I have not seen the report and do not know what is in it—I am therefore not qualified to question the minister closely about it. However, once I have read the report, I hope that the committee will invite the minister back to question him in public on its contents and the Executive's response to it. That will be more vital than this morning's briefing, which is simply a courtesy to the committee before the report goes public.

The Convener: I suggest that we invite the minister to the committee within the next few weeks. We should have a chance to read the expert group's report. That will give us the scope to question the minister about it and we can consider whether we want to question the expert group on its work and any of the groups that are affected. That is the best way forward. I hope that we can then conclude the committee's long-standing involvement with the issue.

I share Nicola Sturgeon's frustration. Some members of the committee have been involved with the matter for years in one way or another—almost since we were elected. John McAllion is absolutely right. There have been two petitions and we have doggedly tried to ensure that the issue does not go away, but it has dragged on for a long time. Two ministers have been involved. I hope that, over the next few weeks, we can work to finalise the committee's involvement with the matter.

Dorothy-Grace Elder (Glasgow) (Ind): That the minister must definitely come back and be questioned openly puts a different complexion on the matter. I have not seen the report either—I have not even heard a hint of what is in it—but if there is any way of influencing the minister if what the committee wants is not being done, it might be better to influence him strongly in private in advance of questioning in public as soon as possible. That should happen next week, if possible, although I do not know whether our agenda makes it possible.

Nicola Sturgeon: I do not want to prolong discussion about the matter. What members think is clear, but I want to record in the *Official Report* my opposition to going behind closed doors to discuss the issue.

The Convener: With that dissent noted, are members happy to take item 5 in private on the basis of the minister's request and to find a spot in the next few weeks to question the minister in public? Having read the report, we can decide—possibly next week—whether we want to question anybody else at that time.

Members *indicated agreement*.

Mental Health (Scotland) Bill: Stage 1

The Convener: Agenda item 2 is our final evidence-taking session on the Mental Health (Scotland) Bill at stage 1. I welcome the witnesses and thank them for their written evidence. It was partly as a result of their written evidence that we decided that we wanted to hear from them orally.

I am happy for you to make short statements before we ask questions. We are up against time limits this morning so, rather than all three of you answering every question that is asked, you can decide among yourselves who you think is best qualified to answer a particular question. We will try to ensure that everybody gets a say. If anyone has a burning desire to add anything, we hope to have time at the end to provide that opportunity.

Kay Tisdall (Children in Scotland): Children in Scotland and its members appreciate this opportunity to come and speak to the committee about the bill. We are a national membership agency for organisations that work with children and their families. We are here today because we are concerned that children's issues are not yet adequately considered within the bill.

To set the bill in context, it seems appropriate to start with a quotation from a young person. One of our members, Childline Scotland, has provided this quotation from a 15-year-old young woman who phoned its telephone line:

> "I was raped a year ago. I started cutting myself to try and cope with the pain. My GP referred me to a psychiatrist ages ago, but I haven't heard a thing. She said it could be a while, but I don't know how I can keep going on."

That quotation reminds us of the bill's context, which is the huge dearth of child mental health services in Scotland. Across Scotland, young people must on average wait 12 weeks before they can meet a psychiatrist. There are only 35 in-patient beds for children and young people in Scotland, yet it is estimated that one in 10 children have a mental illness that is severe enough to affect their daily lives.

We welcome the bill and we welcome the fact that the Scottish Executive has been so open in seeking consultation, from the Millan committee onwards. We welcome particular provisions of the bill that recognise children's needs, such as the provision that all children will now have the right to education even if they are in hospital. There are some welcome components, but we still have significant concerns, which are detailed in our written evidence.

We have divided those concerns into seven points. First, we believe that including the principles of reciprocity and best interests in the bill would make a significant difference because it would underline the needs of children and protect them. Secondly, we ask the Executive to announce a timetable for reviewing the inclusion of learning disabilities within the definition of mental disorder. Thirdly, we believe that all those who make critical decisions about children and young people under the bill—such as mental health officers and the tribunal—should have specialist expertise and training when they are making those decisions.

Furthermore, although we are pleased that the bill provides for a duty to promote well-being and social development, we argue that that does not sufficiently include children at present. Most children do not have the label of mental disorder, so they will not get services under that duty, even though they experience mental illness. The title of section 21 is encouraging, because it talks about promoting social well-being and development, but there is no preventive duty written into the bill. In addition, as I have already alluded to, there is a lack of age-appropriate services for children with mental health difficulties. We ask for a duty or something equivalent to ensure that that need is met. Lastly, there are particular problems to do with children's consent to so-called voluntary treatment and how the key role of a named person is legislated for within the bill.

Those are our seven main concerns. We will be glad to discuss those with the committee.

Bill Butler (Glasgow Anniesland) (Lab): Children in Scotland's written evidence highlights the omission of a principle of child welfare. What matters should a specific provision on child welfare include?

Kay Tisdall: We need a key principle that underlines that all decisions under the bill will need to be taken in the best interests of the child. One link in that would be the provision of age-appropriate services. For example, a mental health officer would need to consider the best interests of the child in making a decision about the child. For example, the care plan would need to consider education, social contact and so on. From our experience with the Children (Scotland) Act 1995, which has similarly overarching principles that are weaved into particular sections, we have found that to be an effective way of ensuring that children's needs are considered.

Margaret Jamieson: You indicate that you have concerns about the inclusion of personality disorder. Will you explain what those concerns are and will you clarify whether you are against the inclusion of personality disorder in principle, or whether you object to the description of children's behaviour?

09:45

Eddie Follan (Children in Scotland): We have broad concerns about the definitions. We are concerned about the definition of personality disorder. That issue should be examined. It is inappropriate to diagnose anyone under the age of 18 with personality disorder.

Margaret Jamieson: You also suggest that the definition of the right to service provision should be widened to include children who are at significant risk of having a mental disorder, because children who are mentally ill tend to be labelled as having social and behavioural difficulties, for example. Are you saying that psychiatrists cannot be relied on to make an objective diagnosis of mental illness, regardless of the age of the patient?

Sarah Carpenter (ChildLine Scotland): We are linking the issue to sections 21 and 25, which relate to the existing duty to promote well-being and social development. There is a tendency not to label children and young people as suffering from mental disorder. We welcome that tendency. For example, they might be described as suffering from social, emotional and behavioural difficulties, which would not count as mental disorders.

At ChildLine Scotland, we hear from many children who harm themselves and who contemplate suicide. We hear about the dreadful effects of physical and sexual abuse. Those children and young people who call us do not necessarily have the label of mental disorder, but they need psychiatric services. We struggle to get such services for young people who want them. The definition should be widened to include children who are at significant risk of mental disorder. That would cover the children and young people who require psychiatric services.

Janis Hughes (Glasgow Rutherglen) (Lab): I note from your submission that, in relation to the tribunal proposals, you are concerned about the fact that a member of the tribunal need not have experience of dealing with children. Is a tribunal the best place to deal with children who demonstrate challenging behaviour that might be attributable to mental illness or would the children's hearings system be more appropriate on some occasions?

Eddie Follan: It is my understanding that the tribunal will be used only when a child is detained under the Mental Health (Scotland) Bill, once it has been enacted. It would be difficult to envisage circumstances in which such a child would go to the children's hearings system. There should be a member of the tribunal who is a specialist on children in relation to mental health, or the tribunal should at least have access to someone who is a specialist in that area. That applies to the Mental Welfare Commission for Scotland as well.

Kay Tisdall: As a former member of a children's panel, I think that there is a link. It is clear that the children's panels deal with young people who experience mental health problems. There is talk about what should happen following the bill. Panel members need to be trained and supported so that they can recognise such problems and access services. We feel that the role of the tribunal is separate.

Shona Robison (North-East Scotland) (SNP): Will you comment further on the training and qualifications that are important to members of the tribunal, whom you feel should have experience and knowledge of children's issues?

Sarah Carpenter: We consider that anyone who considers children and young people's mental health should have an understanding of mental health issues in relation to children and young people. Communication skills are also important. Communicating with children and young people is very different from communicating with adults. At ChildLine Scotland, we train our counsellors to hear certain things that children say. Adults might be more direct. For example, in relation to the tribunal, we discussed the issue of mental health officers having specialist training. Of course, as mental health officers are social workers, a section of their training is on child development even if they specialise in mental health. In addition to that, we think that a course of four or five days or more is necessary to train those professionals in dealing with children and young people because they might be called out to deal with a 15-year-old.

Shona Robison: So you advocate that a specific training course for potential tribunal members should be established in advance of children or young people appearing before a tribunal.

Sarah Carpenter: Yes, or that a professional in the adolescent and child mental health field should be present on the tribunal.

Kay Tisdall: There are two points. One is that everybody who is involved needs basic training in dealing with children and young people. Mental health officers already receive that, which is good, and we suggest an additional two or three days' training as a supplement. The other point is that there should be access to a specialist. We are aware that emergencies occur and that it is not always possible for a specialist to be present, but one should be on call. As matters proceed, an expert should be brought in. For example, when the care plan is worked out with the mental health officer, there should be an input of specialist expertise.

Shona Robison: So you do not go as far as to say that the tribunal should not proceed unless a specialist is present at all times. You would be content with specialist input at some point in the system.

Kay Tisdall: We realise that that might have to be the case in practice.

Nicola Sturgeon: The bill provides that the responsible medical officer should be a child and adolescent psychiatrist. There is also provision that, in some cases, treatment should be preceded by consultation with a specialist. Is that sufficient to address your concern that the bill should be tailored to the needs of children and young people?

Eddie Follan: The issue of training and professionalism is about child proofing the bill. Ideally, when a child comes into contact with services, a specialist in child and adolescent mental health should be present or accessible. That crosses over with the previous question, so I refer you back to Kay Tisdall's comments.

Shona Robison: On average, how many young people receive treatment in hospital for a mental disorder or are detained for mental health reasons? Do you have accurate, up-to-date figures on that?

Kay Tisdall: We do not have the figures with us, but we could provide them for the committee. The numbers are small.

Shona Robison: That leads to my next question. Given the relatively small number of young people who require treatment, is it a realistic possibility to provide an age-appropriate setting for the majority of them, regardless of where they reside?

Kay Tisdall: I will go back to figures that were presented to the committee previously. Dr Jim Dyer told the committee that in 2000-01, there were 30 admissions of people who were under 16—the figure does not include under-18s—21 of which were to adult wards. Given those numbers, it is impractical to expect every health board in Scotland to have a unit or a separate ward.

We tried to be careful in using the term age-appropriate services. When children are in adult wards, it is possible to make adaptations and to provide services that make a big difference to the child's experience. More methods could be investigated. We want age-appropriate services, but we recognise that areas such as the Highlands might not be able to have a separate unit.

Eddie Follan: We should remember that the term age-appropriate services refers not only to in-patient services, but to primary care services and services in the community. The Executive has said that the on-going Scottish needs assessment programme—SNAP—review on the issue is due to report at the end of the year. We know that child and adolescent mental health services are underresourced. I want to put it on the record that having age-appropriate services is not only about in-patient services, but about primary care and out-patient services.

Shona Robison: Just to clarify, rather than have a Scotland-wide unit to which young people would have to travel from all over, would you prefer specialist services tailored to young people within adult psychiatric service units? Would that be acceptable?

Sarah Carpenter: We need to take into account children in, for example, the Highlands and Islands. If there were just one unit in the central belt, it would mean that they would have difficulty gaining access to it, or if they were in-patients, they would be miles away from what they were used to. We should make the facilities that are available at the moment more child friendly.

Shona Robison: Why do you think that the Executive has not listened to the arguments and has rejected the Millan recommendations for age-appropriate services?

Eddie Follan: One reason touches on what Sarah Carpenter just said. For many young people with a mental disorder, to be transferred from the Highlands and Islands to Glasgow would be distressing in itself. However, we must balance that with the fact that it may be more distressing to be admitted to an adult ward. The Mental Welfare Commission's figures in this year's annual report say that seven out of 10 children under section were admitted to adult wards. Some of those were under 16, and in some cases, 15-year-olds were admitted to intensive psychiatric care units. That is another point—there is no secure provision available for children with mental health problems.

To address your question, part of the reason is the balance between keeping young people in their local area and the stress that moving them to Glasgow might cause. I am using Glasgow just as an example.

Ben Wallace (North-East Scotland) (Con): Where health boards have not had the facility to place children in appropriate wards, for example in the Highlands and Islands, have you seen them develop better practice or just ignore the problem?

Eddie Follan: I would not like to comment on each health board's practice—it is not for me to do that. The figures for children admitted to adult wards suggest that the resources do not exist. I do not know whether that is ignoring the problem. I am sure that the care in the adult wards is of a high standard; it is just that the environment is inappropriate and the staff might not have the specialist training to deal with children. It would be difficult for me to comment on individual health boards, but the figures for admissions to adult units speak for themselves.

Margaret Jamieson: Have you considered children under the age of one year? In particular, I am thinking of children up to the age of six weeks whose mother might have to be detained. It is not something that happens every day, but nevertheless a significant number of women have to be detained after giving birth. Have you given any thought to the impact that that will have on the child, if it is unable to be detained along with the mother to start the bonding process, and to the services that should be available for mother and child?

Eddie Follan: I have to admit that we have not given that particular point consideration. From my experience, I know that the psychiatric services make every effort to keep the mother with the child, but I would not be the one to say what services should be available for a mother and child to be admitted to hospital at the same time.

Margaret Jamieson: As we are talking about age-appropriate services, would you agree that a facility that does not have a single room, for instance, would not be appropriate to allow bonding and to allow the mother to receive the appropriate mental health care?

Eddie Follan: I agree with that. From my previous experience of working in psychiatry, I know that a mother and child need specialist provision. They need a safe, single room where the baby can sleep. We would support those facilities as age appropriate for a newborn child.

10:00

Nicola Sturgeon: Your written submission suggests that there should be an obligation on health boards and local authorities to provide preventive services. What do you mean by preventive services?

Sarah Carpenter: As we said before, the majority of children who call ChildLine Scotland do not have a mental disorder, but they might be in need of services. At present, those services are sometimes not available. The sort of services that we would like to be mentioned in the bill would include services in the education field. We know how important school, and the support that it provides, is for children and young people. The Executive is putting a lot of emphasis on community schools at the moment, and that approach should be welcomed, but that should also be included in the bill to specify the services.

Mr McAllion: The key for this committee is that we do not draft the bill. It is not our responsibility to do that, but we can amend it at stage 2. I am interested in what is meant by placing a duty on local authorities and health boards to provide age-appropriate services and preventive services. Defining those services is the key. Once you have placed a legal duty on authorities to provide a service, they can be challenged in the courts if they fail to provide it. Is that what you are looking for?

Eddie Follan: I would say so. In earlier evidence, Jim Dyer of the Mental Welfare Commission for Scotland and Bruce Millan said that placing a duty on health boards and local authorities would not necessarily mean that the resources would be in place to provide the services. Nevertheless, we feel that such a duty would certainly concentrate the minds of local authorities and health boards. We hope that the SNAP review will recommend a duty on local authorities and health boards to support the findings of that process. We obviously cannot pre-empt that, but it is no secret that the lack of resources will be highlighted.

Mr McAllion: If we pass a bill that places a duty on health boards to provide age-appropriate services for people under 18, and a health board then places a young person in an adult ward, would not that health board be in breach of its statutory duty and could not it be challenged in the courts by that young person's family?

Kay Tisdall: The legislation does not specify that there must be a children's ward.

Mr McAllion: Could it be specified?

Kay Tisdall: We would have to get expert legal advice on that, but if the phrase "age-appropriate services" were used, an adult ward that has thought carefully about providing those services could put certain things in place for young people. A younger child might need access to certain leisure facilities, books or other things that feel friendly. Young people might need to be separated in some way from experiences that could be frightening and violent. There are things that could be done within a unit to take proper consideration of the child or young person's age that would mean that a health board was meeting that duty.

Mr McAllion: I am trying to explore the role that the committee can play in placing a duty on health boards and local authorities as part of the legislation and in insisting that the Executive provide guidance or a code of conduct that specifies the meaning of age-appropriate. That way, people will know what they are entitled to in law, and the health boards and local authorities can be sued in the courts if they do not provide those services. Resources will be made available only if they have to be made available. If we do not make it a legal necessity for authorities to provide age-appropriate services, the chances are that they will not provide them because they do not have the resources. Is not that the case?

Kay Tisdall: That is an example of an area in which it might be appropriate to have a duty in legislation that is wide enough to be defined in more detail in guidance. As we know, a health board should follow guidance, but there can be exceptions. Given the legal status of guidance in Scottish law, we think that that would probably be an appropriate balance.

Dorothy-Grace Elder: Could you expand on the points that were made about children's capacity to consent to or refuse treatment? What provisions should be set out in a framework for a child's consent in such situations? That is dealt with on the last page of Children in Scotland's submission, which also refers to Barnardo's. I suppose that it depends on what people think the level of maturity of the child is.

Kay Tisdall: Since the Age of Legal Capacity (Scotland) Act 1991 came into force, we have had a fair amount of experience of children's capacity to consent to or refuse medical treatment. The Millan committee and the Scottish Executive recognised that there is a legal anomaly around parental responsibilities in relation to voluntary treatment in the Age of Legal Capacity (Scotland) Act 1991, because it is possible for the parent to okay treatment without the child's consent.

We firmly support the proposal that a section be put into the bill that would set a framework in relation to children's legal capacity. For example, a 15-year-old could be considered to be legally competent, so there should be a framework that would allow him or her to consent to or refuse treatment. Regulations could further specify the sorts of treatment for which a second opinion would be required. We think that the sorts of treatment are too extensive for us to say that every single case would need a second opinion. However, parents might agree to serious treatments involving drugs that would have a significant effect and we think that those should require a second opinion. Regulations should specify that they should be consulted upon. In reality, regulations can be changed more easily than can primary legislation and they can evolve as treatments for children and young people evolve.

Dorothy-Grace Elder: You referred to 15-year-olds, who are technically still children. What would happen with mentally mature 12 or 13-year-olds, who might have treatment inflicted upon them without their consent?

Kay Tisdall: The Age of Legal Capacity (Scotland) Act 1991 would cover children in that situation. I support the stretching of the presumption of legal capacity beyond the age of 12. The act sets the presumption at age 12, but it allows for cases of children who are younger than that. Children in Scotland firmly believes that legal capacity should not be based solely on a child's age, but on their ability to make the decision. It is true that that puts a responsibility on the medical professionals who make the decision about a child's competency. In other venues we have argued strongly that medical people should have the training to ensure that they are able to judge that competency.

In English law, there has been concern that when a child refuses mental health treatment, the process becomes circular, which undermines the child's competency. We hope that the bill will underline that when a child is considered competent, they can refuse treatment.

Dorothy-Grace Elder: I want to move on to the suggestion that a child or a mature minor—

The Convener: Sorry, Dorothy-Grace—

Dorothy-Grace Elder: My questions are linked.

The Convener: Yes, but Margaret Jamieson has a supplementary that relates to your previous question and it makes more sense for her to ask it now.

Dorothy-Grace Elder: Of course.

Margaret Jamieson: I am concerned about circumstances involving a young person who is anorexic and who refuses medical attention. The parent would obviously want their child to be treated, but the young person's views also have to be taken on board. Given that detention would be required, would it be appropriate for the tribunal to appoint an advocate to act as a safeguard for the young person and their family?

Eddie Follan: I would have to think through the question on the tribunal. Any advocate that is appointed for a child or young person at any stage should have appropriate training and we think that they should be appointed at a very early stage after the person has been admitted to hospital. That goes back to the point about training medical professionals to make decisions about competency. We would certainly support the idea if the committee were to consider it.

Margaret Jamieson: There are situations around detention in which a safeguard would be appropriate. People would have an interface with services in the community before a final decision was made. There can be tensions between the young person and their family, which can cause greater problems.

My point is about advocacy in the first instance. Advocacy is built into the bill, but are you suggesting that there should be training for the people who will act as advocates on behalf of children and young people?

Kay Tisdall: It would be possible to have established specialists who were used to working with children and young people and their families, as you suggest. Your question is helpful because it highlights that competency is not a one-off event and that it is important to ensure that people realise that such decisions are made and that other people are involved. Advocacy can help in that regard. Research by Priscilla Alderson points out that people judge the competency of children who make such decisions on treatment much higher as they become familiar with the treatment and are given that kind of support.

Dorothy-Grace Elder: If, as is suggested, the child or mature minor is able to choose a named person, would the procedure be the same as it would be for an adult who was choosing a named person or should anyone with an interest be able to challenge the nomination of that named person to avoid children being pressured into picking an inappropriate family member?

Kay Tisdall: In the bill, one of the child's parents is automatically designated as the named person—the child does not get to choose. There is no provision to get that designation changed, apart from through family law, which would not be in the child's best interests. More needs to be done. There is talk about a provision being introduced to allow anyone to go to a tribunal to make an argument about changing the named person. We fully support that. Further, it is important that the mental health officer or somebody should explain to the child that, if they are unhappy, they have the right to go to the tribunal.

Dorothy-Grace Elder: Would you recommend that that be clearly stated in the guidelines?

Kay Tisdall: The provision relating to the ability to go to the tribunal to argue for the changing of the named person should be in the bill. An instruction that the child should be informed of the option and supported in any appeal should also be included in something stronger than the guidelines, such as a code of practice. On balance, we support the system of automatically assigning a parent to be the named person, because a child's situation is different from an adult's, but it is critical that that can be challenged in a tribunal.

Dorothy-Grace Elder: Is the risk of an inappropriate person being appointed greater to a child than it is to an adult because of the automatic element?

Kay Tisdall: The automatic element is an important difference. Although, of course, most parents are working in the best interests of the child, there are circumstances in which that will not happen—obviously, there might be tie-ups between the child's mental health problems and those of their parents. That is why strong protections must be included in the legislation.

Dorothy-Grace Elder: I have a specific question for ChildLine, as it is trying to prevent mental health problems and suicide in children.

A few years ago, you used to give out the statistic that only one in 10 children who plucked up the courage to make the call got through to ChildLine at the first attempt. Is the situation still as bad as that now?

Sarah Carpenter: I am not sure when that statistic was used, but the most recent statistic is that about 270 young people a day get through to ChildLine in Scotland, which is about half the number of children who try to do so. The number of calls that come into our Glasgow centre is more than that, but we calculated our figures on the basis that a lot of children will try four or five times to get through before getting through.

Dorothy-Grace Elder: You are probably the best-known point of contact, so I am asking about your figures to try to highlight how difficult it is for children to get help.

10:15

Sarah Carpenter: Last year, around 1,000 children who contacted us talked about self-harm or about feeling suicidal, depressed or lonely. That is the severe end of mental disorder. We help and support about 22,000 children every year. One thousand of those children spoke of the specific problems to which I have referred. One alarming statistic is that the number of young people and children who talk about self-harm has quadrupled over the past four years. That group comprises only a small percentage of the calls that we receive—just over 1 per cent of calls. However, the fact that the number has quadrupled is alarming.

Many young people say that they find ChildLine Scotland helpful, but that they want face-to-face and more intensive counselling. Our volunteers are only volunteers. Children may need psychiatric support from people who are trained professionals. Often we try to access that support but are unable to get it. We might be told that we must wait for six months or a year. Six months or a year in the life of a young person who is struggling with the effects of sexual or physical abuse is a very long time.

We ask for a duty to provide preventive services to be added to the bill. I understand that the matter may be covered by the Children (Scotland) Act 1995, which places a duty on authorities to provide services to children in need. However, no extra or long-term funding has been made available for many of the services that children need. Many of those services are related to health. For that reason, we argue that a duty to provide preventive services should be included in the bill.

Dorothy-Grace Elder: You say that 22,000 children in Scotland contact you every year. We have heard that only a few children are confined to hospitals each year. I assume that, if they are not helped early enough, a considerable proportion of the 22,000 children to whom you refer may end up having mental health problems, because of the suffering that they are experiencing.

Sarah Carpenter: We know from research that was done by the Mental Health Foundation that having a mental illness or mental disorder in childhood—or even having the feelings that many of the children who ring us talk about—can lead to mental health problems in adult life. That is especially true of child sexual abuse. It is important that children or young adults who have suffered sexual abuse should receive the services that they require. Often the people who end up on our streets or in our psychiatric wards have suffered sexual abuse as children.

Eddie Follan: The committee might already be aware that a recent report from Save the Children indicated that Scotland has the highest rate of young male suicide in the UK. That supports the point that Sarah Carpenter has just made.

The Convener: Thank you for your written and oral evidence. I am glad that Dorothy-Grace Elder was able to ask her last question, as the answer provided a powerful record of the problems that we must seek to alleviate.

Our next witnesses are Sheriff Scott and Sheriff Dickson from the Sheriffs Association. Am I right to say that Sheriff Scott saw our meeting last week?

Sheriff Richard Scott (Sheriffs Association): I looked in.

The Convener: You saw what we were up to.

Good morning, gentlemen. I thank you for attending and for your submission. Do you wish to make a short statement before we ask questions?

Sheriff Scott: Yes. This is the first time that the Sheriffs Association has appeared before the committee, and we appreciate the opportunity that the committee's invitation has given us to say something that we want to say and that ought to be said.

The committee will appreciate that, as we are members of the judiciary, we cannot be compelled to appear before parliamentary committees. In replies to consultative documents and comments on proposed legislation, we try to make a contribution if we feel that we can do so usefully and appropriately.

We are subject to considerable constraints, because we must maintain our independence. We cannot be involved in anything political or controversial, and we cannot, or should not, say anything that would inhibit our ability to deal openly, fairly and appropriately with any issue that might come before us in court. We must be somewhat reticent at the same time as we try to assist the Parliament and other bodies on matters that concern us.

The committee is dealing with the bill because it concerns mental illness, the treatment of mentally ill persons and the best way of tackling the manifold problems related to that. However, the bill is also a justice bill in an important way, because it is largely about compulsion. It concerns the state and the law depriving people of liberties that they would otherwise have. Compulsion and treatment should be considered as separate concepts. It is important that the compulsion aspect of the bill should be considered.

Compulsory treatment orders under the bill provide for the compulsory treatment of people while they are detained in hospital or are in the community. We detect in the bill a move towards treating patients in the community. The committee will have heard from people who consider that to be—as it might be—as much of an inhibition of their liberty as hospital detention is.

In a crisis, a patient might end up in hospital and be glad to be there, because it is asylum. A patient might consider a hospital a place where they can get well again quickly. The long-term restrictions on people’s liberty in the community include inspections and the requirement to submit to conditions as if they were offenders on bail or on probation. A breach of an order—that is the language of the bill—can result in more severe measures of restraint and compulsion. That is a significant infringement of people’s liberties.

Against that background, we said in our written submission that the appropriate forum for determining questions of the liberty of the subject is a court of law, not a tribunal that has been set up primarily to deal with health issues. We think that the importance of that aspect has been overlooked, both in the Millan committee’s recommendations and in the Executive’s decision to seek to set up a mental health tribunal.

Whether or not the tribunal is set up is a matter for the Parliament—not the Executive, not the Millan committee and not us. The Health and Community Care Committee is a very important forum: if you consider that the issues of the liberty of the subject are as important as we believe them to be, you can say that the Executive has got it wrong and that the Parliament should not give its approval to the setting up of the tribunal.

The Convener: Before we move to questions, I ask committee members to note that Maureen Macmillan joins us this morning as a representative of the Justice 1 Committee. I should also put it on record that Ben Wallace is substituting for Mary Scanlon.

Margaret Jamieson: I want to pursue your comments about the proposed mental health tribunal. The Millan committee pursued that issue; you disagree with its recommendations. However, you agree with most other elements of the Millan committee’s conclusions.

Is it perhaps the case that you do not have sufficient experience of the other tribunals that are available to people in Scotland, such as children’s panels and employment tribunals? Are you opposed to tribunals in principle, or are you saying that we need a totally different system and need to grasp the opportunity—I admit that I have a bit of a hobby-horse about this—to set up a family division in the courts, under which sheriffs, solicitors and others would be appropriately trained in the relevant areas and could expedite matters in a totally different way compared with the system that we have been used to for many years?

Sheriff Scott: On your first point, we come to the office that we hold with very considerable background. My background, for example, was as an advocate, and I was well aware of what employment tribunals do. I worked there; I know what they do—even now, in general terms.

I am glad that you mentioned children’s panels. There is a clear distinction in the legislation—in the Children (Scotland) Act 1995 and in social work legislation—between what might be called treatment and what might be called the legal aspects. Children’s panels provide a good analogy. Imposing compulsory measures of care on a child is an interference with the child’s liberty. However, the child must, in the perception of the reporter, be subject to one of the conditions that renders them appropriate candidates for compulsory care. If they challenge that, they can go to the court and approach the sheriff, and the matter is then determined in a legal way. Thereafter, if grounds are established, they go to a hearing, where there is input from a number of people, and where discussion takes place in an informal setting. We lead the world in some features of that system.

10:30

There is a distinction between what is legal—the compulsory measures—and what is treatment, which is a consequence of the compulsion being appropriate. The legal aspect comes first and we should not lose sight of it or we will end up being paternalistic.

I have said that we all have different backgrounds. I deal with children day in, day out at children’s hearings—in connection with their offending and in matrimonial and family law disputes. I am aware of the trends and the discussion about how we can best deal with them.

The bill proposes to set up something that does not exist. There is something like it in England, which has not worked well, as members will know. Its inadequacies were played down in the Millan report. Members heard last week what Professor Owens had to say about it; he had no axe to grind and has experience of both systems. He says that his colleagues in England are amazed that we in Scotland should be thinking of importing such an inadequate and chaotic system, which is riddled with delays and is much more expensive than the court system. That is eloquent, independent testimony to the point that we are trying to make.

If the tribunals are established in the fullness of time, no doubt they will require some form of expertise, but the necessary expertise is in dealing with the cases. The understanding of the issues that a so-called expert brings should be out in the open. The attitude should not be, "Oh, this is all right, I am appearing before this body of experts so I know that, because they are experts, they will do the right thing by me". The person who is being exposed to the possibility of compulsory measures needs and is entitled to have everything out in the open. There should be expert witnesses giving evidence and being questioned so that the value of what they are saying is out in the open and can be tested and the result can be fair.

That was rather a long answer.

Margaret Jamieson: Surely what you describe is something that we would hope to dispose of by introducing the tribunal system. Because of your background in the legal profession, you talk about people giving evidence, but we seek a less legalistic and more person-friendly system, although I accept that it must fall within the legal framework. Courts are daunting buildings for the vast majority of the public who do not frequent them. The way in which business is conducted in them is off-putting and people do not understand it, although I accept that some notorious people know how the courts work. We must remove that daunting aspect.

When we talk about dealing with children in court, those whom conduct proceedings say, "Well, we do not have the wigs" and they try to be less formal, but that is not sufficient. A tribunal system is more person-friendly and therefore lends itself more to children and to those who have a mental illness.

Sheriff Robert Dickson (Sheriffs Association): Sheriff Scott endeavoured to make the initial point that it is of fundamental importance that we remember that we are dealing with and interfering with people's liberty and their right to carry on their normal lives. We feel that that decision is so important that it must be made by an independent tribunal—a judicial body. I accept Margaret Jamieson's point that people's perception of courts is based, perhaps, on their one appearance when they fall foul of a speed camera or when somebody has broken into their house. Many of my colleagues and I do not conduct children's hearings so formally—I conduct them very informally in my room, to which the public does not have access. Other people conduct them in totally separate rooms.

I will be personal for a moment. On my wall, I have about 25 drawings by children who have come to see me. The drawing that I am most proud of has a little squiggle and tiny triangle on it. It was done by a child who attends a special school and who, it was thought, would never be able to say anything to me. That child was excited by drawing for me. He saw the drawing on the wall, showed it to his parents and told everybody about it. In the process, he told me a great deal about his parents and where he would be happiest. One of the teachers from the school was with him. The enthusiasm that the child gave to the hearing convinced me that if work can be done informally, there is no reason why one cannot achieve the best for the child, which is what one sets out to do.

Initially, however, we feel that we are interfering with a person's liberty. In effect, we will be depriving people of the freedom to do what they want to do. Either we put people into their houses and have them looked after when they might not wish to be looked after, or we deprive them of their liberty by placing them in hospital care when they do not feel that they need it. Such matters are so fundamental that it is important that an independent body deal with them. That opinion is supported by the Millan committee's report; in its summary, that committee said that patients perceive the sheriff court to be independent of doctors and feel that it offers a non-medically dominated place in which cases can be decided.

I welcome many parts of the bill; I welcome the right of appeal in particular. I welcome the fact that people will be entitled to legal representation and that they will be able to bring their friends and supporters with them. That is important.

I will make another point. My experience is that a patient's friends and relatives are often anxious to find out what is happening, to feel that their loved one is being properly looked after, to know that what is best for their loved one has been taken into consideration and that the issues have been considered independently. With great respect, I cannot see how tribunals could, without considerable inconvenience, give such people the right to be heard on a sufficiently local basis.

There are currently 49 sheriff courts and last year 40 of them had to deal with mental health cases. I am grateful to the Executive officials for all the time and trouble that they have taken to explain to me how the tribunals might work and I accept that the matter is at an early stage and that much planning has still to take place. However, I understand that it is not intended that the tribunal will sit in as many as 40 places. At the moment, patients who come from the Elgin area or the Stranraer area can have their cases heard at their local sheriff court by the local sheriff, who is totally independent and has no interest in financial or hospital pressures. He considers cases solely from the point of view of the patient and judges them solely on the basis of whether what has been done is legally right. I fear that tribunals will not be able to do that on a local basis and that they will also be unable to deal with cases within the time scale that is proposed.

That takes us back to the issue of interference with people's liberty. Under section 21 of the Mental Health (Scotland) Act 1984, a sheriff must hold a hearing within five days. That legal requirement was inserted in the 1984 act by a 1991 amendment, but there is no provision for that in the bill. There is provision for extending for five days an order that has been made, but there is no requirement for a hearing. If we intend to interfere with people's liberty—in effect, to impose compulsory orders on them—it is terribly important that they have the right to have a hearing as soon as possible, before that decision is made.

A tribunal cannot conduct such a hearing because of all the steps that have to be taken. Intimation must be made to the tribunal and the tribunal must then pass the case to a part-time chairman. The part-time chairman must consider whether a hearing is necessary and if so, that chairman must find two colleagues and arrange a date and place for the hearing. All those steps take time and during that time the patient's relatives are waiting to find out what will happen. They are asking themselves whether what is proposed is right—they may think that it is not fair and want to have their say.

Maureen Macmillan (Highlands and Islands) (Lab): Last week, the Justice 1 Committee took evidence on the bill. I am interested in the comments that Sheriff Dickson has just made. Consideration must be given to the informality and more user-friendly aspects of tribunals; sheriff courts conjure up visions of gowns and wigs. However, I am pleased to hear Sheriff Dickson say that hearings take place in private and informally.

In how many cases is it difficult to decide whether someone needs to go into hospital? I would have thought that in the majority of cases decisions would not be difficult and that a tribunal, with legal advice, would be able to make them. However, there might be cases that are more difficult to decide. In such cases, would not it be sufficient for people to have a right of appeal to the sheriff against a decision?

Sheriff Scott: The member asks how often we have to make difficult decisions and the answer is that we do not have to do so often. The Millan committee commented on the fact that, at the time that it carried out its research, nearly all applications were granted. Decisions are not difficult for us to make, because we decide on the basis of the material that is before us. We are used to assessing such material, so deciding is not very difficult and, as Sheriff Dickson said, we do that quickly—much more quickly than English tribunals. We make decisions within two or three weeks, rather than two or three months.

However, it is too easy a let-out to say that a decision by an inexpert body—that does not have experience of assessing evidence, or of being dispassionate and keeping its prejudices out of decisions—can be put right on appeal. When a case goes to appeal, the issue to be considered is not whether the decision that the tribunal took was correct, but whether it approached the case in the right way and asked the right questions. The court seeks to ascertain whether the tribunal made an obvious mistake by taking into account wrong considerations or by ignoring relevant ones. Appeal is an inadequate resource for people who might be the victims of wrong decisions.

The court affords total impartiality and careful consideration of the issues. There is nothing legalistic, in the pejorative sense, about that. We examine whether, on the basis of the material that is before us, the law has been satisfied. It has already been acknowledged that in our private discussions, in our approach to cases and in our judicial studies we are developing more responsive and informal ways of dealing with issues. We are doing so to ensure that everyone can have his or her say and does not feel inhibited when they appear before the courts. We have the advantage of coming to cases with a completely open mind and with expertise in decision making.

Maureen Macmillan: Would not legal expertise be provided if the tribunal had a legal adviser?

I understand your point about the tribunal process taking longer, but that is a housekeeping issue. The questions about where tribunals sit and how long the process takes can be dealt with.

Is legal advice being given to a tribunal inferior to a sheriff deciding? Sheriffs make decisions based on advice from medical experts. The tribunal, which might include medical experts, would make decisions on advice from legal experts.

The Convener: My understanding is that the tribunal conveners would be lawyers.

10:45

Sheriff Scott: Yes. The tribunal conveners would be lawyers, not judges.

The matter is not as simple as that. The court is the place where people go if they are to have their liberty taken away or if they want to vindicate their liberty—a tribunal is something else.

Tribunals would probably not take place in public but in places that are difficult to find. In England, it has been reported that tribunals have taken place in hospital corridors. Maureen Macmillan says that that is a house-keeping issue but, with respect, the English mental health review tribunals have existed since the early 1960s and have still not got it right. The Richardson committee, which was set up to review the working of those tribunals, found a vast number of defects, including failure to comply with the European convention on human rights. That committee also found that there were many delays and that the tribunals often met in inappropriate forums. The committee found that patients were not so much intimidated as baffled by what was going on.

When our people come along, they know what the court is about. It has been mentioned that people are inhibited if they go to court and others have talked about people being intimidated because criminals go to court. However, what intimidates patients is not that Sheriff Dickson is sitting there, but that they might have their liberty taken away. What intimidates them is the ghastly serious nature of what is happening to them, which is not unlike being treated as a criminal. A compulsion order is like a community sentence in a criminal case and has the same sort of consequences. That which makes appearing in a court intimidating is equally intimidating before a tribunal. What is intimidating is that the matters are serious and involve people's liberty and that other people seem to be in charge.

The Convener: Shona Robison will expand a little bit on question 14.

Shona Robison: Paragraph 16 of the Sheriffs Association evidence states that decisions should not be taken

> "in round-table discussion, with the person whose liberty is to be taken away being encouraged to participate."

Why should it be a problem for the person concerned to participate in those discussions? Why are there concerns about that?

Sheriff Scott: Let me clarify that, lest there be a misunderstanding.

There are two issues: one is whether there should be compulsion; the other is what forms of treatment should be given. We believe that it is highly desirable that patients should participate in both those matters. They should have what the law gives them, which is the opportunity to oppose what is proposed. We want participation in that and we want people to be represented by lawyers, advocates, friends, named persons or unnamed persons. We want as much material as possible to ensure that what is being done is done fairly. That can be provided just as readily in the court system—and a lot more effectively in some cases—than in a tribunal system that is yet to be put together.

Participation in treatment plans and so on is fine. Obviously, it is therapeutically desirable that patients should be enthusiastic, or at least willing, to co-operate in what is proposed for them and be satisfied that it is in their best interests. However, the Millan committee and this proposal use the words "participation" and "discussion" to wrap up and obscure the issues. One issue is whether the provisions of the act are satisfied. Is the person suffering from a mental disorder and is medical treatment likely to prevent the condition from getting worse? Those are questions of fact and law, which are straight questions. They are not for discussion but for evidence and there must be evidence in some form or another.

Participation at that point involves the person being allowed to test the evidence, either by himself or through an advocate, friend or whatever. Treatment is another opportunity when discussion of a different sort can be had. However, we are talking about doing something that a person does not want to have done to him or her. To ask someone to agree to being detained in hospital or to having his liberty in the community restricted at the same time as he is opposing it can result in a conceptual muddle. That is the paternalistic approach—which Millan acknowledged exists—that can lead ultimately to breaches of people's rights and to injustice. The dear old children's hearings system that we love and admire is sometimes in danger of leading to that, and we can see it sometimes happening in appeals. In their zeal to be fair—

The Convener: Can I stop you there? We have an awful lot of questions, and I would like to move on to a couple of other issues.

Ben Wallace: In your submission, you mentioned the changes in the Swedish system. Will you expand on that? Do you know why that system in effect moved from orders being made by medical practitioners without judicial guidance except on appeal, to a system of judicial assessment in conjunction with medical opinion?

Sheriff Scott: I can tell you how that came to my attention. I was in Sweden at a European Union seminar on administrative law at which I heard a lecture by a Swedish judge who gave the history of how that country dealt with mental health. As we state in our submission, in the

1980s the Swedish examined their system—which was very similar to that in England and Wales—and decided that it would not do. They believed that mental health orders should go before a court because of the constitutional aspect in the infringement of people's liberties. That fascinated me, because the Swedish changes were going in the opposite direction from what was happening in England and Wales at that time.

We, too, were introducing initiatives at that time. Amendments were made to mental health legislation to give people the opportunity to be heard which, thank heavens, they are. In Scotland, that opportunity existed in practice before the changes, but the Swedish went further on that point and provided for the right to go to court—as people in Scotland have been able to do until now. That is about all that I can tell the committee about the Swedish system. I tried to get some information, and I have a summary in English of the report of the committee of the Swedish Parliament that proposed the legislation.

The Convener: We will take that as evidence. I am glad that it is in English rather than Swedish—my Swedish is a bit rusty.

Ben Wallace: Can I ask a supplementary question?

The Convener: We are very tight for time. Malcolm Chisholm, the Minister for Health and Community Care, is waiting to speak about three different sections. We want to move on, and there are two or three other questions that I want to field.

Ben Wallace: Briefly, when the Swedish moved to a court system, they had similar guidelines. Section 53(5), which you mention in your submission, concerns when orders can be issued. I understand that the Swedish have to take into account whether a treatment is available and, if it is not, the court can refuse to issue the order. Should sheriffs be given that ability in order that you assess not only why an order in needed, but whether the treatment exists to treat the individual?

Sheriff Scott: In deciding whether the treatment is necessary and whether the compulsory order should be granted, it would follow that if treatment were necessary and available it would be appropriate for us to grant the compulsory order. If the treatment were not available, it would be a disproportionate interference with people's liberty to detain them because they needed that treatment. That is a simple question of fact. We can make those decisions perfectly adequately on the basis of the material that is presented to us.

I did not find out how the Swedish make those decisions, although I know that they go around hospitals. That will please some people, because the Millan committee seems to think that it is better to have hearings in hospitals than in courtrooms. The people in Sweden told me that there are perhaps two or three hearings a day, which means that they probably spend more time on them than we do. They develop expertise, because the judges who make the decisions are not general judges, but administrative judges who also adjudicate on planning and licensing matters—they are probably more specialised than we are.

As part of our training, we could continue to develop what we do already, which is discuss what we should do about applications and appeals. We could learn more from getting mental health workers, psychiatrists and users to talk to us. That is part of a continuing process of which we are aware and in which we are taking part.

Nicola Sturgeon: One of the points that you make towards the end of your written submission in your argument against tribunals is on the estimated increase in legal aid costs. Could not that be seen from the opposite perspective as a good thing, in that it will mean that more people will be represented under the new system than are represented at present?

Sheriff Dickson: No. It is a question of getting people to go along to the tribunals. We are not suggesting that we cut down the number of people who are represented. The process costs less if the lawyer is already in the court building. There is a feeling that if we have to pay for them to go elsewhere, the cost will be increased as a result. We are not suggesting that we cut down the number of lawyers or the users' right to representation in any way, because we welcome that right.

Nicola Sturgeon: I have a final catch-all question. Putting aside your views on tribunals, do you think that the cost projections in the financial memorandum are realistic?

Sheriff Dickson: No, they are not realistic. As far as I can make out, the number of hearings increases every year. The original figures were based on something like 1,100 applications a year. Last year's figures show that the number of applications was in excess of 1,380. The number of applications is increasing and an application often involves more than one hearing to enable everybody to be heard and represented fully.

Janis Hughes: You have made it clear in your evidence today and in your written submission that you would prefer not to go ahead with the tribunal proposals. However, if the Parliament decided to go down that road, what steps could be taken to ensure that your concerns were addressed and that some of the advantages of the current system were retained in the new proposals?

Sheriff Scott: We heard about training. I suppose that we could provide help.

The Convener: We have a number of questions that are on the more criminal aspects of the bill, such as on compulsory treatment orders and offences and so on. Given that we are short of time, would it be acceptable for us to ask you to respond to those in writing?

Sheriff Scott: We will certainly consider those matters. I do not think that we can say very much about them, but we would be delighted to consider the questions and answer in writing.

The Convener: We will take into account the comments that you made at the beginning of your evidence. It would be helpful if you could assist us with the questions in any way. Thank you for your written submission and for the oral evidence that you have given this morning.

Sheriff Dickson: I have one small point to make about training. The committee might not appreciate fully the fact that there exists the Judicial Studies Board and that sheriffs are subject to constant training. If tribunals are not introduced and if we remain involved in the process, a major part of that board's work will be to ensure that we are trained adequately and brought up to speed as we have been trained in relation to the Adults with Incapacity (Scotland) Act 2000 and other matters.

The Convener: Thank you. Nobody trains us, by the way.

10:59

Meeting suspended.

11:05

On resuming—

The Convener: Welcome back everybody. We move to the final evidence-taking session at stage 1 of the Mental Health (Scotland) Bill. We are joined by the Minister for Health and Community Care, Malcolm Chisholm, and representatives of the bill team. We have a mammoth session ahead of us, which covers four items.

The Minister for Health and Community Care (Malcolm Chisholm): I hope that I do not get the items jumbled up.

The Convener: Do you want to make a statement, or are you happy to answer our questions and to pick up on anything that we have not covered at the end?

Malcolm Chisholm: That is the best way.

Shona Robison: Why have not all the Millan principles, particularly the principle of reciprocity, been included in section 1?

Malcolm Chisholm: I am keen to make further progress on including the principles in the bill. We had a similar situation with the two previous bills with which I was involved, the Regulation of Care (Scotland) Bill and the Community Care and Health (Scotland) Bill. The committee was helpful on those bills and we made progress.

There is a continuing dialogue with the draftsmen and lawyers on the issue. We must at least respect and listen to what they say about translating principles into something that has legal meaning and can be interpreted and enforced. We cannot put into the bill general aspirations that cannot be implemented. Some progress has been made on section 1, but I hope for more progress at stage 2. I do not regard the bill as it stands as the end of the matter, but we must accept that, in some cases, there are difficulties in expressing the principles in a way that has legal meaning and force.

Shona Robison: Is it your intention to lodge an amendment at stage 2?

Malcolm Chisholm: I certainly want to make further progress on that.

Margaret Jamieson: Why have you not included the mental health tribunal in the section 1(3) list of bodies that must apply those Millan principles that are in the bill in discharging their functions?

Malcolm Chisholm: It is intended that the tribunal should act in accordance with the Millan principles. It is attractive that the Millan report contains overarching principles. Some of the principles are stated explicitly in the bill; others—as I could have said in response to the first question—are implicit. Reciprocity is implicit in the fundamental idea that the tribunal must ensure that there is an appropriate care plan before granting a compulsory order. Perhaps one of my officials wants to say whether there is a specific reason why the matter is not explicit in the bill. It does not appear to me that there is a reason, but I might be missing something.

Colin McKay (Scottish Executive Health Department): We are exploring the question of to whom the principles apply.

One of the technical difficulties of principles is that for something to have legal effect, it must apply to someone. We envisage that the tribunal will judge whether other people have applied the principles—it will judge whether the care plan is in accordance with the principles and whether the application meets the principles. The tribunal will have the almost judicial capacity of considering whether the principles have been fulfilled, but it will not deliver care and treatment. That might be why the tribunal is in a different category from the list of bodies such as local authorities and boards. We would like to examine the issue to assess to what extent the tribunal should be bound by the principles. To some extent, that will depend on how the principles end up looking.

Mr McAllion: In its written evidence on the bill, the Commission for Racial Equality pointed out that the Scottish ministers have a duty to promote racial equality and are required to make an assessment of the likely impact of new policies on the promotion of racial equality. The commission went on to point out that the bill shows little evidence that its implications for racial equality have been considered and addressed. Is that a fair criticism? If it is not, will you point out parts of the bill in which cultural, ethnic and religious differences are dealt with sensitively?

Malcolm Chisholm: Section 1(2) refers to the encouragement of equal opportunities and, in particular, to

> "the observance of the equal opportunities requirements."

That basic statement covers equality and respect for diversity. We would be prepared to consider whether we could strengthen the requirement to have respect for diversity by adding to that provision. I should also flag it up that equal opportunities is a reserved matter, which we need to bear in mind when the Scottish Parliament passes legislation. However, the reserved status of equal opportunities does not exclude the possibility of strengthening the requirement. I am keen to consider whether we might be able to do that.

Mr McAllion: Does the bill include any safeguards to ensure that, when someone is being assessed for mental illness, their conduct is not misinterpreted because of their cultural background?

Malcolm Chisholm: I am not sure whether it would be possible to include such safeguards in the bill. If particular examples were provided, we would consider them. I suspect that that is more a matter for the code of practice. It is not immediately apparent how that could be dealt with in the bill, other than through the general requirement to have respect for diversity.

Mr McAllion: The CRE makes the point that a principle of respect for diversity should be included in section 1, as the Millan committee recommended. Why was such a principle not included in section 1?

Malcolm Chisholm: I covered that in my answer to Shona Robison. I said that I would be open to considering how we could strengthen the bill in that respect.

Mr McAllion: Are you saying that the Executive would support an amendment to that effect at stage 2?

Malcolm Chisholm: I am saying that I am keen to make progress on that. I cannot undertake to give carte blanche to any form of words that you come up with. I would consider such an amendment sympathetically.

The Convener: I am sure that we will take on that issue at stage 2.

We will move on to consideration of the tribunal. Some of our witnesses, including those from the Sheriffs Association, whom you will not have heard, and Professor David Owens of the Royal Edinburgh hospital, raised concerns about the tribunal. They suggested that a court is the most objective and dispassionate forum for deliberating on an individual's rights and that, in the absence of such objectivity, a tribunal might deprive someone of their liberty. What is your view on those arguments?

Malcolm Chisholm: I did not hear the Sheriffs Association's evidence. Who was the other person to whom you referred?

The Convener: It was Professor Owens, who gave us evidence last week. He has had experience of the English and the Scottish systems.

Malcolm Chisholm: I am slightly disadvantaged because I have not read the *Official Report* of last week's meeting, which came out only this morning, so I do not know what people said. I get the sense that the tribunal proposal is among those that have received the greatest degree of approval. The different interests—most important, the service users and the people who work in the service—all seem to have responded positively to it. The fact that the tribunal proposal has been so widely welcomed as an improvement on the current situation has not given me much pause for thought.

The proposal represents nothing against the legal profession, which will be represented on the new tribunals, but it is reasonable to say that broadening the group's composition is more likely to make it sensitive to somebody's mental disorder situation. Obviously, I am willing to examine the arguments that were presented last week and this week, but given the general welcome for that proposal, it is unlikely that we will change our minds about it.

11:15

The Convener: There are two key points to sum up. The Sheriffs Association's argument is that if the bill is to take away somebody's liberty or to restrict their liberty in the community, the duty to consider that would ideally be placed with a court of law, rather than a tribunal.

Last week, Professor Owens talked about resourcing tribunals, likely delays and some problems that attached to tribunals in England.

Have you learned anything? What have you done to study how the system has worked in England and to learn from that?

What plans do you have to monitor tribunals' performance, if and when they are established under the bill when passed? Will you take on board the Law Society's suggestion that, in a few years, the performance of tribunals should be compared with that of sheriffs deliberating on cases that have been brought under the Adults with Incapacity (Scotland) Act 2000?

Malcolm Chisholm: You asked many questions.

The Convener: Mary Scanlon is not present, so I thought that I would do her questions for her.

Malcolm Chisholm: Right enough—where is Mary? Goodness me.

Margaret Jamieson: She is unwell.

Malcolm Chisholm: I am sorry.

It is obvious that the bill has resource implications. I am sure that questions will be asked about them. We have taken on board the fact that we have not followed the lowest cost options in the bill.

We want to monitor the bill's implementation. That might come up in other contexts. The Mental Welfare Commission for Scotland will be one body that has an important role in monitoring the tribunals and I am sure that it will monitor compulsory treatment orders in the community. I accept that point.

Perhaps I have not grasped the details that relate to the convener's third point. We can consider how different systems work as they pertain to different acts of Parliament. There is no problem about doing that. We want to see how systems work. If there are problems as the bill is implemented, we will act to address them. However, the arguments that the convener presented do not make me think that we are adopting the wrong course of action.

James Brown (Scottish Executive Health Department): We based our cost estimates of running tribunals on an average of 3,000 cases a year. That differs slightly from evidence earlier this morning.

Maureen Macmillan: I will ask a couple of questions about the criminal justice system. I appreciate that that is not the minister's area of expertise, but if he cannot answer now, perhaps he could write to me. The Justice 1 Committee heard evidence on what happens if someone who might have a mental illness is taken to court and charged with an offence. The proposal is that the prosecution—the Crown Office—or the sheriff can ask for an assessment of the person's mental health, but defence counsel cannot. The Justice 1 Committee wondered about the reason for that. Does that not discriminate against the person involved?

Colin McKay: That relates to assessment and treatment orders, which part 8 introduces. If someone who appears before court seems to have a mental disorder, they can be remanded to hospital for assessment, care and treatment pending any trial.

The bill allows the Crown to bring to the notice of the court the fact that a person apparently has a mental disorder, or to move for an assessment order on the basis of medical evidence. It also allows ministers to move for such an order, although that is intended for a situation in which somebody is already in prison, and it would be the Scottish Prison Service that would try to move them to hospital. The bill also allows the court to make such an order at its own hand.

The provisions for assessment and treatment orders are really just a reworking of provisions that are already in the Criminal Procedure (Scotland) Act 1995 and the Mental Health (Scotland) Act 1984 in relation to mentally disordered offenders who appear before the court. It is currently the duty of the Crown to draw to the attention of the court any apparent mental disorder.

There are difficulties in putting a statutory obligation on the defence to bring certain matters before the court, because the defence's duty is to its client. It is conceivable that the client might not want his or her mental disorder to be brought before the court, and the defence could therefore be in some difficulty if it were placed under a legal duty. However, given the way the system operates in practice, there should not be any difficulty in the defence indicating to the Crown that it has had difficulty in getting instructions from a client who appears to be unwell or, if need be, making a motion at its own hand to the court. We do not see there being any problem with a mentally disordered person being brought to the court's attention and the necessary arrangements being made. However, if there are practical concerns about how that might happen, we would be happy to consider them.

Maureen Macmillan: Section 53 proposes to replace interim hospital orders with interim compulsion orders. It seems that existing interim hospital orders are available to a larger group of offenders and that the new orders will be available only to people who commit more serious offences. What will happen to people at the minor end of the scale, who may have a mental health difficulty but who have been charged with something relatively minor?

Colin McKay: I think that you are referring to section 53 of the Criminal Procedure (Scotland) Act 1995, rather than to section 53 of the bill.

Maureen Macmillan: Yes.

Colin McKay: It is important to understand that interim hospital orders are quite a long-term and intensive disposal. An interim hospital order means that a person can be detained for up to a year in hospital to have his or her mental disorder fully assessed. The current requirement in legislation is that there should be a prospect that the person might be given a hospital order with the state hospital being specified. Even at the moment, it is more likely to be offending at the more serious end of the spectrum that would justify an interim hospital order. It is possible for the court to remand for reports people who are less serious offenders under section 200 or 201 of the 1995 act. There is therefore a procedure by which the court can get information about a person's mental state.

Under the 1995 act, a person who starts out in the district court, where the offence may be perceived as less serious, and is identified as having a mental disorder can be remitted to the sheriff court. In that situation, an interim hospital order can be imposed. That is not in the bill as drafted, but that is probably just a drafting omission, which we would try to correct at stage 2.

Janis Hughes: The intention in the bill is to move away from using emergency detention provisions and towards short-term detention provisions. That has stimulated some discussion during our evidence sessions. What safeguards will the Executive put in place to prevent that move leading to the possible, unintended consequence of people spending more time in detention, because they are subject to short-term detention orders rather than to emergency orders, which are shorter?

Malcolm Chisholm: It is obviously meant to be an improvement to the present system, because a large number of people now go into the system through emergency orders. However, orders for longer-term detention would still have to be referred to the tribunal, which is the main defence against any abuse of the system. I do not see that the system is open to abuse in that sense.

Janis Hughes: The concept of short-term orders being preferable to patients in terms of treatment is obviously understood. However, there is concern that someone who is subject to a short-term detention order will be kept in detention longer than they would be if they were subject to an emergency order. Under an emergency order, they would be detained for 72 hours and then might not be detained further.

Malcolm Chisholm: The short-term order is only for a maximum of 28 days.

Janis Hughes: The point is that there is a big difference between 72 hours and 28 days.

Malcolm Chisholm: There is, but we think that we will have a better system if we have less use of emergency detention orders. It could be said that the downside of that is that longer time periods will be involved.

Janis Hughes: We are not disagreeing with the principle, but it would be useful if you could undertake to consider the matter, given the evidence that we have taken at stage 1 that has raised concerns.

Malcolm Chisholm: I would be happy to do so.

Colin MacKay: A number of safeguards are built into the system, one being that the patient would have the power to appeal to the tribunal, another being that there is a requirement on the responsible medical officer to continually review the status of the patient. There is also the practical consideration that, if the patient turns out only to need a night or two in hospital, it is unlikely that a busy consultant will keep them in hospital just for the sake of it.

Since the change is significant, we would monitor the concerns that you raise as part of the continuing research programme into the implementation of the bill. If there turned out to be untoward consequences, that would be brought to our attention.

Dorothy-Grace Elder: Section 198 provides for the police to remove someone to a place of safety. Do you share the concerns of the Royal College of Psychiatrists that that provision might lead to a person's being removed to an inappropriate place? Do you agree that the most appropriate place of safety would be a hospital with a psychiatric unit?

Malcolm Chisholm: I am aware that there are concerns around that, particularly in rural areas—we allocated funding to ensure that alternative arrangements could be made in the Highlands, for example. However, the explanatory notes make it clear that the place of safety would most likely be a psychiatric hospital. The only problem is that there are situations in which that is not likely to be possible, which are more likely to arise in rural areas, which is why it would be problematic to insist on the place of safety being a psychiatric hospital. We accept that it is not appropriate that the place of safety be a police cell or somewhere similar.

Dorothy-Grace Elder: While you accept that it is not appropriate for the place of safety to be a police cell, they have been used as such for years. You are not actually legislating against that. Do you intend to strengthen the bill in that regard at stage 2?

Malcolm Chisholm: If you are suggesting that we should say that the place of safety has to be a psychiatric hospital, I would have to point out once again that there are practical difficulties with that. Are you suggesting a positive way of ensuring that people are placed in an appropriate place of safety or are you suggesting that certain places should be excluded?

Dorothy-Grace Elder: I am suggesting that certain places be excluded. That might be more practical.

Colin MacKay: Section 198 defines a place of safety as being any

> "suitable place (other than a police station)",

but there is a proviso, which states that

> "If no place of safety is immediately available, a constable may … remove a relevant person to a police station".

The intention is to discourage the use of police facilities as a place of safety. However, we would not want to make the legislation so restrictive that, if the police could not put someone in some other place, they had to let them go.

Dorothy-Grace Elder: Quite. Perhaps being placed in a police cell would not be as bad if the person were not kept there overnight. I take it that you will consider the concerns that have been raised in this regard.

You mentioned the difficulties relating to finding suitable places in rural areas, but you will also be aware of the acute lack of provision in cities such as Glasgow. When the committee visited Parkhead hospital, we were told that no bed was ever empty for more than two hours throughout the year and that patients sometimes had to be shifted as far as Aberdeen to get a bed for the night.

Malcolm Chisholm: Obviously, we are concerned about that service issue. There are many similar issues that must be addressed.

Janis Hughes: Some witnesses have expressed concern about the fact that tribunals do not appear to have the power to revise care plans that are prepared by a mental health officer. Is that your interpretation of the legislation?

Malcolm Chisholm: The concern that Janis Hughes raises pertains to section 53, which I have examined. The officials may want to comment on this matter, but my interpretation of section 53 is that it is the intention that tribunals should be able to say that a care plan is not acceptable and to insist that it should be reconsidered. Section 53(4)(b) states that the tribunal may "refuse the application." In effect, that means that the tribunal may ask for the care plan to be re-examined. It will not make the order unless a satisfactory care plan is forthcoming.

11:30

Colin McKay: That is the intention. Additional provisions relating to interim orders may need to be added at stage 2 to deal with the process, if the tribunal is not satisfied with the care plan. Something may need to be done immediately. We intend it to be possible for the tribunal to make a temporary order for up to 28 days, to give the services time to return to the care plan. It is not intended that the tribunal should write the care plan or write things into it. At the end of the day, the tribunal is not the body that is delivering care. It is important that services should devise the proposals. It is for the tribunal to be satisfied that those proposals are adequate.

Janis Hughes: Should the bill make it clear that the patient has a right to question the care plan and that the Mental Welfare Commission for Scotland can refer a care plan that it considers inadequate to the tribunal?

Malcolm Chisholm: The patient should have a strong voice at the tribunal. That is one reason for making advocacy services an important part of the bill. The patient should be able to question the care plan. I am not sure whether Janis Hughes is suggesting a further addition to patients' rights.

Janis Hughes: If a patient questions a care plan, the tribunal should be able to reconsider it. The bill should make provision for that to happen.

Malcolm Chisholm: A patient may question a care plan while the tribunal is meeting. Are you saying that that should be possible after the care plan has been agreed?

Janis Hughes: Yes.

Malcolm Chisholm: I do not think that the bill makes provision for that.

Colin McKay: The care plan exists at the time that the application is made. It is appropriate for the patient to question the plan when it is before the tribunal, at which they will have representation. The bill proposes that the tribunal should have the power to specify that certain services are essential. It should be able to mark up certain services as fundamentally important to the care plan. If subsequently it becomes clear that those services are not being delivered, the patient should be able to tell the tribunal that they are not receiving services that were included in their care plan.

Janis Hughes also asked about the commission. Its powers in relation to orders are not included in the bill as drafted. We intend to add those at stage 2. The provisions in this area were delayed because, as members may recall from the policy statement, we consulted on precisely what the commission's powers should be. The proposals were not finalised until quite late in the process.

The intention is that, in an extreme case, the commission should be able to discharge a patient from the order to which they are subject. If it were not satisfied that the care plan was being delivered, it would have the power to refer the case back to the tribunal.

Mr McAllion: One of the Millan committee recommendations was for a gateway provision. A tribunal would not be able to authorise compulsory care unless it was first established that it was not possible to obtain the patient's consent to treatment. Section 53 of the bill waters down that proposal and requires simply that a compulsory treatment order should be necessary. Why has that been done?

Malcolm Chisholm: We need to reconsider that issue. The wording that now appears in the bill has been inserted by the draftsmen. I think that the original wording was better. The officials may correct me if I am missing something, but the wording that Millan recommended seemed more straightforward.

Mr McAllion: I am happy with that answer, if you want to leave it at that.

Malcolm Chisholm: I just want to ask Colin McKay whether I missed a qualification.

Colin McKay: No, although I think that we will have to look at the issue. It was thought to be implicit that, if the patient agreed to the treatment, the order was obviously not necessary. However, we are examining how to spell that out.

Mr McAllion: I hope that we get a similarly positive response for this question. Why have you left out from section 53 the gateway provision that proposed that compulsory treatment should be the least restrictive and invasive available?

Malcolm Chisholm: Again, we will examine that. The advice was that, if that principle were stated at the beginning of the bill and then later as well, that would create a difficulty. It is not obvious to me that the obstacle is insuperable, but that is the legal advice at present. I suppose that it follows legal precedent on legislation, which is that, if we state the principle at the beginning, that governs everything thereafter in the bill. I am keen to re-examine that, but I am stating what I have been told by the lawyers and draftsmen.

Mr McAllion: That is two Executive amendments that we can look forward to.

Malcolm Chisholm: Well, as with the first question, there is a qualification, because we must ensure that the laws that we are passing make legal sense and can be interpreted and enforced. In principle, I accept what you are saying, but with that qualification.

Ben Wallace: I want to pursue that briefly. Whenever I have attended mental health summits in England, I have been told that many people in England envy the provision about appropriateness, which they say is what makes the legislation so much better in Scotland. If you decide to keep it out of section 53, will you allow us to see the legal opinion?

Malcolm Chisholm: Obviously, we will revisit the point. With respect, many of these questions are stage 2 questions, because they are specific to particular sections of the bill rather than to the underlying principles. However, we will examine the point again at stage 2 and give the legal advice as we have it.

Nicola Sturgeon: We have taken a lot of evidence on community-based compulsory treatment orders, about which service users and providers have expressed concerns. The fear is that in practice the orders may become the cheap option. Two concerns have been expressed. The first is that the orders might be used as a compensation for a shortfall in the number of hospital beds—we have just heard from Dorothy-Grace Elder about the pressure on hospital beds. The second is that some patients, who with the right support in the community might not require compulsion, will end up being subject to the orders because the community services do not exist. How do you respond to those concerns to reassure the people who have expressed them?

Malcolm Chisholm: We thought that the community treatment order might be the most controversial part of the bill. To some extent, that is turning out to be the case, although different evidence is coming from service users and I am listening carefully to what they and the Scottish Association for Mental Health have to say. I read the latter's evidence—its two main points were that it feared that the orders would be overused and that it questioned the evidence base. I suppose that Nicola Sturgeon has raised another issue, which is that the orders might be used because of the acute bed situation.

I want to reassure people on all those points, which, if Parliament passes the bill, will have to be closely monitored. As I said, the Mental Welfare Commission will have an important role in that. I do not envisage that there will be a huge number of compulsory treatment orders. If more people are suddenly subject to compulsion because of the bill, we will have to examine that carefully. It is important that the orders are used appropriately and we think that the bill deals sufficiently with the role of the tribunal to ensure that that is the case. The criteria for compulsion in the community are the same as those for compulsion in hospitals, so the orders should not catch a population of people who would not otherwise be subject to compulsion.

There is also the hospital bed issue. The reality is that some bed closures in mental health care have been a good and progressive thing in terms of long-term care. Some people who are receiving community treatment might in the past have been in a long-term care bed and would never have left it.

My general attitude to community treatment orders is that they are the corollary of the move to community care and therefore a positive development. In accordance with the principle of the least restrictive alternative, people will have the opportunity to stay in their own home. In principle, it is right that such orders should be available, but we must be sure that they are not misused. If members want to propose amendments to underpin that even more strongly in the bill, I would be happy to consider their suggestions.

The evidence base argument is interesting, because we must consider the effect of the bill if it is carried into law. Some people say that the orders are an alternative to community services—I think that was stated in Nicola Sturgeon's question. They are not an alternative to community services; indeed, they will not be available unless a care package accompanies them. It is not a question of either/or; it is a question of both. We must continue to examine the evidence base. Other countries have been referred to, but we must remember that other countries have different health care systems, so we might not be comparing like with like. However, in principle, we must examine carefully how the orders operate and whether they achieve their intended effect.

Nicola Sturgeon: With one or two exceptions, the concerns that have been raised about the orders are not concerns of principle, but concerns about how the orders will operate in practice. That is closely related to the issue of resources, with which we will deal later. People who have raised concerns will welcome the commitment to close monitoring of the practical use of the orders.

Some service providers have raised another concern. They are worried that, if they have to assume a policing role in respect of the community orders, there is a danger that their relationships with patients will be damaged. How do you respond to that?

Malcolm Chisholm: To some extent, that situation already arises. You will know about leave of absence. Somebody came to one of my surgeries on Saturday and described a situation in which a person who had leave of absence was visited by a community psychiatric nurse to ensure that she took her medication at home. The situation is not new; what we are proposing develops something that happens already. It has happened for a long time in hospitals so, in principle, I am not sure that it would be different if a member of staff had that role in the community. We want to hear of any relevant concerns and find out how things work in practice.

Bill Butler: Concern has been expressed that the bill does not provide a right to appeal against the level of security under which people are being detained in hospital. Will the Executive address those concerns at stage 2?

Malcolm Chisholm: That important issue has arisen several times recently, often in relation to people who are trapped in Carstairs, although we could equally be talking about other institutions. The problem is that the alternative accommodation is not yet available in some cases. Your question is highly relevant to the kind of controversies that the committee dealt with a few weeks ago about the medium-secure unit at Stobhill. That issue will arise for the rest of the west of Scotland quite soon.

Until we have alternative facilities in place, it will be difficult to say that somebody has a right, given that that right cannot be delivered because the service does not exist. We must deal with the concern in some way. Our thinking at the moment concerns the power of the tribunal to be able to point out that—a bit like sending back a care plan—something must be done about the level of security under which somebody is held. I am not sure that that is too far away from the Mental Welfare Commission's proposal. The tribunal could say that the suggestion was not acceptable and that alternative accommodation must be found. If we strengthen that to say that a person has a right to alternative accommodation, I am not sure how that would be resolved, either in practice or in law, if that accommodation were not available.

The Convener: On the point about whether a place is available, does the Executive have plans to take the issue forward? We were impressed by what we saw when we visited the medium-secure unit at the Royal Edinburgh's Orchard clinic. The staff were very impressive. Is the way forward to ensure that such places are available at Stobhill and elsewhere in Scotland?

11:45

Malcolm Chisholm: The Orchard clinic is certainly successful and is the model for the facilities that are required in Glasgow and the west of Scotland. However, as the committee will know, it is not in my power to say that those facilities will be delivered tomorrow, or even the day after tomorrow. Obviously, I am keen that the proposals be progressed as quickly as possible.

Shona Robison: I want to move on to resources, which, it is fair to say, is the issue that has met with the greatest degree of disapproval. Concerns have been raised by nearly every organisation and individual that has given evidence.

To give the minister a flavour of that, in case he has not seen it himself, let me read out a couple of quotations. When Professor Cheetham was giving evidence on the bill, she said:

> "it will be a tragedy if it remains aspirational and is not backed up by resources. There are serious issues. The funding of mental health services is a chronic and endemic problem".

Bruce Millan said:

> "The bill, as it stands, can represent a considerable improvement in the rights of patients and the services that are available to them, but it can do that only if the resources are available."—[*Official Report*, *Health and Community Care Committee,* 25 September 2002; c 3061 and 3082.]

It is clear that there are great concerns at the highest level. What will the minister do to address those concerns?

Malcolm Chisholm: I am sure that members have read the financial memorandum. We have not done nothing, although people will always say that we should have added a nought to the figures that we have given. Substantial extra resources are being provided to fund the bill.

The reality is that we have an historic problem with mental health expenditure—not for nothing has it been called a cinderella service. Since the Parliament was established, there have been significant increases in mental health spending both in the national health service and by local authorities. In the health service, the increases have been 8 or 9 per cent in two of the past three years. In local authorities, there have also been significant increases. Two weeks ago, I was pleased to increase the mental illness specific grant for next year.

Expenditure is already moving in the right direction and the financial memorandum indicates a further boost, in particular to the local authority side, although £6 million extra will be contributed by NHS boards. Local authorities will receive significant further increases: £7 million for improved day care and aftercare facilities and £2 million for improvements in packages of care for those who are on compulsory treatment orders. Moreover, 45 new full-time mental health officers will be funded at a cost of £2.5 million. Half the extra money for the new duty to support advocacy will also come through local authorities, which will receive £1.5 million for that. That is only the revenue expenditure. A significant amount of capital expenditure will also be allocated to local authorities for crisis services and respite care.

That is a significant boost to local authority expenditure on mental health. Over and above that, there is expenditure in the NHS and by the Executive at the centre. People will always say that there should be more, but I argue that the increases are significant.

Shona Robison: You mentioned the figure given in the financial memorandum of £2 million for improvements in the packages of care that will be available to people who are subject to community-based compulsory treatment. That is one of the more controversial aspects of the bill and concerns have been expressed about it. You must admit that £2 million for Scotland's local authorities does not add up to an awful lot of money per local authority. There is also the concern that the money will not be used for that purpose when it reaches local authorities. I have two questions. First, how did you come up with the figures and what are they based on? Secondly, is there an argument for ensuring that the moneys are spent on mental health by ring fencing them?

Malcolm Chisholm: It should reassure the committee to know that most people assume that only a relatively small number of people will be put on community treatment orders. The main fear about community treatment orders is that they will be abused and that too many people will end up being put on them inappropriately. My memory might serve me wrongly—I am sure that Colin McKay will tell me if it does—but I think that the figure is based on 200 people at £350 a week, which translates into £2 million a year.

You asked about ring fencing. That issue comes up often and no doubt will come up when we discuss the budget process. There is an issue of ring fencing for NHS boards and there is the different issue of ring fencing for local authority budgets. Some people like the mental illness specific grant because it is, in effect, ring fenced. Members will know that policy on local government finance is moving against further ring fencing and that other arrangements such as outcome agreements are coming into place. To some extent, we must follow the general policy.

I ask Colin McKay whether I got the figures on community treatment orders right.

Colin McKay: Paragraph 460 of the financial memorandum explains how the £2 million for patients who are subject to community-based compulsory treatment was arrived at.

Shona Robison: I want to probe the figure of £350 further. Is that the cost of an average package? What level of service is the figure based on?

Colin McKay: We considered figures such as those from the Accounts Commission for Scotland, which recently examined mental health services. It is difficult to find out how much mental health services cost, but, if we take into account cheap and expensive services, the average might range from £150 to £350 a week. The amount is difficult to estimate because we have no idea until the orders are in place exactly what services might be expected of local authorities.

Shona Robison: On that basis, what room do you have for manoeuvre if the figures are shown to be out?

Colin McKay: The services might be cheaper or more expensive. The financial memorandum points out that there is a significant margin of error when one tries to project into the future for orders that do not exist at present. The £2 million will be aggregated with the £7 million that local authorities will receive for improving services generally and with other resources. It will be for local authorities to deliver the services. It is important to remember that the service providers sought community treatment orders and that we anticipate that they will apply for an order only when they feel that they can deliver it for a particular person. Perhaps that is a self-limiting mechanism.

Shona Robison: I am not convinced about that.

You might have answered my next question. Is the margin of error of £5 million intended to give some flexibility?

Malcolm Chisholm: There has to be flexibility. We must make an estimate, but we cannot be sure that it is correct.

Margaret Jamieson: I will not come in on the back of Shona Robison's question, but I have a question about the work force. We have heard in evidence that there is a shortfall of social workers, particularly those with mental health officer status. Recently, general practitioners have been on MSPs' backs complaining about the work load that has arisen as a result of the Adults with Incapacity (Scotland) Act 2000.

What dialogue has the Executive undertaken with local authorities on the subject of social workers and the need to have a sufficient number of mental health officers? Local authorities will need to consider work loads when planning for the provisions of the bill. What dialogue has the Executive had on the training and expertise of general practitioners?

Malcolm Chisholm: Many work force issues have arisen in the committee's evidence-taking sessions. I have read all the evidence apart from the evidence from last week's meeting, but only because the *Official Report* of the meeting takes a week to appear—my apologies for that.

In general, the Executive has many initiatives on work force development. Creating the infrastructure that is required to develop the work force is a big area for us this year. We are doing that in a way that has not happened before. As part of those arrangements, we have selected mental health as the first work force area that we will examine. We will see how we can plan the work force and get it working in different ways. We are looking at a team-based approach. For example, although it is agreed that we have a shortage of clinical psychologists, the question arises whether everyone who is referred to a clinical psychologist needs to see one. The question is whether they could see another member of the work force, whether that is a nurse or whoever.

We are considering the team-based approach to the development of the mental health work force. That is the over-arching work that we are undertaking in mental health. It is the pioneering part of our new work on work force planning and development. Specific groups of the work force are important. That includes the mental health officers whom Margaret Jamieson mentioned among others. The financial memorandum includes the payment of

"45 new full-time equivalent mental health officers".

One of the issues that arose in evidence, perhaps from Ruth Stark, was that quite a lot of local authority social workers have mental health officer training but are not using that skill at present. I do not say that addressing that will entirely solve the problem, but it is part of the solution.

Training issues arise and that is why we have set aside money in the financial memorandum for that area. There is also the issue of the present shortage of psychiatrists. We have to address that issue at the senior level of the medical work force, but some of the skills issues will come into play for many other roles in mental health services.

Margaret Jamieson: Surely you will accept that you cannot create a consultant psychiatrist overnight—it takes many years of training for someone to achieve that level of expertise. Is it not the case that we should be considering a five or seven-year phase-in period for the legislation? That would also provide us with the opportunity to consider the financial aspects as they emerge rather than when we have a crisis.

I appreciate that you are saying that we should not distrust our local authority colleagues by continually ring fencing money but, if we consider the mental health specific grant, we can all point to areas in which it has not reached the part for which it was intended. The situation is difficult to manage in terms of work force planning. How are you going to achieve that?

Malcolm Chisholm: The bill does not have a specific implementation date, which means that, in principle, implementation could be delayed if that was felt to be essential. One of the difficulties is that the whole bill hangs together. That makes it very difficult to stage implementation, as has been done with some acts of Parliament, in which one bit can be implemented one year and another bit in the following year. There is no definite implementation date. It will not be before 2004. If there were overwhelming obstacles to its implementation, the bill could be delayed.

Margaret Jamieson: The reason for asking the question is that we have had evidence that we are 27 consultant psychiatrists short throughout Scotland. If 3,000 people are expected to appear before a tribunal, that will be an added work load for the remaining consultant psychiatrists. I do not know how many will retire between now and the bill's commencement. That is a difficult matter. The bill cannot be implemented without consultant psychiatrists.

12:00

Malcolm Chisholm: Colin McKay might want to comment on that. I am obviously concerned about the situation with psychiatrists, but I do not hear any consultant psychiatrists giving evidence that the bill should be delayed because of that situation. Diverse psychiatrists, including those who are reaching retirement or who are retired, might wish to be involved in tribunals. Margaret Jamieson makes an important point. I am concerned about the situation.

Colin McKay: There is not too much more to say. Dr Coia said in evidence that one issue is not just the number of psychiatrists, but the work that they must do and whether others can undertake some of that work. Some of the responsibilities under the bill might be administrative. Better administrative support for psychiatrists might relieve some of the pressures on them. That is part of the broader issue of considering the skill mix and how teams operate, to which the minister referred.

Margaret Jamieson: You must also consider the people who are referred to the services. If general practitioners make inappropriate referrals because they do not have expertise in mental health, that situation will continue. Has provision been made to examine that side of the service to ensure that people are not inappropriately referred? The same thing happens in acute services.

Malcolm Chisholm: Referral is fundamental to dealing with some of the waiting issues and other issues. Referral guidance has been issued for many illnesses. The redesign of services involves much work. More generally, we will consider who the appropriate person is for a referral to be made to. That cuts across doing things differently in the health service.

Dorothy-Grace Elder: Margaret Jamieson was correct about the shortage of psychiatrists. There are 29 vacant consultant posts and the Royal College of Psychiatrists projects a shortage of 47 to 57 consultant psychiatrists by the time that the bill is enacted, principally in child and adolescent psychiatry, the enormous need for which we heard about this morning. I add that to what Margaret Jamieson helpfully said.

Why does the bill not set out clear provisions for categories such as force-feeding, drugs to reduce sex drive and medication that is sometimes above the normal recommended dose? Why does it seem that you will bury such provisions in regulations? Pages 106 and 107 of the bill contain references to several other categories. I do not expect you to plough through them all now.

Malcolm Chisholm: That is all right. Matters cannot be slipped through in regulations—especially with a committee such as the Health and Community Care Committee. Just because a provision is in regulations, that does not mean that it has not been consulted on or that the committee has not scrutinised it. However, there is no fundamental reason why such provisions should not be in the bill. I would be sympathetic to including such medical treatments in the bill, unless I am advised that strong reasons to the contrary exist.

Dorothy-Grace Elder: That is helpful.

The vast majority of witnesses who have had any involvement with electroconvulsive therapy treatments are against them. Is it ever appropriate for ECT to be administered to people who cannot consent? Do you consider that what safeguards there are in the bill are adequate? There do not seem to be many safeguards in relation to patients who are allegedly incapable of consenting.

Malcolm Chisholm: What can be said about the bill is that it extends the right to refuse beyond what applies at the moment. At present, anybody who is under section can be given ECT, but the bill says that, even if someone is under compulsory treatment, they can refuse it if they are capable of doing so. I accept that there is perhaps an element of subjectivity around capability, but it does extend the right to refuse ECT from what exists at present.

Different views on ECT have been expressed and not everyone has been against it. In fact, some witnesses have taken a contrary view, and psychiatrists will certainly argue that there is an evidence base for ECT. Service users are divided on that, and some service users who have had ECT would say that it has been beneficial to them. In a way, it is not my business to get too involved in those clinical areas, but I am clear about the fact that the bill will extend the right of people to refuse ECT, by making a stricter test than exists at the moment. I am pleased that we have moved in that direction. To move further, to the position that you have adopted, might be a bit more difficult.

Dorothy-Grace Elder: Would you be amenable to considering raising the safeguards to mirror the provisions in section 164, which covers Court of Session approval and the arguments that the court would go into?

Malcolm Chisholm: The practical problem with that is that ECT is a far more common treatment than the ones that require the Court of Session's approval.

The Convener: Perhaps you can come back to us with some facts and figures.

Malcolm Chisholm: My general statement is correct, but I am not sure whether facts and figures about how many people get ECT are available. I can certainly find out.

The Convener: That would be helpful.

Margaret Jamieson: There does not appear to be much in the bill to prevent people with a primary diagnosis of personality disorder, who might not even have a mental illness at all, from being scooped up into the tribunal system and into compulsory treatment. Most of the professionals whom we have heard from agree that it is not generally appropriate to treat people with a primary diagnosis of personality disorder within the mental health system. Are you satisfied that the bill will not allow that to happen?

Malcolm Chisholm: I am surprised to hear you say that. One of the main differences that people are pointing out between our bill and the English bill is that our bill does not capture the category of people to whom you are referring. Without getting too embroiled in matters that are nothing to do with me, the English bill appears to be causing a great deal of concern on precisely those grounds.

The key issue is that compulsion requires that treatment should be of benefit to the patient. Someone with personality disorder would therefore be caught by it only if it was thought that the treatment was of benefit to them. I cannot stray into clinical areas, but I know that the traditional view of psychiatrists is that personality disorder is untreatable. In so far as the personality disorder that is presenting itself is untreatable it will not be caught by the provisions of the bill, although there could be elements of personality disorder that are treatable. I may be getting beyond my territory, but that is the general principle on which the bill is founded.

Margaret Jamieson: It would certainly concern me if children and young people who are being treated for personality disorders with Ritalin were scooped up into the mental health system.

Malcolm Chisholm: That is very controversial. There is a Scottish intercollegiate guidelines network guideline on that. That is what I have to say on that.

Margaret Jamieson: It was worth a try.

Malcolm Chisholm: No one would be caught up in that unless the case met the criteria. There are pretty clear criteria for compulsory treatment. All the tests have to be passed, as it were, so I do not think that somebody ought to be caught in the way that you suggest.

Margaret Jamieson: We are saying that we do not believe that there are sufficient safeguards in the current legislation to prevent that.

Malcolm Chisholm: One of the positive things that people say about the Scottish bill as against the English bill is that it is a narrow gateway into compulsion; it is not relatively broad, as some people say the English gateway is. However, you are saying that the gateway is still too broad, and that you want us to narrow it down even further.

Margaret Jamieson: Yes.

Malcolm Chisholm: I am not aware that many criticisms have been made in that direction, but if there is evidence of that we will look at it.

Margaret Jamieson: The other point that I want to raise is your intended review and the appropriateness of including people with learning disabilities in the legislation.

Malcolm Chisholm: There is no doubt that we need to review that before too long. I think that most people accept that we have to have learning disability in the bill at present, just to avoid situations where somebody with a learning disability might end up in prison rather than in hospital. We need in due course—and Millan recommended it—to look at that separately. We need to have the bill implemented. There is no point in us reviewing the situation before 2004 or so, but as soon as that point comes we should look at it.

Margaret Jamieson: Why would you have to wait until the bill is implemented?

Malcolm Chisholm: I suppose that it would be a bit odd to pass legislation and then to change it before we have started to implement it.

Margaret Jamieson: Everybody is saying that they do not accept that learning disabilities should be within the bill. We accept that you are saying that we need to make provision to ensure that people do not fall foul of the court process because they have a learning disability but, surely, if we are doing that in a pre-emptive way, allowing us as a Parliament to look at legislation specifically for that group of people would effectively give us one year in which to catch up. I do not think that it is rocket science, as we are already committed to doing that.

Colin McKay: There might be more rocket science to it than is immediately apparent. It is an issue that has been raised with "The same as you?" implementation group. As the committee will know, "The same as you?" was the review of learning disability services. There are a lot of different things happening in the world of learning disability in terms of a quite fundamental reorganisation of services and changes in education legislation, so the Mental Health (Scotland) Bill is in a much bigger context, as many different things are happening in relation to disability. Similarly, the introduction of the Adults with Incapacity (Scotland) Act 2000 has had significant implications for learning disability.

A legal review might therefore be broader than just asking, "Why is learning disability in the Mental Health Act?" It would have to take account of a lot of the wider issues. The people you would have to speak to would be the kind of people who are involved in "The same as you?" implementation group. The issue is trying to fit it into the process. There is still quite a lot of work going on to implement "The same as you?" so there is a concern not to load the process up with too many different initiatives at once. That is why it is felt that in about a year's time, when it is clearer what the bill will say and when all the other things have settled down a bit, that might be an opportune time to look at the issue in the broader context.

Janis Hughes: Section 182 places a duty on local authorities to provide advocacy services, but it does not appear anywhere else in the bill that patients have a right to access those services. Why not?

Malcolm Chisholm: I know there has been a lot of discussion of that. I do not think that there is a great deal of difference in practice between the right and the duty, which is a significant new duty on local authorities and NHS boards to ensure that independent advocacy services are available. We have discussed concerns with advocacy interests, and have inserted a provision in the bill—the particular section number escapes me at the moment—to ensure that information about advocacy services is made available to anyone who enters a tribunal situation and might possibly be subject to compulsory treatment.

We have moved to address any existing concerns. However, I am certainly keen to consider any other steps that can be taken to tighten up advocacy provisions, because I think that advocacy is very important. The bill creates a more general duty that will benefit all users of mental health services, not just people who are subject to possible compulsion.

In practice, it might be difficult to enshrine the right to access advocacy services in the bill. For example, we would have to state exactly what such a right would consist of, the people who would have it and so on, and I am not persuaded that the duty is very different.

12:15

Janis Hughes: Some witnesses suggested that the provision of advocacy services could be fleshed out by stating the different types of services that are available. One obvious example would be advocacy services that are specifically for children. Would there be any value in clarifying the points in a patient's journey through compulsion at which advocates would have the right to attend meetings and represent them?

We accept that there is a duty on local authorities and NHS boards to provide advocacy services. However, that does not necessarily mean that patients will always be given those services when they need them. Perhaps they might not even be in a position to identify that need.

Malcolm Chisholm: Some of that will go into the code. However, I acknowledge that people are interested in strengthening the provisions. Unfortunately, I cannot find the section that mentions giving information about advocacy. We might be able to tighten that provision in some way because I realise that there are concerns about how people will really know that services are available. Perhaps simply mentioning the fact might not be enough.

Your question raises two issues. The first relates to the different kinds of advocacy, which are mainly collective advocacy and representative advocacy—although there is also citizens advocacy. The other issue is whether there should be specific provision for children. The same question could be asked with reference to different bits of the bill, which sometimes makes particular mention of children. For example, part 13 mentions child and adolescent psychiatrists. We can certainly consider other areas where children could be specifically mentioned.

On the issue of definitions, I realise that the issue of defining collective advocacy is giving people some difficulty. I am certainly a great supporter of such advocacy. I know that the committee took evidence from the Highland Users Group last week, although I have not yet read that evidence. That group and the Consultation and Advocacy Promotion Service from Edinburgh are excellent examples of collective advocacy in practice.

I am struggling with the issue. Although I would be happy to consider any definitions of collective advocacy, the danger is that defining it might somehow limit it. The nature of such advocacy is that it is driven by users of services.

Janis Hughes: I take your point. As the evidence from the Highland Users Group and CAPS highlighted, the people who use those services speak very highly of the benefits that they received from them. However, they know about those services. I am thinking more of patients being informed of the services that are available to ensure that they benefit from them as much as others have.

Malcolm Chisholm: That section might need to be strengthened. However, I do not know where it is in the bill.

Colin McKay: Section 50(3)(c) deals with the preparation of a report for an application to the tribunal by the mental health officer and states that the mental health officer has to include in that report the steps that have been taken to inform the patient of advocacy services. We anticipate that the tribunal would want to be satisfied that advocacy had been considered.

Janis Hughes: What is your view of the suggestion that advocates should have access to patients' medical records?

Malcolm Chisholm: I would like to hear what patients have to say about that.

Janis Hughes: Patients say that, if they want to give advocates that right, they should be able to do so.

Malcolm Chisholm: I should not make a snap judgment but, if that is what patients want, I would have no objection to that suggestion. However, I would have to take advice on the matter.

Dorothy-Grace Elder: Some witnesses have pointed out that the bill would not permit any young person under the age of 16—even a child deemed to be competent to make such decisions in terms of the Age of Legal Capacity (Scotland) Act 1991—to appoint a named person. Why is the Executive opposed to allowing competent children under the age of 16 to appoint a named person? The matter is dealt with largely in sections 176 to 181.

Malcolm Chisholm: We could see a role for the tribunal in relation to that matter. There should certainly be a right of appeal to the tribunal if a child wants to change their named person. That might go halfway towards meeting your concern. However, I suppose that your more general point is to do with the stage at which a child is deemed to be competent to make a decision for themselves. In practice, that might be when they are 14 or 15 and an argument could be made for allowing them to designate their named person at that age. I will reflect on that, but the current thinking is that there should be a right of appeal to a tribunal, which would then make a decision.

Dorothy-Grace Elder: Some witnesses told us earlier that they believed that some children were perfectly capable of making that decision at the age of 12 or 13, or whatever—it depends on the child. Do you accept that a parent or guardian who was automatically deemed to be the named person for the child might be a manipulative abuser who contributed to the child's mental health problems in the first place?

Malcolm Chisholm: That is entirely possible, but I would expect the tribunal to take account of such situations. In practice, it might be better for the decision to be made through the tribunal because it is often not easy for a child in such a situation to stand up to a figure with authority over them. Some difficult issues are involved and I want to reflect on them.

The Convener: It was pointed out that a safeguarder advocate would have quite an important role in that set of circumstances.

Colin McKay: We would envision a role for advocacy. However, a difficulty would arise if too many different appointed people checked up on each other.

We are considering what the relationship between the parent and the named person ought to be. I suppose that we start from the fundamental position that, if the parent's parental rights and responsibilities have not been removed by the child's being taken into care, they should have a role in the hearing as they are, prima facie, the parent. There will be situations in which the child has a difficult relationship with the parent but, nevertheless, they are still a child and their parent should have a role to play. The named person is not the same as a guardian under the Adults with Incapacity (Scotland) Act 2000; they do not stand in place of the child, who would have the right to appoint representation and to be represented in court.

Dorothy-Grace Elder: You accept that it might be extremely difficult for a child to communicate to someone that they might either be afraid to speak against the person or, as in many cases of abuse, be virtually brainwashed into not doing so, or prevented from doing so, by the affection that they hold for the person, even though the person is entirely wrong for them. Is not advocacy extremely important in such cases? Should not it be put extremely clearly to the child and the health professionals that the child must have an advocate?

Malcolm Chisholm: I agree that advocacy is important in that situation, although the sensitivity of mental health services to the dimension to which you referred is equally critical if abuse is taking place. There are lots of issues for mental health services around those matters, but advocacy is certainly an important part of them.

Dorothy-Grace Elder: Even in relation to adults, the bill gives relatives "of the whole blood", as the bill terms them, much greater importance than those "of the half blood"—step children and other siblings. I take it that the Executive accepts that sometimes it can be the other way round: sometimes the person who has a slightly more distant blood relationship might be of more use and act more like a guardian to a vulnerable adult or a child.

Malcolm Chisholm: I am struggling to find that section.

Dorothy-Grace Elder: The bill places a rather old-fashioned emphasis on blood relationships.

Colin McKay: I am aware that concern has been expressed that the list of nearest relatives is rather long and complicated. It is important to understand that the starting point for the appointment of a named person for an adult would be the person whom the adult chose. If the adult were unable to choose anyone, the named person would be the person's primary carer. Only if the adult had not chosen or were unable to choose somebody and there were no primary carer who could take on the role would we need to fall back on another way of finding a named person. That is where the list of nearest relatives comes in. We felt that there was nothing else for it but to list the normal degrees of relationship, given that the adult had not made a choice and that we cannot know in advance who would deal most intimately with a person. It is possible for the named person to resign from that role. Somebody who was a close relative but had nothing to do with the person could say that they did not want to take on that role.

Dorothy-Grace Elder: The system will rely on good will, of course.

Colin McKay: Yes, to some extent.

Margaret Jamieson: I have real concerns about some of the things that you are saying about children and young people and how the bill will relate to the Children (Scotland) Act 1995 and to the possibility that a commissioner for children and young people will be appointed in the near future; insufficient cognisance has been taken of those matters. The evidence that we have received and heard this morning from those who are involved in child services leaves me with many concerns. I ask that you reconsider this aspect of the bill. I do not believe that your proposals put the child at the centre, which flies in the face of what we have tried to achieve in other legislation.

Malcolm Chisholm: I did not hear what Children in Scotland said, although I met it over the past few days. I am aware of its concerns and am prepared to consider its suggestions. That is an area that we will have to consider, but we will have to do so in terms of concrete proposals.

The Convener: We go back to Dorothy-Grace Elder. I am keen to get through the questions on the bill that we must get through, if we possibly can. Try to move us along a little, Dorothy-Grace.

Dorothy-Grace Elder: I will try. My question refers to section 181(6). The Equality Network objected to the definition of cohabitant that is used in the bill because it requires cohabiting couples—unlike couples who are legally married—to prove that their relationship is based on a previous or subsisting sexual relationship. The definition that was used in the Adults with Incapacity (Scotland) Act 2000 did not require such proof. Why did you not use that earlier definition? Why are you putting such emphasis on the existence of a sexual relationship?

Malcolm Chisholm: I repeat that we are getting into stage 2 territory with some of these questions. It is slightly unreasonable to ask us for details of a specific subsection at stage 1. All that I can undertake to do is to reconsider that at stage 2.

Dorothy-Grace Elder: I would be grateful if you would. As you will appreciate, some very deep relationships may not be sexual.

12:30

Bill Butler: What time scale is envisaged for the consultation process prior to the publication of the code of practice?

Malcolm Chisholm: I will have to ask one of my officials about that. The consultation on the bill has been a model of the new procedures in the Scottish Parliament. That is why, notwithstanding the points that members have raised, there is a much greater degree of consensus around the bill than there is around the legislation that is under consideration in England. In the same spirit, we will consult on the code of conduct. I do not know the proposed length of the consultation period, but I assure you that it will be substantial.

Shona Robison: Many witnesses, including those from the Law Society of Scotland, have commented on the fact that the bill is difficult to interpret. It will be especially difficult for users and carers to ascertain what their rights and duties are. For example, there are several different descriptions of what constitutes a patient—they are referred to as a "patient", an "individual", a "relevant person" and a "specified person". What will be done to tidy up the bill to make it easier to interpret?

Malcolm Chisholm: The same question could be asked about any bill that is introduced here or in the Westminster Parliament. It is a fact of life that bills are written for specific purposes so that they can be implemented and interpreted; they are not written primarily to be understood by everybody in the world. However, it is important that we explain what the bill does, and the policy memorandum does that to an extent. We must ensure that the bill's provisions are explained in understandable language to everybody who has an interest. However, I do not think that we can redraft this or any other bill simply to make it readily and immediately comprehensible to anybody who reads it. I do not think that it is possible to do that.

Shona Robison: I agree, but there could be consistent terminology, rather than different descriptions of the same thing. You have already said that aspects of the bill may have to be redrafted. Are you confident that there will be enough time for you to get all those aspects right?

Malcolm Chisholm: We will ensure that there is enough time. In some cases, members' time will be required as much as ours. The bill is inherently complex and difficult, and there will be amendments at stage 2. Most will introduce something extra or respond to your and other people's concerns, and some may be required to clarify the meaning of a section or subsection. It is important that legislation can be clearly interpreted; otherwise, we may have to depend on the courts to determine what it means. If changes have to be made to make things legally clear, we should certainly make them. That is one of the issues that members will think about when they lodge amendments, and we will do that as well.

The Convener: Several witnesses have suggested that the short title is misleading and that, instead of being a mental health bill it could be a mental ill health bill or, because it is about people with mental disorders, a mental disorder bill. Are you minded to change the short title?

Malcolm Chisholm: I am open-minded on that subject. Although the bill's short title is not its most important aspect, I am open to suggestions for a different one. People have expressed concerns because the present title might not accurately describe what is in the bill. Concerns also exist about the relationship between the bill and wider work on the promotion of mental health and well-being. I am prepared to consider such arguments, but I imagine that we will stick with the present title, unless someone comes up with a good alternative.

The Convener: Thank you for your evidence. We will put together our stage 1 report over the next few weeks.

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 13) (Scotland) Order 2002

(SSI 2002/465)

The Convener: We move to item 3, which is consideration of two emergency affirmative instruments. The Subordinate Legislation Committee has nothing to report on the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 13) (Scotland) Order 2002 (SSI 2002/465) and no comments have been received from members. As members do not wish to debate the order, I invite the minister to move the motion.

Malcolm Chisholm: I can see that you will not let me make my little speech.

The Convener: I am sorry—I assumed that you would not want to make a little speech.

Motion moved,

That the Health and Community Care Committee, in consideration of the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 13) (Scotland) Order 2002 (SSI 2002/465), recommends that the order be approved.—[*Malcolm Chisholm*.]

Motion agreed to.

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 14) (Scotland) Order 2002

(SSI 2002/482)

The Convener: The next instrument is the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 14) (Scotland) Order 2002 (SSI 2002/482). The Subordinate Legislation Committee has nothing to report and no members' comments have been received. As members do not wish to debate the order, I invite the minister to move the motion.

Motion moved,

That the Health and Community Care Committee, in consideration of the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 14) (Scotland) Order 2002 (SSI 2002/482), recommends that the Order be approved.—[*Malcolm Chisholm*.]

Motion agreed to.

The Convener: I thank colleagues for their assistance. Before we move on to item 4, which is on the budget process, we will have a short break.

12:36

Meeting suspended.

12:41

On resuming—

Budget Process 2003-04

The Convener: Are you quite happy to go straight to questions, minister, or are you in a position to make a statement?

Malcolm Chisholm: We can go straight to questions.

The Convener: We want a long question from Nicola Sturgeon, as the minister is eating.

Nicola Sturgeon: It is rude to speak with your mouth full, Malcolm.

One of the difficulties in scrutinising the budget, particularly the allocation of extra resources, is that we cannot distinguish between baseline expenditure and additional expenditure. Is it possible to provide figures that make that distinction? That would aid us considerably.

Malcolm Chisholm: Well, if you compare—

Nicola Sturgeon: Apples and oranges.

Malcolm Chisholm: The general point is that if you compare this year's budget with last year's budget, you will see the differences in the baseline figures.

Nicola Sturgeon: Is it possible to break the figures down, in global terms?

Malcolm Chisholm: There is a general question about how far we are asked to disaggregate and, for the board budget, how far we can disaggregate. That theme has run through all our discussions about the budget in the past three and a half years. For the first half of that period, I was asking the questions.

I understand that we should try to distinguish better between baseline expenditure and additional expenditure. However, the more fundamental point on resources is that that is not an adequate way in which to consider the health budget, because it is not a question of saying, "We do that with the old resources. Here are the new resources and we'll see what we'll do with them." We are trying to do things differently with the whole budget. There are certain problems with separating the figures into baseline expenditure and additional expenditure. That is not to say that we should not try to flag up what the additional money is and what it is being used for, but there are complications in doing so.

Nicola Sturgeon: I am not quite sure what the end result of that answer was. Is it possible to give more information in the budget than has been given to date?

Malcolm Chisholm: I have given a concrete example of what you would like that is not contained in the document at the moment.

The Convener: You could come back on that one, Nicola.

Bill Butler: Would the minister care to outline what mechanisms are in place to ensure that NHS boards' expenditure reflects Executive priorities? Is he content that those mechanisms are adequate?

Malcolm Chisholm: The last time that we discussed the budget, we spent a lot of time talking about the performance assessment framework, which examines the implementation of the Executive's priorities. We said last time that the budget documents were public. I hope that members have managed to see the reports that went out to each board. They contain detailed information about their performance in a range of areas.

That covers how we do things in general, although there is obviously scope to take specific action if particular problems arise in a given board area. Such action was recently exercised. As members will know, we sent some people to Argyll and Clyde NHS Board because issues needed to be addressed there. We are prepared to take such action if we think that there are problems that demand our attention.

12:45

Bill Butler: So you would say that the mechanisms are satisfactory thus far.

Malcolm Chisholm: It would be interesting to get the committee's view on that. The question of tension between national decision making and local decision making runs through all our discussions. Even in a given area, there might be tension between the board and a health care co-operative, for instance. There are all sorts of issues around the appropriate level at which decisions should be made, and I am sure that that will run through our discussions today.

Are there areas where we should intervene more and insist that more be controlled from the centre? That is a critical issue in health policy, and we have to be clear about it. What do we have the right and the responsibility to insist on from the centre? What should we leave to local decision making, not necessarily to boards, but perhaps to front-line staff, so that they may have the freedom to innovate and do things differently?

People should think carefully about the balance and the tension between those areas. I think that we have the right to insist on certain priorities. Waiting times are a big priority for us, although that does not always go down well—sometimes it does not go down well even with clinicians. I might have to point out that the desire to reduce waiting times comes from the public, and that we really have to make progress on it. We put a lot of pressure on boards and trusts to ensure that they make progress. We know how difficult that is, but we are putting on pressure to ensure that that priority is delivered.

We have made progress towards ensuring that clinical priorities such as cancer, heart disease and stroke and mental health are high on the agenda of NHS boards. I am not sure whether members have already picked this up in what they have read, but it is relevant to today's discussions: we have reduced the number of different priorities that we give boards for next year. Some members might criticise that, but there comes a point when we have to ask how many priorities we can ask boards to deliver simultaneously. It might be argued that if we have too many priorities, we do not have any priorities at all.

The priorities that we have given boards for their health plans next year are: health improvement; delayed discharges; 48-hour access to primary care; cancer; coronary heart disease and stroke; mental health; health care-acquired infection; waiting times; public involvement; work force development; financial break-even, which is not irrelevant, because if a board does not have money, it cannot do any of those; and, last but probably the most important overarching priority of all, service redesign. Unless boards engage in service redesign, they will probably not deal with many of the problems that they face in relation to waiting, cancer or mental health, for example.

The fact that we have reduced the number of priorities might be useful for the discussion. I suppose that the corollary of that is that we will be even more determined to ensure that the objectives and targets are met in those areas.

Margaret Jamieson: What mechanisms exist to measure the clinical effectiveness of health expenditure? How is that reported?

Malcolm Chisholm: There are different ways of measuring clinical effectiveness. The work of the Clinical Standards Board for Scotland represents a key new development in the lifetime of the Parliament in setting national standards and ascertaining whether those standards are being implemented in the various parts of the health service.

There is a history of clinical audit in Scotland, using guides such as clinical outcome indicators. Indeed, Scotland pioneered the development of many of the indicators, which show whether progress is being made on particular diseases, for example. We are keen to extend clinical audit work and strategies such as the cancer strategy and the recently announced coronary heart disease and stroke strategy.

More clinical audit is crucial for the development of evidence-based best practice. Many different mechanisms are in play, and I am confident that the health service is making great strides. Much of the discussion of the health service is in quantitative terms, which is fair enough as we have to ask how much activity there is and how long people are waiting, but we are also improving the quality of care. Many of the activities and mechanisms did not exist in the past, and I am sure that I have omitted to mention others.

Margaret Jamieson: However, the current emphasis is on reducing waiting times. We are putting in funding when we should really be measuring the effectiveness and outcome of the clinical treatment. It would be great if someone was referred today and seen by the specialist next week, but if they did not have a good outcome, it would be meaningless.

Malcolm Chisholm: There is a vast amount of information about that, and I referred to some of it earlier. It includes clinical indicators and there is an audit of surgical mortality, which at least moves us in the right direction, although there is always room for further improvement. As I said, there is an increasing amount of clinical audit.

I agree with the member entirely. No patient in Scotland would want to have a shorter wait at the expense of the quality of care. Some members will undoubtedly have seen the remarks of Dr Peter Terry, chairman of the Scottish Committee for Hospital Medical Services, in last week's *The Sunday Times*. He said rightly that consultants' work is divided into three parts: emergency care, which as always has to come first; routine clinical work; and sessions spent on audit. That was a statement of fact, and all parts are important. I am sure that Margaret Jamieson is not drawing the conclusion that waiting is not important. Obviously, it is important to patients, which is why it is important to us, and in some cases, waiting too long can affect the quality of the outcome. For all those reasons, we attach great importance to waiting.

The Convener: Perhaps Nicola Sturgeon will string her various questions together.

Nicola Sturgeon: The first one has been dealt with under Bill Butler's question, so I will move on to the next. The budget makes several references to projects such as rolling out NHS 24 throughout the country and funding measures to improve the recruitment and retention of front-line NHS staff. Should not figures be given on the planned expenditure for those projects?

Malcolm Chisholm: The figures are given for the roll-out of NHS 24, and there is a budget line for NHS Education for Scotland. Some of the budget lines might be at a lower level, because we were asked only to give certain lines in the budget report. It might be possible to give more detailed information. We have had the specific initiative on nurse recruitment and retention, to which we put £5 million this year, so that will be carried forward, although some of it will be contained in different budget lines.

We can certainly consider giving more information. Some of the funding is more generic, and happens through the work of bodies such as NHS Education for Scotland, which covers several different staff groups. The answer to many questions is that a lot of the funding is rolled into boards' budgets. The budgets for continuous professional development are part of board budgets and become part of trust budgets.

This year, we have tried to boost some of those budgets by putting £1.5 million into continuous professional development for nurses, for example. However, the bulk of the budget is within the general budget for boards and trusts. That might lead people to ask why we do not simply split up the budgets of boards and trusts and put rings round this or that budget. There is always an interesting argument or discussion to be had about that.

Nicola Sturgeon: As the draft budget makes clear, any salary increases must be met from health board allocations. The minister will have given thought to the costs of the new consultants contract—if it is implemented—and any increase in nurses pay that may result from the pay review process. Is the minister confident that the proposed allocations will allow health boards to meet those obligations comfortably?

Malcolm Chisholm: One feature of the fact that health service pay is still agreed at a UK level is that the money for the consultants contract, for the GP contract and for "Agenda for Change" was all part of the UK spending settlement. That was reflected in the English health budget and in the Scottish health budget as well.

Nicola Sturgeon makes a fair point when she says that a lot of the increases will go towards pay. I do not make any apologies for that. The staff in the health service are the health service. The staff are the people who not only deliver and improve the services but who, by and large, lead the changes, so they should be rewarded. A feature of those contracts—those that have been agreed and those that are still being discussed around "Agenda for Change"—is that, yes, there will be extra money, but new ways of working must go with that. That is part of our approach to pay.

Nicola Sturgeon: I questioned not the merits of the salary increases but the ability of health boards to pay for them.

Lastly, I have a detailed question about the "Draft Budget 2003-04". I know that the document cautions against making direct comparisons between the figures that it contains and those contained in the annual expenditure report, but I was struck by one entry, under "Other Health Services". Is there an easy explanation for the 29 per cent reduction between the figure that was in the annual expenditure report and the one that appears in the draft budget?

Malcolm Chisholm: John Aldridge will correct me if I am wrong, but I think that the fundamental reason for that is that NHS 24 and the Health Education Board for Scotland have been removed from "Other Health Services" and now have a separate line. I think that that makes up all of the difference.

John Aldridge (Scottish Executive Health Department): There were a couple of changes. First, the Health Education Board for Scotland and NHS 24 used to appear under the "Other Health Services" heading, but are now under the heading "Hospital, Community and Family Health Services". The other change is that the money for the National Board for Nursing, Midwifery and Health Visiting for Scotland, which used to appear under "Other Health Services", has also moved, because it has been merged into NHS Education for Scotland.

Nicola Sturgeon: Are all those things now under "Hospital, Community and Family Health Services"?

John Aldridge: Yes. They are all now under that section.

Nicola Sturgeon: I am sure that all the figures work out when the sums are done, but a 29 per cent reduction in "Other Health Services" and a 4.36 per cent increase in "Hospital, Community and Family Health Services" does not seem to be right.

Malcolm Chisholm: "Hospital, Community and Family Health Services" is a much bigger budget. I am sure that it comes to the same thing.

Nicola Sturgeon: I simply ask for an assurance that we have been given a full explanation.

John Aldridge: Yes. I have explained it.

Janis Hughes: How has this year's budget improved public involvement in local and national decision making on health expenditure?

Malcolm Chisholm: There is a great deal of activity around public involvement in local decision making. I do not have much to add on the involvement of the public at national level in the budget process since my previous appearance before the committee, but I can say that the health department's policy-making process is inclusive and involves a large number of outside interests, as the committee's next agenda item will illustrate.

At local level, a lot of work is going on, as I tried to describe when I last appeared before the committee on 18 September. Following on from our framework document "Patient Focus and Public Involvement", we had a series of initiatives, most of which worked at local level, but some of which were to establish new national structures to support and facilitate public involvement. Obviously, the future of health councils is a key issue. I hope that, before too long, we will have a document about that. A great deal of activity is under way, but much of it is taking place at local level. Boards are being supported to engage better with the local public. The new draft guidance on public involvement in service change, which we discussed last time, is part of that work. The situation is in flux, but I hope that we are moving in the right direction.

13:00

Janis Hughes: I accept that a number of initiatives are on-going and that there are a number of draft documents and draft proposals. However, although the Parliament has now been established for a few years, members of the public frequently say that they do not feel that they have any input into spending decisions. We often tell people how much money we are spending, but it is difficult to track that through the system. Is there any indication of the time scale for making the decision-making process more transparent, so that people feel that they can have an input into it?

Malcolm Chisholm: There is a local dimension to that issue, as many spending decisions on health are made locally. There is also a national dimension to the issue. Much of the involvement of patients and the public relates to particular service organisation issues. There is increasing patient involvement in decisions about particular disease areas, because of the cancer strategy, the CHD and stroke strategy and the mental health strategy, which we have just discussed. Some of those decisions involve funding decisions. One feature of the cancer strategy is that local cancer advisory groups have made decisions about investment priorities. Patients have been involved in all parts of the cancer strategy.

There are many strands to the issue that Janis Hughes raises. I do not know whether she is asking specifically whether there should be greater public involvement in decisions about the issues that we are discussing now. My response to that question at a national level must relate to the processes that we undertake for the budget as a whole. I would welcome more public involvement in decisions about spending, because it is important that an increasing number of people become aware of the nature of political choices. There is always a danger of people believing that they need only to say that something is desirable in order to have it. Politics is about making choices, which are often spending choices.

Janis Hughes: We can empower people to accept choices only if we give them full information in the first place.

Malcolm Chisholm: Janis Hughes is absolutely right. I am committed to having greater transparency. I am aware that members will not be satisfied with the degree of transparency in the health budget. I am not satisfied with it, either. There are inherent difficulties, which we have described previously, that relate mainly to the fact that such a large proportion of the health budget is assigned to NHS boards. That raises an issue that we touched on a moment ago. To what extent should we instruct boards on what they do? To what extent should they make choices and exercise responsibilities at a local level? To what extent should we say, "You will get so many pounds for this and so many pounds for that"? There are inherent difficulties in making the budget more transparent, but that does not mean that we should not try to do so.

Janis Hughes: Another issue that has arisen frequently and is of concern to the public is postcode prescribing. What progress has been made on tackling that problem?

Malcolm Chisholm: Progress has been made on that issue. Are you asking about postcode prescribing in the narrow sense—with respect to drugs? Often postcode prescribing covers postcode care.

Janis Hughes: I am asking about postcode issues in general.

Malcolm Chisholm: We are faced with a dilemma, because this is the question that we have already discussed in a different form—to what extent should we direct services from the centre? The corollary of directing that more of one service should be offered is that less of another service will be available. We need to decide how much we will insist on and how much local variation we will allow.

I accept that on some matters it is unacceptable to have postcode care. We have sought to deal with that issue through the performance assessment framework, for example, which identifies priorities that we intend to monitor. We believe that the Scottish Parliament and Scottish Executive have a right to insist on those priorities, because of their democratic legitimacy. However, it would be dangerous to take that approach too far.

On postcode prescribing specifically, the Health Technology Board for Scotland comments on the National Institute for Clinical Excellence judgments on particular drugs. We have made it clear that boards should take account of that and make sure that the drugs are available to meet clinical need, if the HTBS has given that recommendation.

That approach has been rolled out in Scotland over the past year. We are saying that NHS boards should be following HTBS advice on drugs and ensuring that those drugs are available to meet clinical need. Again, however, we do not want to interfere with clinical decisions in any way.

Janis Hughes: I do not think that anyone disagrees with the principle behind the process. The problem is that, at the local level, the advice does not seem to be followed in practices. MSPs' postbags are full of letters from patients who say that, if they lived three doors up, they would be in a different NHS board area and would be able to get a different drug. That is the problem with postcode prescribing. The principle might be right but the right thing is not happening on the ground. What are you doing about that?

Malcolm Chisholm: The process is working better this year than it was last year but that is not to say that the problem will suddenly disappear. The reality is that the option is not a cost-free one. If a certain drug has to be made available, that will have a cost. Obviously a drug should be made available, but NHS boards still have to make spending allocations to make that happen.

We have made the judgment that we want to do something about postcode prescribing, but we also have to accept that, in the real world, that will cost money. Some drugs are expensive and we obviously have to give NHS boards a little bit of time to find the funding to ensure that those drugs can be delivered.

You have already touched on two of the most important issues in health: pay and drugs. The cost of pay and drugs is an important feature of health budgets. If we decide to spend more on drugs, that will have consequences for other parts of the health budget.

The Convener: Margaret Jamieson has a supplementary question and then I will come back to John McAllion.

Margaret Jamieson: Minister, I appreciate what you have said about health boards having to consider the financial implications of making a new drug available. However, that is not the way in which individual health boards areas are looking at the issue. If NICE makes a recommendation in January and the HTBS considers that advice and makes its recommendation at the end of February or the beginning of March, it will be August before my constituents have an opportunity to receive, or not, the drug. Each organisation is rehashing the same process.

If the HTBS says that drug B provides a better clinical outcome for a specific group of patients, I challenge any health board to say that it has greater expertise than the people who are involved in the HTBS and NICE. However, health boards often rehash the whole procedure. I accept that what you are saying is correct and happens at the top of the chain but, at ground level, it ain't happening. We ask that you consider that and perhaps put another tick box in the performance assessment framework. You knew that I would not miss an opportunity to talk about the PAF.

Malcolm Chisholm: It is best to proceed example by example. If there are particular problems, we should consider them. However, I do not think that a certain amount of time lag is unacceptable. You might be asking a question about the future of the HTBS with reference to the current issue, but perhaps you are not. The time delay between the HTBS and NICE making their recommendations does not seem to be all that long. However, there might be financial or other reasons for a further time delay.

Margaret Jamieson: The people who are sitting on my advisory group are not accountants, but clinicians. They are considering the merits and demerits of new drugs and I do not think that that is the best use of their time. However, that issue might be for another day.

What progress has the Executive made in identifying unmet need in relation to Arbuthnott? The question is similar to the one that Janis Hughes asked about postcode issues. Can the Executive provide evidence to show that health inequalities are being targeted?

Malcolm Chisholm: A sub-group of the Arbuthnott group is considering the issue. That sub-group, under the chairmanship of Professor Kevin Woods, is looking at the formula on an on-going basis. Its report will come out quite soon. Although I have heard about the report only in general terms, I think that it will be good. The whole issue of unmet need is an important dimension of health inequalities. All committee members understand the issues, but, to put it simply, someone in a more deprived area might be less likely to use services. That should be taken account of in resource allocation. The report is an important piece of work. It demonstrates one way in which we take health inequalities seriously. I hope that there are other illustrations of that.

Another important piece of work, which is also coming to a conclusion, is the development of health inequalities indicators. That is an important part of taking health inequalities seriously. If we do not have indicators, we might just be talking fine principles and aspirations. I will get the important report from that group quite soon.

We have flagged up one aspect of health inequalities in the document "Closing the Opportunity Gap", which was released as part of the budget process. One of the indicators that we flagged up was mortality from coronary heart disease among people under the age of 75. The figures show some shocking inequalities between different social groups. We have said that we will look at that area.

Margaret Jamieson also asked how we ensure that health boards focus on tackling health inequalities. Aspects of the performance assessment framework are focused on that area. The development of indicators will be helpful in that regard. Until we have indicators, progress might be difficult to measure and demonstrate.

Margaret Jamieson: Will the ownership of community plans by local authorities make it possible for us to see a move towards the application of a localised Arbuthnott formula?

Malcolm Chisholm: Are you tempting me to stray into the area of local government finance?

Margaret Jamieson: No. The situation is that local authorities are legally in charge of drawing up community plans, but health colleagues are part of the group that is involved in pulling that together. A large amount of the money involved will come not from the local authorities, but from the health budget. Local authorities are in a far better position to identify areas of deprivation or rurality, or areas in which it is insufficient just to have a visiting GP. Authorities might move towards a mini-Arbuthnott formula more quickly than would have been the case if community plans had been left with our colleagues in the NHS boards.

Malcolm Chisholm: You are talking about the distribution of money within community planning partnerships, rather than our distribution of money to local authorities. I am pleased about that. You are right that local authorities have a lot of experience in that regard, as they do of issues such as social inclusion partnerships. Community planning is a big issue for us in the health area. When we talk further about health improvement strategies, community planning will be an important part of that discussion. A focus on health inequalities has to underpin all our health improvement work. I am sure that the experience of local authorities will be useful in that regard.

Mr McAllion: I will turn to the issue of the private finance initiative.

Malcolm Chisholm: You surprise me, John.

Mr McAllion: The committee has recommended that the Executive should provide and publish all the details that are contained in a contract. You have responded to that recommendation by saying that private companies who enter into those contracts

> "should have the right to exclude or delete text from documents if the publication of that text would put their interests at risk or allow competitors access to commercially sensitive information."

Who decides what text is to be deleted from those published documents—the private companies or the Executive?

13:15

Malcolm Chisholm: That issue arose last time I came before the committee. We promised to send a letter. I have with me a letter from John Aldridge, dated 30 May. He indicates that the issue is not necessarily a health department matter. I should let him answer the question, because he wrote the letter.

John Aldridge: It is for the private company to decide whether there are matters that are commercially sensitive.

Mr McAllion: Does the private company decide that or does it consult the Executive?

John Aldridge: The situation has never arisen, so I do not know what happens.

Mr McAllion: A private company has never deleted anything from a published document.

John Aldridge: I am not aware of that having happened. The health board that enters into the contract will have a copy of the contract.

Mr McAllion: I am thinking about the public, rather than the health board.

John Aldridge: If any information had to be deleted from a contract for publication purposes, the health board would be aware of that.

Mr McAllion: The Scottish Executive would not necessarily be aware of any such deletion.

John Aldridge: No—there is no particular reason why we should be aware of a deletion, as we do not hold the contracts centrally.

Mr McAllion: We would have to quiz the NHS trusts that are involved in contracts with private companies to find out whether any information was being withheld.

John Aldridge: It is open to anyone to ask the relevant NHS trust or health board for copies of the documents. If concerns exist about the withholding of information, the body concerned can be asked what has been withheld.

Mr McAllion: The issue is of public interest across Scotland, because PFI is a highly controversial method of investing in the national health service. Should not the Executive publish the information in its budget plans, so that ordinary people can look at those plans and find out how much has been spent on PFI contracts, how much the private sector has put in and how much the health boards are paying? Do we not have a right to access that information?

Malcolm Chisholm: I do not think that such information would be withheld.

Mr McAllion: We do not know whether it is. We have heard that the Scottish Executive does not know what information is withheld.

Malcolm Chisholm: I am happy to explore that issue. Information on annual cost issues is certainly not withheld or hidden away. Some of that information is outlined in the report that we have provided.

Mr McAllion: The recommendation is that all such information should be in the published budget.

Malcolm Chisholm: I am not aware that information on any of the issues to which you refer is withheld.

Mr McAllion: I am not suggesting that such information is withheld. I am asking why all such information is not made available, in detail, in the budget documents that the Scottish Executive publishes. Usually, the only thing that is published is the cost of the PFI contract to the private sector.

Malcolm Chisholm: I am ready to be corrected, but I believe that all the major PFI contracts are available through the Scottish Parliament information centre.

Mr McAllion: I am asking why that information is not available in the budget document.

Malcolm Chisholm: We wrote a longer budget document, but we were told that there was a desirable length and that we could not include everything that we wanted to.

Mr McAllion: I would not object to the inclusion in the budget document of any amount of detail on PFI contracts. I suspect that the public would not object to that, either. Why do not you do it? Do you have something to hide?

Malcolm Chisholm: The PFI contracts are available through SPICe. I am sure that you have read them all.

Mr McAllion: I want them to be accessible, not simply available. It is not right that people have to burrow and do research to find out such information, which is of public interest. PFI contracts are highly controversial and people want to know how much they cost the NHS and how much they cost the private sector. Why do you not publish the information?

Malcolm Chisholm: We publish the overall figures.

Mr McAllion: The information is not published in the documents that are made available to the Health and Community Care Committee.

Malcolm Chisholm: Much of the information is in the documents that you have been provided with.

The Convener: The PFI contracts are available through SPICe. We have taken up that issue in the past.

Mr McAllion: The information might be available through SPICe, but why is it not available in the documents?

Malcolm Chisholm: The main figures relating to PFI and public-private partnership contracts are in the documents.

Mr McAllion: Until this year, the figures have not been in the documents.

Malcolm Chisholm: I think that the figures are in them now.

The Convener: I want to move on. In a way, that question was almost predictable. The next question is utterly predictable.

Dorothy-Grace Elder: Will the minister explain the inconsistencies—that is the word that the committee’s adviser, Professor Midwinter, uses—between his attitude to increased improvements in neurological services and his attitude to chronic pain services? The minister appears to agree that neurological services are inadequate and to want an improvement—the implication is that he will give the issue a national steer. However, he leaves the pain question to local health boards. Highland NHS Board, for example, has no chronic pain services.

The committee made only two requests. One was that neurological services—particularly those that affect 30,000 epilepsy patients—be improved throughout Scotland and the other was that comprehensive chronic pain services be established throughout Scotland. Why does the minister seem to have let down chronic pain patients so badly?

Malcolm Chisholm: I am not convinced that there is an inconsistency. That relates to the general point that I made at the beginning. How much will we direct from the centre and how much will we leave it to boards or—more fundamentally—front-line staff to develop and improve services? I have said on the record many times in the past few weeks that we cannot have a command-and-control health service. We will not change the health service by operating in that way.

We must take our responsibilities seriously and ensure that the priorities that we set are delivered on. I read out the 12 priorities that we have set. Dorothy-Grace Elder asks me to add chronic pain to those priorities. Chronic pain services are important. They are different from some other services, because, to put it simply, pain is a symptom, not a disease. However, that is not to say that something should not be done about it. We are active in that area. Mary Mulligan has had several meetings on that recently, including one with the cross-party group on chronic pain. She is involved in developing work on the matter.

We want to examine good practice to find out whether we can facilitate its development and encourage co-operative approaches to care across board boundaries in some cases. I recently read about a managed clinical network for pain services in Tayside, which seems a good way forward.

Dorothy-Grace Elder: Tayside is a centre of excellence that is overloaded with patients from other areas. A health board survey showed that patients in pain from Scotland are being sent as far as Liverpool and London and are being shifted up from the Borders to Aberdeen. As Highland has nothing—you again leave the matter to Highland NHS Board, which admits that it has no chronic pain services—Aberdeen, Glasgow and Edinburgh are overloaded with that area's patients.

The situation is scandalous. As you know, more than 500,000 patients are in pain. You talked about giving a steer from the centre—we ask you to do that. The committee appeals to you because we have had a steer from the public. As you know, 130,000 people responded to the pain campaign in the Parliament. The budget says—rightly—that the Executive wants to hear from the public. You are anxious for a public response, to the point of holding roadshows. The public have given us a steer. They have virtually given us our orders—they want their pain treated adequately. I am sorry, but you are not doing that. Will you say something better?

Malcolm Chisholm: I am partly describing the dilemma. We must ask how much the health department should dictate the range and nature of services throughout Scotland. We must facilitate and support change. I want chronic pain services to be developed, but you are asking me to add chronic pain to the list of priorities.

Dorothy-Grace Elder: The committee has asked you to do that.

Malcolm Chisholm: The issue is important, but that could be said of many other issues, too. I want progress to be made. We must acknowledge that the issue is difficult and is different in the way that I described—it is not a disease, but a symptom of many diseases. Indeed, important progress has been made on issues such as cancer pain. In the past year, there have been many developments in palliative care through managed clinical networks and the extra consultants in that area at the Beatson clinic.

I do not disagree with your desire to develop pain services. However, I would find it helpful if I knew the committee's precise demands. Are you asking me to issue guidance, ring fence money or add the issue to the health plan's list of priorities? I could argue that we are progressing the matter because of the interest that we are taking in the area. We are certainly trying to support, encourage and facilitate the development of those services.

Dorothy-Grace Elder: In what way? You are leaving the matter to the boards. The public have already asked you to give them a steer. They do not rely on the boards. After all, pain is not a vague thing; there are centres for it. However, Highland has nothing and other centres are overloaded.

Malcolm Chisholm: I have made it quite clear that I think that the area is very important. I ask people to think about where they want the balance to be struck in the things that I dictate. Worthy as pain services are, one could produce a list of 20 services that were equally worthy.

Dorothy-Grace Elder: Not for an area with a population of 500,000.

Malcolm Chisholm: There has to be a balance between what we dictate and what the local areas decide that they need. The issue is also partly about developing new models of care. In fact, it would not be right to impose a central model of care for such an area, because different members of the work force have their own important roles to play. For example, we should consider the crucial role of allied health professionals in pain services.

Dorothy-Grace Elder: But they need encouragement.

Malcolm Chisholm: I am certainly happy to encourage, Dorothy-Grace, but I am not clear whether you are asking me to do more and, if so, what more you want me to do.

The Convener: I should point out that the committee issued a questionnaire. We were disappointed by some of the responses that we received from parts of the country, because they showed that there was a patchy service. However, we should take on board the minister's point that there is probably no one-size-fits-all solution. Highland is one of the areas that does not appear to have any sort of pain service at all; indeed, committee members probably remember taking evidence from Highland Health Board when the matter came up. However, there are particular issues around the needs of rural and remote areas that might make it more difficult to provide certain services there than in other parts of the country.

Minister, we have written to you to raise some of the issues that emerged from the questionnaire. We will take the matter forward when we receive your response and perhaps suggest a set of recommendations that you can accept or not. We are still trying to get to the bottom of information about what services are available and the direction in which the Executive, the boards and the trusts are travelling on the issue. However, you made a valid point when you said that a lot can be done by learning from people who have done the work and by rolling out that best practice into other areas where services may not exist.

I am aware that we have another small agenda item that we should move on to. That probably brings us to the end of our budget questions to the minister.

Dorothy-Grace Elder: Minister, I just want to know what I can tell the public and the cross-party group.

Malcolm Chisholm: Well—

The Convener: With respect, I have said that there will be a way forward for the committee to finalise its work on the issue when we receive a response from the minister. At that point, Dorothy-Grace, it will be up to the committee to propose specific recommendations that the minister can act on or not, as the case may be. If I may say so, that will be about action, not rhetoric.

With that, I bring the public part of the meeting to a close and thank the minister for attending. However, he is not leaving just yet.

13:29

Meeting continued in private until 14:27.

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