HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 8 January 2003
(*Morning*)

Session 1

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CONTENTS

Wednesday 8 January 2003

Col.

ITEMS IN PRIVATE 3573
MENTAL HEALTH (SCOTLAND) BILL 3573
SUBORDINATE LEGISLATION 3574
Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 16) (Scotland) Order 2002 (SSI 2002/544) 3574
MENTAL HEALTH (SCOTLAND) BILL: STAGE 2 3575

HEALTH AND COMMUNITY CARE COMMITTEE
1st Meeting 2003, 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:

Scott Barrie (Dunfermline West) (Lab)
Mr Adam Ingram (South of Scotland) (SNP)
Mrs Mary Mulligan (Deputy Minister for Health and Community Care)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Graeme Eliot

LOCATION

Committee Room 1

Scottish Parliament

Health and Community Care Committee

Wednesday 8 January 2003

(*Morning*)

[THE CONVENER opened the meeting at 09:35]

Items in Private

The Convener (Mrs Margaret Smith): Good morning everyone, and welcome to the Health and Community Care Committee. It is our first meeting of the new year, so I wish everyone a happy new year. We have a fairly interesting year ahead of us, one way or another.

The first item on the agenda is to decide whether to take two further agenda items in private. Item 5 concerns witness expenses, and item 6 is consideration of our draft report on genetically modified crops. It is normal practice for the committee to consider reports in private until they are published. I suggest that both those items be taken in private. Are we agreed?

Members *indicated agreement.*

Mental Health (Scotland) Bill

The Convener: Agenda item 2 is a motion in my name, as printed on the agenda, concerning the order of consideration of stage 2 of the Mental Health (Scotland) Bill.

Shona Robison (North-East Scotland) (SNP): I will not object to the motion, but we must be careful about changing the running order for our consideration of the bill. Apart from the committee, several groups and organisations plan around the order that is specified. So long as there will not be continual change to the order of consideration, I am happy to support the proposed change.

The Convener: I understand that we are changing the order of consideration to include the definition, from which many things follow. I informed members of the change informally before the recess to give them a little bit of time. We have been caught out because we are starting stage 2 consideration immediately after the Christmas break, which has made things a little more difficult. However, I take your point on board.

Motion moved,

That the Health and Community Care Committee consider the Mental Health (Scotland) Bill at Stage 2 in the following order: section 227, sections 1 and 2, schedule 1, sections 3 to 18, schedule 2, sections 19 to 62, sections 64 and 65, section 63, sections 66 to 91, sections 161 to 212, sections 92 to 160, section 213 to 226, sections 228 and 229, schedules 3 and 4, sections 230 and 231.—*[Mrs Margaret Smith.]*

Motion agreed to.

Subordinate Legislation

Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No 16) (Scotland) Order 2002 (SSI 2002/544)

The Convener: I welcome the Deputy Minister for Health and Community Care to the meeting for agenda item 3, which is consideration of an affirmative instrument.

The Subordinate Legislation Committee had nothing to report on the instrument, and no comments have been received from members. If no one wishes to comment or raise any questions at this stage, I invite the deputy minister to move the motion.

Motion moved,

That the Health and Community Care Committee recommends that the Food Protection (Emergency Prohibitions) (Amnesic Shellfish Poisoning) (West Coast) (No.16) (Scotland) Order 2002, (SSI 2002/544) be approved.—*[Mrs Mary Mulligan.]*

Motion agreed to.

Mental Health (Scotland) Bill: Stage 2

The Convener: Members have received briefing documents for agenda item 4. I hope that we can just about remember what we are meant to do; it has been some time since we considered a bill at stage 2. If we take it nice and slowly, we should get through it.

Section 227—Meaning of "mental disorder"

The Convener: Amendment 1, in the name of the deputy minister, is grouped with amendments 2 and 234.

The Deputy Minister for Health and Community Care (Mrs Mary Mulligan): Amendments 1 and 2 will amend the general definition of mental disorder in section 227. The definition is crucial because the powers and duties throughout the bill relate to people who have, or in some cases appear to have, a mental disorder.

Section 227 currently defines mental disorder as

"any mental illness, personality disorder or learning disability, however caused or manifested."

That is the general approach that was endorsed by the Millan committee in recommendation 4.2 of its report. The Millan committee also recommended that, as with section 1 of the Mental Health (Scotland) Act 1984, there should be certain exclusions from the definition of mental disorder. The list of recommended exclusions includes sexual orientation or behaviour; alcohol or substance abuse; anti-social behaviour; and acting as no prudent person would act.

When the Executive issued its policy statement, "Renewing Mental Health Law", we stated that we were minded to accept Millan's approach. Following consultation with mental health and equality groups, we also proposed excluding gender identity. However, the draft bill, which we published last June, did not specify any particular exclusion to the definition of mental disorder. It seemed arguable that it was no longer necessary to exclude certain aspects of personality or behaviour, which would not now be thought to constitute mental disorders. In response to the draft bill, however, the general consensus was that the exclusions should be reinstated. The Executive considered that carefully but had not reached a final view when the bill was introduced to the Parliament.

The Health and Community Care Committee considered that, to avoid doubt, it would do no harm to specify that certain things are not mental disorders. The Executive concluded that that was right, and amendments 1 and 2, therefore, provide that, for the purposes of the bill, a person will not be considered to be mentally disordered by reason only of any of the matters listed. The list is based generally on the Millan recommendations. The Executive has added specific references to transsexualism and transvestism to reflect its intention to exclude gender identity from the definition of mental disorder and the Health and Community Care Committee's recommendation that gender dysphoria be excluded. I invite the committee to accept amendments 1 and 2.

I regret that, at this stage, the Executive is not minded to support amendment 234, but I will listen to the debate.

I move amendment 1.

The Convener: I invite Scott Barrie to speak to amendment 234 and the other amendments in the group. Scott will then leave to attend a meeting of the Justice 2 Committee before returning to this committee.

Scott Barrie (Dunfermline West) (Lab): Amendment 234 would amend section 227 to say that no person under the age of 18 should be labelled as having a personality disorder. Anyone who knows anything about labelling theory will know that the amendment is important, because it is necessary to be very careful about the early diagnosis of severe mental disorder conditions. People, rightly, require appropriate services as soon as possible, but giving someone an exact diagnosis at an early age can severely affect that person's life chances. One of the greatest stigmas that a young person can suffer is to be labelled as having a personality disorder and, if that label is attached at a young age, the effect on the young person's life chances in later life is hugely increased.

Given that much debate takes place between psychiatrists and clinical psychologists about definitions of mental illness, and given that diagnosis is not an exact science and takes a long time, we should be careful about attaching such labels to young people. That is the intention behind amendment 234.

It is appropriate that we ensure that young people receive the services that they require. However, we must be careful about the labels that we give to people. Sometimes it is convenient—I experienced this in my previous career—to attach a medical diagnosis of any sort to a young person so that he or she can obtain certain services. If the label of personality disorder is being attached to someone only in a therapeutic way, in order to provide them with a service, we must be careful about what the long-term effects of that diagnosis might be.

Amendment 2, in the name of Mary Mulligan, is welcome. It is good that there is an explicit recognition of the various things that would not count towards the definition of a personality

disorder. In the past, such things would have been seen as counting towards that definition, but thankfully society has moved on.

09:45

Mrs Mulligan: Amendment 234 seeks to provide that a child under the age of 18 cannot, for the purposes of the bill, be treated as having a personality disorder. The bill's approach follows the recommendation of the Millan committee that three categories of mental disorder should be specified and not further defined in the bill. In fact, it is highly unlikely that a child would be diagnosed as having a personality disorder. Standard clinical definitions of personality disorder are clear: personality disorder becomes apparent in adulthood and cannot normally be diagnosed before the age of 16 or 17. Ultimately though, diagnosis must be a matter of clinical judgment, applying accepted diagnostic criteria, and we cannot say with certainty that no person under the age of 18 could correctly be diagnosed as having a personality disorder. It is not the job of the bill to legislate against a specific diagnosis.

We will ensure that the code of practice contains guidance on the application of appropriate diagnostic criteria to the definition of personality disorder, including the relevance of the age of the person. I hope that, with that reassurance, Scott Barrie will feel able not to press amendment 234.

Amendment 1 agreed to.

Amendment 2 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Does Scott Barrie wish to move amendment 234?

Scott Barrie: The minister gave an assurance that diagnosis of personality disorder will be included in the code of practice. With the convener's indulgence, I would like to ask the minister a brief question. Will the code come back to any of the parliamentary committees?

Mrs Mulligan: It will be laid before Parliament.

Scott Barrie: On that basis, I will not move amendment 234.

Amendment 234 not moved.

Section 227, as amended, agreed to.

Before section 1

The Convener: Amendment 105, in the name of Mary Mulligan, is grouped with amendments 105A, 105B, 105C, 110, 111, 113, 114 and 145 to 147.

Mrs Mulligan: I think that we will find some of the groupings rather extensive, so I hope that members will bear with me. I shall try to shorten my comments where possible.

Amendments 105 and 110 are part of a group of amendments that the Executive has lodged in response to the Health and Community Care Committee's recommendation that the bill should contain explicit reference to the 10 Millan principles. During the stage 1 debate, Malcolm Chisholm and I gave undertakings that we would lodge amendments designed to reflect the Millan principles more fully in the bill, while ensuring that the drafting worked legally. The amendments fulfil those undertakings.

I will explain how the amendments affect the structure of part 1. In the bill as introduced, part 1 comprises a single section. Amendment 110 will remove part of section 1, which will be replaced by the new section that will be introduced by amendment 105. Subsections (1) to (3) of the original section 1 will be retained.

The proposed new section 1 sets out requirements in relation to equality of opportunity. That relates to Millan's principle of equality. As members know, legislation concerning equal opportunities is largely reserved to Westminster, but the proposed new section 1 goes as far as it can in making specific reference to equal opportunities in a bill of the Scottish Parliament.

Most of amendment 105 applies to adult patients, while amendment 106 makes separate provision for children. I will explain how the various Millan principles relate to the proposed new section. Amendment 105 is extremely broad in its effect. It applies whenever anyone is exercising functions under the bill, unless they are excluded by subsection (7) of the proposed new section. That exclusion occurs because the aim of the principles is to influence the behaviour of people—such as doctors and mental health officers—who make an intervention in the life of a patient. We do not think that it is right that the patient or the patient's informal carers should be bound by legal principles, nor that such principles should bind people who represent the patient or an informal carer. The Health and Community Care Committee recommended that the principles should apply to the mental health tribunal, and I am pleased to say that the section that is proposed in amendment 105 applies to the tribunal.

Proposed subsections (1) to (3) set out a range of matters that a person or body exercising functions under the bill must take into account. Among the matters to be taken into account are the wishes and feelings of the patient, and the importance of the participation of the patient and of appropriate information being provided to enable the patient to participate. Those all reflect Millan's principle of participation.

Proposed subsections (3)(c) and (3)(d) are new provisions that were not included in the original

section 1. I am pleased that we have been able to go considerably further in enshrining the principle of respect for carers. The subsections provide that proper account must be taken of the views of any person who provides a substantial amount of informal care, regardless of whether they are the primary carer. Furthermore, subsection (5) specifically requires that the needs of such carers should be taken into account.

We have added new provisions in proposed subsections (3)(g) and (3)(h) to reflect the principles of respect for diversity and non-discrimination. They emphasise the need to ensure that a person is not treated less favourably than someone who does not have a mental disorder unless there is justification for doing so and the need to take account of the patient's particular characteristics, such as their gender, cultural and linguistic background and sexual orientation.

Proposed subsection (4) is particularly important because it enshrines the principle of the least restrictive alternative. Like the rest of the proposed new section, that provision applies in a range of circumstances. Those circumstances include the preparation of an application for a compulsory treatment order; decisions by doctors and mental health officers about emergency or short-term detention; decisions by the tribunal about whether to approve a compulsory treatment order and about its terms; and decisions by doctors under part 13 of the bill, concerning what medical treatment to give.

Whenever there is a choice to be made in any of those situations, the relevant person is placed under a legal duty to choose the option that involves the minimum restriction on the freedom of the patient that is necessary in the circumstances. The measure is profound and will affect the operation of the legislation in many ways. It is reinforced by proposed subsection (3)(e), which ensures that the full range of options must be considered in every case.

We have added a new provision concerning reciprocity in proposed subsection (6). That provision expresses the general importance of ensuring that anyone who is, or has been, subject to compulsory measures receives appropriate services, including continuing care following discharge. Although that statement is important, we have always said that a general statement alone will not deliver the Millan principle of reciprocity. The principle also underlies the bill's specific provisions concerning compulsory treatment. No compulsory treatment order should be approved without the establishment of an adequate package of care. I shall be happy to return to those specific provisions when we reach the relevant parts of the bill.

Proposed subsection (3)(f) contains a provision that reflects the importance of providing maximum benefit to the patient. Read alongside proposed subsection (4), that provision also reflects the Millan principle of benefit. Like reciprocity, however, the principle is not only a general statement but underlies the drafting of the provisions in the bill that relate to compulsory care and treatment. Members should bear that in mind, particularly when we review parts 5 to 7.

I have covered nine of the Millan principles. The remaining principle is informal care—the principle that care should be provided without compulsion wherever possible. Again, specific provision to ensure that that is so is made in parts 5 to 7. The section that is proposed by amendment 105 contains further provision to reinforce that, including requirements to consider the full range of options and to discharge functions in a way that appears to involve the minimum restriction necessary in the circumstances on the freedom of the patient.

I hope that members agree that we have listened to what the committee and mental health groups said about the importance of the Millan principles. I am confident that our amendments will greatly improve the effectiveness of part 1.

I move amendment 105.

Mary Scanlon (Highlands and Islands) (Con): Amendments 105A and 105B were submitted by the Law Society of Scotland and the Mental Welfare Commission for Scotland.

The purpose of amendment 105A is to ensure that Executive amendment 105 provides a faithful and accessible expression of the Millan committee principles. It is thought that neither section 1 as introduced, nor the new section that is proposed in Executive amendment 105, adequately reflects those principles.

The minister said that the Executive supported the 10 Millan principles in its policy statement, "Renewing Mental Health Law". The Health and Community Care Committee in its stage 1 report conveyed the strong wish that the bill set out the principles in full. It is therefore believed that section 1 is unsatisfactory and requires amendment, as it states only four of the 10 Millan principles. Even if section 1 were amended by the Executive amendment, it would fail to reflect adequately the principles that were recommended by Millan. After amendment, section 1 would include only nine of the 10 principles and would omit the principle of informal care. In many cases, that omission would mean that the person acting would be required merely to have regard to the importance of certain matters, rather than to act in a particular manner. That seriously weakens the effect of the principles.

Other principles, such as benefit and non-discrimination, are given meanings that are distant from those that were accorded by Millan. My amendments attempt to rectify those deficiencies.

The first proposed new subsection in amendment 105A—subsection (3A)—would insert the principle of informal care, which is absent from the Executive amendment. The principle will appear in the provisions for compulsory treatment orders, but not in the short-term and emergency detention provisions. I do not understand the reason for that, particularly as the principle was incorporated in the Mental Health (Scotland) Act 1984. The informal care principle should appear in section 1 as an underlying principle.

Proposed subsection (3B) would insert the principle of benefit. A person intervening under the act would have to be satisfied that such an intervention would benefit the patient. Executive amendment 105 would merely require the person to

"have regard to the importance of"

benefiting the patient.

Proposed subsection (3C) relates to the principles of participation and respect for carers. Those who carry out functions under the act would have to support the patient and carers to participate in decisions about care by providing them with adequate information and support. Again, Executive amendment 105 would merely require the professional to

"have regard to the importance of"

doing that.

Proposed subsection (3D) would insert the principles of non-discrimination and respect for diversity. Executive amendment 105 defines non-discrimination as treating a patient with a mental disorder the same as a person who is not a patient. That does not make sense. Amendment 105A reflects the Millan recommendation. As far as possible, a patient should be treated in the same way as patients with other health needs. In other words, patients with mental illness should not be discriminated against compared with patients with physical illness. Executive amendment 105 attempts to cover the principle of respect for diversity but, as before, rather than requiring service providers to respond to the needs of a diverse community, it merely requires them to

"have regard to the importance of"

doing so.

10:00

Amendment 105B concerns the principle of reciprocity underlying the bill. It seeks to strengthen amendment 105 so that it more accurately reflects the Millan principle of reciprocity, which the committee endorsed in its stage 1 report.

Executive amendment 105 states in subsection (6) that a person exercising functions under the act should

"have regard to the importance of"

ensuring that a person who is subject to compulsory measures has adequate services. That is far removed from the principle of reciprocity that was outlined by Millan, as it imposes no more than a requirement to consider what services can be provided to the patient. The Executive accepted the principle in "Renewing Mental Health Law" when it said:

"where society imposes an obligation on an individual to comply with a programme of treatment and care, it should impose a parallel obligation on the health and social care authorities to provide safe and appropriate services, including ongoing care following discharge from compulsion."

Amendment 105B attempts to reflect that statement by the Executive and to give proper effect in law to the principle of reciprocity.

I lodged amendment 105C because I believe that proposed new subsection (10) is sufficiently covered in proposed new subsection (3)(d), which states the importance of providing information and support to the patient as necessary to enable participation by the patient.

I move amendment 105A.

Shona Robison: I support amendment 105A. The first key issue is the missing principle of informal care, which, as Mary Scanlon pointed out, was incorporated in the Mental Health (Scotland) Act 1984. It therefore seems strange that the principle of informal care does not appear in the new bill.

The other principles are fine, but, as Mary Scanlon said, they should be strengthened. To merely have regard to the importance does not go far enough. We should ensure that the principles contain a requirement for action, rather than a requirement to have regard to their importance, which can be too readily ignored.

As Mary Scanlon pointed out, the intention of the principles of non-discrimination and respect for diversity is for patients with a mental illness to be treated in the same way as those with a physical illness. That should be the comparison, and amendment 105A would achieve that. The principle of respect for diversity relates to having regard to the importance of doing that. That needs to be strengthened, and amendment 105A would achieve that.

The principle of reciprocity has been a key issue for the groups and organisations that submitted

evidence to the committee. We should ensure that that principle is given all the strength that it can be given in the bill. The term

"have regard to the importance of"

does not go far enough. Amendment 105B, which would "ensure" that appropriate services were provided, would strengthen the Executive's amendments and must be agreed to.

Mr John McAllion (Dundee East) (Lab): When the minister replies to the debate, will she focus on the principle of reciprocity? It is the key to the act. Millan placed a parallel obligation on the Executive and the health service to provide the services that patients require in exchange for their freedom being taken away. Why would the minister resist replacing the wording "have regard to" with "ensure"? What is wrong with putting the word "ensure" in the bill?

Secondly, how will "appropriate services" be defined? It is a catch-all phrase—it could mean everything and it could mean nothing. It could mean whatever the NHS can afford, which would be a breach of the Millan principles.

The Convener: I ask Mary Scanlon to wind up and to state whether she wishes to press or withdraw amendment 105A.

Mary Scanlon: I will press amendments 105A and 105B. As John McAllion said, the principle of reciprocity was an underlying reason for the bill. Everyone who gave evidence supports it. The committee also supports it, as does the Executive in the "Renewing Mental Health Law" report. If we were to water down the principle of reciprocity, it would weaken the bill.

Mrs Mulligan: Unfortunately, on behalf of the Executive, I advise members that we will not support amendments 105A and 105B. The Executive's legal advice is that subsection (3A) in amendment 105A would add nothing to the bill and could be dangerous. Later parts of the bill set out clearly when compulsory measures are justified and, if those criteria need to be tightened, the proper place to do so is in those parts of the bill. If subsection (3A) were added, we do not know what effect a court or a tribunal might give it.

There are concerns that the requirement in Executive amendment 105 to have regard to various matters is not strong enough. Proposed subsections (3B), (3C) and (3D) seek to provide that certain steps must be taken. Again, the Executive's clear legal advice is that that would be dangerous. We cannot predict what the legal effect would be if a person alleged that any of those duties had not been carried out, and it would open the door to legal action to overturn a decision under the act, even where that decision was quite justified.

It may be helpful if I give an example of that. If subsection (3B) were given effect, it could create a similar loophole to that which was closed by the Mental Health (Public Safety and Appeals) (Scotland) Act 1999, following the Ruddle case. Restricted patients who are dangerous could argue that they must be discharged because they are no longer benefiting from treatment.

Numerous other difficulties might arise. Under subsection (3C), would medical information always have to be given to carers, even when the patient expressly requested that that should not happen?

Another criticism of the Executive's amendment 105 is that it sets out the principle of non-discrimination, and proposed subsection (3D)(a) outlines an alternative draft.

John McAllion referred to reciprocity. The intention of amendment 105B is to strengthen the principle of reciprocity. Millan is right that, where a person is compelled to accept treatment, society owes an obligation to provide appropriate care and support. We have reflected that in the bill, but amendment 105B would not work. The duties that it would impose would apply to anyone who discharges functions under the act in relation to a person who is, or was, subject to detention or compulsory treatment. The amendment would require any such person to ensure the provision of appropriate services to the patient, but many of the people who would discharge those functions would have no power to ensure that services are provided. A mental health officer, for example, cannot ensure that a patient gets suitable care. A responsible medical officer or a general practitioner cannot ensure that a person gets suitable community services. The amendment is simply not a practical way in which to enshrine reciprocity in the bill.

Millan set out a general aim that services should be under an obligation to provide adequate care and support to people subject to compulsion, but a bill cannot deliver that simply by saying that that is a principle. What duties are imposed and on whom must be set out clearly, and that is what we have done, particularly in part 7. For the first time, the care that a patient receives will be a consideration in making a compulsory treatment order. Services will have to set out clearly what care is to be provided and satisfy the tribunal that the order is justified against the background of that care plan. In coming to a decision, services and the tribunal will be required to apply the principles set out in amendment 105.

Amendment 105C would remove subsection (10) of the new section that amendment 105 proposes. That would make sense only if we were accepting amendment 105A and, as I have indicated, I am not able to do that.

I hope that I have shown that our objections are nothing to do with resistance to the Millan principles in themselves, but are purely about ensuring that the act works properly. On that basis, I ask Mary Scanlon not to press her amendments.

The Convener: The question is, that amendment 105A be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Robison, Shona (North-East Scotland) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Sturgeon, Nicola (Glasgow) (SNP)

AGAINST

Butler, Bill (Glasgow Anniesland) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
McAllion, Mr John (Dundee East) (Lab)
Smith, Mrs Margaret (Edinburgh West) (LD)

The Convener: The result of the division is: For 3, Against 5, Abstentions 0.

Amendment 105A disagreed to.

Amendment 105B moved—[Mary Scanlon].

The Convener: The question is, that amendment 105B be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Robison, Shona (North-East Scotland) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Sturgeon, Nicola (Glasgow) (SNP)

AGAINST

Butler, Bill (Glasgow Anniesland) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
McAllion, Mr John (Dundee East) (Lab)
Smith, Mrs Margaret (Edinburgh West) (LD)

The Convener: The result of the division is: For 3, Against 5, Abstentions 0.

Amendment 105B disagreed to.

Amendment 105C not moved.

Amendment 105 agreed to.

The Convener: Amendment 106, in the name of Mary Mulligan, is in a group on its own.

Mrs Mulligan: I am pleased to propose amendment 106, which makes special provision for children in part 1 of the bill. Members will recall the compelling testimony from children's groups at stage 1 about the need to improve the care and treatment that we offer to children and young people who experience mental distress.

We will discuss services for children later, but Children in Scotland and others who gave evidence felt that it was particularly important that the bill should set out right at the start a statement of principle concerning the welfare of children. That was also recommended by the Millan committee as the last of its 10 principles.

We attach tremendous importance to the welfare of children who are involved in the mental health system. We have considered carefully how we can give best effect to the child welfare principle and how that should interact with the other nine Millan principles as well as with the specific requirements of later parts of the bill.

Amendment 106 is a well thought-through response to that complex problem. The amendment will create a new section under part 1 that will apply whenever someone discharges a function under the bill with respect to a person aged under 18 who has, or appears to have, a mental disorder. For example, the new section will apply when a tribunal is making a decision on a compulsory treatment order or when a doctor or mental health officer is considering whether there is a need for a child to be subject to compulsory measures.

10:15

The fundamental requirement is to exercise any discretion in the manner that best secures the welfare of the child. The approach is similar to that in the Children (Scotland) Act 1995, as it ensures that the welfare of the child is paramount, although the precise wording has been adapted to meet the different context of the bill.

As in amendment 105, subsection (1) of the proposed new section makes it clear that the legal requirements of the new section do not bind the patient or informal carers, or people such as advocates or legal representatives who represent the views or interests of the patient or carer. Other than that, the provision is extremely wide in its effect.

In making the decision about what best secures the welfare of the child, the new section will bring in other Millan principles. The principles of the least restrictive alternative and informal care are reflected in subsection (5)(c) of the proposed new section. That subsection emphasises the importance of acting in a way that involves the minimum restriction on the freedom of the child. Subsections (5)(a) and (5)(b) provide that account must also be taken of the other considerations that are set out in amendment 105. Those reflect other Millan principles, including participation, respect for carers, respect for diversity, non-discrimination, benefit and reciprocity.

Amendment 106 is a truly radical provision. I hope that members will understand why we had to take care to get it right. We believe that

amendment 106 will act as a guide to everyone who uses the provisions once they have been enacted. They will provide consistency with other children's legislation. Most important, they will better protect children with mental health problems and learning disabilities.

I move amendment 106.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): When the minister winds up, will she clarify why amendment 106 refers to the age of 18? I have concerns that various pieces of legislation use the age of 18, while others use the age of 16. We need to ensure that we address that issue, so that there is one common age throughout all such legislation.

The Convener: If there are no other comments from members—I am trying to give the minister time to be briefed on that issue—perhaps the minister will wind up.

Mrs Mulligan: Margaret Jamieson's question is one that I have asked, too. Various pieces of legislation refer to different ages. I understand that the reason for that is the way in which they interact with previous pieces of legislation, which apply at different ages. We need to continue to address the different ages where those apply. Throughout the bill, different ages will continue to be used. Either 16 or 18 is used where that is appropriate according to existing legislation.

Amendment 106 agreed to.

Section 1—General principles applicable to the discharge of certain functions etc

The Convener: Amendment 107 is grouped with amendment 108. I ask the minister to speak to both amendments and to move amendment 107.

Mrs Mulligan: Amendments 107 and 108 are purely technical amendments, which will improve the drafting by ensuring that section 1 applies whenever a relevant person discharges "a function" under the bill, rather than "functions".

I move amendment 107.

Amendment 107 agreed to.

Amendment 108 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 109 is grouped with amendments 7, 8, 9, 10, 20, 57, 58, 59 and 60.

Mrs Mulligan: This group of amendments is also technical, so I shall try to be equally brief.

The definition of health boards in section 228 applies to local health boards, and does not include special health boards. Special health boards include the State Hospitals Board for Scotland and other bodies such as NHS Quality Improvement Scotland. Amendment 109 will ensure that the requirements in section 1 to encourage equal opportunities apply to special health boards when discharging functions under the bill.

Amendments 7 to 10 add special health boards to the list of bodies with which the Mental Welfare Commission may deal.

Amendment 20 adds special health boards to the bodies placed under a duty to provide assistance to the commission in discharging its functions under the bill.

Amendments 57 to 60 add special health boards to the bodies that should co-operate with local authorities in respect of local authority duties in sections 20 and 21.

I move amendment 109.

Amendment 109 agreed to.

Amendment 110 moved—[Mrs Mary Mulligan]—and agreed to.

Section 1, as amended, agreed to.

Section 2 agreed to.

Schedule 1

THE MENTAL WELFARE COMMISSION FOR SCOTLAND

The Convener: Amendment 169 is grouped with amendment 170.

Mrs Mulligan: Again, amendments 169 and 170 are technical. Section 228 states:

"'regulations' means regulations made by the Scottish Ministers".

Therefore, there is no need to include the phrase in schedule 1(8). The two amendments delete references to Scottish ministers making regulations, but retain the provision that Scottish ministers shall consult prior to making regulations.

I move amendment 169.

Amendment 169 agreed to.

Amendment 170 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: I call the minister to move amendment 5.

Mrs Mulligan: Paragraphs 3 and 7 of schedule 1 make provision for the Mental Welfare Commission to appoint a chief officer, and for that officer to be an ex officio member of the commission. The Mental Health (Scotland) Act 1984 contains no such provisions for the appointment of a chief officer.

The amendment will make provision in the 1984 act to allow the Mental Welfare Commission to appoint a new chief officer and for that officer to be an ex officio commissioner, which brings the act into line with the bill's provisions. That provision is in line with the recommendations of the policy and financial management review of the Mental Welfare Commission, which Scottish ministers have accepted.

The amendment is required because the present director of the Mental Welfare Commission demits office before the provisions in the bill are planned to come into effect. For the Mental Welfare Commission to continue operating effectively and, in particular, for it to plan for its increased duties under the new act, it will be important for the commission to appoint a new chief officer as soon as possible. It will be preferable for the appointment to be made in line with the provisions for a chief officer as drafted in schedule 1. Amendment 5 enables such an appointment by amending the existing legislation accordingly and makes no other changes to commissioner appointments or to the MWC's powers or duties.

I move amendment 5.

Amendment 5 agreed to.

Schedule 1, as amended, agreed to.

Section 3—Duty to monitor operation of Act and promote best practice

The Convener: Amendment 171 is grouped with amendments 6, 172, 173, 235 and 174.

Mary Scanlon: Again, this group of amendments has been supported by the Law Society and the Mental Welfare Commission.

Amendment 171 concerns the MWC's role and seeks to give the commission a general protective function in relation to people in Scotland with mental disorders. The Mental Health (Scotland) Act 1984 clearly states that the MWC's role relates to the protection of those who are vulnerable through mental disorder—in other words, it focuses on the individual. As currently framed, the commission's general duties under sections 3 and 4, and its particular functions under section 11, do not include powers to visit people in the community who are neither subject to measures under mental health legislation nor living in or using premises specified in section 11(4). For example, the commission has no power to visit people who are not subject to compulsory measures and who live in their own home. Furthermore, section 11 does not include a duty to visit people in the community who are subject to conditional discharge.

All those difficulties could be met by stating that the commission should have a general duty to protect the welfare of persons who have a mental disorder. That would be consistent with the commission's general duty under the existing act.

Amendment 172 concerns notification by the MWC and seeks to add the Scottish Parliament to the list of bodies to whose attention the commission may bring matters of concern. In the Millan committee's report entitled "New Directions: Report on the Review of the Mental Health (Scotland) Act 1984", recommendation 23.12 states:

> "The Commission should be specifically entitled to draw matters concerning the welfare of people with mental disorder to the attention of the Scottish Parliament (and where appropriate, the UK Parliament."

In "Renewing Mental Health Law", the Executive supported such a view.

Adding the Scottish Parliament to the list in section 5 would promote confidence in the commission's independence among users and carers and would contribute to a perception of openness in the commission's reporting relationships.

Amendment 173 also concerns notification by the commission and seeks to add NHS Quality Improvement Scotland to the list of bodies to whose attention the commission may bring matters of concern. Again, the commission will need to be able to make NHS Quality Improvement Scotland aware of deficiencies that it encounters in services for patients.

Finally, amendment 174 concerns the MWC's duty to give advice and seeks to ensure that it can advise the Scottish Commission for the Regulation of Care. Situations might arise in which the MWC needs to give advice to the care commission, which should therefore be included in the bodies listed in section 7. The care commission has a corresponding duty to advise the MWC, where appropriate.

All the amendments seek to ensure that there is better joined-up working and partnership and that we recognise the new bodies that have been set up.

I move amendment 171.

Mrs Mulligan: We understand amendment 171's aim of replicating the general protective function that the MWC currently has under the Mental Health (Scotland) Act 1984. However, the concept of a general protective function for the Mental Welfare Commission is unnecessary. The bill provides the MWC with appropriate powers and duties. The general drafting approach to the commission's functions is different from that in the 1984 act and is mostly more detailed. We do not believe that adding a reference to general protective functions is appropriate or necessary.

We understand the concern to ensure that the MWC's duty to visit is sufficient, but the bill meets the Executive's policy intentions and there is no problem that needs to be corrected by the amendment. [*Interruption.*]

10:30

The Convener: People in the public gallery may not pass notes to committee members during a committee meeting. I say that in case a note that I saw was heading towards a committee member. That is the ruling of the Conveners Group. I am sorry for stopping the minister in her tracks.

Mrs Mulligan: Section 11 provides for the MWC to visit as often as it considers appropriate any person who is subject to compulsory measures under mental health, incapacity or criminal legislation. That is sufficient. Furthermore, section 11(2) provides for the MWC to visit persons who are subject to a compulsion order or an interim compulsion order wherever they reside, which includes the community. With those assurances, I hope that Mrs Scanlon is persuaded to withdraw amendment 171.

Amendment 6 gives the Mental Welfare Commission a duty to monitor the observance of the bill's general principles by those who discharge functions under the bill. That is in line with the commission's duties to monitor the bill's operation and to promote best practice under the bill. The commission has asked for that provision, which we are content to supply. I hope that the committee accepts it.

Amendment 172 is unnecessary. The MWC presents its annual report to the Scottish ministers, who are required to lay that before the Scottish Parliament. The bill continues that practice. Through that, any concerns that the MWC highlights in its report may be brought to the Parliament's attention.

Under section 8, the commission has the power to publish information about matters that are relevant to its functions. That could include information concerning any investigation into deficient care. Once such reports are published, MSPs or parliamentary committees can take up any issues that arise. There is no reason why the commission could not send copies of such reports to MSPs or the committee. I hope that those reassurances will allow Mary Scanlon to feel able not to move amendment 172.

We are content to accept in principle the proposal in amendment 173 to add NHS Quality Improvement Scotland to the list of bodies to whose attention the MWC can bring concerns. However, the amendment is no longer necessary. Amendment 7, which the committee has discussed, added special health boards to the list of bodies in section 5, which makes the provision that amendment 173 would make.

Amendment 174 would amend section 7, which places on the MWC a duty to provide advice to the Scottish ministers and to service providers such as NHS boards and local authorities on any matter that arises from the bill and that has been referred to the MWC. It is unlikely that the Scottish Commission for the Regulation of Care, which does not provide care services, will need to refer matters to the MWC on that basis. Nothing prevents the MWC and the Scottish Commission for the Regulation of Care from advising each other informally. Nevertheless, we are prepared to accept amendment 174, if the MWC considers that the provision would help it in its work.

The Convener: Before I ask Shona Robison to speak to amendment 235 and the other amendments in the group, I reiterate that no one in the public gallery should be passing notes of any kind or of any description to members of the committee. That has been agreed by the Conveners Group, which comprises all the parliamentary committee conveners. That decision was prompted by incidents in the past. I ask that the practice of not passing notes be maintained.

Mr McAllion: On that point, has it also been ruled that civil servants may not pass notes to ministers?

The Convener: I have asked that committee members be provided with the thinking behind the ruling. The decision has already been taken, however, so we have to abide by it for the moment.

Nicola Sturgeon (Glasgow) (SNP): I seek clarification about the status of the Conveners Group. I was not aware that it had any formal status.

The Convener: The status of the Conveners Group is now enshrined formally in standing orders. We voted on that two or three weeks ago.

Nicola Sturgeon: Once the Conveners Group takes decisions, are those decisions binding without discussion?

The Convener: Yes. The group is covered by standing orders now, so its decisions are binding.

Nicola Sturgeon: That is bizarre.

The Convener: It has taken three and a half years for the group's status to be formalised in standing orders.

Nicola Sturgeon: What is the answer to John McAllion's question? Does the same apply to civil servants sitting next to the minister?

The Convener: The decision was taken by the conveners of the committees of the Parliament in

relation to the workings of those committees—it is about a matter of conduct. I have asked for clarification on the thinking behind the decision to be circulated to members. The decision has now been taken. The Conveners Group is now enshrined in standing orders, so its decision is binding on committees.

Nicola Sturgeon: The ruling seems a bit unequal. If I wanted to have a researcher sit nearby and pass me notes, surely that is no different from the minister having a civil servant sit next to her to do the same thing.

The Convener: I have asked for clarification on whether the decision applies to members of the public or to members of parliamentary staff. I think that it probably applies to members of the public. If certain organisations can have members in the public gallery, whereas other organisations cannot, that is unequal. There is always an inequality in that regard and I am asking for clarification.

All that I have been told is that the Conveners Group has taken that judgment. As the group is now enshrined in standing orders, its decisions are binding on parliamentary committees. I do not understand or know the background to the decision. I have asked for the decision to be looked into and for that information to be circulated to committee members. Let us abide by the decision at present. We will come back to the matter when we can circulate further information.

Let us now return to amendment 235 and the other amendments in the group.

Shona Robison: Amendment 235 arises out of the concern that many groups and organisations, in particular the Scottish Association for Mental Health, have about the rise in the levels of compulsion. The Health and Community Care Committee wants safeguards and at least the ability to monitor any rise in the levels of compulsion that may stem from the bill. That is what amendment 235 attempts to achieve.

The amendment would give the Mental Welfare Commission for Scotland an enhanced monitoring role. The first part of the amendment would put a duty on the commission to

"notify the Scottish Ministers and Scottish Parliament of"

any increase in the levels of compulsion beyond 5 per cent. Putting in such safeguards to monitor any such increases seems reasonable, given that, over the past decade, there has been a 284 per cent increase in the episodes of long-term orders under the current legislation.

The second part of the amendment deals with community-based compulsory treatment orders. In the financial memorandum and in comments that ministers have made to the committee, it has been estimated that 200 people will be subject to community-based CTOs. It seems reasonable to provide for a safeguard that would bring to ministers' and the Parliament's attention any increase beyond that, particularly as the financial arrangements would cover only 200 orders.

I believe that the Mental Welfare Commission is well placed to take on such a role. I heard the minister's earlier comments about reports being laid before Parliament, but those reports are clearly of a general nature. We should not leave the matter to chance and hope that someone will pick up a line in a report about increased levels of compulsion. I believe that drawing to ministers' attention any increase in the levels of compulsion would be a useful role for the Mental Welfare Commission. It would constitute a safeguard that a number of groups and organisations that are involved in mental health welfare would welcome.

Mr McAllion: The minister said that the Mental Welfare Commission had asked for the power to monitor the effect of the bill. Would that cover the number of community-based CTOs? Would that figure be included as a matter of course in the reports that are laid before Parliament?

Mrs Mulligan: The direct response to John McAllion's question is yes. The Mental Welfare Commission will be able to monitor the whole effect of the bill, so it would pick up what John McAllion referred to.

We have sympathy with the aims of Shona Robison's amendment 235, which would require the full and effective monitoring of the operation of the bill and the use of CTOs in particular. We would certainly want to know of increases or decreases in the use of CTOs. Indeed, we would want to know that in an even shorter time scale than from year to year. We would want to know how many community-based CTOs were being granted by tribunals and whether there were any variations across the country.

However, we do not believe that specific aspects of the arrangements for monitoring the operation of the bill should be set out in legislation. The commission will have general duties to monitor and report on the operation of the bill. During the implementation period, we will work closely with the commission and with others to develop extensive and detailed arrangements for monitoring, assessing and researching the operation of the legislation. That will include information on CTOs.

I assure the committee that the arrangements that we propose to develop with the commission will go well beyond what amendment 235 proposes. I therefore invite Shona Robison not to move her amendment.

Mary Scanlon: If I understand the bill correctly, I think that amendment 171 is required, as I want

every patient to get the same level of protection and accountability under the Mental Welfare Commission. As I understand it, the commission has no power to visit people who are not subject to compulsory measures. People who are not under a compulsory treatment order but who nonetheless wish to have the same services, care and treatment as someone under a CTO has should be subject to the same level of monitoring and supervision. The treatment of all such patients should be accountable to the Mental Welfare Commission, so I will press amendment 171.

The Convener: The question is, that amendment 171 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Robison, Shona (North-East Scotland) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Sturgeon, Nicola (Glasgow) (SNP)

AGAINST

Butler, Bill (Glasgow Anniesland) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
McAllion, Mr John (Dundee East) (Lab)
Smith, Mrs Margaret (Edinburgh West) (LD)

The Convener: The result of the division is: For 3, Against 5, Abstentions 0.

Amendment 171 disagreed to.

Amendment 6 moved—[Mrs Mary Mulligan]—and agreed to.

Section 3, as amended, agreed to.

Section 4 agreed to.

Section 5—Duty to bring matters generally to attention of Scottish Ministers and others

Amendment 172 not moved.

Amendment 7 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 173 not moved.

Section 5, as amended, agreed to.

Section 6—Duty to bring specific matters to attention of Scottish Ministers and others etc

Amendment 8 moved—[Mrs Mary Mulligan]—and agreed to.

Section 6, as amended, agreed to.

After section 6

Amendment 235 moved—[Shona Robison].

The Convener: The question is, that amendment 235 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Robison, Shona (North-East Scotland) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)
Sturgeon, Nicola (Glasgow) (SNP)

AGAINST

Butler, Bill (Glasgow Anniesland) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
McAllion, Mr John (Dundee East) (Lab)
Smith, Mrs Margaret (Edinburgh West) (LD)

The Convener: The result of the division is: For 3, Against 5, Abstentions 0.

Amendment 235 disagreed to.

Section 7—Duty to give advice

Amendment 9 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 174 moved—[Mary Scanlon]—and agreed to.

Section 7, as amended, agreed to.

Section 8—Publishing information, guidance etc

Amendment 10 moved—[Mrs Mary Mulligan]—and agreed to.

Section 8, as amended, agreed to.

Section 9—Investigations

10:45

The Convener: Amendment 11 is grouped with amendments 12, 13 and 175.

Mrs Mulligan: Section 9 of the bill provides for the Mental Welfare Commission to conduct an investigation into any patient's case where it considers that to be appropriate. Amendments 11, 12 and 13 are technical amendments that seek to implement fully the Executive's policy intentions in respect of the MWC's investigatory powers.

Amendment 11 clarifies that the circumstances in which the MWC may act include when the patient is detained and when the detention is in a hospital.

Amendment 12 deletes the restriction in the bill as drafted of the MWC's investigatory powers to patients whose detention may be improper in some form. The effect of the amendment is to broaden the scope of the MWC's investigatory powers to cover all patients who are detained in hospital.

Amendment 13 extends the MWC's investigatory powers to those patients who are

under a compulsory treatment order, a compulsion order or an interim compulsion order. It will extend the MWC's investigatory powers to those who are under some form of compulsion but are not detained in hospital.

Section 10 of the bill provides for the MWC to hold an inquiry in relation to any investigation into any patient's case where it considers that to be appropriate. We understand the concerns that have given rise to amendment 175, in particular the concern that any penalty for obstructing the work of an MWC inquiry should be a real deterrent. We thank Mary Scanlon for lodging the amendment, which will increase the maximum of any fine from level 1 to level 3—from £200 to £1,000. We are pleased to support the amendment.

I move amendment 11.

Margaret Jamieson: Mary Scanlon is gobsmacked.

The Convener: Mary, you have got the minister.

I ask Mary Scanlon to speak to amendment 175 and the other amendments in the group.

Mary Scanlon: Nicola Sturgeon and Shona Robison have told me that I am on a roll.

As the minister has accepted amendment 175, there is no reason for me to labour the point. I am delighted that the minister has seen fit to accept the amendment.

Amendment 11 agreed to.

Amendments 12 and 13 moved—[Mrs Mary Mulligan]—and agreed to.

Section 9, as amended, agreed to.

Section 10—Investigations: further provision

Amendment 175 moved—[Mary Scanlon]—and agreed to.

Section 10, as amended, agreed to.

Section 11—Visits in relation to patients

The Convener: Amendment 14 is in a group on its own.

Mrs Mulligan: The bill gives the Mental Welfare Commission powers to visit patients who are subject to a guardianship order under the Adults with Incapacity (Scotland) Act 2000. Amendment 14 is a technical amendment that will extend the MWC's powers to visit to persons who became subject to guardianship under the 2000 act as a result of their tutor dative or tutor at law becoming a guardian under the 2000 act.

I move amendment 14.

Amendment 14 agreed to.

Section 11, as amended, agreed to.

Section 12—Interviews

The Convener: Amendment 15 is grouped with amendments 16 to 19.

Mrs Mulligan: The bill gives the Mental Welfare Commission a power to interview patients and other persons as part of the discharge of any its functions under the bill. Amendment 15 will extend that power to the MWC's functions under the Adults with Incapacity (Scotland) Act 2000. The bill also gives the MWC powers to carry out a medical examination of a patient and to inspect their medical records. Amendment 16 will make it clear that those powers extend to the discharge of the MWC's functions under the 2000 act.

The bill gives the MWC a power to inspect patients' medical or other records in relation to the discharge of its functions under the bill. Amendments 17 to 19 will extend the range of persons who may inspect records to include any commissioner or member of staff of the commission who is so authorised by the commission. The measure will enable commissioners and staff who have medical, nursing or social work qualifications to inspect patients' medical or other records while discharging the commission's functions. The facility was requested by the commission and we are content to make provision for it.

I move amendment 15.

Amendment 15 agreed to.

Section 12, as amended, agreed to.

Section 13—Medical examination and inspection etc of records

Amendments 16 to 18 moved—[Mrs Mary Mulligan]—and agreed to.

Section 13, as amended, agreed to.

After section 13

Amendment 19 moved—[Mrs Mary Mulligan]—and agreed to.

Section 14—Duties of Scottish Ministers, local authorities and others as respects the Commission

Amendment 20 moved—[Mrs Mary Mulligan]—and agreed to.

Section 14, as amended, agreed to.

Sections 15 and 16 agreed to.

Section 17—Protection from actions of defamation

The Convener: Amendment 21 is grouped with amendment 22.

Mrs Mulligan: The bill gives the Mental Welfare Commission protection from actions of defamation when it brings matters to the attention of the Scottish ministers and other bodies or when it publishes information or guidance about any matter under the bill. Amendment 21 will extend that protection to the commission's duty to report on matters of concern about the bill's operation. Amendment 22 will extend the MWC's protection from defamation to the commission's duty to publish an annual report on the discharge of its functions.

I move amendment 21.

Amendment 21 agreed to.

Amendment 22 moved—[Mrs Mary Mulligan]—and agreed to.

Section 17, as amended, agreed to.

Section 18 agreed to.

Schedule 2

THE MENTAL HEALTH TRIBUNAL FOR SCOTLAND

The Convener: Amendment 176 is grouped with amendments 177, 178 and 179.

Mary Scanlon: Amendment 176 was submitted by the Law Society of Scotland and the Mental Welfare Commission. Its purpose is to provide that members of the tribunal are appointed not by Scottish ministers but by the Lord President of the Court of Session.

Under schedule 2 to the bill, Scottish ministers will appoint members of the tribunal. The Law Society of Scotland and the Mental Welfare Commission think that that might prove difficult where Scottish ministers are party to cases that the tribunal is considering. The provision also raises European convention on human rights concerns. For example, it might be perceived that the tribunal is not independent in relation to restricted patients whose cases it is considering. In those instances, tribunal members who have been appointed by Scottish ministers will be adjudicating in cases in which Scottish ministers might have an interest, even if they no longer make major decisions in relation to restricted patients.

In other fields, the Lord President appoints tribunal members. The Law Society and the Mental Welfare Commission suggest that the same procedure should be adopted for mental health tribunals. That argument applies to all the amendments in the group.

I move amendment 176.

Mrs Mulligan: Amendments 176 and 177 would replace ministers with the Lord President of the Court of Session in the role of appointing members and a president of the tribunal. I understand that the amendments are based on a concern that, if members of the tribunal were appointed by ministers, that would compromise their perceived independence and might be subject to challenge under the ECHR, particularly because, as Mary Scanlon said, ministers may occasionally be party to a case that the tribunal is considering. Amendments 178 and 179 are consequential to amendment 177.

I am happy to reassure members that, having considered the matter further in light of the amendments, we consider that the provisions of the bill as introduced are compatible with the ECHR. Although members and the president of the tribunal will be appointed by ministers, they will not be subject to removal by ministers. The reappointment arrangements are strictly regulated by the bill. That ensures that, once appointed, the members and the president of the tribunal are independent of ministers in the same way as sheriffs are, for example. From the ECHR point of view, it is important that, once appointed, members have adequate security of tenure. We believe that the bill delivers that and that there is no good reason why appointments should not be made by ministers.

Mary Scanlon: I am happy to accept the minister's assurances.

Amendment 176, by agreement, withdrawn.

The Convener: Amendment 23 is grouped with amendments 24 to 27, 31 and 32.

Mrs Mulligan: Amendments 23 to 27 will do two things. They are intended to revise the structure of panels from which the members of a three-person tribunal will be drawn, matching the provisions on the composition of a tribunal that are inserted by amendment 32. They also add more detail on the requirements that regulations can place on members of each of the panels.

Amendment 27 adds a fourth panel, consisting of all serving sheriffs—including part-time sheriffs and sheriffs principal—who will be members of that panel as of right. Members of the panel will serve as conveners of the tribunal for cases involving restricted patients as specified by amendment 32. However, because they occupy that position by virtue of their role as sheriffs, members of the panel will not be members of the tribunal per se and will not be subject to, for example, the reappointment and disciplinary provisions of paragraph 3 of schedule 2.

Amendment 24 removes the confusion that might be caused by describing members of that panel as conveners of the tribunal, because, in restricted-patient cases, conveners will not be drawn from the panel in question. Amendment 24 provides the alternative title of "legal members"

and amendment 23 confirms that the qualifications, training and experience that regulations may require of that group must be of a legal nature.

Amendments 25 and 26 concern the third panel of members. The bill is completely open about the nature of qualifications, training and experience that regulations could require of the panel. Amendment 25 will implement the policy that members of the panel should have a background in the care of, or in the provision of services to, people with mental disorder, or should have relevant personal experience as a service user or as a carer. Amendment 26 will give the panel the title of "general members" of the tribunal.

11:00

Amendments 31 and 32 deal with the organisation and administration of the tribunal. It has been established that each tribunal—that is, each three-person body that will make the determination in a particular case—should include a legally qualified convener, a medically qualified member and a third member with a care or service provision background. Furthermore, in cases that involve restricted patients, the convener should be a sheriff, a part-time sheriff or a sheriff principal.

The bill allows the composition of a tribunal to be specified by rules of procedure. However, we have given the issue further consideration and, in light of some of the evidence that was received at stage 1, we now believe that the composition of a tribunal should be specified in the bill, as that is a fundamental aspect of the nature and operation of the tribunal system.

Amendment 31 is a direct consequence of amendment 32. It will remove the only existing reference to the composition of a tribunal, which states that a tribunal should be composed of members of the national tribunal. Amendment 32 means that that reference is redundant and should be deleted.

The amendments in the group provide for a robust and appropriate structure for tribunal panels.

I move amendment 23.

Amendment 23 agreed to.

Amendments 24 to 27 moved—[Mrs Mary Mulligan]—and agreed to.

Amendments 177 and 178 not moved.

The Convener: Amendment 28 is grouped with amendments 29 and 30.

Mrs Mulligan: Amendment 28 is purely technical. Its purpose is to ensure legal clarity. Paragraph 2(4) of schedule 2 provides that certain provisions apply to the president as well as to members. Amendment 28 amends paragraph 2(4) to ensure that the way in which the provision applies reflects any necessary modifications.

Amendments 29 and 30 relate to the payment of tribunal members. Amendment 29 clarifies paragraph 5(1) to ensure that it includes payments that might be classed as gratuities, such as compensation for loss of office. Amendment 30 will mean that those payments are included in paragraph 5(2), which will ensure that any such payments to individuals who are subject to the Judicial Pensions and Retirement Act 1993 can be made only in a way that is consistent with the provisions of that act.

I move amendment 28.

Amendment 28 agreed to.

Amendment 179 not moved.

Amendments 29 to 32 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 33 is grouped with amendment 34.

Mrs Mulligan: Amendments 33 and 34 relate to the provision of accommodation for tribunal hearings and for the central office of the national body. Both amendments are necessary to ensure that the tribunal has the accommodation that it needs to work effectively.

Amendment 33 gives ministers the power to provide accommodation for the tribunal. We envisage that that will be especially relevant in accommodating the small, central headquarters for the administrative service that will support the tribunal and, in particular, the president of the tribunal. The location of the office will be subject to the Scottish Executive's relocation policy.

Amendment 34 places a duty on local authorities and health boards, including the State Hospitals Board for Scotland, to provide accommodation for tribunal hearings on the request of the president when it is reasonable for them to do so. We envisage that the tribunal service will work with local authorities and health boards to identify a range of potential venues that will be used as and when individual cases require them. In doing so, the tribunal service will work in co-operation with local authorities and health boards and will not seek to place unreasonable demands on them. It is not envisaged that local authorities or health boards will have to secure new or additional premises for those purposes.

I move amendment 33.

Amendment 33 agreed to.

Amendment 34 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Let us hope that the accommodation that the tribunals get will be a little warmer than the room that we are in this morning.

Amendment 35 is grouped with amendments 36 to 45.

Mrs Mulligan: Amendments 35 to 42 relate to paragraph 9(2), which lists issues that may be dealt with by rules of procedure for the tribunal. The amendments add to or clarify the issues that rules may cover and they clarify the wording of paragraph 9(2) to distinguish between "proceedings" and

"matters that are preliminary or incidental to … proceedings"

or both. "Proceedings" is the term that we apply to the totality of a tribunal's consideration of an individual case—for example, its consideration of whether to make a compulsory treatment order in relation to a specific individual. The "determination of proceedings" is the ultimate decision that the tribunal will have to make on the matter in hand. However, in doing so, a tribunal will have a range of other decisions to make, such as from whom to take oral evidence and whether to commission a medical report. We describe such issues as

"matters that are preliminary or incidental to the determination of proceedings".

Amendments 35, 39, 40 and 42 amend existing sub-subparagraphs of paragraph 9(2) to make it clear whether they cover proceedings, matters that are incidental or preliminary to proceedings, or both.

Amendments 36, 37 and 41 add to the scope of rules. Amendment 36 provides that rules may specify the form in which the tribunal notifies a third party of any matter. Amendment 37 provides that rules may specify that certain preliminary or incidental matters may be decided by the convener acting alone or with specified other members of the tribunal. Amendment 41 provides that rules of procedure may include rules on the admissibility of evidence to the tribunal.

Amendment 38 is consequential on amendment 37, in that it allows for the possibility that the convener, rather than the full tribunal, may decide to exclude from the hearing the person to whom the proceedings relate, if the rules have provided that that is among the decisions that the convener may make acting alone.

The rules of procedure will be important to how the tribunal operates. We intend to consult fully on their development over the coming months and they will be subject to parliamentary scrutiny as and when they are made. The purpose of the provisions and amendments is to enable the development of full and clear rules of procedure that, with the benefit of detailed consultation and further parliamentary scrutiny, will provide a robust and effective basis for the operation of the tribunal system.

Amendments 43, 44 and 45 deal with the tribunal's decision-making powers, specifically where decisions are made by a majority of the tribunal's members. Amendment 44 clarifies the wording of paragraph 12(1) to ensure that decisions must be made by a majority—which, of course, includes unanimity—and on no other basis. Amendment 43 allows for the situation that, on occasion, one member—the convener—acting alone may take decisions on some matters. Amendment 45 provides that, where the decision is to be made by two members, the convener will have the casting vote. The amendments ensure that a tribunal will be able to make decisions by majority in the range of situations that may arise.

I move amendment 35.

Amendment 35 agreed to.

Amendments 36 to 45 moved—[Mary Mulligan]—and agreed to.

Schedule 2, as amended, agreed to.

Section 19—Approved medical practitioners

The Convener: Amendment 46 is grouped with amendments 47, 48, 180, 49 and 50.

Mrs Mulligan: Amendments 46 to 50 make several minor changes to the terms of section 19 to ensure that it fully and correctly implements policy. The purpose of section 19 is to ensure that there is a body of medical practitioners who are approved for the purposes of undertaking relevant functions under the act—for example, granting a short-term detention certificate. A further purpose of the section is to ensure that lists of approved medical practitioners are compiled and maintained by the relevant bodies.

Amendment 49 adds the State Hospitals Board for Scotland to the list of bodies that have a duty to compile and maintain a list of approved medical practitioners. That is necessary because the State Hospitals Board for Scotland is not included within the definition of a health board. Amendments 46 and 47 are directly consequential to amendment 49, in that they restructure section 19 to allow for the fact that not all relevant bodies will be compiling and maintaining a list for a specific area defined as "their area".

Amendment 48 has the effect that experience in the diagnosis and—rather than just or—treatment of mental disorder is required in order for the status of an approved medical practitioner to be granted. Amendment 50 is a technical measure designed to clarify the policy that any medical practitioner who is included in a list compiled

under section 19 is classed as an approved medical practitioner.

Although we understand what lies behind amendment 180, in the name of Mary Scanlon, we do not consider it desirable. We certainly expect approved medical practitioners to have a working knowledge of mental health law. Section 19 provides that ministers shall specify the necessary qualifications, training and experience of approved medical practitioners in directions. That allows scope to set out any requirements concerning awareness of the relevant legislation. In contrast, amendment 180 would leave it up to individual health boards to decide the appropriate level of experience and knowledge of legislation. We do not think that that is appropriate. With that explanation, I hope that Mary Scanlon will feel able not to move her amendment.

I move amendment 46.

Mary Scanlon: As has become obvious during our consideration of the bill, there is undoubtedly a shortage of key personnel. Amendment 180 was submitted by the Law Society of Scotland and the Mental Welfare Commission. Its purpose is to ensure that approved medical practitioners have knowledge and experience of mental health legislation as well as knowledge and experience of treating people with mental disorders. Without the provision, a doctor may be approved who has experience in the diagnosis and treatment of mental disorder, but who works in a subspecialty of psychiatry, such as psychotherapy, in which the use of compulsory powers is extremely rare. The amendment seeks to address the shortage of experienced clinicians and to ensure that all those who have the power to issue a compulsory treatment order are well versed in the legislation.

11:15

Mrs Mulligan: Obviously, we will seek practitioners who have relevant experience. Amendment 48, which replaces the word "or" in section 19(1)(b) with the word "and", would deal with the issue that Mary Scanlon raises.

Amendment 46 agreed to.

Amendments 47 and 48 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 180 not moved.

Amendments 49 and 50 moved—[Mrs Mary Mulligan]—and agreed to.

Section 19, as amended, agreed to.

After section 19

The Convener: Amendment 3 is grouped with amendments 4, 4A and 148. I intend to end this morning's consideration of the bill after this group. We will stop at section 20, because we must finalise the report on our inquiry into genetically modified crops.

Margaret Jamieson: Amendment 3, which is supported by Mary Scanlon and Scott Barrie, recognises the issues that were raised by many organisations at stage 1. Scott Barrie and I, who have worked with groups of young people, believe that it is only appropriate that the bill should make provision for services for children and young people.

Having heard the evidence that was given at stage 1, we are concerned that there is a lack of facilities throughout Scotland for the care of young people who require to be detained. Increasing numbers of young people are being detained in adult facilities, which is not conducive to the treatment that they should receive.

I want to comment on amendment 148, which has been lodged by Adam Ingram and relates to single-sex wards. It is only right and proper for me to say that I do not support the amendment. When members of the committee visited the Orchard clinic, the clinicians advised us that on specific occasions it was in the interest of patients to be placed on mixed wards. They drew our attention to cases in which that had been an issue. If the amendment had referred to a clinical decision to place patients on a single-sex ward, I could have seen the point of it. However, I do not think that individuals should be able to choose to be placed on a single-sex ward. That decision should be made on clinical grounds.

For the sake of consistency, the proposed new section defines a "child or young person" as

"a person under the age of 18 years".

I move amendment 3.

Mr Adam Ingram (South of Scotland) (SNP): Amendment 4A is designed to fine tune amendment 4. Its purpose is to ensure that the bill reflects the principle that the child's needs must be paramount in all decisions regarding admission to hospital with the mother. In most cases, the needs of mother and child are identical, but that may not always be the case, especially where older children are involved. The bill includes provision for children up to two years old, but I understand that existing units routinely admit children only up to their first birthday.

With the best will in the world, an in-patient unit is unlikely to provide adequate and appropriate stimulation for a lively toddler for an admission period that may extend to over one month. In such cases, a child may be better placed with its father or other family members. However, as it stands, amendment 4 excludes other family members from the decision-making process. It should be

remembered that a severely ill mother may not always be able to prioritise the needs of her child, even though there may be no direct risk involved.

The purpose of amendment 148 is to provide the option for women to receive care in a single-sex facility. Research indicates that women are the predominant users of mental health services and that sexual and physical abuse are key factors in much that is diagnosed as severe mental illness. Abuse is strongly linked with the high use of services. Depression Alliance Scotland, among others, reports that women who have contacted its services have expressed concerns about not feeling physically safe on a mixed-sex ward. The women felt that the mixed-sex ward exacerbated their illness and feelings of vulnerability, and hence inhibited their recovery. Women need to be completely sure that their safety is guaranteed. Service provision must meet that need.

Bill Butler (Glasgow Anniesland) (Lab): I hope that the Executive will look favourably on amendment 4, given the complete lack of facilities for mothers and babies and for mothers who are suffering from post-natal depression. I know that there is a move within Greater Glasgow NHS Board to set up a temporary mother-and-baby unit, but what we really need is a statutory requirement for permanent such units to be set up throughout NHS Scotland.

I hope that the minister will be able to state that there is no substantive objection to a statutory requirement to provide joint admission. It is absolutely necessary that we bridge that gap within provision in the NHS in Scotland. I hope that she will be able to give the committee some comfort on that.

Mr McAllion: I know for a fact that, before provision in Dundee was broken into the different trusts, Ninewells hospital had two wards for mental health services. It was therefore easier to provide access to maternity services for patients who were suffering from mental illness. Of course, that was driven out of Ninewells when provision was split between the two trusts. It is more difficult to provide maternity back-up to patients who are held in health care trust accommodation.

I suspect that amendment 4 would require the Executive to develop a policy drive towards providing maternity services back-up to patients who found themselves needing to be admitted along with their children. In many areas of Scotland, that could prove to be a physical difficulty because of the separation of the services into two trusts that have two separate provisions of accommodation in any given area. Will the minister address that point?

Mary Scanlon: I support the point that was made by Margaret Jamieson. In the written and oral evidence, there was some talk of young adults finding the experience of being placed in adult wards quite traumatic. Amendment 3 provides us with an opportunity to address that issue. We need to ensure not only that there is appropriate care but that it is provided in an appropriate setting. I strongly support amendment 3.

The Convener: I also support Margaret Jamieson's amendment.

Mrs Mulligan: I am aware of the time pressures but I hope that members will bear with me because this group of amendments requires a detailed response. The group deals with children's services, mother-and-baby services and single-sex wards. The Executive agrees that more must be done in each of those areas and it is acting in that regard. However, we feel that the new legislation is not necessarily the way forward.

It is tempting to identify areas where there are problems and say that we need a legal duty, but it would be impossible to set out in legislation all the priority areas for the NHS. Once one area is singled out, that implicitly downgrades other NHS responsibilities.

Health legislation rightly requires Scottish ministers to provide a comprehensive health service for all the people of Scotland. Ministers also set out the priorities for NHS Scotland. Current legislation does not—and future legislation should not—single out particular groups or forms of care for special consideration in that general and encompassing duty.

Amendment 3 deals with services for children and young people. The Executive believes that the existing framework for mental health services provides a strong impetus and direction for comprehensive mental health services for all, including those with particular needs, such as children and adolescents.

As I stated in the stage 1 debate on 11 December, the forthcoming report of the Scottish needs assessment programme on the review of mental health services for children and adolescents will provide further impetus for development in the effective delivery of mental health services and support for that important group. The interim report, which was published in May 2002, has provided some direction for the way ahead, and the Executive is responding to the shortage of appropriately trained and qualified staff. More effective joint working among agencies will help, but we also need to focus on improved recruitment and training of the work force and on more flexible working practices.

To facilitate the development of managed care networks and its initiatives on integrated work force development, especially the work-force needs in child and adolescent services, the

Executive has made mental health a pathfinder client group. Identifying core competencies for staff and providing new opportunities for joint training will allow staff to combine more effectively in multidisciplinary teams that provide improved and sustainable services. One of the first priorities will be for mental health workers for child and adolescent services.

Extensive work is under way to ensure that NHS boards, local authorities, schools and other children's services work much more closely to provide integrated, seamless support and specialist help for children and young people, when and where it is needed.

The Executive agrees that it is not acceptable for children and adolescents to be treated in adult psychiatric wards. However, it does not agree that setting out a legal duty will advance the position. We must instead identify and tackle the contributing factors to the position, and the right environment in which to achieve that is being created.

Amendment 4 deals with services for mothers and babies. Again, the key is practical action to ensure that services improve, rather than seeking to add specific duties in legislation, which would not be consistent with the general approach of a comprehensive health service.

Scottish Executive guidance encourages NHS trusts to consider joint admissions of mothers and babies in light of the care and bonding benefits that that can bring. It is the responsibility of NHS boards, trusts and others to work together towards the provision of integrated care services.

The interests of the child and mother come together in our aim to improve services for mothers suffering from post-natal depression. Our works and plans were discussed on 4 December during the members' business debate that was introduced by Bill Butler. At that time, Malcolm Chisholm also stated:

"I will ask the regional planning groups to consider the benefits of providing joint admission services for post-natal depression on a regional basis in the light of the SIGN guidelines and I shall seek a response from them."—[*Official Report*, 4 December 2002; c 16047.]

11:30

Letters have since been sent to NHS Scotland inviting such consideration. It is unlikely to be practical for each NHS board to develop suitable facilities and to establish and maintain the staff skills needed to provide the necessary care. However, it is clear that the provision of such services is highly desirable and although I am not aware of the specifics of the case that John McAllion mentioned, the regional element of planning the service might address some of his concerns.

We believe that developments would best be pursued collaboratively across NHS board boundaries through the regional planning networks. The question of planning and provision of joint mother-and-baby units has been drawn to the attention of NHS boards and regional planning networks. The networks have been invited to commission whatever further collaborative work is appropriate to develop such a desirable initiative. Follow-up on progress of that agenda has been arranged for Easter.

As an encouraging indicator, Greater Glasgow NHS Board has plans for a six-bed joint-admission unit. The location is still to be decided but interim plans are in place that use existing accommodation. We will be looking to other boards under the regional planning agenda to follow that lead.

Amendment 4A would alter the terms of amendment 4 and, as we are not supporting amendment 4, we do not support amendment 4A.

Amendment 148 deals with single-sex wards. The Scottish Executive strongly supports the provision of in-patient care in single-sex wards in all NHS hospitals. Almost all acute psychiatric wards already offer single-sex facilities. Plans are in place to make the remaining wards compliant in the shortest possible time. In the meantime, all trusts have been required to agree with their local health council a policy to ensure that the dignity and privacy of patients is respected at all times in the non-compliant wards.

We do not therefore believe that amendment 148 is required and the legal duty that it proposes could lead to unintended consequences in individual cases. There could well be cases—and I think Margaret Jamieson was referring to this—where the most clinically appropriate form of treatment requires the admission of a person into a ward that is not completely single sex. The amendment would prevent such an admission, reducing the flexibility of services to respond to clinical need and possibly breaching the principle of providing maximum benefit to the patient.

Considerable progress has already been made and the remaining wards will be made compliant in the shortest possible time. The status of NHS in-patient wards will continue to be monitored for single-sex compliance and we are fully committed to achieving that aim throughout the NHS estate.

I am grateful to members for raising those points. The committee has consistently and rightly highlighted concerns about those aspects of NHS provision. I hope that members will accept that the Executive is also committed to delivering the necessary improvements and, on that basis, I ask members to withdraw amendment 3 and not move amendments 4, 4A and 148.

Margaret Jamieson: Having heard what the minister has said about the anticipated SNAP report, I need an assurance that that report will be available within the next six weeks at the latest. It would be helpful to have that information from the minister or her officials so that I can judge whether to move amendment 4.

There are areas where I feel that we have allowed issues to slip. If the SNAP report underpins what the minister has said and sets out a time frame, I will accept that what amendment 4 proposes should not be included in the bill. However, there are other areas where such a provision could apply and I am concerned that the minister did not say that it would be part of future performance assessment frameworks for NHS trusts and boards. John McAllion's point about considering the issue in terms of policy and the delivery of services would give another option.

I do not know whether the procedure allows the minister to respond to me so that I can judge whether to move amendment 4.

The Convener: I always give a little latitude from the chair. Crucially, the member wants to know, as does the committee, whether we are likely to see the SNAP report in advance of the stage 3 debate.

Mrs Mulligan: The indications are that the SNAP report will be available shortly. I do not have a precise date, although I can try to get that for members. Nevertheless, I cannot guarantee the timing of it. Obviously, the member would have the opportunity to return to the matter at stage 3, should she so wish.

Shona Robison: I guess that you will be pressing the amendment, then.

Margaret Jamieson: I can speak for myself, Shona. I do not need you to tell me. You are advising Mary Scanlon this morning.

The opportunity to return to this matter at stage 3 with, it is hoped, the SNAP report, might produce a better amendment. Therefore, I am prepared to withdraw the amendment.

Amendment 3, by agreement, withdrawn.

Amendment 4 not moved.

The Convener: As amendment 4 was not moved, amendment 4A cannot stand on its own and is therefore pre-empted.

Does Adam Ingram wish to move amendment 148?

Mr Ingram: I am reassured by the minister's comments with regards to compliance on single-sex wards, so I will not move the amendment.

Amendment 148 not moved.

The Convener: Amendment 236 is in the name of Mary Scanlon.

Mary Scanlon: Amendment 236 concerns the health boards' duty to ensure adequate places of safety and to require health boards to secure the provision of those places in areas. I point out to the minister that it is a particular problem in remote and rural areas, which she may not have experienced herself. Again, the amendment was suggested by the Law Society of Scotland and the Mental Welfare Commission.

A person picked up by the police may be taken to a place of safety. The Millan committee pointed out that suitable places of safety were often unavailable in some parts of Scotland and that inappropriate facilities, such as police stations, were used in some cases.

Recommendation 20.3 of the Millan report proposed that health boards be under an obligation to secure appropriate places of safety.

The Mental Welfare Commission has encountered cases in which wholly inappropriate and, in some cases, degrading ad hoc arrangements have been made for places of safety because no places had been formally identified.

I strongly urge that health boards be placed under an obligation to designate appropriate places of safety as defined in section 198. Health boards need not provide such places directly; their duty would be to ensure that such a place was provided locally. Again, that requirement is in accordance with the principle of reciprocity.

The issue was brought to my attention by Northern constabulary. An unfair burden is placed on serving police officers, who do not have the training or experience to deal with mentally ill patients, whom they are expected to contain and care for until adequate support is available.

I move amendment 236.

Mrs Mulligan: Amendment 236 would place a duty on NHS boards to provide, or ensure the provision of, a sufficient number of places of safety for those whose behaviour has brought them to the attention of the police.

We fully appreciate the intent behind the amendment. However, we suggest that we approach the desired outcome by another route that encourages co-operation among the relevant agencies—not just between health boards or trusts and local authorities but specifically including the police—and which emphasises the quality of provision and flexibility to meet real life circumstances. People who are detained by the police are not an homogenous group and do not necessarily have needs that are distinct from those of other people experiencing mental distress.

The use of the police powers under the Mental Health (Scotland) Act 1984 is relatively uncommon, so it would not be practical to insist on designated services especially to deal with people who come into the mental health system by that route. That said, we accept that current arrangements for the provision of places of safety vary from area to area. I hope that I can reassure Mary Scanlon that I am equally aware of the concerns particular to remote and rural areas, as raised with me on a recent visit to Skye.

We support a more consistent approach to the location and physical design of places of safety as important factors in their overall effectiveness. However, places of safety that may suit one circumstance and need may be much less suitable for another. In our view, it would be difficult and complex to provide through legislation the flexibility needed by local agencies to address the access, quality and design issues needed to ensure good-quality provision that meets potential demands for places of safety.

We will promote the development of local place-of-safety protocols among the local agencies and interests, including the NHS and the police. The protocols will set out good practice as regards location, design and support to meet the needs of likely users in the area. The protocols will also require regular review of provision among the relevant agencies to ensure that any difficulties are recognised and addressed. With those reassurances, I hope that Mary Scanlon will be prepared to withdraw the amendment.

Mary Scanlon: I will withdraw the amendment, given the assurances on the development of place-of-safety protocols and the assurance that the partnership working support for the police will be regularly reviewed.

Amendment 236, by agreement, withdrawn.

The Convener: That brings our stage 2 work for this morning to a close, and it is also the end of the public part of the meeting. I thank the minister and her officials for their attendance.

11:42

Meeting suspended until 11:49 and thereafter continued in private until 12:07.

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