HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 15 January 2003
(*Morning*)

Session 1

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2nd 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 15 January 2003

(*Morning*)

[THE CONVENER *opened the meeting at 09:37*]

Mental Health (Scotland) Bill: Stage 2

The Convener (Mrs Margaret Smith): Good morning and welcome to this morning's meeting of the Health and Community Care Committee. We have one agenda item: stage 2 of the Mental Health (Scotland) Bill. We welcome Mrs Mary Mulligan, who is Deputy Minister for Health and Community Care. Scott Barrie is also with us, as he has lodged some amendments.

Section 20—Care and support services etc

The Convener: Amendment 51 is grouped with amendments 237, 238, 52, 239 and 53 to 56.

The Deputy Minister for Health and Community Care (Mrs Mary Mulligan): Good morning. I warn members that my first explanation will be lengthy, although I assure them that subsequent explanations will be shorter.

Amendments 51 to 54 supplement local authorities' duties to provide services for certain people who are not in hospital with powers to provide similar services for people who are in hospital.

Under the bill, local authorities will have a duty to provide or to secure the provision of a range of services: care and support services for people with mental disorder; services that are designed to promote well-being and social development for people who have or who have had a mental disorder; and assistance in travelling in connection with those services. However, all those duties will apply only in relation to people who are not in hospital. The Association of Directors of Social Work, in particular, raised concerns that that did not reflect the current pattern of service provision and could act to prevent local authorities from providing services for people who are in hospital.

Amendments 51, 52 and 54 will provide local authorities with powers to provide or to secure the provision of such services for people who are in hospital. In that way, the right framework of duties and powers will be established to enable local authorities to deliver the right services to the right people.

Amendment 53, which is secondary to amendment 52, will ensure that the power that amendment 52 seeks to provide for, as well as the duty that the bill already provides for, will be without prejudice to the operation of the more general duties and powers that are listed in section 21(3).

Amendments 55 and 56 concern the relationship between local authority duties under the bill and duties under the Social Work (Scotland) Act 1968. The bill provides that the duties that it imposes in sections 20 to 22 are without prejudice to local authorities' more general duties under section 12(1) of the Social Work (Scotland) Act 1968 and under section 22(1) of the Children (Scotland) Act 1995. It ensures that the new duties will not reduce or dilute a local authority's duties under those acts.

For the same reasons, we feel that, on reflection, it is also necessary to make it clear that the new duties are without prejudice to the duties that are set out in sections 13A, 13B and 14 of the 1968 act, which relate to the provision of residential accommodation with nursing, the provision of care and aftercare and the provision of domiciliary and laundry services. Amendments 55 and 56 seek to amend section 24(2)(a) to include the relevant provisions of the 1968 act.

Amendments 237, 238 and 239 are in the name of Scott Barrie. Amendment 237 deals with the duties of local authorities to provide services to promote well-being and social development as they apply to children and young people. We understand the desire to ensure that children and young people who have or who have had a mental disorder receive services to promote their well-being and social development. We fully support that aim, which is why section 21(1) applies to children and young people. However, amendment 237 would create duties in mental health law in relation to children who are deemed to be at risk of mental disorder, which it is unnecessary and undesirable to do.

The Children (Scotland) Act 1995 makes provision for addressing the needs of children who might be at risk of developing mental disorder. Local authorities have a duty to safeguard and promote the welfare of children in need by providing a range and level of services that are appropriate to the children's needs. That duty requires local authorities and their partner agencies in, for example, health, education and the voluntary sector to assess the needs of children in their area within the framework for planning children's services that is set out in the 1995 act.

The guidance that was issued for implementation of the 1995 act describes a broad range of needs that call for services under the act. Children who have emotional, behavioural and mental health problems are included, as are children who experience a broad range of circumstances and problems that could increase their risk of developing mental health problems.

There is no obvious way of distinguishing children at risk of mental disorder from children who experience other difficulties and trauma. Although some children will certainly need support from specialist child and adolescent mental health services, they will also need sensitive and skilled support from those who look after them: their parents, their teachers, their social workers, those in mainstream health services and others.

Section 21 of the 1995 act places duties on health services to collaborate with local authorities in ensuring that children's needs are met and to provide resources, where necessary, to help the local authority to discharge its duties. We are concerned about the problems that have been reported in ensuring that children receive appropriate responses from mental health services, particularly when in-patient care is required.

The legislative framework for meeting children's needs is clear. If that is not working, we should tackle the problems in the organisations and services, rather than add more legislation. We must bring children's and adolescents' mental health services into the main stream of services for children, and ensure that those services are given due priority alongside the other supports that they might need.

Amendment 238 would add a duty to provide services aimed at preventing the development of mental disorder. I understand that the amendment might be intended to apply particularly to children and young people, although it is general in effect. Again, we share the wish to ensure that children and young people are supported from their earliest years to develop resilience and well-being. The Executive is committed to providing support for vulnerable and disadvantaged children, so that they are able to reach their full potential. However, we believe that the duty on local authorities to provide preventive services exists already.

09:45

First, as I have said, local authorities have a duty under the 1995 act to safeguard and promote the welfare of children in need by providing a range of services. Secondly, we have put in place a wide range of policies and programmes that have a common aim of improving services for vulnerable children and improving the integration of those services. We need to dismantle the separate silos of children's mental health services and fully integrate those services with other core supports. The action team's report, "For Scotland's children", and our national review of child protection practice highlighted the hardship to be tackled in Scotland, which leaves a lasting legacy of mental health problems. Both reiterate the importance of joined-up responses to children and families and seamless support.

In response to the issues that have been highlighted in the child protection review, the Executive has announced a three-year programme to reform child protection. A team of action officers will work directly with local agencies to promote reform. The programme will include reform of the services that are required to support the mental health and well-being of our most vulnerable children and young people. The programme includes work to tackle the stigma that can be associated with mental ill health and action to tackle the high rate of suicide in Scotland, particularly among young men. We recognise the fact that we must improve self-esteem and confidence, as well as the physical and mental health and well-being of children and young people. Therefore, we are setting up a group to promote that in the school environment.

Finally, amendment 239 would add a duty to provide education and associated activities. We believe that the amendment is unnecessary. Section 189 brings the small number of children who are detained under mental health legislation within the normal duties of education authorities for the first time. Moreover, existing legislation already places a wide duty on education authorities to secure the direction of education to the development of the personality, talents and mental and physical abilities of children and young people to their fullest potential. Furthermore, teachers' duties include a responsibility for pastoral care of pupils, and the guidance system in schools is there to support vulnerable children.

The Executive is about to publish a draft bill on additional support for learning. The proposals in that bill will place a duty on education authorities to identify and address the needs of children and young people who require additional support to benefit from education, including pupils with mental health problems. For adults, too, statutory arrangements exist in relation to further and higher education, which apply equally to people with mental disorder. Those arrangements will be supplemented by the duties in section 21, with respect to training, cultural activities and so forth. I therefore invite Scott Barrie not to move amendments 237, 238 and 239.

I move amendment 51.

Scott Barrie (Dunfermline West) (Lab): I have listened carefully to what the minister has said

about the three amendments in my name. She said that some of what they try to achieve is already covered by section 22 of the Children (Scotland) Act 1995. One of the difficulties that local authorities and other agencies have had in relation to the implementation of that section relates to the definition of "children in need", the guidance that accompanied the act notwithstanding. It is possible to define almost any child as being in need of a particular service. In a world of scarce resources, particularly in relation to health and social work, it can be difficult to work out which people are more deserving of a service. That has been a particular problem with mental health services because of the lack of services for children and adolescents.

Sometimes, children with specific mental and psychiatric conditions lose out because they fall into the broad category of people with social, emotional and behavioural difficulties unless their mental condition is specifically mentioned as part of their disorder. Amendments 237 and 238 try to ensure that that small minority of young people do not lose out and go on to develop more serious conditions later in life, which is what I was talking about last week. Many people who are involved with adult psychiatric services would not have ended up in that situation if they had been helped at an earlier stage.

If there is another way of ensuring that the aim of my amendments is achieved—I listened carefully to what the minister said about other legislation in relation to amendment 239—I would accept that that might be more appropriate. However, the aspect of working together is important. One way of ensuring that that happens is through the development of children's services plans, although I acknowledge that that is not in the minister's remit. In some parts of Scotland, local authorities and their partner agencies have worked closely together to come up with incredibly comprehensive and well-thought-through children's services plans, but that has not happened in other parts of Scotland. That might be a route by which some of what I am talking about might be achieved; it does not have to be done through primary legislation but can be dealt with in legislation that governs things that local authorities and other statutory and voluntary agencies need to do. It would be good if there were some sort of guidance to ensure that the mental health needs of young people were adequately reflected in children's services plans, which local authorities are required to have by the 1995 act. Perhaps the minister could feed that suggestion through to other ministers.

Mary Scanlon (Highlands and Islands) (Con): I want to raise a point that I have made during the passage of both the Community Care and Health (Scotland) Bill and this bill. I am concerned about the joint working that is talked about under the general heading of the provision of services by local authorities because I believe that the patient or the user can get lost somewhere in the middle of that. I fear that the wording of the bill might not be strong enough. Section 26 says that the local authority

"may request the Health Board or National Health Service trust to co-operate"

and that the health board or NHS trust,

"if complying with the request",

should do so only if it

"would be compatible with the discharge of its own functions".

The words "must" or "will" are not used. That section seems like a recipe for buck-passing. As a result of such a situation involving the working relationships between local authorities and the health board, bed-blocking is increasing in the Highlands.

The committee was concerned that there are separate sections for local authorities and health authorities. We have the opportunity to ensure that the patient does not get lost between the two authorities. Therefore, I seek the minister's assurance that the bill will not be a basis for buck-passing between local authorities and health authorities.

The Convener: In the absence of a specific amendment on that wording, I direct the minister to concentrate on the member's general point.

Mr John McAllion (Dundee East) (Lab): As I understand the minister's arguments on amendments 237 and 238, the amendments are redundant because provision is made within the 1995 act for children who may be at risk of mental disorder. However, even though that act has been in place since 1995, services have not been developed under the duty imposed on local authorities. We need some assurance from the minister on what Executive action would be taken to change the current situation if we accept her argument that those amendments are redundant. Something must be done because the services are not developing on the ground. The duty exists in the 1995 act, but it is being ignored. If the Executive does not want an additional duty placed in the bill, the onus of responsibility is on it to say what it will do to change that situation.

Mrs Mulligan: In response to Scott Barrie, I say that the definition of "children in need" was necessarily wide to ensure that all children and young people to whom the definition could apply were recognised, but I understand that that sometimes means that there are difficulties in identifying those children and young people. In drafting guidance for the bill, we could examine the guidance that has been provided under the 1995 act to see whether additional guidance is

required. That could then tighten up the looseness that Scott Barrie referred to as regards identifying those children and young people who would appropriately be covered.

I recognise that we need to ensure that problems are identified early. In fact, several measures are being introduced, especially within schools, to identify at an early stage children and young people who are experiencing difficulties. Through the Scottish health-promoting schools unit and new community schools, several collaborative methods are being taken forward that will identify issues around mental well-being. Those methods could flag up at an early stage where additional support is needed. That is a practical way of proceeding.

In relation to John McAllion's point on the 1995 act, "For Scotland's children" recognised that there are gaps between agencies and, in some cases, problems in engaging health boards in particular in delivering services for children at risk. In light of that report, we are taking action to ensure that planning and integrated working are further developed under the direction of the Cabinet sub-committee on children. The First Minister established that sub-committee to consider specific areas of concern where we felt that the 1995 act was not being adhered to in such a way as to deliver the service for those who needed it.

Mary Scanlon mentioned joint working. We are very concerned that, in several areas where there is joint working between health boards and local authorities, there needs to be guidance to ensure that agencies work closely together and do not blame each other. There is quite clear guidance on how to deal with overlaps and to ensure that people receive the service regardless of who provides it. There is guidance on who takes responsibility for which aspect. It is clear that in several areas where local authorities and health boards or health trusts are working together, they need to be quite clear about their responsibilities and how they should be delivering them.

Amendment 51 agreed to.

Section 20, as amended, agreed to.

10:00

Section 21—Services designed to promote well-being and social development

Amendments 237 and 238 not moved.

Amendment 52 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 239 not moved.

Amendment 53 moved—[Mrs Mary Mulligan]—and agreed to.

Section 21, as amended, agreed to.

Section 22—Assistance with travel

Amendment 54 moved—[Mrs Mary Mulligan]—and agreed to.

Section 22, as amended, agreed to.

Section 23 agreed to.

Section 24—Relationship between duties under sections 20 to 22 and duties under Social Work (Scotland) Act 1968 and Children (Scotland) Act 1995

Amendments 55 and 56 moved—[Mrs Mary Mulligan]—and agreed to.

Section 24, as amended, agreed to.

Section 25—Co-operation with Health Boards and others

Amendment 57 moved—[Mrs Mary Mulligan]—and agreed to.

Section 25, as amended, agreed to.

Section 26—Assistance from Health Boards and National Health Service trusts

Amendments 58 to 60 moved—[Mrs Mary Mulligan]—and agreed to.

Section 26, as amended, agreed to.

Section 27—Appointment of mental health officers

The Convener: Amendment 61 is grouped with amendments 62 to 66.

Mrs Mulligan: This group of amendments deals with the appointment of mental health officers. Section 27 places a duty on local authorities to

"appoint a sufficient number of persons for the purposes of discharging, in relation to their area, the functions of mental health officers under this Act."

It also introduces the concept of "the appointed day", which would be determined by ministers and on which various provisions of the section would come into effect.

MHOs must undertake functions relating to other pieces of legislation besides the act—for example, the Criminal Procedure (Scotland) Act 1995 and the Adults with Incapacity (Scotland) Act 2000. The essential point is that sufficient MHOs should be appointed to carry out the sum total of functions under all those acts. Amendment 61 therefore proposes amending section 27(1) to make it clear that a sufficient number of MHOs must be appointed to discharge their functions under all three pieces of legislation.

The other amendments in the group relate to the concept of the appointed day. Under section 231(2), ministers would have the power to

commence the act in stages—that is, section 27 could be brought into effect at any time, separately from other parts of the act. On reflection, therefore, there is no need for the concept of the appointed day—ministers can simply bring the section into effect at the appropriate time. An order that brings any part of the act into effect will, of course, be subject to parliamentary scrutiny. Amendments 62 to 66 all therefore simplify section 27 by removing the concept of the appointed day.

I move amendment 61.

Amendment 61 agreed to.

Amendments 62 to 66 moved—[Mrs Mary Mulligan]—and agreed to.

Section 27, as amended, agreed to.

Section 28—Duty to inquire

The Convener: Amendment 67 is grouped with amendments 68 to 70.

Mrs Mulligan: The amendments relate to the scope of a local authority's duty to inquire into individual cases. Section 28 sets out the circumstances in which a local authority shall have a duty to inquire into a person's case. If any of a specified range of circumstances applies and it appears to the local authority that the person has a mental disorder and is not in hospital, the local authority has a duty to inquire.

It should also be possible, however, for a local authority to have a duty to inquire even when the person concerned is in hospital. For example, the person may have suffered some deficiency in care before being admitted to hospital, in which case it would be appropriate for the local authority to make an inquiry. Amendment 67 will therefore remove the requirement that the person must not be in hospital.

However, it would not be appropriate for the local authority to have a duty to inquire on grounds of possible ill-treatment, neglect or other deficiency in care while the person is in hospital, as that is already the responsibility of other bodies. Similarly, it would not be appropriate for the local authority to have a duty to inquire on the ground of possible risk to others while the person is in hospital, as that is a matter for hospital managers. Amendments 68 and 69 will therefore amend the circumstances that provide grounds for a duty to inquire; they will remove the possibility that possible ill-treatment, neglect or other deficiency of care while a person is in hospital, or possible risk to others while a person is in hospital, could provide grounds for a duty to inquire.

When a case relates to a person under the age of 16, local authorities already have a range of protective functions under the Children (Scotland) Act 1995, which go wider than the duty to inquire provided for in the bill. It is therefore unnecessary, and potentially confusing, for the provisions in section 28 to apply to persons under the age of 16. Amendment 67 will therefore add the condition that a person must be 16 or over before the local authority can have a duty to inquire into their case under the section.

Amendment 70 will add "the Public Guardian" to the list of persons whom a local authority may ask for assistance when undertaking an inquiry under section 28.

The amendments provide for a more wide-ranging and better-targeted duty to inquire. I therefore move amendment 67.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): I have a point that was raised last year—I mean last week.

The Convener: It just feels like last year.

Margaret Jamieson: Last week, we discussed the fact that some pieces of legislation refer to the age of 18 whereas the bill refers to the age of 16. I have real concerns that, under section 28(2), there is no duty on the local authority to inquire into the ill-treatment of someone who is 14. I have concerns that we may be placing young people at a further disadvantage. I ask the minister to try to persuade me otherwise.

Mrs Mulligan: As we discussed last week, we are using that age to ensure that there are no gaps between the provision in the Mental Health (Scotland) Bill and that in the Children (Scotland) Act 1995, under which the age limit relating to the local authority's duty to inquire is 16. Therefore, we are using an age limit of 16 in the bill to ensure that there is no discrepancy between the two pieces of legislation that would allow young people aged between 16 and 18 to fall outside that duty.

Amendment 67 agreed to.

Amendments 68 and 69 moved—[Mrs Mary Mulligan]—and agreed to.

Section 28, as amended, agreed to.

Section 29—Inquiries under section 28: co-operation

Amendment 70 moved—[Mrs Mary Mulligan]—and agreed to.

Section 29, as amended, agreed to.

Section 30—Inquiries under section 28: warrants

The Convener: Amendment 71 is grouped with amendments 267, 72, 73, 268, 74, 269, 75, 76, 77, 270, 79, 271, 80, 81, 82 and 272.

Mrs Mulligan: I am sure that you will remind me if I miss something, convener.

The amendments deal with section 30, which sets out circumstances in which a mental health officer may apply for a warrant in relation to an inquiry under section 28.

Amendments 71, 72, 74 and 77 will correct a technical fault. The bill gives justices of the peace a power to grant warrants under section 30. However, the bill as introduced referred only to "a justice". For clarity, each of those references should be amended to read "a justice of the peace". That would be the effect of amendments 71, 72, 74 and 77.

Amendment 73 seeks to deal with the effect of a warrant granted under section 30(1). That subsection gives sheriffs and justices of the peace the power to grant a warrant authorising a specified MHO and any other specified person to enter specified premises and to open any lockfast places on specified premises for the purposes of an inquiry under section 28. However, where such a warrant is granted, it would be sensible for any local police constable also to be granted authority to enter the specified premises. Indeed, a local constable rather than the mental health officer should have the authority to open lockfast places.

The authority granted by such a warrant should not be open ended; it should endure for a limited period only. Amendment 73 therefore seeks to amend substantially section 30(2) to give effect to the policy that I have just described. In particular, it provides that the authority granted by such a warrant will endure only for eight days from the granting of the warrant.

Amendments 75, 76, 270 and 79 deal with the granting of warrants authorising detention for medical examination and requiring access to medical records for the purposes of an inquiry under section 28. Section 30(3) gives powers to a sheriff or justice of the peace to grant a warrant authorising detention of a person for three hours for the purposes of medical examination by a specified medical practitioner and requires any person holding relevant medical records to produce them for inspection if required to do so by the specified medical practitioner. However, on occasion, only a medical examination might be necessary or only the inspection of records might be necessary. It should therefore be possible for a warrant to grant one but not the other. Amendment 270 substantially revises section 30(3) to provide for two separate warrants: one authorising detention for the purposes of examination under section 30(3); and one requiring the provision of records under proposed section 30(4B).

Amendments 75, 76 and 79 are directly consequential on amendment 270; they will simply restructure other parts of section 30 to ensure that they are consistent with the new provisions. Together, the four amendments will provide for a more flexible and potentially less intrusive system of warrants in connection with the examination and the inspection of medical records.

Amendments 80 to 82 deal with the requirements on the relevant MHO to notify the Mental Welfare Commission for Scotland when warrants are granted under section 30. Section 30(5) requires the relevant MHO to notify the commission of the making of an application under the section and of whether a warrant has been granted or refused, as soon as practicable after the application is made. However, the commission needs to be informed only of whether an application has been granted. Clearly, the MHO cannot inform the commission of that until it has happened, which will obviously be at least some time after the application is made.

Amendments 80 and 82 will revise section 30(5) to provide that an MHO need notify the commission "as soon as practicable" after the decision is made and will remove the requirement to notify the commission that an application has been made. Amendment 81 is a direct consequence of amendment 270 and reflects the fact that one more kind of warrant of which the MHO might have to notify the commission will exist if amendment 270 is agreed to. Together, amendments 80 to 82 will place more sensible and meaningful notification requirements on MHOs.

10:15

Amendments 268 and 271 are intended to specify which sheriff or justice of the peace will have jurisdiction over applications for warrants under section 30. For applications under section 30(1), amendment 268 specifies that the jurisdiction is to be determined by the area in which the premises concerned are located. For applications under section 30(3), amendment 271 specifies that the jurisdiction is to be determined by the area in which, for the time being, the person concerned is. We do not need a separate amendment to define the jurisdiction for an application under proposed section 30(4B), because that is dealt with as an integral part of amendment 270, which will introduce that new subsection.

Amendments 267 and 269 deal with which mental health officer may apply for a warrant under section 30. As introduced, sections 30(1) and 30(3) provide that "a mental health officer"—which means any mental health officer—may apply for a warrant under those sections. However, not just any mental health officer should be able to apply. Amendments 267 and 269 will constrain which MHO may apply by inserting the word "relevant" before the words "mental health officer" in sections 30(1) and 30(3). Again, no separate amendment is required for applications

under proposed section 30(4B), because the word "relevant" is included in amendment 270.

The meaning of "relevant mental health officer" for the purposes of amendments 267 and 269 will be provided by amendment 272. For warrants under section 30(1), mental health officers should be able to apply only if they have been appointed by the local authority for the area in which the premises concerned are located, which is the definition of a relevant mental health officer that amendment 272 provides. In relation to warrants to detain an individual for medical examination or to gain access to an individual's records, an MHO should be able to apply only if they have been appointed by the local authority that causes the inquiries to be made, which is the definition of relevant mental health officer that amendment 272 provides.

Amendment 272 also deals with appeals against a decision to grant a warrant under section 30, on which the bill as drafted is silent. It would not be desirable for decisions under section 30 to be subject to appeal, because it will very often be important to proceed urgently with inquiries on the basis of a warrant that has been granted. However, if section 30 remains silent on the matter, an appeal might be pursued under other legislation, such as the Sheriff Courts (Scotland) Act 1907. Therefore, it is necessary for the section to rule out expressly the possibility of appeal, which is one effect of amendment 272. The amendment will ensure that inquiries under section 28 cannot be impeded by appeals against warrants that have been granted under section 30.

I move amendment 71.

Amendment 71 agreed to.

Amendments 267, 72, 73, 268, 74, 269, 75, 76, 77, 270, 79, 271, 80, 81, 82 and 272 moved—[Mrs Mary Mulligan]—and agreed to.

Section 30, as amended, agreed to.

Section 31—Emergency detention in hospital

Amendment 111 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 112 is grouped with amendments 115, 136 and 138.

Mrs Mulligan: The amendments clarify the procedures that are to be undergone when an emergency or short-term detention certificate has been issued for a mentally disordered patient. Amendments 112, 115, 136 and 138 will ensure that, when the patient is admitted to hospital from the community, the detention in hospital is authorised only when hospital managers possess the detention certificate.

I move amendment 112.

Amendment 112 agreed to.

Amendments 113 and 114 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 181 is grouped with amendment 192.

Mary Scanlon: Amendment 181's purpose is to ensure that a person is not detained in hospital under an emergency detention certificate if he or she will accept treatment voluntarily. The amendment embraces the principle of the least restrictive alternative and is supported by the Law Society and the Mental Welfare Commission.

One of the Millan principles relates to informal care. A person should not be made subject to mental health legislation if he or she is willing to accept treatment. That ground is stated in the Mental Health (Scotland) Act 1984 but is omitted from the bill. The bill should make it clear that compulsory measures should be used only when no alternative is available.

I move amendment 181.

Mrs Mulligan: Amendments 181 and 192 raise one of the most important matters in the bill—the criteria for detention—and deal with emergency and short-term detention. I know that the committee—rightly—takes that extremely seriously, so I intend to respond to the amendments fairly fully.

In its stage 1 report, the committee expressed concern that the criteria in parts 5 and 6 did not give full expression to the test, as set out in the Millan report, that compulsory detention should be authorised only if, among other things, the patient's agreement to be voluntarily detained could not be obtained. Mr Millan made that point in his evidence to the committee.

We strongly endorse the Millan committee's view that informal care should be preferred wherever possible. We have considered carefully whether there would be a benefit in rewording the criteria for emergency and short-term detention to specify the general principle differently. We have concluded that the principle is already given effect by sections 31(5) and 35(4). We do not believe that the amendments would add anything; indeed, they might even make the provisions less clear.

For emergency detention, the detaining doctor must believe that it is likely that the patient has a mental disorder and that that has impaired their ability to make decisions about treatment. They must be satisfied that there would be a significant risk if the patient were not detained and that it would take too long to grant short-term detention. On top of all that, the doctor must be satisfied that it is necessary as a matter of urgency to detain the patient in hospital for the purpose of determining what medical treatment requires to be given.

Amendment 181 seeks to add the words:

"and that such a determination could not be made if the patient were not so detained."

If the determination could be made without detaining the patient, it follows logically that it would not be necessary to detain the patient for that purpose. The qualification that the amendment seeks to add is already there.

The same applies to amendment 192 in relation to short-term detention. The detaining doctor must consider it likely that the patient has a mental disorder that has impaired significantly their ability to make treatment decisions, that there is a risk of harm and that it is necessary to detain the patient to determine what treatment should be given or to give medical treatment. There is also a general requirement that it should be necessary to grant a short-term detention certificate. Amendment 192 would add a further requirement that the treatment could not be given, or the determination of treatment could not be made, unless the patient was detained. However, that is what section 35(4)(c) requires the doctors to certify. Amendment 192 does not tighten up the criteria and it could cast doubt on the effect of what is already in the bill. We believe that, far from making the criteria easier for doctors and MHOs to understand, the proposed addition might make things worse.

We will ensure that the issue that amendments 181 and 192 raise is addressed clearly and fully in the code of practice. With those reassurances, I hope that Mary Scanlon will feel able to seek to withdraw amendment 181 and not move amendment 192.

Mary Scanlon: The point that the amendments address is important, because many patients have raised it and there is a fear that they might get heavy-handed treatment when they are participating in treatment willingly. I am pleased to receive the minister's assurance, not just about the code of practice, but about the fact that the Executive will monitor the approach. On that basis, I am happy to seek to withdraw amendment 181.

Amendment 181, by agreement, withdrawn.

Amendment 115 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 116 is grouped with amendments 288 and 194.

Mrs Mulligan: Amendment 116 clarifies the point at which the period of emergency detention begins. If a patient is admitted to hospital from the community, the detention period begins on admission. If the patient is already in hospital, the period begins with the granting of the certificate.

Amendment 137, on the first marshalled list, has been modified and appears as amendment 288 on the second marshalled list. Amendment 288 clarifies the point at which the period of short-term detention begins. If a patient is admitted to hospital from the community, the detention period starts at the beginning of the day of admission. If the patient is already in hospital, the detention period starts at the beginning of the day on which the certificate is granted. The need to modify amendment 137 was brought to our attention through Mary Scanlon's amendment 194. I am grateful to her for raising the issue and assisting us in sharpening up the drafting.

We have recognised the ambiguity about the time at which short-term detention commences under section 35(5)(b). Executive amendment 288 clarifies that the 28 days commences at the beginning of the day on which the admission or granting of the certificate took place, depending on whether the patient was in hospital at the time the certificate was granted. The bill makes it clear that the three-day removal period in section 35(5)(a) begins with the granting of the short-term detention certificate. Therefore, the three-day period is counted in hours and minutes from the granting of the certificate.

With those reassurances that the time periods in section 35(5) are now made clear, I invite Mary Scanlon not to move her amendment.

I move amendment 116.

10:30

Mary Scanlon: I am not absolutely clear about whether the minister is supporting my amendment 194 or is asking me not to move it. Let me speak briefly to it. The amendment aims to pin down how the times are measured. From midnight on a Monday to midnight on a Thursday is three whole days. However, if someone goes into hospital at 2 o'clock on a Tuesday afternoon and is released at 10 o'clock on the Thursday morning, that is much less than 72 hours. Is it intended to categorise that as three days? I do not think it enough to specify three days because that does not cover shorter periods that span three days. Such a period could be less than 48 hours. I wish to be clear about what exactly the minister means.

Mrs Mulligan: For emergency detention, the period starts immediately. For short-term detention, the period starts at the beginning of the day if someone is being admitted from the community or if someone is already in a hospital.

Mary Scanlon: Considerable difficulty has arisen under the current legislation over the interpretation of periods of time given in days. It is thought that it would be helpful to make it absolutely clear whether time intervals such as those mentioned in paragraphs (a) and (b) of section 35(5) are to be measured from the exact

time when a certificate is granted or produced to the managers of the hospital, or are to be measured from the midnight preceding that granting or production—in other words, in whole days. It is suggested that time periods used in relation to short-term detention should be measured in exact hours and minutes from the starting point.

I should mention that amendment 194 has been supported by the Mental Welfare Commission for Scotland.

Mrs Mulligan: The Executive amendments 116 and 288 themselves clarify what Mary Scanlon is asking about—my apologies if my own explanation did not. With the Executive amendments, it will be clear in the eventual legislation what the time periods are.

Amendment 116 agreed to.

The Convener: Amendment 117 is in a group on its own.

Mrs Mulligan: Amendment 117 spells out in a little more detail what should be contained in a certificate authorising emergency detention. When a medical practitioner is satisfied that a person requires to be subject to a period of emergency detention, he or she must fill out an emergency detention certificate. Amendment 117 ensures that the medical practitioner records on the certificate his or her reasons for believing that the patient meets the criteria for emergency detention. The criteria are laid out at sections 31(4) and 31(5). The amendment further ensures that the medical practitioner must sign the emergency detention certificate. It should also be noted that section 224 allows regulations to prescribe in greater detail what should be on the detention certificate.

I move amendment 117.

Amendment 117 agreed to.

The Convener: Amendment 182 is grouped with amendment 193.

Mrs Mulligan: Amendments 182 and 193 are necessary to set out the procedures to be undergone when a medical practitioner issues an emergency or short-term detention certificate in respect of a mentally disordered patient who is already in hospital. The two amendments ensure that the practitioner who issues the certificate should give the certificate to the managers of the hospital as soon as is practicably possible.

I move amendment 182.

Amendment 182 agreed to.

Section 31, as amended, agreed to.

Section 32—Notification by medical practitioner

The Convener: Amendment 118 is grouped with amendments 119, 120 and 126 to 135.

Mrs Mulligan: This group of amendments relates to the duties on medical practitioners and hospital managers to notify certain parties of the fact that an emergency detention has taken place. Amendments 118 to 120 ensure that the medical practitioner who granted the detention certificate should inform the managers of the hospital in which the patient is to be detained of the matters outlined in section 32(2). Those matters include the practitioner's reasons for granting the certificate and notice as to whether or not the consent of a mental health officer had been obtained.

In the bill as introduced, section 32(1) placed on the medical practitioner a duty to notify several other parties, such as the Mental Welfare Commission, of the matters listed at section 32(2). However, members of the mental health legislation reference group, as well as Dr David Love of the British Medical Association in his evidence to the committee at stage 1, pointed out that such notification duties would place a potentially heavy administrative burden on already hard-pressed general practitioners. We have therefore accepted the advice of the reference group and the BMA, and have transferred the notification duties from medical practitioners to the managers of the hospital in which the patient is to be detained.

Most of the remainder of the amendments in the group relate to how hospital managers should carry out those notification duties. Amendments 126 and 127 clarify that the hospital managers are required to inform certain parties, listed at section 33(5), of the emergency detention within 12 hours. They further provide that, within seven days of receiving notice, hospital managers will inform the same parties of the matters listed at section 32(2). The parties to be notified are listed in amendments 128 to 134.

Amendment 135 seeks to remove section 34, which is unnecessary, given that it duplicates provision made in section 171 for the notification of urgent treatment.

I move amendment 118.

Amendment 118 agreed to.

Amendments 119 and 120 moved—[Mrs Mary Mulligan]—and agreed to.

Section 32, as amended, agreed to.

Section 33—Duties on hospital managers: examination, notification etc

The Convener: Amendment 121 is grouped with amendments 122 to 125.

Mrs Mulligan: When a patient is admitted to hospital on the authority of an emergency detention certificate, hospital managers, in accordance with section 33(2), must arrange for the patient to be examined by an approved medical practitioner and ensure that a responsible medical officer is appointed. Amendment 121 seeks to change the trigger for those duties, so that they should be undertaken as soon as is practicable after the period of detention begins. Amendments 122 to 125 are technical amendments that aim to improve the drafting of section 33.

I move amendment 121.

Amendment 121 agreed to.

Amendments 122 to 125 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 84 is grouped with amendments 85, 183 and 86 to 104.

Mrs Mulligan: Amendments 84, 87, 90, 95, 99 and 101 are necessary to ensure that a medical practitioner who is appointed to act as the patient's responsible medical officer will be an approved medical practitioner. In other words, the patient's RMO should always have specialist training and expertise in the field of psychiatry.

Amendments 85, 88, 91, 96, 98, 100 and 102 will implement a proposal that was made by the BMA in its stage 1 evidence to the committee. If we take the example of amendment 85, when a patient is admitted to hospital on the authority of an emergency detention certificate, section 33(2)(b) places a duty on the hospital managers to appoint an approved medical practitioner to act as the patient's responsible medical officer. Occasions might arise, however, when no consultant psychiatrist is available to act as the patient's RMO. Through the deletion of the phrase

"who is on the staff of the hospital"

the amendment allows for an approved medical practitioner on the staff of a different hospital to be appointed as the patient's RMO. The amendment therefore makes it clear that the patient's RMO should always be a consultant psychiatrist, if necessary from a hospital other than the one to which the patient has been admitted, rather than a consultant in another field of medicine.

Amendments 88, 91, 96, 98, 100 and 102 will extend that clarification to other areas of the bill relating to, respectively, short-term detention, a compulsory treatment order, a compulsion order, a hospital direction and a transfer for treatment direction. The amendments reflect the view that it is more important for a patient to be treated by an appropriately qualified medical practitioner rather than by one who is located in the hospital where the patient is detained.

Amendments 86, 89, 92 and 183 also relate to the appointment of the patient's responsible medical officer. When a patient is made subject to short-term detention or a compulsory treatment order, he might already have a responsible medical officer. That scenario is most likely to arise when the detention period has been preceded by another detention period. Amendments 86, 89, 92 and 183 will enable the existing responsible medical officer to be appointed in respect of the patient.

Amendments 93, 94, 103 and 104 will further amend the bill in relation to the patient's responsible medical officer. Specifically, the amendments will allow hospital managers, where necessary, to appoint a new RMO or to authorise another approved medical practitioner to act in the place of the originally appointed RMO.

I move amendment 84.

Amendment 84 agreed to.

Amendments 85 and 183 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 184 is grouped with amendments 185 to 187.

Mrs Mulligan: Section 33(2) stipulates that once the patient is admitted to hospital on the authority of an emergency detention certificate, he or she must undergo an examination by an approved medical practitioner.

The four technical amendments relate to a situation in which the approved medical practitioner, following such an examination, is not satisfied that the criteria for emergency detention are still met. In that situation, the approved medical practitioner must revoke the emergency detention certificate. Amendment 185 will modify the criteria that must be met when the approved medical practitioner is deciding whether to revoke the emergency detention certificate. The amendment will remove paragraphs (a) and (c) of section 31(5) from the list of criteria. Those criteria are logically no longer applicable when the approved medical practitioner carries out the examination, because the emergency detention certificate has already been granted.

Similarly, amendment 187 will replace the removed references to paragraphs (a) and (c) of section 31(5) with a parallel provision to reflect the fact that the practitioner is carrying out the examination after the emergency detention certificate has been granted.

Amendments 184 and 186 are technical amendments that will smooth the drafting of the section as a result of amendment 185.

I move amendment 184.

Amendment 184 agreed to.

Amendments 185 to 187 and 126 to 134 moved—[Mrs Mary Mulligan]—and agreed to.

Section 33, as amended, agreed to.

10:45

Section 34—Urgent medical treatment: notification

Amendment 135 moved—[Mrs Mary Mulligan]—and agreed to.

Section 34, as amended, agreed to.

After section 34

The Convener: Amendment 188 is grouped with amendments 189, 210, 216, 217 and 233.

Mrs Mulligan: This is an important group of amendments concerning the powers of the Mental Welfare Commission for Scotland. Currently, the commission has the power to discharge patients from detention; Millan recommended that it should retain that power. Initially we had doubts about the retention of the power, in case it cut across the role of the tribunal. However, the consensus among groups that we consulted, including the commission, was that the power should remain as an additional safeguard for patients.

Amendments 188 and 216 will give the commission the power to revoke an emergency detention certificate and a short-term detention certificate or extension certificate respectively.

Amendments 189 and 217 set out the notification requirements associated with that power.

Amendments 210 and 233 are technical amendments that will enable extension certificates to be referred to throughout the bill and are necessary, not least to enable the commission's power to apply to extension certificates.

I move amendment 188.

Amendment 188 agreed to.

Amendment 189 moved—[Mrs Mary Mulligan]—and agreed to.

Section 35—Short-term detention in hospital

The Convener: The next amendment for debate is amendment 190, in the name of Mary Scanlon, which is in a group of its own. I am not sure whether that is a reference to the amendment or to Mary Scanlon.

Mary Scanlon: Both.

The Convener: I invite Mary Scanlon to move and speak to amendment 190.

Mary Scanlon: Amendment 190 concerns the time limits for short-term detention. The purpose of the amendment is to ensure that a person is not detained under the short-term detention procedures unless the medical reports on his or her condition are up to date.

The amendment is supported by the Law Society of Scotland and the Mental Welfare Commission for Scotland, on the basis that a person should not be detained under the short-term detention procedure unless the medical reports on his or her condition are up to date. That principle has been accepted for all other compulsory measures in the bill. For example, applications for long-term measures must be submitted within 14 days of the reports being made. A certificate for emergency detention must be issued within 24 hours of an examination having taken place. The failure to include such a provision for short-term detention appears to be simply an omission from the bill.

I move amendment 190.

Mrs Mulligan: I am grateful to Mary Scanlon for raising this issue and am happy to say that we support the amendment.

The Convener: Does Mary Scanlon want to say anything about that?

Margaret Jamieson: She is gobsmacked.

Mary Scanlon: I am speechless.

The Convener: Can we have more of that, minister?

Amendment 190 agreed to.

Amendment 136 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 191 is grouped with amendments 139 and 140. I invite Mary Scanlon to move amendment 191 and to speak to all the amendments in the group.

Mary Scanlon: I am sorry, but I have lost my papers.

The Convener: I will suspend the meeting for two or three minutes for a comfort break, to allow Mary Scanlon to find her place. We have considered the bill for an hour, so this is not a bad point at which to take a break.

10:50

Meeting suspended.

10:56

On resuming—

The Convener: We return to the point at which we stopped proceedings. I ask Mary Scanlon to speak to and move amendment 191, which is grouped with amendments 139 and 140.

Mary Scanlon: Amendment 191 would simply make it clear that the mental health officer had given consent. The amendment would require that the MHO give consent in writing by signing a form.

I move amendment 191.

Mrs Mulligan: I warned that consensus would not go on forever. We do not accept amendment 191, although we understand the concerns that have been expressed.

We acknowledge the importance of ensuring that the mental health officer's consent is meaningful. There is no evidence that doctors have been untruthful in certifying the consent of MHOs, but there may have been situations under the current legislation in which MHOs have felt that their consent was seen as a rubber-stamp. That is not the case in law and is not what we intend.

However, amendment 191 is not the answer to any such concerns because it could create practical difficulties, in particular in rural areas. For example, let us suppose that an MHO examined a patient who agreed to remain in hospital as an informal patient, but changed their mind after the MHO had left. If the MHO could not offer consent by telephone, there could be considerable practical difficulties, which could jeopardise the welfare of the patient.

The Executive amendments in the group would strengthen the duties on MHOs to ensure that they are fully involved in the process of short-term detention. I hope, therefore, that Mary Scanlon will feel able to seek to withdraw amendment 191.

I turn to Executive amendments 139 and 140. Once an approved medical practitioner considers that it is likely that a patient meets the criteria for short-term detention, the medical practitioner should consult the mental health officer, as required by section 35(3)(b). The mental health officer should then interview the patient and, on the basis of that interview, decide whether to consent to short-term detention and notify the medical practitioner accordingly. Amendment 139 will make it clear that the mental health officer should attempt to interview the patient before deciding whether to consent.

11:00

Amendment 140 is one of a number of amendments that are intended to strengthen the position of advocacy in the bill. The amendment will require the mental health officer to inform the patient of the availability of advocacy services, but also to take appropriate steps to ensure that the patient has the opportunity to make use of those services, again before deciding whether to consent to short-term detention.

Mary Scanlon: Given the minister's response, I seek to withdraw amendment 191.

Amendment 191, by agreement, withdrawn.

Amendment 192 not moved.

Amendment 288 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 138 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 193 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 194 not moved.

Section 35, as amended, agreed to.

Section 36—Mental health officer's duty to interview patient etc.

Amendment 139 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 140 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 149 is grouped with amendments 150, 153 to 156, 218 to 220, 167, and 221 to 232. I call Adam Ingram to speak to and to move amendment 149 and to speak to all amendments in that group, and I welcome him to the committee.

Mr Adam Ingram (South of Scotland) (SNP): The amendments arose from representations by voluntary organisations—notably the National Schizophrenia Fellowship (Scotland)—that have a strong carer interest in mental health issues. That organisation's concern is that in many cases the named person will not be a carer of the individual involved and that, as a consequence, those caring for the individual will be cut out of the information loop.

In the past, carers of people with serious and enduring mental illnesses have experienced much frustration and anguish at being denied, under the cloak of the confidentiality of the doctor-patient relationship, information about the treatment of those for whom they care. However, carers can more often than not offer much insight into how those for whom they care respond and react to different forms of treatment, and what support is required at various stages of illness. Carers' lives can be blighted by being shut out of the decision-making process, which often has as many

consequences for the carers as it does for those for whom they care.

The amendments in the group would help to ensure that primary carers and others involved in care and support are informed and involved in a fashion that enables them to provide their support to best effect. Agreement to the amendments will go some way towards recognising carers' rights and the importance of carers in the mental health care system which, as I have indicated, has too often been found sadly lacking.

I move amendment 149

Shona Robison (North-East Scotland) (SNP): I very much sympathise with Adam Ingram's points.

The carers with whom I have had dealings have had difficult problems; one of the common themes about which they have spoken is that—not in all cases, but frequently—they feel frozen out of the process. Carers' knowledge of the people for whom they care is, of course, extensive, but the carers' ability to recognise early any signs that those for whom they care are becoming unwell is not given attention or taken seriously. Adam Ingram's points were well made, and I hope that the amendments are considered seriously by the minister.

Mrs Mulligan: This group of amendments seeks to insert references to notification to the primary carer, and in some cases, to carers in general. Unfortunately, some of the amendments to later sections are to provisions in the bill that will be amended. Therefore, we will return to those.

The Executive attaches great significance to the interests of family and informal carers. Amendment 105 to part 1 has strengthened their position in two respects. First, in discharging a function under the bill, there is a duty to have regard to the views of any carer of the patient, provided that it is not unreasonable or impractical to do so. Secondly, where relevant, and so far as is reasonable and practicable, the needs and circumstances of the carer must be taken into account. The Executive thinks that those are significant new provisions, on which it will build in the code of practice.

The amendments seek to add more specific provisions that will require notification of certain matters. That raises one of the most difficult issues in the bill, which is the balance that is to be struck between the needs and wishes of the patient and the interests of the carers. Those will often coincide, but we cannot duck the fact that that is not always the case. Although it is rare, it can happen that the person who is, or was, the carer does not truly have the patient's interests at heart. It can also happen that some patients do not wish relatives or former carers to be told certain things that would normally be confidential to the patients.

The Executive does not believe that the patient's stated wishes, which might be affected by his or her mental disorder, should always be upheld. On the other hand, we do not wish to provide that information must always be passed on, even if the patient has expressly asked that it should not be.

The named person plays an important role. The Executive anticipates that the primary carer will normally be the named person and will therefore be entitled to information about compulsory proceedings. Only if the patient has specifically chosen it, or the tribunal has ordered it, will the primary carer not be the named person. If that happened, it would be going too far to make it a legal requirement that all carers must be given information about patients. However, the requirements in part 1 would mean that doctors, mental health officers and the tribunal should liaise with carers when it is practicable and reasonable to do so.

Amendments 149 and 150 would require the MHO to ascertain the name and address of the patient's primary carer when a short-term detention certificate is in prospect. Amendments 153 and 154 would require a responsible medical officer to notify the primary carer of the revocation of a detention certificate.

The primary carer, unless acting as a named person, does not have a statutory role in short-term detention, which is why primary carers are not listed in section 36. The MHO will contact the primary carer; for example, in connection with the preparation of a social circumstances report. However, it is not appropriate that they be specifically listed in section 36.

Similarly, if an RMO revokes a short-term detention certificate, the Executive would expect that he or she would normally keep carers informed. Amendment 150 would require the RMO to take account of the needs and circumstances of the carer as far as that would be relevant. The named person must also be told of the revocation, but for the reasons that I outlined, it would not be right to insist that the person who cared for the patient before detention must always be notified, regardless of the views of the patient.

Amendments 155 and 156 concern applications for compulsory treatment orders. The bill already provides that the primary carer is entitled to appear and lead evidence at the tribunal hearing. In order that the primary carer has an opportunity to do so, the mental health officer's report must identify him or her. The amendments would require the MHO to identify all carers and give them the right to lead evidence at the tribunal. Although the MHO will need to conduct a

reasonably thorough investigation of the patient's situation when preparing an application for a compulsory treatment order, it would be too onerous to require the MHO to identify everyone who might provide some informal care.

As for the hearing itself, section 53(3)(g) provides that anyone

"appearing to the Tribunal to have an interest in the application"

has a right to be heard. That would include carers who are not the primary carer.

Amendments 218 to 223 deal with various measures taken when a CTO is already in place. Amendment 224 deals with advance statements, and amendments 225 to 232 deal with forensic orders. The bill does not generally make the same provision for the primary carer at those later stages as it does when a CTO is made. We think that there is a difference between the initial making of an order and certain things that happen subsequently. The person who was the primary carer may no longer be directly involved. However, we want to have another look at the matter, so we might consider lodging amendments at stage 3.

In preparing stage 2 amendments for the later provisions of the bill, we gave serious consideration to the role of carers and of the primary carer. We do not believe that the majority of amendments under consideration in this group are appropriate, because they interfere too much with the patient's right to make a choice about whom he or she informs of changes to the compulsory measures to which he or she is subject. However, we will consider carefully everything that has been said about the issue. On that basis, I hope that Adam Ingram will feel able to withdraw amendment 149.

The Convener: I invite Adam Ingram to wind up and to indicate whether he wishes to press his amendments.

Mr Ingram: I am certainly reassured by the minister's remarks about the place of carers in the bill. It is important to strengthen the references that exist—as the minister has already said—because carers must be brought into the mental health care system in a much more systematic way than has been the case in the past. There are a lot of people with grievances out there. As the minister has said that she is considering lodging more amendments to the bill in line with that objective, I will withdraw amendment 149.

Amendment 149, by agreement, withdrawn.

Amendment 150 not moved.

Section 36, as amended, agreed to.

Section 37—Hospital managers' duties: notification etc.

Amendments 86 to 89 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 141, in the name of the minister, is in a group on its own.

Mrs Mulligan: Section 37 contains a requirement on hospital managers to notify the tribunal and the commission of a short-term detention. It is important that that information is made available, because the tribunal may hear an appeal for revocation from the patient, and the commission is responsible for monitoring the act and may wish to exercise its power to revoke the certificate.

Amendment 141 will strengthen that requirement so that hospital managers must provide the tribunal and the commission with a copy of the detention certificate. That will ensure that both the tribunal and the commission have the necessary information to discharge properly their statutory functions, including the statistical and data-gathering role of the commission.

I move amendment 141.

Amendment 141 agreed to.

Section 37, as amended, agreed to.

Section 38 agreed to.

Section 39—Responsible medical officer's duty to review continuing need for detention

The Convener: Amendment 195 is grouped with amendments 196 to 200, 151, 201, 152, 202, 203 and 204. I ask the minister to speak to and move amendment 195 and to speak to all the amendments in the group.

Mrs Mulligan: All the amendments in the group apply to section 39. Under that section, the responsible medical officer has a duty to review the continuing need for short-term detention. Amendments 196, 198 and 199 are technical amendments that will improve the clarity of the test that the responsible medical officer should apply in determining whether there is a continuing need for detention.

Amendments 195, 197, 200 to 202 and 204 will extend the duties that are placed on the responsible medical officer so that they include a duty towards patients on extension certificates. Amendment 203 will add the mental health officer to the list of people who should be notified if a short-term detention or extension certificate is revoked.

I regret that we are unable to accept amendments 151 and 152, which have been lodged by Adam Ingram. We accept the

importance of making adequate arrangements for patients who are discharged from hospital. That is important not only for patients who are discharged from detention but for patients who are discharged from an informal stay in hospital.

11:15

For short-term detention, section 38 requires that a social circumstances report be produced, which will inform the mental health officer and detaining doctor of the situation that is likely to face the patient when the patient is discharged from hospital. That report should enable the mental health officer and the doctor to make suitable arrangements for the care of the patient upon discharge.

Amendment 152 is therefore unnecessary. In fact, such a provision could work against the patient's interests. If the detention criteria no longer apply, the patient is entitled to be discharged. The effect of amendment 152 would be to continue the detention for an unspecified period while consultation took place and a care plan was drawn up. Potentially, that could breach patients' rights under the European convention on human rights.

Given that explanation, I hope that Adam Ingram will not press amendments 151 and 152.

I move amendment 195.

Mr Ingram: I am still inclined to press amendments 151 and 152. In essence, the amendments will ensure that those who are subject to short-term detention will not be released into the community to fend for themselves without an appropriate support plan being identified and agreed prior to discharge. A common failing of the current system is that people are released back into the community with inadequate support. For example, Depression Alliance Scotland reports that such people must wait for anything from six weeks to six months for psychological support, yet it is well known that people are at their most vulnerable during the first few days after release, when they most need support to maintain their recovery.

Failure to provide such support often leads to recurrence and eventual readmittance into hospital. That vicious circle can, I believe, be broken by adopting best practice, which the amendments would ensure. I do not agree with the minister that a social circumstances report is equivalent to a support plan or package. I do not believe that individuals' rights under the ECHR would be breached if particular time scales were built into the bill to force the professionals to draw up a particular support plan in due course. On that basis, I will press my amendments.

Mrs Mulligan: I repeat that, if the circumstances are such that the patient should be returned to the community, it would be inappropriate to delay that further. That is why, unlike Adam Ingram, I believe that the section 38 social circumstances report is preferable, because that will require the professionals to put in place a plan to support such individuals when they return to the community.

We will also ensure that guidance is included in the code of practice to make sure that the professionals carry through what is required under the social circumstances report. That is the way for us to ensure that no one is returned to the community without the support that Adam Ingram seeks to ensure.

Amendment 195 agreed to.

Amendments 196 to 200 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 151 moved—[Mr Adam Ingram].

The Convener: The question is, that amendment 151 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)
Elder, Dorothy-Grace (Glasgow) (Ind)
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 6, Abstentions 0.

Amendment 151 disagreed to.

Amendment 201 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 152 not moved.

Amendments 202 and 203 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 153 not moved.

Amendment 204 moved—[Mrs Mary Mulligan]—and agreed to.

Section 39, as amended, agreed to.

Section 40—Short-term detention certificate: patient's right to apply for revocation

The Convener: Amendment 205, in the name of the minister, is grouped with amendments 142, 206, 207, 208 and 209. I ask the minister to speak

to and move amendment 205 and to speak to the other amendments in the group.

Mrs Mulligan: All the amendments in the group apply to section 40, which gives the patient a right to apply to the tribunal for revocation of the short-term detention certificate. Amendments 205, 207 and 209 will extend the right to patients on extension certificates.

Amendment 206 is a technical amendment that will improve the clarity of the test that the tribunal should apply in determining whether to revoke the certificate.

Amendment 208 will provide that, when a short-term detention certificate is revoked, any extension certificate already granted will also be revoked, and amendment 142 will clarify the rights of certain persons listed to make representations or lead evidence to the tribunal when the patient makes an appeal to the tribunal for revocation of a short-term detention or extension certificate.

I move amendment 205.

Amendment 205 agreed to.

Amendment 142 moved—[Mrs Mary Mulligan]—and agreed to.

Amendments 206 to 209 moved—[Mrs Mary Mulligan]—and agreed to.

Section 40, as amended, agreed to.

Section 41—Extension of detention pending application for compulsory treatment order

Amendment 210 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 211, in the name of the minister, is grouped with amendments 212, 213, 213A, 214, 143, 144 and 215. I ask the minister to speak to and move amendment 211 and speak to the other amendments in the group.

Mrs Mulligan: This group of amendments applies to sections 41 and 42, which deal with the extension of detention pending application for a compulsory treatment order. Our policy is that, apart from the time limits, there is no difference from the patient's perspective between being on short-term detention and the extension of detention. Amendments 211, 213 and 214 will make it clear that, as with short-term detention, a patient who is detained under an extension certificate may be given medical treatment in line with part 13 of the bill.

It might not always be possible to obtain a mental health officer's consent to the extension of short-term detention. If that is the case, no mental health officer or local authority will be aware that the extension has taken place. Amendment 215 will ensure that the local authority for the area in which the patient resides is informed of the extension certificate.

As the purpose of granting an extension certificate is to enable the application for a compulsory treatment order to be made, and as the making of such an application will require the co-operation of professionals who are available primarily during office hours, our policy is that the patient may be detained for up to three working days. Amendment 143 will modify the calculation of working days at section 41(5) to take account of local bank holidays.

We believe that it is not appropriate to make conflict of interest provisions in primary legislation for medical examinations prior to granting an extension certificate. As a result, amendment 144 will remove those provisions from section 41.

I turn to amendments 212 and 213A, which are members' amendments. We do not believe that amendment 212 is necessary, because the Mental Health (Scotland) Act 1984 refers to a change in the condition of the patient. We are not aware of any problems with that provision. Of course, it will usually mean that there has been a deterioration in the patient's condition if it becomes necessary to apply for a CTO late in the period of a short-term detention. However, we feel there is a risk that the narrower term "deterioration" might create doubts in a few cases. The important safeguards are that the criteria for short-term detention must still be met and that the charge has made an application for a CTO necessary.

With regard to amendment 213A, I am grateful to Mary Scanlon for raising the question of when the three-day period of detention under an extension certificate begins. We have accepted that our original amendment 213, as it appeared on the first marshalled list, was ambiguous on that point. In the light of amendment 213A, we have modified the text of amendment 213 to ensure that it is clear that the three-day extension commences when the short-term detention certificate expires. As a result, I invite Mary Scanlon not to move amendment 213A and thank her for drawing the matter to our attention.

I move amendment 211.

Mary Scanlon: I agree with the minister that amendment 212 is not necessary, and will not move it.

Amendment 213A was an attempt to make amendment 213 more precise. I accept the minister's reassurances in that respect, and will not move amendment 213A.

Amendment 211 agreed to.

Amendment 212 not moved.

Amendment 213 moved—[Mrs Mary Mulligan].

Amendment 213A not moved.

Amendment 213 agreed to.

Amendment 214 moved—[Mrs Mary Mulligan]—and agreed to

Amendments 143 and 144 moved—[Mrs Mary Mulligan]—and agreed to.

Section 41, as amended, agreed to.

Section 42—Extension certificate: notification

Amendment 215 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 154 not moved.

Section 42, as amended, agreed to.

After section 42

Amendments 216 and 217 moved—[Mrs Mary Mulligan]—and agreed to.

Sections 43 and 44 agreed to.

The Convener: That ends today's business.

Meeting closed at 11:30.

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