HEALTH AND COMMUNITY CARE COMMITTEE

Tuesday 21 January 2003
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
3rd 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:

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

Tuesday 21 January 2003

(*Morning*)

[THE CONVENER *opened the meeting at 09:35*]

Mental Health (Scotland) Bill: Stage 2

The Convener (Mrs Margaret Smith): Good morning everybody, and welcome to the Health and Community Care Committee. The only agenda item is our continuing stage 2 consideration of the Mental Health (Scotland) Bill. We are joined again by the Deputy Minister for Health and Community Care and her team, whom I wish a good morning.

The Deputy Minister for Health and Community Care (Mrs Mary Mulligan): Good morning.

Section 45—Mental health officer's duty to apply for compulsory treatment order

The Convener: Amendment 145, in the name of the minister, has been debated with amendment 105.

Amendment 145 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Now it starts to get a bit more complex. Amendment 492, in the name of Shona Robison, is grouped with amendments 158, 497, 498, 499, 500, 501 and 502. If amendment 500 is agreed to, I cannot call amendment 404, and if amendment 421 is agreed to, I cannot call amendment 501. I ask Shona Robison to move amendment 492 and to speak to all the amendments in the group.

Shona Robison (North-East Scotland) (SNP): The aim of amendment 492 is to ensure that the grounds for compulsory treatment reflect the Millan principle of informal care. Millan recommended that it should be possible to impose compulsory measures only if a tribunal is satisfied that the necessary care and treatment cannot be provided by agreement with the patient. As drafted, the bill does not state that explicitly; it merely requires the tribunal to be satisfied that the CTO is "necessary". Millan recommended against the use of vague and subjective language and was in favour of using clearly spelt out language in the bill. Amendment 492 follows the wording of the Mental Health (Scotland) Act 1984, which says that an order cannot be made unless it is established that care and treatment can be provided only under compulsion.

The other amendments in the group are consequential on agreement to amendment 145.

I move amendment 492.

The Convener: I ask Adam Ingram to speak to amendment 158 and the other amendments in the group.

Mr Adam Ingram (South of Scotland) (SNP): Amendment 158 spells out why it is necessary to treat compulsorily, along the lines of what Shona Robison said, because that is not entirely clear in the bill as drafted. It is a technical, tidying-up amendment.

Mrs Mulligan: The committee members' amendments in the group raise the issue of enshrining in the criteria for compulsion the principle of informal care. In our view, the amendments share the same problems as amendments 181 and 182, which concerned emergency and short-term detention and were debated last week. I hope that members will accept that I do not want to repeat at length all those arguments.

Amendment 492 seeks to replace the requirement that the order be necessary with a provision that the relevant

"medical treatment cannot be provided unless a compulsory treatment order is made".

Amendments 497 to 502 deal with the same point, but in connection with later reviews rather than the making of the original order. We do not think that amendments 492 and 158 would provide the patient with any further protection. The current test whether the order continues to be necessary would prevent a CTO from being renewed in any situation in which the relevant treatment could be provided without the CTO's remaining in place.

Amendment 158 would add—to the existing requirement that the order is necessary—the words,

"because the care and treatment which the patient needs cannot be provided with the patient's agreement".

Again, we do not think that that would provide the patient with any meaningful additional protection. We cannot envisage circumstances in which a tribunal would decide that an order is necessary, as the bill requires, if the care and treatment can be provided with the patient's agreement.

We also believe that introducing into the bill a wholly new concept—

"the care and treatment which the patient needs"—

could have unforeseen consequences. Because the phrase is not defined, it is not clear what should happen if, for example, the patient's needs were to change.

In short, the bill already provides the safeguards that the amendments seek. With that reassurance, I hope that the members will feel able to withdraw or not move their amendments.

The Convener: Does Shona Robison want to seek to withdraw or press amendment 492?

Shona Robison: On the basis of what the minister has said, I seek to withdraw amendment 492.

Amendment 492, by agreement, withdrawn.

The Convener: Amendment 289 is grouped with amendment 290. I ask the minister to speak to the amendments and to move amendment 289.

Mrs Mulligan: Amendments 289 and 290 deal with the matters that are to be included on a medical practitioner's mental health report, which is submitted prior to the application for a compulsory treatment order. Both amendments are technical amendments, which clarify the drafting of section 45. Their effect is to transfer from section 45(5)(a) to section 45(4) the requirement on the practitioner to explain why he believes that the conditions that are laid out in paragraphs 45(3)(b), (c), (d) and (e) are met.

I move amendment 289.

Amendment 289 agreed to.

Amendment 290 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 291 is grouped with amendments 292, 293, 295 and 296. I ask the minister to speak to the amendments and to move amendment 291.

Mrs Mulligan: The amendments in the group relate to the mental health reports that a medical practitioner is expected to produce in advance of the mental health officer's application for a compulsory treatment order. The amendments relate specifically to the circumstances in which a medical practitioner may recommend to the mental health officer that the patient should not be given notice of the application for a compulsory treatment order. Amendments 291 and 293 will tighten up the provisions on withholding notice from a patient. Amendment 293 will ensure that a medical practitioner could recommend that notice be withheld from the patient only when he is satisfied that the giving of such notice would be likely to cause significant harm to the patient or to other people. Amendment 291 will further ensure that the medical practitioner who makes such a recommendation should be an approved medical practitioner; in other words, such a recommendation could come only from a practitioner who has sufficient training and expertise in psychiatry.

Amendment 292 is a technical amendment that will tidy up the drafting of section 45, in the light of agreement to amendments 291 and 293.

Amendments 295 and 296 will amend the mental health officer's right to disregard the approved medical practitioner's recommendation that notice should not be given. The bill as drafted lays out a series of steps that the mental health officer would need to undertake once he had decided to go against the practitioner's recommendation. On reflection, we think that that is unnecessarily cumbersome. Amendments 295 and 296 will allow the MHO simply to inform the patient of the application where he considers it appropriate.

I move amendment 291.

Amendment 291 agreed to.

Amendments 292 and 293 moved—[Mrs Mary Mulligan]—and agreed to.

Section 45, as amended, agreed to.

Section 46—Medical examination: requirements

09:45

The Convener: Amendment 493 is grouped with amendments 494 and 294. I ask Shona Robison to speak to the amendments and to move amendment 493.

Shona Robison: Amendments 493 and 494 would require that, where appropriate, a patient's general practitioner carries out the second medical examination that is required for a compulsory treatment order. The Millan committee recommended that the second medical examination for a compulsory treatment order should continue to be given by the patient's GP, because that is the person who will know the patient best.

As drafted, section 46(4) might have the unintended consequence of encouraging patients' general practitioners not to be involved in giving medical recommendations, because it says simply that the second medical examination "may" be given by the patient's GP.

Amendments 493 and 494 would provide that the second medical examination should generally be made by the patient's GP. The advantage that can be gained from input by the patient's doctor is something that should obviously be encouraged. The wording of the amendments is similar to the wording that is used in the Mental Health (Scotland) Act 1984.

I move amendment 493.

Mrs Mulligan: Amendment 294 is intended to clarify the possible conflicts of interest that might arise when two medical practitioners examine a patient for the purpose of an application for a compulsory treatment order.

As Shona Robison said, amendments 493 and 494 seek to make it more likely that the second medical examination is carried out by the patient's GP rather than by an approved medical practitioner. The argument is finely balanced; it is important that there are strong links between primary care and specialist services and that the tribunal gets a broad perspective on the patient's state of health. We agree that the GP will often have much to contribute to that broad perspective, which is why the GP is the only doctor who is not an approved medical practitioner who may provide a report for the purposes of a CTO.

We have, however, also listened to the points that have been made by some GPs, who have pointed out that many patients might have little direct contact with their GP, and that not all GPs are expert in psychiatric issues. Furthermore, if a patient has been in hospital prior to the CTO application, the GP might have little direct knowledge of the situation. It therefore seems sensible to keep the provision in the bill flexible so that the second medical opinion may be provided by the doctor who is most suitable in the particular case. That might be either the patient's GP or an approved medical practitioner.

I hope that Shona Robison will therefore feel able to seek to withdraw amendment 493 and not to move amendment 494.

Shona Robison: I seek clarification. Could the minister ensure in some way that GPs are given every encouragement to take part in the process, perhaps through notes of guidance or the code of conduct?

Mrs Mulligan: I think that that would be possible. As I said, the way in which the bill is currently worded will allow a GP to play that role if he or she is the most appropriate person. Obviously, that role will be encouraged where the GP is the most appropriate person. We can address that issue in the guidance.

The Convener: Does Shona Robison wish to press amendment 493?

Shona Robison: Given those assurances, I seek to withdraw amendment 493.

Amendment 493, by agreement, withdrawn.

Amendment 494 not moved.

Amendment 294 moved—[Mrs Mary Mulligan]—and agreed to.

Section 46, as amended, agreed to.

Section 47 agreed to.

Section 48—Application for compulsory treatment order: notification

Amendments 295 and 296 moved—[Mrs Mary Mulligan]—and agreed to.

Section 48, as amended, agreed to.

Section 49—Mental health officer's power to request assessment of needs

The Convener: Amendment 297 is grouped with amendments 298 and 299. I ask the minister to speak to the amendments and to move amendment 297.

Mrs Mulligan: Amendments 297 to 299 seek to broaden the provisions of section 49. They will mean that a mental health officer will have the power to request a local authority to make an assessment of needs for any patient, whether an adult or a child, for the purposes of the bill or of the Children (Scotland) Act 1995.

Amendment 297 seeks to generalise section 49(1). It will have the effect of extending the mental health officer's power to request an assessment of needs under the Social Work (Scotland) Act 1968 to any patient for whom such an assessment would be relevant for the purposes of the bill or of the 1995 act. Section 49(1) will restrict the request for an assessment of needs to applications for compulsory treatment orders.

Section 49(2) will amend the Children (Scotland) Act 1995 by adding mental health officers to the list of people who may request an assessment of needs for a child from a local authority. Amendment 298 will extend that right of mental health officers; rather than apply just to applications for compulsory treatment orders, their power to request an assessment of needs for a child will extend to any child for whom such an assessment would be relevant for the purposes of the bill or of the 1995 act.

Amendment 299 is a technical amendment that will remove section 49 from chapter 1 of part 7 of the bill and will place it after section 160, as the section will now apply across the bill.

I move amendment 297.

Amendment 297 agreed to.

Amendment 298 moved—[Mrs Mary Mulligan]—and agreed to.

Section 49, as amended, agreed to.

Amendment 299 moved—[Mrs Mary Mulligan]—and agreed to.

Section 50—Mental health officer's duty to prepare report

The Convener: Amendment 300 is grouped with amendments 301, 302, 303, 412, 423 and 443.

Bill Butler (Glasgow Anniesland) (Lab): I am sorry to interrupt, but I would like clarification. Have we agreed to section 49?

The Convener: I believe so. We must agree to a section before we can agree to move it.

Mrs Mulligan: Amendments 300 to 303 will strengthen patients' rights in relation to access to advocacy services. Amendment 301 will add important paragraphs to section 50(2), which will ensure that when a mental health officer informs a patient of their advocacy rights, the officer must also take steps to ensure that the patient will have the opportunity to make use of the services.

Amendments 302 and 303 relate to the mental health officer's duty to interview the patient, which is laid out in section 50(2)(a). Amendment 302 will provide for situations in which it would be impracticable to comply with the duty to interview the patient. Amendment 303 will ensure that when such a situation arises, the mental health officer must record on the mental health report the reasons why it was impracticable to interview the patient.

Amendment 443 will remove section 74, which is no longer necessary, because its provisions are contained elsewhere.

Amendment 412 will introduce a new section that sets out the mental health officer's duties once the MHO has been informed by the responsible medical officer, under section 66, that the RMO intends to make a determination that will extend the compulsory treatment order at the review stage.

Amendment 423 will introduce a new section that imposes requirements on the mental health officer after they have been informed that the responsible medical officer proposes to apply to the tribunal for extension and variation of the CTO.

I move amendment 300.

Amendment 300 agreed to.

Amendments 301 and 302 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 155 not moved.

Amendment 303 moved—[Mrs Mary Mulligan]—and agreed to.

Section 50, as amended, agreed to.

Section 51—Mental health officer's duty to prepare care plan

The Convener: Amendment 304 is grouped with amendments 307, 322, 326, 345, 511, 346, 346A, 369 and 353. I point out that if amendment 369 is agreed to, I will not be able to call amendment 254.

Mrs Mulligan: The amendments in the group relate to the preparation of a patient's care plan, which forms a key part of the process of an application for a compulsory treatment order.

Amendments 304, 307, 322 and 326 are technical amendments that will add the word "proposed" before the term "care plan". It is necessary to clarify the fact that, at that stage of the application process, the care plan is a draft or proposed care plan that is still to be considered by the tribunal.

Amendments 345, 346 and 353 seek to clarify the Executive's policy intentions on the contents of the finalised care plan, once it has been approved by a tribunal hearing. Amendment 345 will ensure that the patient's responsible medical officer draws up a final version of the care plan following the tribunal's determination. Amendment 346 specifies the precise categories of information that must be included in the final version of the care plan. Amendment 353 is a technical amendment that will update the definition of the term "care plan" in the light of amendments 345 and 346. Amendment 369, which is also a technical amendment, will remove a reference to the patient's care plan from section 60(3)(c)(i).

We are happy to accept amendments 346A and 511, which Shona Robison has lodged.

I move amendment 304.

The Convener: Do you wish to speak to amendments 511 and 346A, or have you lost the power of speech?

Shona Robison: I have lost the power of speech.

The Convener: Members will find amendments 511 and 346A on a separate sheet; they are manuscript amendments that were accepted after the deadline.

Amendment 304 agreed to.

The Convener: Amendment 240 is grouped with amendments 241, 242, 243, 244, 246, 247, 248, 249, 253, 254, 255, 256, 263, 264 and 265. I could get a job as a bingo caller. If amendment 369, which has already been debated with amendment 304, is agreed to, I will not be able to call amendment 254.

Mr Ingram: The amendments in the group seek to effect a change of attitude or intent from one of

passive care to one of active recovery and from one of clinical intervention to one of social rehabilitation.

According to the Scottish Public Mental Health Alliance's report, "With Health in Mind: Improving mental health and wellbeing in Scotland", which was published last year, 70 to 80 per cent of people who are diagnosed as having severe mental illness recover. Therefore, it is anomalous not to use the language of recovery that is used in every other area of health care. Nicola Sturgeon and Mary Scanlon spoke in favour of such a change in perspective during the stage 1 debate in December and I hope that other committee members will share that view.

10:00

The amendments—especially amendments 241 and 244—would make it absolutely clear that the national health service's duties towards recovery under the eventual act do not end, but continue after the period during which a patient has been formally detained under a CTO. Amendment 247 would add a requirement to elicit the patient's signature to the recovery plan, and it would require that the patient's assent or dissent to the plan be noted. That would ensure that the Millan principle is followed and that tribunals have clear information about patients' participation in compilation of their recovery plans. It would also enable tribunals to judge mental health services' engagement of independent advocacy in the compilation of recovery plans.

In summary, recovery shifts the emphasis on to social therapies and joint working, in recognition of the fact that clinical interventions alone do not work. In other parts of the world where such an approach is followed, recovery rates for people who have schizophrenia can reach 60 per cent to 80 per cent. In this country, the recovery rate is 30 per cent, which is no different from the level that was attained in 1938.

I move amendment 240.

Mrs Mulligan: This group of amendments would amend the provisions on care plans. Although we are sympathetic to many of the points that have been raised, we do not feel that we can accept them.

On the amendments that propose to change "care plan" to "recovery plan", it is important to emphasise that care and treatment should be directed at assisting the individual to recover from an episode of mental illness. We welcome the innovative work of organisations such as the Scottish Development Centre for Mental Health and the Scottish Human Services Trust that is aimed at embedding the concept of recovery into mental health services. However, under the bill, not all the elements of the care plan are directly about recovery, and the term "recovery" might not be appropriate in some situations—for example, in relation to a person with a learning disability. The term "care plan" is widely used, well understood and we wish to retain it.

Amendment 244 would add detailed provisions to the care plan, which must be prepared before an application for a CTO is submitted, on how the measures in the plan would be expected to aid the patient's recovery. We must remember that the care plan must already contain a considerable amount of detail. It must set out the patient's needs; details of the care, treatment and services to be provided and who is to provide them; and the objectives of the treatment and services. It must be prepared in less than a fortnight—sometimes, it must be prepared over an even tighter time scale—and requires extensive consultation. We do not think that it would be right to add further complexity to that procedure.

I am afraid that we think that amendment 241 is unworkable. We cannot say that the care plan is being prepared in order to reduce

"the likelihood that a compulsory treatment order will need to be made in the future".

Under section 51, the purpose of the care plan is to inform the tribunal's consideration of whether to make a CTO and what such an order should contain. Of course, we hope that if the order works, future orders might not be needed, but that is not the only reason, or even the main reason, for preparing a care plan or granting a CTO.

The effect of amendment 247 would be that a care plan could not be finalised until the patient had signed it. As an application for a CTO requires a care plan, that would mean that the patient could veto the application simply by refusing to sign the document, which is clearly unacceptable.

I hope that Adam Ingram will not press amendment 240.

The Convener: Do you intend to press amendment 240, Adam?

Mr Ingram: Yes.

The Convener: The question is, that amendment 240 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 (Glagow 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 240 disagreed to.

Amendment 241 not moved.

The Convener: Amendment 305 is grouped with amendment 306. Agreement to amendment 305 will pre-empt amendment 242, which has already been debated with amendment 240.

Mrs Mulligan: Amendments 305 and 306 are technical amendments that aim to clarify the drafting of section 51(4) with respect to who must be consulted in the preparation of the care plan.

I move amendment 305.

Amendment 305 agreed to.

Amendments 306 and 307 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 243 not moved.

The Convener: Amendment 308 is grouped with amendments 309 to 320, 357, 321, 245, 323, 324, 325, 354 and 356.

Mrs Mulligan: This group of amendments may take a little longer to deal with than the previous group.

The amendments relate to the contents of the proposed care plan that will be submitted to the tribunal as part of an application for a CTO. Amendment 319 would provide that the care plan may suggest what care and treatment should be specified by the tribunal and makes it clear that any kind of care, treatment or service can be set out in the plan. The care plan will make suggestions only—the tribunal will reach its own view.

Earlier, we gave a commitment to implement the Millan recommendation that a change in the category of the patient's mental disorder—the three categories of mental disorder are given in section 227—would prompt a review by the tribunal at the date of the next renewal of the order. Amendment 308 would ensure that the proposed care plan specifies the type of mental disorder that the patient has.

A number of amendments seek to clarify the care, treatment and services that should be in the plan. Amendment 309 seeks to clarify that the needs of the patient referred to in section 51(4)(a) are those that relate only to the patient's medical treatment. As introduced, the bill could have been read as referring to any need, whether medical or non-medical. Amendment 316 seeks to clarify references to care, treatment or services that do not fall within the general categories of medical treatment and community care services or relevant children's services. Amendments 317 and 318 would tighten up the requirement to specify which compulsory measures that may be granted by the tribunal are being sought.

Amendments 323, 354 and 356 would move the definitions of "community care services" and "relevant services" to section 228, which is the general definition section. Amendments 310, 311, 314 and 315 would modify the wording of section 51(4) to reflect the fact that the care plan is still only draft or proposed at that stage of the application process.

Amendments 312, 313, 320, 321, 324, 325 and 357 are all technical drafting amendments.

We do not feel that amendment 245 is desirable. It seeks to require the care plan to set out how the proposed measures take into account various aspects of the patient's background and qualities. However, that would mean that every care plan would have to include a checklist of how the patient's age, sex, sexual orientation, religious persuasion and so on have been addressed. We think that that would be needlessly complicated. As I said in relation to amendment 244, we must be careful not to make the care plan so complicated that it is unworkable. Therefore, I invite Mary Scanlon not to move amendment 245.

I move amendment 308.

Mary Scanlon (Highlands and Islands) (Con): Given the minister's comments that the care plan is already needlessly complicated—indeed, we would all agree that the bill itself is exceptionally complicated—I will not move amendment 245.

Amendment 308 agreed to.

Amendments 309 to 320, 357 and 321 moved—[Mrs Mary Mulligan]—and agreed to.

Amendments 244 and 245 not moved.

Amendment 322 moved—[Mrs Mary Mulligan]—and agreed to.

Amendments 246 and 247 not moved.

Amendment 323 moved—[Mrs Mary Mulligan]—and agreed to.

Section 51, as amended, agreed to.

Section 52—Application for compulsory treatment order

Amendment 324 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 248 not moved.

Amendments 325 and 326 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 249 not moved.

Section 52, as amended, agreed to.

Section 53—Powers of Tribunal on application under section 52

The Convener: I call Shona Robison to speak to and move amendment 495, which is in a group on its own.

Shona Robison: Amendment 495 seeks to ensure that the tribunal hears a case promptly following an application for a compulsory treatment order. The Mental Health (Scotland) Act 1984 provides that a sheriff must hear an application within five days of the sheriff clerk receiving the forms. The committee heard concerns about delays with the mental health review tribunals south of the border, and amendment 495 seeks to ensure that the tribunal hears applications for long-term compulsory measures within five business days of the application having been made.

I move amendment 495.

Mrs Mulligan: We appreciate the concerns behind amendment 495. It is important that tribunal hearings are held quickly. Indeed, the Millan report emphasised that we must not allow the delays that have plagued the English system to happen here.

However, we do not believe that amendment 495 is necessary. Amendment 42 already makes the necessary provision to ensure that the tribunal rules can specify time limits for all tribunal proceedings. It would be premature to include a specific time limit in this part of the bill before the practical arrangements for hearings are more fully worked out. However, I am happy to reassure members that we intend to ensure that all tribunal hearings take place within a reasonable time frame.

With that reassurance, I hope that Shona Robison feels able to withdraw amendment 495.

Shona Robison: On a point of clarification, will another part of the bill or the tribunal rules include a more specific time period to cover the "reasonable time frame" that the minister mentioned, or will the matter simply be left at that?

Mrs Mulligan: We could consider including something in the tribunal rules. Obviously, we would want to balance that with the ability to be flexible on the matter, but such an option is open to us.

Shona Robison: On that basis, I will withdraw amendment 495.

Amendment 495, by agreement, withdrawn.

The Convener: Amendment 496 is grouped with amendments 504 to 506. I should point out that if amendment 470, which is to be debated later, is agreed to, I cannot call amendment 504. Further, if amendment 485, which is to be debated with amendment 482, is agreed to, I cannot call amendment 506. I hope that that is clear to everyone.

Shona Robison: Amendment 496 seeks to ensure that people who appear before the tribunal have the right to call and cross-examine witnesses. Although the bill provides that people who appear before the tribunal at various stages have the right to make representations and to lead or produce evidence, it does not specifically set out the right to call witnesses or cross-examine other parties. Amendment 496 simply seeks to clarify that such rights are included. The other amendments in the group deal with appeals against the renewal or variation of a CTO.

I move amendment 496.

10:15

Mrs Mulligan: The right to call witnesses is important. However, we feel that the bill already grants such a right, in that it grants the parties set out in section 53(3) the right to "lead or produce evidence". We are satisfied that that would include the right to call witnesses.

That said, the right to request

"clarification of the evidence of any other person with an interest"

is slightly trickier. It is not totally clear what that would involve, or what obligations it would impose on the tribunal or other parties. We envisage that the patient or the patient's representative should be able to ask questions of the doctors, the mental health officer and anyone else who appears in support of the application. The same would apply to questions that the named person or the primary carer might have.

We are reluctant to set out too many detailed procedural requirements in the bill, in case such a step leads to the hearings becoming unduly legalistic. It will be up to tribunal conveners to ensure that everybody involved has a reasonable opportunity to put forward their views and comment on the evidence. We want the conveners to have a reasonable amount of discretion, not least to avoid the likelihood of the patient being unduly pressured by other participants in the hearing who may dispute his or her point of view.

Nevertheless, we will review the point and, if necessary, we will deal with it when we prepare the tribunal rules. With that reassurance, I hope that Shona Robison feels able to withdraw amendment 496.

Shona Robison: Given the minister's assurances that her interpretation of the bill will be set out in the tribunal rules, I am content to withdraw amendment 496.

Amendment 496, by agreement, withdrawn.

The Convener: Amendment 327 is grouped with amendments 328, 390, 429, 471 to 473, 480 and 481.

Mrs Mulligan: This group of amendments concerns proceedings during a tribunal hearing. Amendment 327 would strengthen a patient's rights by giving their guardian or welfare attorney the right to participate in the tribunal hearing.

Amendment 328 would make it clear that the curator ad litem who may be appointed by the tribunal in line with section 53(3)(f) is appointed in respect of the patient, not in respect of any other participant at the tribunal hearing, which the drafting of the bill appears to suggest.

Amendment 390 would provide clarification of the individuals listed at section 65(2) who should be informed of a determination revoking a CTO. The amendment would ensure that the patient's guardian or welfare attorney is added to that list. Further, amendment 429 would ensure that the patient's guardian or welfare attorney is informed of an application for extension and variation of a CTO.

Amendments 471 to 473 would make similar changes with respect to a tribunal review hearing following any of the triggers listed in section 77(2).

Amendments 480 and 481 would modify the list of persons who are entitled to make representations to the tribunal when it considers an application made to it by the patient for revocation or variation of the CTO or by the responsible medical officer for variation of the CTO. The persons are the same as those identified in section 77(5), as amended, and any other persons who appear to the tribunal to have an interest in the application.

I move amendment 327.

Amendment 327 agreed to.

Amendment 156 not moved.

Amendment 328 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 157 is grouped with amendments 159 and 160.

Mr Ingram: Amendments 157, 159 and 160 were prompted by the "let's get it right" campaign, which is supported by the Scottish Association for Mental Health and 63 other voluntary organisations.

Amendment 157 would pave the way for amendment 160, which would qualify the use of community–based compulsory treatment orders in line with the original intention in the Millan report. Although amendment 159 would ensure that the making of a compulsory treatment order was the least restrictive option for the patient—again, in line with the Millan report—it would also allow patients, advocates, carers and named persons to comment on the restrictiveness of using community-based compulsory treatment orders for that person.

User groups in particular are deeply sceptical of the notion that community-based compulsory treatment orders will always be the least restrictive form of treatment. Given the many gaps in community-based services such as day care, psychological therapy and rehabilitation schemes, the suspicion is that the new orders will amount to little more than compulsory medication in the patient's own home in response to the suspension of normal freedoms.

The bill does not differentiate between the types of patient for whom a community-based compulsory treatment order would be more appropriate than a hospital-based compulsory treatment order. Amendment 160 spells out the Millan committee's recommendations regarding those who are most suitable for community-based treatment, which are detailed in my proposed new subsection (5B). As can be seen in that subsection, the clear intention was for community-based compulsory treatment orders to be used as preventive measures to stop people becoming so ill that they had to be hospitalised. The fear is that, unless conditions for their use are tightly drawn, community-based compulsory treatment orders might significantly increase compulsion. Furthermore, it is feared that the orders might be used as a resource management tool to relieve pressure on an understaffed national health service that has a decreasing bed capacity.

The movement towards the creation of an environment in which individuals take ownership of their condition could well be compromised by the bill's provisions.

If the Executive were to accept amendments 157, 159 and 160, people's fears could be effectively allayed. I suggest that the bill's credibility with service users would also be considerably enhanced.

I move amendment 157.

Mr John McAllion (Dundee East) (Lab): I am particularly concerned about this matter. It was clearly the intention of the Millan committee that compulsory treatment orders should be limited in their application. Millan said that it was impossible to forecast the precise number of people who might be subject to such an order, but he noted that, in 1994, before leave of absence was restricted to 12 months, 129 people were on leave of absence for more than a year and that, as it was likely that the people most suitable for an order for treatment in the community might be those who in the past would have been on a long-

term leave of absence, that was the sort of number that he would envisage.

Throughout our consideration of the bill, we have heard of the concerns of users that the new community-based compulsory treatment orders will lead to a great increase in compulsion in the community, contrary to what Millan suggested. That is partly because the pre-1994 situation was different from the situation in which users now find themselves; there has been widespread closure of in-patient beds across Scotland and much greater provision in the community. There is a genuine threat that, because of the new circumstances, there will be a use of community-based compulsory treatment orders on a scale that Millan did not envisage. I would like to hear strong arguments as to why the amendments could not be supported.

Mary Scanlon: John McAllion mentioned a figure of around 129 people, but the bill's explanatory notes mention a figure of about 200. The figure has risen since the Millan committee made its estimate.

No one has ever explained to us why community-based compulsory treatment orders are necessary. It would be important for that to be stated now, because genuine concerns have been expressed in that regard by people such as Marcia Reid and Maggie Keppie, who, as Adam Ingram said, do not feel that compulsory treatment orders are the least restrictive option.

Another point that was raised with us is what would happen if someone refused compulsory treatment in the community. Can the minister clarify that?

Mrs Mulligan: In our view, amendments 157 and 160 are unhelpful, because they would restrict the tribunal's discretion to make an order that best reflected the needs and wishes of the patient.

One of the fundamental aims of the Millan report and the bill is to provide for flexible orders that are based on the needs of the patient and which respect the principle of using the least restrictive alternative. The amendments would work against that, because they would mean that a tribunal could not make a community-based order even if a compulsory treatment order were necessary and the patient would prefer an order in the community to detention.

We understand the wish to ensure that community-based orders are not misused, but safeguards to ensure that they are not misused are already present. The tribunal must be persuaded that the criteria for making the order are met and that the order is necessary. The tribunal will consider the specific terms of the order against the background of the care plan and it must exercise its powers in the way that appears to it to involve the minimum restriction on the freedom of the patient that is necessary in the circumstances. Those are stringent tests, but they allow the tribunal the flexibility to ensure that the order is truly based on the needs of the patient. The amendments would remove that flexibility.

Amendment 159 would add a new condition that would have to be met before the tribunal could make a compulsory treatment order. The condition would be that the proposed treatment would be the least restrictive available treatment that was compatible with the safe and effective care of the patient. The committee, in its stage 1 report, asked us to add that condition to the gateway criteria. We considered that request carefully and addressed it in amendment 105, which amended part 1. As a result, the tribunal will be required to make a decision that it believes to impose the minimum necessary restriction on the freedom of the patient. That is the right test and we do not want to compromise its effect. We think that adding another reference in different terms at this point of the bill would be confusing and have an uncertain effect.

In response to points raised by members, we have sought at all times to continue the principle of least restrictive practice, but we also wish to allow the tribunal to decide on the most appropriate recommendation for the patient. We feel that amendments 157, 159 and 160 would remove that flexibility, which is why we ask Adam Ingram to seek to withdraw amendment 157 and not to move amendments 159 and 160.

10:30

Mr Ingram: I am prepared not to move amendment 159 in the light of the minister's remarks, but it is incumbent on me to press amendment 157 and to move amendment 160. Millan was very prescriptive in outlining the use of community-based CTOs as targeted at a small number of people for specific reasons. I tend to agree with the committee that that should remain the object and that it should not be open to a tribunal to make an order in respect of anyone. As I indicated, that leaves too many questions unanswered. Hence, I shall press amendment 157 and I shall move amendment 160.

The Convener: The question is, that amendment 157 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 (Glagow 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 157 disagreed to.

The Convener: Amendment 329 is grouped with amendments 330, 331, 334, 335 and 355.

Mrs Mulligan: Amendment 330 will provide that the compulsory treatment order made by the tribunal may specify particular forms of care, treatment or services. If those services are not delivered, the tribunal should be informed, because it may call into question whether the order is still justified or needs to be varied. Amendment 330 will also add a requirement that the order specify which category of mental disorder the patient is found to have. That is necessary to give effect to Millan's recommendation that, if the category changes at a later review, that must also be referred to the tribunal.

Amendment 331 will provide that where parties are present at the hearing, they need not be formally notified of any change from the measures sought in the application that the tribunal might decide to make.

Amendments 329, 334 and 335 are technical amendments that will improve the drafting of sections 53 and 54 by making more explicit the duration of a compulsory treatment order. Amendment 355 will add the term "recorded matter" to section 228.

I move amendment 329.

Amendment 329 agreed to.

Amendment 330 moved—[Mrs Mary Mulligan]—and agreed to.

Amendments 158, 159 and 160 not moved.

Amendment 331 moved—[Mrs Mary Mulligan]—and agreed to.

Section 53, as amended, agreed to.

After section 53

The Convener: Amendment 332 is grouped with amendments 333, 341, 358 to 367 and 490. If amendment 252, which is to be debated with amendment 161, is agreed to, I will not be able to call amendment 341.

Mrs Mulligan: This group of amendments will remedy an omission from the bill as introduced by inserting provisions relating to a tribunal's power to grant an interim compulsory treatment order. It might be useful for me to outline briefly by way of an introduction the circumstances in which such an order might be granted.

Generally speaking, interim compulsory treatment orders would be granted when the tribunal was not prepared to grant the application for a CTO at the first hearing or a later hearing. That could happen for several reasons. First, the tribunal might wish to hear further evidence, perhaps from an independent source, as requested by the patient. Secondly, the tribunal might not be satisfied that the proposed care plan is adequate and it might decide that a revised care plan should be submitted before it comes to a final determination. Thirdly, the tribunal might be minded to grant powers different from those applied for. In that case, sections 53(4) and 53(7) require the tribunal to give notice to parties not present at the hearing.

Amendment 332 sets out the power to make an interim compulsory treatment order for up to 28 days. The several technical amendments that arise from amendment 332 are amendments 333, 341, 358, 359 and 360. Those five amendments will smooth the drafting of sections 54 and 55.

Amendment 490 is a further consequential technical amendment, which will insert into the interpretation in section 228 a definition of the term "interim compulsory treatment order".

Amendments 361 to 367 relate to the procedures that follow the granting of an interim compulsory treatment order. They will bring the provisions on interim compulsory treatment orders generally into line with those on full compulsory treatment orders.

Amendments 361 and 362 will ensure respectively that, once the interim order has been granted, hospital managers will appoint a responsible medical officer in respect of the patient and that the mental health officer who made the original application for the treatment order will produce a social circumstances report, except where that MHO sees the report to be of

"little, or no, practical purpose".

Amendments 363 and 365 will ensure that the patient's responsible medical officer and the Mental Welfare Commission will revoke the interim order if they are satisfied that the conditions for the continued applicability of the order are no longer met.

Amendments 364 and 366 will further provide for the responsible medical officer and the commission to give notice to certain individuals and parties that they have revoked the interim order.

Amendment 367 makes it clear that an interim

order ceases to authorise the measures that it authorised originally as soon as a full compulsory treatment order is granted in respect of the patient.

I move amendment 332.

Amendment 332 agreed to.

The Convener: I propose to take a few minutes for a comfort break.

10:38

Meeting suspended.

10:49

On resuming—

Section 54—Compulsory treatment order: measures that may be authorised

Amendments 333 to 335 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 161 is grouped with amendments 336, 250, 337, 251, 338 to 340, 252, 342 and 491. If amendment 336 is agreed to, I cannot call amendment 250. If amendment 250 is agreed to, I cannot call amendments 337, 251, 338 and 339. If amendment 337 is agreed to, I cannot call amendment 251. If amendment 340 is agreed to, I cannot call amendment 252. If amendment 252 is agreed to, I cannot call amendment 341.

Questions will be asked in a moment to see who was listening.

Mr Ingram: The Scottish Association for Mental Health and 63 supporting organisations want the tribunal to be given the kind of flexibility that the minister indicated was required when she spoke against amendment 160. SAMH and others want the tribunal to have the powers to exclude particular treatments from being given to patients who are subject to a CTO by allowing the tribunal to make a general treatment authority subject to such exclusions or limitations as it may consider appropriate.

Such powers would be in line with the Millan committee's proposal for tribunals that compulsory intervention should be tailored to the individual patient's needs. Crucially, if the patient had concerns about particular kinds of treatment, the tribunal could take those concerns into account before it decided whether to approve the plan of care. The implication of the proposal is that, if an individual had a strong wish not to have a particular treatment, for example electroconvulsive therapy, the tribunal could take that into account. That would allow it to exclude such treatments from being given.

Members will be aware from the evidence-taking sessions that the experience of being subject to compulsory powers under the Mental Health (Scotland) Act 1984 can be extremely traumatic. That applies not only to being deprived of liberty, but to being compelled—sometimes forcibly—to accept treatments that might be controversial, invasive or involve unpleasant and distressing side effects. Through experience over time, service users become knowledgeable about treatments that work for them and others that are so distressing that they would not wish to accept them under any circumstances, regardless of any benefit that professionals may claim that they will have.

Too often, professionals dismiss those wishes, in what is often regarded as an arrogant and patronising way, on the ground that the recipient lacks insight into their condition. The bill will reinforce that approach. The effect of section 54(1)(b) as drafted will be to give the tribunal a blunt choice: to grant or refuse a general authority for treatment in accordance with part 13. I suspect that few if any CTOs will be refused and that many people will thus be forced to endure unnecessary ordeals in treatment. A more humane, sophisticated and flexible regime is called for.

I move amendment 161.

Mrs Mulligan: Before I comment on Adam Ingram's amendment 161 and Mary Scanlon's amendments 250 to 252, I will explain briefly the effect of Executive amendments 336 to 340, 342 and 491. In general, the Executive amendments will clarify the Executive's policy intentions with regard to the measures that a tribunal may authorise.

Amendment 336 helps to clarify that the measures that are outlined in section 54(1) are not cumulative and that the tribunal may authorise as many or as few of those measures as it sees fit.

Amendment 337 lays out in greater detail the types of compulsory measures that a compulsory treatment order may impose on a patient. It will also remove the notion of monitoring the patient in his or her home. That responds to some of the concerns that Mary Scanlon will probably raise.

Amendments 338 to 340 are technical amendments. Amendments 338 and 339 will clarify the drafting of sections 54(1)(c)(iv) and 54(1)(c)(v) in light of amendment 337. Amendment 340 will delete the definitions of the terms "authorised period", "community care services" and "relevant services". Those terms are now defined elsewhere in the bill as a consequence of amendments 329, 354 and 356.

Amendments 342 and 491 will rectify an omission from the bill. They will provide the necessary authority to convey a patient who is ordered to reside in a particular place to that place.

We will not support amendment 161. The effect of that amendment would be to allow the tribunal to exclude certain treatments or impose limitations on their use when granting authority for treatment in a CTO. The Millan committee considered that point and concluded that that would not be right. The Millan report recommended that, in approving a plan of care, the tribunal should be entitled to satisfy itself that the necessary safeguards would be followed, but not to add further safeguards. The appropriate safeguards are elsewhere, particularly in part 13 of the bill.

We agree with the Millan committee's analysis. The tribunal's job is to consider whether compulsory powers are justified and what they should be, but ultimately, the responsible medical officer has the responsibility for the patient's care and must choose which treatments are appropriate. The tribunal does not have the RMO's clinical knowledge and cannot predict how the patient's mental state might develop.

The Executive also cannot accept amendments 250 and 252. They would remove from the measures that a tribunal may authorise the powers that are associated with community-based CTOs. The Millan committee considered that matter exhaustively and recommended that community-based compulsory treatment orders should be possible. The Executive agreed, but added further safeguards to protect patients.

The committee heard a great deal of evidence from supporters and opponents of community-based CTOs and concluded that it was not opposed in principle to their operation. The matter was discussed again in the stage 1 debate in the Parliament, when the bill was endorsed unanimously. After all that detailed consideration and debate, the Executive sees no reason to abandon such a fundamental aspect of the bill.

We are sympathetic to amendment 251 and have lodged amendment 337, which will have a similar effect. I therefore hope that Mary Scanlon will not move amendment 251.

Mary Scanlon: In my enthusiasm to sign up to amendments that organisations suggested, I lodged amendment 250 as a probing amendment. It would delete the paragraph that I wish to amend in amendment 251. As the points that Adam Ingram raised in amendments 157, 159 and 160 have been covered and those points are the basis of amendment 250, I will not move that amendment.

Amendment 251 was supported by the Scottish Association for Mental Health and 63 other organisations. It is based on concern that the bill would allow access to the patient's home for monitoring purposes. It is noted that "monitoring" is a vague term and there is concern that the provision might lead to unnecessary intrusion into a patient's home life. Amendment 251 represents an attempt to remove or at least limit that possibility.

In addition, the bill would allow visits in the patient's home by persons responsible for providing care or treatment, but does not say that the visits would have to be for the purpose of providing such care and treatment. Amendment 251 sets out to clarify that point.

11:00

Mr McAllion: I am confused by the minister's arguments. When she opposed amendment 160, I accepted her argument that the amendment would have been too restrictive on the discretion that will be available to the tribunal. Of course, if amendment 160 had been agreed to, it would have implemented the Millan recommendations. The minister now says that she cannot support amendment 161 because it goes against the Millan recommendations, although she went against them in the earlier argument.

Amendment 161 would widen the discretion of the tribunal and allow it to make a decision that is in the patient's interest. That is the most important point. I accepted the minister's argument on amendment 160 that sometimes what the patient's interests are should not be tied down in statute. Amendment 161 would increase the tribunal's flexibility and improve its ability to put the patient's interests first. I do not think that the minister's arguments hold much water. Tribunal hearings will involve medical people who can make decisions—we are not talking about three lay people intervening in the decisions of those with medical expertise.

There is extreme concern out there about compulsory treatment orders and it would not sacrifice any great principle for the minister to concede that the tribunal should be given more flexibility and discretion in deciding what is in the patient's interests. If the tribunal system does not work, the bill will not work. We must put faith in that system and support amendment 161.

Mrs Mulligan: We argued against the tribunal making recommendations about a patient's treatment and the services offered because, at the stage concerned, the tribunal will be taking a decision on whether the treatment should be compulsory and will not be examining what that treatment should involve. We feel that the most appropriate person to decide what the treatment should involve is the responsible medical officer who is treating the patient.

As the patient's condition might develop or change, we must ensure that the RMO has the ability to change the treatment accordingly to meet

the patient's needs. If the tribunal were allowed to make recommendations or give directions at an earlier stage, it would be difficult for the RMO to change the treatment without having to go back to the tribunal, which might be detrimental to the patient because of delay. That is why we feel that it would not be helpful for the tribunal, at the stage concerned, to lay down what the treatment should be.

Mr Ingram: I am not suggesting that the tribunal should be required to approve every treatment that is proposed for every individual. The tribunal should consider whether particular treatment should be given only where an individual has expressed a strong view on that treatment. That is where the flexibility that John McAllion mentioned comes in. I will press amendment 161.

Mrs Mulligan: I have one further point of clarification for members. When offering treatment, the RMO will have to take into account the patient's advance statement, which will allow the views of the patient to be taken into consideration at all stages, even when there is a change during the patient's treatment. That is an added safeguard and will allow the patient's views to be taken into consideration.

The Convener: The question is, that amendment 161 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

McAllion, Mr John (Dundee East) (Lab)
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)
Smith, Mrs Margaret (Edinburgh West) (LD)

The Convener: The result of the division is: For 4, Against 4, Abstentions 0.

I have the casting vote, so I will vote against amendment 161.

Amendment 161 disagreed to.

Amendments 336 to 341 moved—[Mrs Mary Mulligan]—and agreed to.

Section 54, as amended, agreed to.

Section 55—Compulsory treatment order authorising detention: ancillary authorisation

Amendments 358, 342, 359, 491 and 360 moved—[Mrs Mary Mulligan]—and agreed to.

Section 55, as amended, agreed to.

Section 56—Extension of short-term detention pending determination of application

The Convener: Amendment 343 is grouped with amendment 344.

Mrs Mulligan: Amendments 343 and 344 are technical amendments that will rectify omissions from the bill as introduced. Amendment 343 will add the phrase "an extension certificate" to section 56(a) to reflect the fact that, while the determination of an application for a compulsory treatment order is pending, the patient might be detained under the authority of either a short-term detention certificate or an extension certificate. At present, section 56(a) refers only to a short-term detention certificate.

Amendment 344 will clarify the length of time for which a patient may be detained under an extension certificate and will make it clear that medical treatment may continue to be given to the patient during that period.

I move amendment 343.

Amendment 343 agreed to.

Amendment 344 moved—[Mrs Mary Mulligan]—and agreed to.

Section 56, as amended, agreed to.

After section 56

Amendments 361 to 367 moved—[Mrs Mary Mulligan]—and agreed to.

Section 57—Appointment of patient's responsible medical officer

Amendments 90 to 92 moved—[Mrs Mary Mulligan]—and agreed to.

Section 57, as amended, agreed to.

Section 58—Care plan: placing in medical records

Amendment 345 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 511 is a manuscript amendment that was submitted by Shona Robison. It is not in the marshalled list of amendments but is on a separate sheet.

Amendment 511 moved—[Shona Robison]—and agreed to.

Amendment 253 not moved.

Amendment 346 moved—[Mrs Mary Mulligan].

The Convener: Amendment 346A has been debated with amendment 304. It is another manuscript amendment.

Amendment 346A moved—[Shona Robison]—and agreed to.

Amendment 346, as amended, agreed to.

Section 58, as amended, agreed to.

Section 59 agreed to.

Section 60—First mandatory review

The Convener: Amendment 368 is grouped with amendments 378, 381, 382, 393, 396, 401, 419 and 422.

Mrs Mulligan: Amendment 368 is a technical amendment that will restrict the phrase "first review" to part 7. Amendments 378, 393, 401, 419 and 422 are technical amendments that will clarify that there is only one first review.

Amendments 381, 382 and 396 will clarify the conditions relating to the criteria for long-term compulsion that must be met, or fail to be met, in order for the patient to remain subject to a compulsory treatment order or have that order revoked, as appropriate. For a patient to remain subject to a compulsory treatment order, he must continue to meet all the relevant criteria.

I move amendment 368.

Amendment 368 agreed to.

Amendment 497 not moved.

Amendment 369 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 254 not moved.

The Convener: Amendment 370 is grouped with amendment 371.

11:15

Mrs Mulligan: Amendments 370 and 371 will clarify the persons whom the responsible medical officer should consult when he is carrying out a first review of a compulsory treatment order. Those persons are the mental health officer, persons who appear to the responsible medical officer to provide treatment or services of the kind specified in the care plan and any other person whom the responsible medical officer considers appropriate.

I move amendment 370.

Amendment 370 agreed to.

Amendment 371 moved—[Mrs Mary Mulligan]—and agreed to.

Section 60, as amended, agreed to.

Section 61—Further mandatory reviews

The Convener: Amendment 372 is grouped with amendments 373, 375, 376, 408 to 411, 163, 164, 413 to 417, 421, 165, 166, 424 to 428, 430 to 432, 434 to 439, 445 and 464 to 466.

Mrs Mulligan: This is a rather large group. All the amendments relate to changes to the sections dealing with extension, extension with variation and variation of a compulsory treatment order.

Amendment 373 is a technical amendment, which clarifies that the order referred to in section 61(2) is a compulsory treatment order.

Amendment 376 will remove the reference to section 78 orders from the obligation to carry out a further review. Orders granted under section 78 do not affect the time limits for first and further mandatory reviews.

Amendments 408 to 411 will amend section 66. The responsible medical officer's duty to make a determination extending the order has been removed to a new section, which is introduced by amendment 413. Section 66 is now primarily the trigger for consulting the mental health officer when the responsible medical officer believes that extension, without variation, is appropriate.

Amendment 413 will introduce a new section, which concludes the process whereby the responsible medical officer is required to make a determination extending a compulsory treatment order, without variation, where he believes that to be appropriate. The amendment is a reorganisation of the provision previously found in section 66 and connects with the amendments made to previous sections. Amendments 372, 375, 414, 445 and 464 are technical amendments consequential on amendment 413.

Section 67 deals with the notification requirements after a determination to extend a compulsory treatment order, without variation, has been made. Amendment 415 will amend section 67(1); it will remove the requirement on the responsible medical officer to give notice within seven days of making the determination. The responsible medical officer is now required to give notice prior to expiry of the compulsory treatment order.

Amendment 416 clarifies an ambiguity in section 67. When the RMO records that the MHO expresses no view, that is intended to mean that the MHO has not complied with his duty to confirm whether he agrees or disagrees with the RMO's view. The amendment makes that clear.

Amendment 417 will require the RMO to record, when preparing a record of his determination under section 67, the type of mental disorder that the patient has and whether that is different from what was recorded in the compulsory treatment order. That is necessary to implement the policy that the tribunal should arrange for a hearing when the type of mental disorder has changed from what was recorded in the compulsory treatment order.

Amendment 421 will amend section 68, so that, instead of being the section under which the RMO makes an application to extend and vary the order, it requires the RMO to consult the MHO when he is proposing to make such an application. Amendment 424 introduces a new section to conclude the process, whereby the RMO will be required to make an application for extension and variation of a compulsory treatment order to the tribunal.

Amendments 425, 426, 428, 413 and 431 are technical amendments to section 69. Amendments 427 and 432 will implement the policy modification that the patient must always be notified of an application for extension and variation of a compulsory treatment order. Amendment 432 will remove subsections (2) to (4) of section 69, which relate to the circumstances in which the RMO withholds notice from the patient. Amendment 435 will consequently remove the reference to withholding notice from the patient of an application to the tribunal under section 70.

Amendment 436 will replace section 71 and elements of section 62, which we aim to delete. Amendments 437 and 438 are technical amendments to section 72 and are consequential on amendments 436 and 427. Amendment 439 is a technical amendment, which will harmonise the content of an application to the tribunal for variation of a compulsory treatment order under section 73 with that of an application for extension and variation of a compulsory treatment order under section 70.

Where an RMO makes a determination extending a compulsory treatment order and the type of mental disorder from which the patient suffers has changed, the tribunal should review the determination. Amendment 465 implements that. The tribunal should review an RMO's determination to extend a compulsory treatment order where the MHO has failed to comply with his duty to provide the RMO with his opinion on whether or not he agrees with the determination. However, as drafted, section 77(2)(a) requires the tribunal to review a determination only where the MHO disagrees with the determination. Amendment 466 will expand that provision to include instances where the MHO fails to comply with his duty, as well as where he disagrees.

On members' amendments, we do not support amendments 163 to 166, which would require a CTO to be renewed every six months, instead of the current requirement, which is to review such orders at six and 12 months, and annually thereafter. The time periods in the bill are those that Millan recommended and they are appropriate. The annual renewals are additional to the duty on RMOs to keep orders under continuing review, and there are other safeguards, such as the right of the patient and named person to appeal regularly. Formal reviews are rightly a complex and time-consuming process. We believe that the bill strikes the right balance between practicality and protecting the patient.

I move amendment 372.

Mr Ingram: Amendments 163 to 166 are probing amendments. Given that we are dealing with issues of human liberty, the authorities and authorised persons should be required to justify the appropriateness of CTOs and their extension more frequently than once a year. Although I appreciate that a patient, carer or named person can call for a review, the onus to raise such issues should be on the powers that be, rather than on vulnerable people. I would like to hear what the minister has to say on the time scales.

Mrs Mulligan: As I said, part of the RMO's role is to review the compulsory treatment order continually and to ensure that, should particular circumstances come about, there would be a move to withdraw the order. As Adam Ingram says, patients can appeal, which could also add to the support that they would have. We have no reason to believe that CTOs will last longer than justified, but we are concerned that that should be monitored once the system is introduced. We will emphasise the importance of the on-going review under the RMO in the code of practice.

Amendment 372 agreed to.

Amendments 373, 375 and 376 moved—[Mrs Mary Mulligan]—and agreed to.

Section 61, as amended, agreed to.

The Convener: I propose to end this morning's meeting at that.

Meeting closed at 11:26.

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