HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 29 January 2003
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
5th 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)

WITNESSES

Dr Mac Armstrong (Chief Medical Officer for Scotland)
Malcolm Chisholm (Minister for Health and Community Care)
The Very Rev Graham Forbes (MMR Expert Group)
The Deputy Minister for Health and Community Care (Mrs Mary Mulligan)

CLERK TO THE COMMITTEE

Jennifer Smart

SENIOR ASSISTANT CLERK

Peter McGrath

ASSISTANT CLERK

Graeme Eliot

LOCATION

Chamber

Scottish Parliament

Health and Community Care Committee

Wednesday 29 January 2003

(*Morning*)

[THE CONVENER *opened the meeting at 09:41*]

The Convener (Mrs Margaret Smith): Good morning and welcome to this morning's meeting of the Health and Community Care Committee.

The first item on our agenda is consideration of the Mental Health (Scotland) Bill. I suggest that we have a break between this item and the other two items on our agenda—hepatitis C and the measles, mumps and rubella vaccination—to discuss lines of questioning on those issues. I also suggest that at the end of the meeting we meet briefly in private to discuss the evidence that the Minister for Health and Community Care has given on hepatitis C and MMR, before we make decisions about further action that the committee may want to take on those issues.

Members *indicated agreement*.

Mental Health (Scotland) Bill: Stage 2

The Convener: We continue with stage 2 consideration of the Mental Health (Scotland) Bill. This morning we are joined by the Deputy Minister for Health and Community Care and her team.

Section 83—Suspension of order

The Convener: The first amendment for debate is amendment 507, in the name of Shona Robison, which is grouped with amendments 257, 258, 604, 605 and 612.

Shona Robison (North-East Scotland) (SNP): The purpose of amendment 507 is to ensure that a community-based compulsory treatment order—CTO—can be suspended to allow patients to demonstrate over a trial period that a compulsory order is no longer necessary in their case. The amendment provides that, wherever the responsible medical officer is considering invoking a CTO, he or she may suspend the order for up to three months. That is a sensible way of assessing whether a compulsory order should remain in place.

I move amendment 507.

Mary Scanlon (Highlands and Islands) (Con): The amendments are supported by the Scottish Association for Mental Health. They are intended to tighten up the notice requirement provisions relating to the suspension of CTOs. The desired effect of the amendments is to reduce the period within which notice must be given from 14 days to seven days, and to ensure that the responsible medical officer gives reasons for granting the suspension. The amendments will ensure that the responsible medical officer gives notice of the circumstances in which a suspension may be terminated and that reasons are given for early revocation of that suspension. Although the suspension certificate is a clinical tool, it could be used to test whether it is appropriate to revoke a CTO by having what amounts to a trial discharge.

Surely it is desirable that the RMO gives reasons for granting the suspension certificate and makes clear to the patient, the named person and others any circumstances that might lead to the revocation of the certificate before the period that is specified in the certificate expires. If the certificate is revoked early, surely the RMO should provide reasons for that. It is appreciated that it might be desirable for the RMO to have some discretion in making such decisions, but the bill is about ensuring transparency, inclusion and participation by patients with mental illness. Executive amendment 612 does not explicitly require reasons to be given for granting or revoking a suspension certificate; it requires only

notice of either the proposal to grant it or the decision to revoke it.

The Scottish Association for Mental Health told me that the Executive amendments were lodged late and that little opportunity was available for organisations to discuss or consider amendments to them. I understand that everyone else is required to give five days' notice, but the Executive lodged its amendments without allowing other organisations an opportunity to respond.

09:45

The Convener: The Executive made it within the deadline of two days, although we hope to have as many amendments as possible lodged by five days before the meeting. However, provided that the Executive lodges its amendments by two days before the meeting, we cannot disallow them. The Procedures Committee has examined such matters seriously, because many people feel that although organisations have enough time at stage 1 to consider and give their opinions on the Executive's proposals, that is not the case at stage 2.

Some of the amendments that are lodged late are good amendments that are the result of the Executive listening, but we found at stage 2 of the Adults with Incapacity (Scotland) Bill that when the Executive had listened to such an extent that another set of people was unhappy with the amendments that had been lodged, those people did not have the same amount of time that was available at stage 1 within and without the Parliament to consider the full ramifications of some of those amendments. I have much sympathy with the views that seem to be coming through the Procedures Committee that further time should be given for stage 2. However, we must work within the present standing orders. I suggest that we should look to the next Parliament to change those rules.

Mary Scanlon: The Scottish Association for Mental Health says that everyone except the Executive is required to give five days' notice. A misunderstanding seems to have occurred. Did you say that the time limit for everyone, including the Executive, is two days?

The Convener: Yes.

The Deputy Minister for Health and Community Care (Mrs Mary Mulligan): I assure the committee that the Executive is making every attempt to lodge amendments as soon as possible. I am sorry if people have been inconvenienced on this occasion, but the cause is the pressure of the number of amendments. We are making every effort to give people time to consider the amendments.

Amendment 604 will remove section 83 and amendment 612 will introduce a new section after section 90 to replace section 83. Section 83 allows the suspension, for up to three months, of a hospital-based compulsory treatment order. The new section that amendment 612 will introduce allows the suspension for up to three months of any combination of measures—except a detention measure—specified in a compulsory treatment order.

The only measure that may not be suspended under the new section is hospital detention, which may be suspended for up to six months under section 90. That more flexible approach is closer to the original aim of the power to suspend, which is to allow patients an opportunity to show that a CTO may safely be revoked.

Amendment 605 is technical and will clarify that section 85 applies to a failure to comply with any measure that has been "authorised by" a compulsory treatment order and not just to a failure to comply with those that are "specified in" the order.

Amendments 507, 257 and 258 would modify section 83. Executive amendment 604 proposes the deletion of section 83 and Executive amendment 612 will introduce a new section after section 90 as a replacement. If the Executive amendments are approved, amendments 507, 257 and 258 will be redundant.

Amendment 507 would extend section 83 to community-based compulsory treatment orders so that any order—whether hospital based or community based—could be suspended. Executive amendments 604 and 612 have the same effect. Any combination of measures that relate to a community-based compulsory treatment order can be suspended in the section to replace section 83. In effect, we have accepted the general principle behind amendment 507 through the Executive amendments that will replace section 83 and I therefore invite Shona Robison to withdraw amendment 507.

Amendment 257 seeks to reduce from 14 days to seven days the period within which the responsible medical officer must give notice to certain persons of the fact of the suspension of the order. We have accepted the spirit of that amendment and have indeed gone further in the proposed replacement section. The patient, the patient's named person and the mental health officer must be given notice of the proposal prior to granting a certificate for suspension. However, we have retained a 14-day notice period for the commission in accordance with the commission's longer-term data-gathering and monitoring functions. Therefore, I invite Mary Scanlon not to move amendment 257.

Amendment 258 seeks to specify in more detail the matters that must be notified to the persons who are entitled to receive notice. It emphasises the responsible medical officer's discretion to revoke the suspension certificate at any time and provides for the giving of notice of the revocation of the suspension certificate to the same persons who were informed of its granting.

The replacement section for section 83 does not specify the information that must be communicated to persons who are entitled to receive notice, as we believe that that matter can be adequately dealt with by the code of practice. The revocation of a suspension certificate will be covered by section 91, through Executive amendment 613, which provides the grounds for the revocation of the suspension certificate and for the notification of persons following the revocation. Therefore, we believe that we have addressed the issues that are raised by amendment 258 and I invite Mary Scanlon not to move it.

The Convener: I invite Shona Robison to press or withdraw amendment 507.

Shona Robison: On the basis that the Executive's proposals cover the intention behind amendment 507, I am happy to withdraw it.

Amendment 507, by agreement, withdrawn.

The Convener: I invite Mary Scanlon to move or not move amendment 257.

Mary Scanlon: I have a point of clarification. Will the minister confirm whether the Executive's amendment requires reasons to be given for granting or revoking a certificate of suspension, or only notice? I am keen for reasons to be given.

Mrs Mulligan: We do not propose that reasons be given—we ask only that notice be given.

Mary Scanlon: In that case, I want to move amendment 257.

Amendment 257 moved—[Mary Scanlon].

The Convener: The question is, that amendment 257 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Elder, Dorothy-Grace (Glasgow) (Ind)
McAllion, Mr John (Dundee East) (Lab)
Robison, Shona (North-East Scotland) (SNP)
Sturgeon, Nicola (Glasgow) (SNP)
Scanlon, Mary (Highlands and Islands) (Con)

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 5, Against 4, Abstentions 0.

Amendment 257 agreed to.

Amendment 258 moved—[Mary Scanlon].

The Convener: The question is, that amendment 258 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Elder, Dorothy-Grace (Glasgow) (Ind)
McAllion, Mr John (Dundee East) (Lab)
Robison, Shona (North-East Scotland) (SNP)
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Smith, Mrs Margaret (Edinburgh West) (LD)

The Convener: The result of the division is: For 5, Against 4, Abstentions.0.

Amendment 258 agreed to.

Amendment 604 moved—[Mrs Mary Mulligan].

The Convener: The question is, that amendment 604 be agreed to. Are we agreed?

Members *indicated agreement*.

The Convener: Does anyone disagree?

Members: No.

The Convener: Okay. That is agreed and section 83 is removed.

Shona Robison: On a point of clarification. If amendment 604 is agreed, does that mean that the other amendments to section 83 are no longer valid?

The Convener: Yes. That is why I asked whether anyone disagreed to the amendment.

Shona Robison: In the past, you have said that if such-and-such an amendment is passed, it will delete—

The Convener: I did not have any pre-emptions noted. However, the minister said that if amendment 604 were accepted it would take out the other amendments, as it would take out the whole of section 83.

Shona Robison: It would be nice to try to reach some sort of compromise. Clearly, the will of the committee was to support Mary Scanlon's amendments 257 and 258. However, there is a technical problem—

The Convener: There is a technical problem, as we cannot go back. I asked whether anyone—

Shona Robison: Will you please let me finish? The Executive's amendment 604 has now deleted section 83. However, as the Executive has now heard the will of the committee to support the previous amendments, could we have an indication whether it will acknowledge the sentiments of Mary Scanlon's amendments? Otherwise, this becomes a bit of a farce.

The Convener: I will clarify the situation and then ask the minister for her input. [*Interruption.*] I am advised that there was no pre-emption. Pre-emptions exist only if amendments amend text that has already been taken out, and section 83 had not been taken out at that stage. The text was still there and could have been amended. Amendment 604 could then have been disagreed to, and that would have been okay. The minister said that, if amendment 604 were accepted, the other amendments to the section would not have effect, as the amendment would remove that section.

We cannot go back, as we have taken the relevant votes. There are two ways forward. First, it is open to any member to lodge similar amendments at stage 3. Given the points that Shona Robison has made about the will of the committee, there might be some sympathy for that. I would suggest that to the Presiding Officer. Secondly, Shona has requested that the Executive at least take on board the sentiments behind Mary Scanlon's amendments, which gained the support of the committee. I ask the minister to respond on that point.

Mrs Mulligan: Amendment 604 has been agreed to. However, having heard the views of the committee, I think that it is only right that we take those on board. We would be happy to lodge an amendment at stage 3 that would take those views into account.

The Convener: I thank the minister for that. Let us move on.

Section 84—Failure to attend for medical treatment

The Convener: Amendment 572, in the name of Mrs Mulligan, is grouped with amendments 347, 348, 349 and 573.

10:00

Mrs Mulligan: Amendments 572, 573 and 347 to 349 relate to the procedures that follow a patient's breach of a compulsory treatment order. Amendment 572 extends the provisions of section 84 to include patients subject to an interim compulsory treatment order. It also deletes section 84(1)(a)(i), which is not required, as a compulsory treatment order can never authorise detention, which is dealt with in section 54(1)(a), while also imposing a requirement to attend for medical treatment, which is dealt with in section 54(1)(c)(i).

Amendment 573 similarly extends the provision of section 85 to patients on an interim compulsory treatment order. Amendments 347 to 349 are technical amendments that improve the drafting of section 84.

Amendment 572 moved—[Mrs Mary Mulligan]—and agreed to.

Amendments 347 to 349 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 350, in the name of the minister, is grouped with amendments 351, 352, 574 and 575.

Mrs Mulligan: Amendments 350 to 352 modify section 84(4) and introduce new section 84(5). The amendments increase the safeguards for a patient who is conveyed to hospital as a result of failing to comply with a requirement in his compulsory treatment order to attend at a specified place to receive medical treatment.

Such a patient may not be detained in hospital for longer than necessary and certainly not for longer than a period of six hours from his arrival in hospital.

The amendments emphasise the fact that, where the compulsory treatment order does not authorise the giving to the patient of medical treatment, which is dealt with in section 54(1)(b), section 84 does not authorise the giving of treatment without consent.

Amendments 574 and 575 tighten up the duration of the period for which a patient may be detained in hospital under section 85. Amendment 575 removes section 85(7), which states that the patient can be detained in hospital until the completion of the medical examination, which could, in theory, last for an indefinite period. Amendment 574 replaces that section with new section 85(5A), which states that the patient may be detained in hospital for a period of 72 hours after their arrival at the hospital. That mirrors the time limits on emergency detention.

Amendment 350 moved—[Mrs Mary Mulligan]—and agreed to.

Amendments 351 and 352 moved—[Mrs Mary Mulligan]—and agreed to.

Section 84, as amended, agreed to.

Section 85—Non-compliance generally with order

Amendments 573 and 605 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 508 is grouped with amendments 576 to 584, 509 and 585 to 590.

Shona Robison: Amendments 508 and 509 provide that the mental health officer should be required to consent to the compulsory admission to hospital of a patient who is in breach of a compulsory treatment order.

My concern arises from the fact that under section 86 a mental health officer's consent is not required for short-term detention, although under section 85 an MHO is required to consent to a patient's removal to hospital for assessment. It could be argued that it is more important for the mental health officer to be required to consent to the patient's detention than to be required to consent to the patient's removal; certainly, the two are equally important. It would not be practical to require the mental health officer to consent twice, which is why the amendment will transfer the provisions of section 85(2) to section 86. That would make detention under section 86 subject to the same safeguards as short-term compulsory orders under section 35.

I move amendment 508.

Mrs Mulligan: Amendments 508 and 509 are intended to amend the responsibility of the MHO in situations where the responsible medical officer admits a patient to hospital following a breach of the terms of a compulsory treatment order. Instead of having to consent to the initial admission, the consent of the MHO will be required for the continued detention of the patient following examination on admission. The Executive agrees with the intention behind the amendments, and we are grateful to Shona Robison for highlighting the points that they raise.

It is the decision to detain the patient for a period of up to 28 days, while applying for a variation of the order or considering such an application, which should be authorised by the MHO. We therefore accept amendment 508. Amendment 509 is superseded by the Executive amendments. Amendment 584 proposes to include new subsection (2C) in section 86, and that will do what amendment 509 seeks to do, so I hope that Shona will be able to withdraw that amendment.

Executive amendment 576 is a technical amendment that will restrict the provisions in section 86(2) to the procedures that follow a breach of the terms of a community-based CTO. Where an interim CTO has been breached, the consequences are set out in amendment 584.

Amendments 577 to 581 are necessary to correct an error in the drafting of section 86. The section allows for the detention of a patient in hospital for up to 28 days following a breach of a CTO based in the community. It should be possible to exercise that power if the responsible medical officer believes that it is necessary to modify the CTO to detain the patient in hospital for a longer period, or if it is necessary to detain the patient in hospital while that option is considered. The current drafting is incorrect in that it would require the doctor to decide that the order should be modified before completing the assessment necessary to reach that decision.

Amendment 582 is technical and clarifies that the responsibility for deciding whether an application should be made to the tribunal for the modification of a CTO lies with the RMO where a patient has failed to comply with the terms of a community-based CTO.

Amendments 583 to 590 relate to the procedures that must be followed when a patient breaches the terms of a community-based CTO, or an interim CTO, and is conveyed to and detained in a hospital under the authority of sections 85(5) and 85(5A).

Amendment 584 lays out the provisions that relate to interim CTOs. To explain the provisions relating to interim orders, it is useful to point out that section 86(2) allows a responsible medical officer to grant a certificate authorising a 28-day period of hospital detention for a patient who has breached the terms of a full CTO based in the community. The amendment will therefore bring the provisions for interim orders in line with the provisions under section 86(2). It will empower the RMO to grant a certificate that authorises the patient's detention in hospital until the expiry of the interim order if he is satisfied that the conditions outlined in proposed new subsection (2A) of section 86 are met.

Proposed new subsection (2C) of section 86 will further ensure that a period of short-term detention following a breach of the terms of an order, whether interim or full, can be imposed only if the consent of the MHO has been obtained. That will implement the effect of amendment 509, lodged by Shona Robison.

Amendment 589 is a technical amendment that is consequential to amendment 584. Amendments 583, 585, 588 and 590 are further technical amendments. Amendment 586 provides that where a responsible medical officer issues a certificate granting a period of short-term detention following a breach of the terms of an interim or full order, he must list on the certificate his reasons for believing that the conditions necessary for granting it are met. Amendment 586 gives rise to amendment 587, which is a further technical amendment to smooth the drafting of section 86.

Amendment 508 agreed to.

Amendments 574 and 575 moved—[Mrs Mary Mulligan]—and agreed to.

Section 85, as amended, agreed to.

Section 86—Short-term detention following examination under section 85(6)

Amendments 576 to 584 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 509 not moved.

Amendments 585 to 590 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 591 is grouped with amendment 592.

Mrs Mulligan: Amendments 591 and 592 are technical amendments. Amendment 591 removes from section 86 provisions that are now contained in three new sections in the bill, which are introduced by amendments 592 to 594. Amendment 592 replaces sections 86(9) and 86(10) with a new section dealing with an application for the variation of a compulsory treatment order following detention under section 86.

I move amendment 591.

Amendment 591 agreed to.

Section 86, as amended, agreed to.

After section 86

Amendment 592 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 593 is grouped with amendment 594.

Mrs Mulligan: Amendments 593 and 594 are also technical amendments. Amendment 593 replaces sections 86(11) and 86(12) with a new section that deals with the responsible medical officer's duty to review whether the conditions for detention under section 86 continue to be met. Amendment 594 replaces sections 86(13) and 86(14) with a new section dealing with the patient and the patient's named person's right to apply to the tribunal for revocation of a detention certificate granted under section 86(2) or proposed section 86(2B). Both the amendments arise from amendment 584, which deals with the detention of patients subject to interim compulsory treatment orders.

I move amendment 593.

Margaret Jamieson (Kilmarnock and Loudoun) (Lab): Amendment 593 uses the phrase "from time to time", but that does not tell us whether we are talking about hours, days, months or years. What is intended by that phrase?

Mrs Mulligan: It is meant to allow for an on-going situation, so it is flexible.

Amendment 593 agreed to.

Amendment 594 moved—[Mrs Mary Mulligan]—and agreed to.

Section 87—Transfer of certain detained persons

10:15

The Convener: Amendment 512 is grouped with amendments 513, 523, 525, 526 and 535.

Mrs Mulligan: The amendments in this group are technical amendments that remove from sections 87, 88 and 89 several references to the phrase "hospital unit". The provisions regarding formal transfers will apply only to transfers from one hospital to another. Originally, it was thought that it might be desirable to allow for individual units within a hospital to be specified, so that a transfer from another part of the hospital to that unit would be subject to an appeal right. We now think that that would be unnecessarily complicated.

I move amendment 512.

Amendment 512 agreed to.

Amendment 513 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 514 is grouped with amendments 515 to 522, 524, 531 and 539.

Mrs Mulligan: The amendments in this group are also technical amendments, which smooth the drafting of section 87. Amendments 515, 517 to 520, 524 and 531 tighten up and clarify provisions relating to the notice that must be given to a patient subject to a hospital-based CTO who is to be transferred from one hospital to another.

Amendment 517 provides that the seven-day period of notice of a transfer may be waived in a case where it is necessary that the transfer take place urgently. Amendment 518 adds a subsection to section 87, which ensures that, where that seven-day period of notice has not been given, notice should be given to the patient, the patient's named person and the patient's primary carer as soon as is practicably possible. Amendment 518 further provides that notice need not be given if the patient gives his consent to the transfer.

Amendment 520 inserts into section 87 a further three subsections relating to a situation in which a proposed transfer to another hospital does not take place within three months of the original notice having been given. That amendment ensures that, where such a situation arises, the proposed transfer can take place only where the managers of the receiving hospital still agree to the transfer, and where the patient, the patient's named person and the patient's primary carer have once again been given at least seven days' notice of the transfer, unless one of the exceptions to the requirement for the notice applies.

Amendments 515, 519, 524 and 531 are all consequential technical amendments that are necessary following amendments 517, 518 and 520. Amendments 514 and 516 are also technical amendments that help to smooth the drafting of section 87.

Amendments 521 and 522 modify and tighten up the provisions laid out in section 87 relating to the notice that must be given to the Mental Welfare Commission when a patient who is subject to a hospital-based compulsory treatment order is transferred from one hospital to another. Amendment 521 puts right an omission from the bill as introduced, by adding to the list of pieces of information that must be given to the commission details of the hospital to which the patient is being transferred. Amendment 522 ensures that, where seven days' advance notice has not been given, hospital managers must inform the Mental Welfare Commission of the reasons why the patient had to be transferred so urgently. Hospital managers must also inform the commission of what period of notice, if any, was given to the patient, the named person and the primary carer.

Amendment 539 rectifies an omission from the bill as introduced. It is a technical amendment that ensures that a responsible medical officer will be appointed in respect of a patient when a transfer from one hospital to another takes place or when an appeal against a transfer is upheld by the tribunal and the patient is returned to the hospital from which he was transferred.

I move amendment 514.

Amendment 514 agreed to.

Amendments 515 to 523 moved—[Mrs Mary Mulligan]—and agreed to.

Section 87, as amended, agreed to.

Section 88—Transfer to hospital other than state hospital: appeal to Tribunal

Amendment 524 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 273 is grouped with amendment 274.

Shona Robison: Amendments 273 and 274 seek to exclude from the appeal provision transfer to another hospital or unit within the same NHS trust for the purpose of treatment of a physical disorder. As section 88 reads at present, it could give the patient a right of appeal against being transferred to a hospital for the treatment of a physical disorder, such as a drug overdose or some other medical condition that required treatment. It would be interesting to hear whether that was intended or whether it represents an oversight.

I move amendment 273.

Mrs Mulligan: Amendment 273 would restrict the patient's right to appeal against a transfer to situations in which the transfer was for the purpose of receiving treatment for mental disorder. We understand that the intention is that the appeal right should not apply in situations in which the patient is transferred to a general hospital for treatment of a physical condition.

We are sympathetic to the aims of amendment 273, as the general intention behind sections 87 to 90 is to grant rights to patients who are transferred between psychiatric hospitals. It is not really the tribunal's role to adjudicate on the treatment of any physical illnesses that patients might have. However, we would like to have the opportunity to consider the issue further, because we are not sure that the drafting of amendment 273 works. We also want to consider whether section 87 needs to be amended.

I am happy to give an undertaking that we will discuss the issue further with the Mental Welfare Commission and other parties, with a view to a possible stage 3 amendment. Therefore, I hope that Shona Robison will withdraw amendment 273.

We are not minded to accept amendment 274, which would prevent a patient from appealing against a transfer to a hospital that was managed by the same NHS trust or island health board as the hospital from which the patient was being transferred. Amendment 274 would bring about an unnecessary and unwarranted dilution of the patient's rights.

Amendment 273, by agreement, withdrawn.

Amendments 525 and 526 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 274 not moved.

The Convener: Amendment 527 is grouped with amendments 528, 532 and 533.

Mrs Mulligan: The amendments in this group clarify and strengthen the rights of the patient and the patient's named person to appeal to the tribunal against a transfer to a different hospital, including a state hospital, where the patient is subject to a hospital-based compulsory treatment order.

The committee will be aware that the Millan report recommended that the patient and the patient's named person be given a right of appeal against a transfer. Such a right is not available under the Mental Health (Scotland) Act 1984, except when the transfer is to a state hospital.

The amendments build on the provisions laid out in the bill as introduced. Amendments 528 and 533 slightly amend the time periods within which the patient or the patient's named person may

appeal to the tribunal. For transfers to a state hospital, the time limit for an appeal has been extended from 10 to 12 weeks by amendment 533. Where notice is given to the patient or named person after the transfer has taken place, the time limit for an appeal runs from the date of notice, not the actual date of transfer.

Amendments 527 and 532 are technical amendments that simplify the drafting of the subsections to which they refer.

I move amendment 527.

Amendment 527 agreed to.

Amendment 528 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 529 is grouped with amendments 530 and 534.

Mrs Mulligan: Amendments 529 and 534 ensure that, where an appeal against the transfer has been lodged in advance of the transfer taking place, the transfer may not take place except where the tribunal orders that the transfer take place pending the outcome of the appeal. Amendment 530 empowers the tribunal to make an order that a transfer to a hospital that is not a state hospital should not take place or that the patient should be returned to the transferring hospital. Therefore, the amendment brings the provisions on appeals against the transfer to a hospital other than a state hospital into line with those in the bill as introduced on appeals against the transfer to a state hospital.

I move amendment 529.

Amendment 529 agreed to.

Amendment 530 moved—[Mrs Mary Mulligan]—and agreed to.

Section 88, as amended, agreed to.

Section 89—Transfer to state hospital: appeal to Tribunal

Amendments 531 to 535 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Amendment 536 is grouped with amendments 537 and 538.

Mrs Mulligan: The amendments clarify the bill's provisions with regard to the reasons why the tribunal should uphold an appeal against a transfer to a state hospital. The amendments make clear that a patient is sent to a state hospital because of a need for special security, which might not arise directly from the patient's mental disorder. Where the tribunal is not satisfied that the patient requires the level of special security provided by a state hospital, it may uphold the appeal and make an order that the transfer should not take place or that the patient be returned to the hospital from which he was transferred.

I move amendment 536.

Amendment 536 agreed to.

Amendments 537 and 538 moved—[Mrs Mary Mulligan]—and agreed to.

Section 89, as amended, agreed to.

After section 89

Amendment 539 moved—[Mrs Mary Mulligan]—and agreed to.

Section 90—Suspension or variation of detention

The Convener: Amendment 606 is grouped with amendments 510 and 607 to 611. If amendment 606 is agreed to, I cannot call amendment 510 because of the pre-emption rule.

10:30

Mrs Mulligan: Amendment 606 removes the first three subsections of section 90, which deal with the suspension of a detention requirement, and replaces them with five new subsections. The amendment is largely technical in nature, clarifying the provisions of section 90.

Amendment 607 is a technical amendment that clarifies that the responsible medical officer may suspend a detention requirement subject to conditions in which that is necessary for the protection of any other person, whether that be the public in general or one person in particular.

Amendments 609 and 610 are further technical amendments that clarify that the responsible medical officer setting the conditions that are attached to a suspension of detention certificate must be the patient's responsible medical officer.

Amendment 611 changes the notification arrangements in relation to leave of absence of more than 28 days. The aim is to make the arrangements more flexible and closer to the original Millan recommendations. The amendment also restricts the application of section 90 to patients who are subject to hospital-based compulsory treatment orders by removing subsection (8), which extended the provisions for short-term detention. The Executive will lodge amendments at stage 3 to allow for suspension of detention for patients who are subject to orders other than compulsory treatment orders and interim compulsory treatment orders.

Amendment 510 proposes broadening the scope of section 90(2), so that a suspension of detention certificate can specify an occasion or series of occasions on which the detention

requirement is suspended. That could mean, for example, allowing the patient out of hospital every Thursday afternoon for the purpose of attending a class. We are in favour of the effect of the amendment; however, Executive amendment 606 replaces subsections (1) to (3) in section 90 and makes provision for suspension of detention for an occasion through new subsection (3)(b). That makes amendment 510 unnecessary, so I hope that Shona Robison will not move amendment 510.

I move amendment 606.

Amendment 606 agreed to.

Amendment 510 not moved.

Amendments 607 to 611 moved—[Mrs Mary Mulligan]—and agreed to.

Section 90, as amended, agreed to.

After section 90

Amendment 612 moved—[Mrs Mary Mulligan]—and agreed to.

Section 91—Power to terminate suspension, or variation, under section 90

The Convener: Amendment 613 is grouped with amendments 614 and 615.

Mrs Mulligan: Amendments 613 and 615 make significant improvements to section 91. Section 91, as amended, will provide the responsible medical officer with the power to revoke a suspension of detention under section 90 and the power to revoke a suspension of any of the compulsory measures under the new section introduced by amendment 612. The amendments clarify the criteria for revoking a suspension of detention certificate, as only the responsible medical officer may revoke the certificate. Amendment 615 introduces notification requirements for the revocation of any type of suspension certificate. The persons who are required to be notified mirror those who are required to be notified of the granting of the certificate in the first place.

Amendment 614 is a technical amendment that clarifies that the responsible medical officer may make suspension of a detention requirement subject to conditions in which that is necessary for the protection of another person, whether that is the public in general or one particular individual.

I move amendment 613.

Amendment 613 agreed to.

Amendments 614 and 615 moved—[Mrs Mary Mulligan]—and agreed to.

Section 91, as amended, agreed to.

Section 161—Designated medical practitioners

The Convener: Amendment 540, in the name of the minister, is grouped with amendments 543, 544, 548, 549, 558, 559, 570 and 571. I ask the minister to move amendment 540 and to speak to all the amendments in the group.

Mrs Mulligan: Part 13 of the bill will require that certain decisions about medical treatment for children must involve a child specialist, either as the RMO or as the designated medical practitioner appointed by the Mental Welfare Commission to give a second opinion. The amendments in the group are technical amendments that will clarify the provisions regarding child specialists.

Amendment 540 will bring the drafting of the term used for a medical practitioner with special qualifications or experience in treating children in section 161 into line with later sections of part 13. The bill as drafted specifies in relation to certain medical treatments that, where the patient is a child whose RMO is not a child specialist, two additional opinions are required. One of those opinions must come from a designated medical practitioner and one must come from a child specialist who is also a designated medical practitioner. That goes beyond Executive policy, which simply requires the involvement of a child specialist at some point in the child's assessment for treatment.

Amendments 543, 544, 548, 549, 558 and 559 will provide that, where the patient is a child and their RMO is a child specialist, the additional opinion may be given by any designated medical practitioner. However, where the RMO is not a child specialist, the additional opinion must be given by a designated medical practitioner who is also a child specialist.

Amendments 570 and 571 are technical amendments that will clarify the definition of a child specialist. Currently, the bill applies the definition only to designated medical practitioners, when in some cases it should also apply to the patient's RMO.

I move amendment 540.

Margaret Jamieson: I am delighted that the amendments have been lodged and that the minister has, in order to ensure that young people are safeguarded, taken on board some of the issues that committee members and others raised in the stage 1 debate.

Amendment 540 agreed to.

Section 161, as amended, agreed to.

Section 162—Certain surgical operations etc

The Convener: The next amendment for debate is amendment 275, in the name of Shona

Robison, which is grouped with amendments 276, 280, 282 and 284. I ask Shona Robison to move amendment 275 and to speak to all of the amendments in the group.

Shona Robison: The amendments relate to neurosurgery for mental disorder, or NMD, a matter with which I am still struggling, despite the lengthy debate on it that took place in the committee at stage 1. I want to debate the subject further because it continues to present me with a number of dilemmas.

The purpose of amendments 275 and 276 is to prevent NMD from being given to patients who are incapable of consenting to the treatment. I am concerned that the treatment is irreversible and that there is insufficient evidence about its benefits and the risk of adverse effects. As members know, the only unit that performs the treatment is in Dundee. That unit's report does not support the use of NMD on patients who are incapable of giving informed consent.

It has been suggested that, if a treatment is available to those who can consent, it should also be available to those who are incapable of consenting, and that to make a distinction on the basis of capacity is discriminatory. I am not sure about that argument because, on the same basis, the bill's provisions could be said to be discriminatory, in that they will render NMD unavailable to a category of incapable patients—those who resist or object to the treatment. How far should we pursue that argument? We need to consider whether we accept that any treatment, regardless of risk or efficacy, is better than no treatment at all. I am not convinced that that is the case.

The Court of Session is supposed to be a safeguard, but I am concerned about whether that is sufficient. The question is whether treatment should be given to someone who cannot consent to it. That involves moral issues that are best decided in legislation rather than in court. That is one reason why I lodged my amendments.

I move amendment 275.

Mr Adam Ingram (South of Scotland) (SNP): It should be drawn to the committee's attention that the bill puts Scotland in breach of a resolution of the United Nations General Assembly that was adopted in December 1991 and which states:

"Psychosurgery and other intrusive and irreversible treatments for mental illness shall never be carried out on a patient who is an involuntary patient in a mental health facility and, to the extent that domestic law permits them to be carried out, they may be carried out on any other patient only where the patient has given informed consent and an independent external body has satisfied itself that there is genuine informed consent and that the treatment best serves the health needs of the patient."

The Council of Europe's steering committee on bioethics passed a similar resolution.

I suggest that the Executive must make a convincing case to overturn such international opinion but, as Shona Robison suggested, the Executive has not advanced a convincing argument. The Court of Session is not necessarily a sufficient safeguard. We do not allow the courts to decide on key moral questions in this country; for example, we do not allow the courts to decide whether capital punishment should be allowed. It is up to bodies such as the Scottish Parliament to make such moral decisions on behalf of society.

The treatment in question is extremely controversial and it is irreversible. No significant body of evidence proves that it has significant benefit. On the contrary, a strong body of evidence shows that such treatment can cause considerable damage, so it cannot be regarded even as a treatment of last resort, because we do not have sufficient evidence to convince us that the benefits of such treatment outweigh its risks. I support Shona Robison's amendments.

Mr John McAllion (Dundee East) (Lab): At stage 1, we all accepted that the subject was one of the most difficult issues—if not the most difficult—with which the committee has had to struggle. With respect to Adam Ingram and others who have pursued his argument, I say that his interpretation of the United Nations General Assembly's resolution is not accepted by all. At a meeting of the cross-party group on mental health that Adam Ingram chaired, Jim Dyer of the Mental Welfare Commission for Scotland took issue with him and said that that was not what the United Nations resolution meant. The situation is far more complex than the arguments that have been made so far have presented it to be.

We have a genuine split of opinion among all those who think that they have patients' interests best at heart. What swung my opinion in the various arguments that went back and forth at stage 1 was the evidence that if we deleted section 164 as the amendments suggest, people who are less ill and can exercise judgment would be able to access the treatments, but people who are more severely ill and cannot exercise judgment would be denied the treatments by the committee's act and the Parliament's legislation: we could deny treatment that might make people better. I will not support the amendments.

Mrs Mulligan: John McAllion is right that the issue is one of the major ones in the bill and we have all had to consider it carefully. I am grateful to Shona Robison for lodging amendment 275 because it has allowed us to have the debate, which was foreshadowed when last year we withdrew by regulation the reference to neurosurgery for mental disorder from the Adults

with Incapacity (Scotland) Act 2000 on the basis that that treatment would best be addressed in the Mental Health (Scotland) Bill.

10:45

We all accept that treating patients without their consent is a sensitive matter that requires a great deal of forethought. Part 5 of the Adults with Incapacity (Scotland) Act 2000 enables general and specific treatments to be provided subject to a framework of checks and balances that protects patients and health professionals. We approached the issue of neurosurgery in the bill with the same desire to ensure that patients' interests are best served. Our stance has been informed by the work of a number of expert groups, notably the clinical resource and audit group's 1996 "Report on Neurosurgery for Mental Disorder", the Scottish Law Commission's 1995 "Report on Incapable Adults" and the Millan report. All of those groups agreed about what is the kernel of the issue, which is, as John McAllion said, that it would be wrong to deny patients, possibly desperately ill patients, access to a treatment that could be to their benefit. The Executive shares that view.

We are also clear that strong safeguards must be in place to ensure that patients' interests are paramount. That is why we have extended the safeguards in the bill to all patients, whether or not they are subject to formal powers under the bill. For patients who can consent, the safeguards include assessment by a designated medical practitioner and two persons appointed by the Mental Welfare Commission for Scotland.

For patients who cannot consent—who are the subject of this group of amendments—our view was that treatment should be considered in three distinct steps. The first is that a designated medical practitioner who is not the patient's RMO should certify that the patient is incapable of consenting and does not object to the treatment. That person should also decide whether the treatment is in the patient's best interests, having regard to the likelihood of the treatment's alleviating or preventing deterioration in the patient's condition.

The second step is that two persons who are not doctors and who are appointed by the Mental Welfare Commission should certify that the patient is incapable of consenting and does not object to the treatment. The third step is for the Court of Session to make an order declaring that the treatment may lawfully be given. The court must be satisfied that the patient does not object to the treatment.

There has been a question whether such decisions should be taken by a court or by the legislative assembly. The legislation will provide the framework, but the court can consider and judge on individual situations and circumstances, which will be unique for every individual. Those are fairly formidable provisions. We do not envisage a case in which meeting those safeguards would prevent a patient from receiving a treatment that carries a real hope of recovery, because such prevention would not be in the patient's best interests.

Under the practice that is currently in place at the unit in Dundee, if a patient objects, the treatment does not go ahead, but we must ensure that that remains the case through legislation because the personnel or the practice might change.

We are aware of the UN resolution that was mentioned and we have given it serious consideration, but it is not binding on domestic legislation. We feel that we are right to go further than that resolution.

The Convener: Although we know that the unit in Dundee does not give treatment if a patient objects, what safeguards are in place at the moment? Are the three steps that you outlined an increased level of safeguard?

Mrs Mulligan: Absolutely. Although the practice is carried out at the unit in Dundee, it happens only with the full agreement of a consenting person. As the safeguards that I have listed will add to patient safety in future cases, we feel that it is important to include them in the legislation just in case circumstances change.

The Convener: I call Shona Robison to wind up and say whether she will press amendment 275.

Shona Robison: I have listened carefully to the minister's comments and accept some of her arguments. However, the concerns that remain are sufficient for me to press amendment 275.

The Convener: I know that this is a difficult issue for all members.

The question is, that amendment 275 be agreed to. Are we agreed?

Members: No.

The Convener: There will be a division.

FOR

Robison, Shona (North-East Scotland) (SNP)
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)

ABSTENTIONS

Elder, Dorothy-Grace (Glasgow) (Ind)
Scanlon, Mary (Highlands and Islands) (Con)

The Convener: The result of the division is: For 2, Against 5, Abstentions 2.

Amendment 275 disagreed to.

Section 162 agreed to.

Section 163—Treatment mentioned in section 162(2): patients capable of consenting

The Convener: I call the minister to speak to and move amendment 541, which is grouped with amendments 542, 545 and 278.

Mrs Mulligan: Amendments 541 and 545 are technical amendments that will clarify that where a patient does not have a responsible medical officer within the meaning that is set out in the legislation, any such reference should be taken to include the medical practitioner who is primarily responsible for the patient's treatment. That might be the case for a voluntary patient who is not subject to compulsory powers under the legislation. Amendment 542 is a technical amendment that is consequential on amendment 541.

I understand that amendment 278, in the name of Shona Robison, seeks to strengthen safeguards in relation to electroconvulsive therapy and drug treatment for consenting patients by requiring a certificate from a designated medical practitioner. At the moment, such treatments may be certified by either the patient's RMO or a designated medical practitioner. I am afraid that we feel that the additional safeguard that is proposed in amendment 278 is impractical, although we understand the concerns that have prompted it. The purpose of a second opinion is to act as a safeguard where the patient does not give consent, and imposing such a check on all cases in which patients have given consent would put severe strain on the system, particularly because the number of designated second-opinion doctors is limited. The Mental Health (Scotland) Act 1984 allows an RMO to certify treatments in the case of a consenting patient, and Millan also recommended that there should be consent or a second opinion for such treatment. The bill will deliver those provisions.

In recognition of the concerns that have been expressed about consent given, the bill will add the further safeguard that the patient must consent in writing to treatment. We will also ensure that the code of practice provides guidance on the matter. However, we accept that there might still be situations in which there is some doubt about whether a patient has genuinely consented to treatment. We believe that any such situations might best be addressed by strengthening the Mental Welfare Commission's powers of intervention in cases where there is evidence that a patient has not given consent. As a result, we intend to lodge a suitable amendment at stage 3 that will probably seek to extend the commission's powers in section 174. In the light of those comments, I invite Shona Robison not to move amendment 278.

I move amendment 541.

Shona Robison: I am satisfied by the minister's reassurances on the matter and will not move amendment 278.

Amendment 541 agreed to.

Section 163, as amended, agreed to.

Section 164—Treatment mentioned in section 162(2): patients incapable of consenting

Amendments 542 to 545 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 276 not moved.

Section 164, as amended, agreed to.

Section 165—Electro-convulsive therapy etc

The Convener: Amendment 546 is grouped with amendments 564, 616, 597, 598, 617 and 565.

Mrs Mulligan: Part 13 of the bill contains a range of safeguards for various kinds of treatments. Inevitably, situations will arise in which treatment must be given urgently, for example, before there is time to obtain an independent second opinion. Section 171 will allow for treatment to be given urgently in such cases, and the group of amendments deals with the relationships between that provision and the normal safeguards for particular treatments.

Amendment 546 relates to treatments in section 165, namely electroconvulsive therapy and other treatments as specified in regulations. It makes it clear that such treatments may be given without the normal safeguards where such medical treatment is urgently required by the patient. That is the situation under the Mental Health (Scotland) Act 1984, and we think that it is still appropriate—subject to what I will say in a moment.

Amendment 564 is a technical amendment that will clarify the definition of urgent medical treatment under part 13. Amendment 565 is another technical amendment that will clarify the timing of the sending to the Mental Welfare Commission for Scotland of notification of treatment given under section 165.

Amendments 616 and 617, in the name of Shona Robison, aim to exclude ECT from the treatments that may be given to a patient in an emergency if the patient is capable of consenting, but does not consent. We are content to accept the principle behind those amendments. We

appreciate the concerns of many people that patients should be able to refuse ECT in any situation if they have the capacity to do so. However, we wish to make it clear that any relevant amendment should not go further than excluding just ECT, by also excluding any treatment that is specified in regulations made under section 165(3)(b) in the future.

I am not sure whether that is the intended effect of amendment 617, but I am advised that its drafting is not absolutely clear on that point. Unfortunately, we are therefore unable to agree to amendments 616 and 617 as drafted. I undertake, however, to lodge suitably worded stage 3 amendments to ensure that the provisions of section 171 cannot be used to override a competent refusal of ECT. On that basis, I hope that Shona Robison will be content not to move amendments 616 and 617.

I understand that the aim of amendments 597 and 598, also in the name of Shona Robison, is to clarify the circumstances under which urgent treatment may be given to a patient in hospital. There is concern that section 171(4) might prevent a patient from receiving urgent treatment, because the threshold for authorising the treatment is too high. The amendments would change the threshold from one of absolute certainty that the patient "will not" suffer harm to its being "not likely to" happen.

We are content to accept amendment 597. We agree that, under the bill as introduced, the test for a patient's being able to receive treatment might be too stiff. We are not, however, persuaded that amendment 598 is necessary. Section 171(4)(b) already allows for consideration of risk and probability through its inclusion of the expression "hazard to the patient". Indeed, the wording in the bill is the same as that which is used in the 1984 act, and we are not aware that that has caused any difficulties. I hope that Shona Robison will wish to press only amendment 597.

I move amendment 546.

Shona Robison: I take on board what the minister has said about amendments 616 and 617. If there are drafting difficulties, I am happy to co-operate by not moving those amendments on the basis of the minister's commitment to lodge at stage 3 amendments that would achieve the same aim. I also accept what the minister said about amendment 598 and will be happy not to move it.

Amendment 546 agreed to.

11:00

The Convener: Amendment 277 is grouped with amendments 279, 281, 283, 285 and 286. We shall see whether Shona Robison is on a roll.

Shona Robison: Again, I return to an ethical issue with which I have struggled—the issue of incapable patients and the use of electroconvulsive therapy. The purpose of the amendments is to prevent ECT from being given, other than in urgent situations, to patients who are incapable of consenting to the treatment. If the amendments are agreed to, it will be possible for ECT to be given only with the patient's consent under section 166 or under the urgent treatment provisions in section 171, which we have just debated.

A difficulty with the issue emerged in evidence to the committee. I listened intently to the evidence at stage 1. Current opinion differs as to whether ECT is an effective treatment for certain people with mental disorders. There is certainly a lot of controversy about its adverse effects, and particularly its long-term effects, such as memory loss. The Scottish Association for Mental Health made strong representations on behalf of service users who have received ECT, many of whom were concerned about its effects. In the light of such evidence, I believe that no one should be given ECT unless they have given informed consent.

I move amendment 277.

Mr McAllion: This is a difficult issue. In the stage 1 report, the committee said that, on balance, it

"considers that the safeguards for neurosurgery for mental disorder and electro-convulsive therapy in the Bill are generally adequate, but would recommend ongoing monitoring of how these provisions operate in practice."

We also recommended additional protections. Will the minister tackle that issue? Will there be the additional protections that the committee sought? Will the Executive's proposals make a substantial difference? I am worried that there might be non-emergency treatments from which patients could benefit, which patients might be denied simply because they could not give their consent.

Mrs Mulligan: Over the years, the issue has been much debated and it is right that the committee should return to it in debating the bill.

Currently, the law enables ECT to be given to patients who are detained under the Mental Health (Scotland) Act 1984 and are unable to consent, if a second medical opinion has been obtained. Under regulations that were made under the Adults with Incapacity (Scotland) Act 2000, the treatment can also be given to patients who are unable to consent, subject to the same second-opinion safeguard. The latter provision followed the recommendations of the Scottish Law Commission's 1995 report on incapable adults.

The Millan committee considered the matter carefully. Its report recognised that ECT is

controversial, but noted that most Scottish psychiatrists regard it as a safe, effective and well-evidenced treatment in appropriate cases—for example, for severe depression—and that much research supports that view. The Millan committee also said that many service users report considerable benefits, although others regard the treatment as an almost uniquely invasive and distressing intervention.

The Millan committee recognised the concerns that were expressed by service users and recommended that ECT should continue to attract special safeguards. In addition, it said that it should be explicit that any patient who is capable of making a treatment decision at the time of treatment should be entitled to refuse ECT. The bill takes that line. I appreciate the concerns that lie behind Shona Robison's amendment 277, which is supported by Adam Ingram. However, the key question is whether an acutely ill patient who, on account of that illness, is incapable of giving consent, should be denied a treatment that has proved to be of significant benefit to many other patients.

The Mental Welfare Commission, which was established to safeguard patients' interests, supports the present position, as does the Royal College of Psychiatrists. The Executive believes that the position that is taken in the bill is correct.

John McAllion referred to the Health and Community Care Committee's report at stage 1. The committee concluded that

"the safeguards for … ECT in the Bill are generally adequate",

but recommended that the Executive introduce

"additional protections for patients for whom ECT is proposed, who are incapable of consenting and who are objecting to or resisting the treatment".

We are not sure that there is anything more that could reasonably be added to this part of the bill. If other amendments had been lodged, we would have considered them but, at the moment, we do not believe that there is anything more we can add to the safeguards.

The amendments that are before us would go much further than simply to deal with concerns about ECT, which is why we will not accept them. They would remove altogether the provisions that would allow an incapable patient to receive ECT, even if the patient wanted the treatment. We think that that could deny some patients the treatment that would remove their incapacity.

The bill also contains other safeguards to reduce the risk of ECT's being forced on an unwilling patient. Both the treating doctor and the doctor who supplies the second opinion must have regard for the patient's past and present wishes before deciding whether to administer the treatment. The treating doctor must also take proper account of any advance statement by the patient, and we intend to add provisions that would impose a similar requirement on the doctor who supplies the second opinion.

I therefore invite Shona Robison to seek to withdraw her amendment.

The Convener: Shona, do you want to withdraw the amendment?

Shona Robison: That is a difficult question to answer. Obviously, my amendment would still allow for urgent treatment to be given under section 171, if required. However, on the basis of what has been said, I seek leave to withdraw amendment 277.

Amendment 277, by agreement, withdrawn.

Section 165, as amended, agreed to.

Section 166—Treatment mentioned in sections 165(3) and 168(3): patients capable of consenting

Amendment 278 not moved.

Section 166 agreed to.

Section 167—Treatment mentioned in section 165(3): patients incapable of consenting

The Convener: Amendment 547 is grouped with amendments 550, 557, 560 and 563.

Mrs Mulligan: This group of amendments makes clear an important point of principle, which is that forcible treatment cannot be given under the bill except in a hospital setting. Although part 13 might authorise the giving of medical treatment while the patient is in a community setting, the authority to treat given by sections 167, 169 and 170 does not extend to the giving of medical treatment by force to that patient.

I move amendment 547.

Mary Scanlon: What happens to patients under a CTO who are unwilling to consent to compulsory treatment in the community?

Mrs Mulligan: If a patient who is not prepared to accept treatment in the community is in breach of their CTO, the provisions of sections 84 and 86 of the bill might be used to move them to the hospital for assessment and treatment.

Mary Scanlon: Might be used?

Mrs Mulligan: Those sections might be used to move the patient, yes.

Mary Scanlon: If the patient does not co-operate in the community, will they be forced to go into hospital?

Mrs Mulligan: If a patient is not complying with their treatment order and it was felt that it was appropriate to administer that treatment forcibly, that would happen only in a hospital situation. The patient would not be forcibly treated in their home.

The Convener: Once in hospital, would they be reassessed before further treatment was given?

Mrs Mulligan: Yes, there would be an assessment. Obviously, if treatment were needed urgently, that point would be taken on board.

Amendment 547 agreed to.

Amendments 548, 549 and 550 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 279 not moved.

Section 167, as amended, agreed to.

Section 168—Treatments given over period of time etc

The Convener: Amendment 551 is grouped with amendments 552, 595, 553, 554, 596, 555, 555A and 556.

Mrs Mulligan: This group of amendments deals with the treatments specified under section 168, which can be given only with the consent of the patient under section 166 or with the authorisation of an independent designated medical practitioner under section 169. Section 168 currently specifies drug treatment for mental disorder that is given for more than two months and any other treatment that might be added by regulations.

Amendment 551 makes it clear that those treatments may be given without the specified safeguards if the patient requires such medical treatment urgently under section 171.

Amendment 553 adds further treatments to those specified in the bill as requiring the special safeguards provided by section 168. The amendment also clarifies the meaning of the term "medicine" in the section and the timing of the safeguards. The treatments that amendment 553 adds to the bill are forcible feeding and drug treatments—other than by surgical implantation of hormones—given for the purpose of reducing sex drive. Provision remains to specify further treatments by regulations. The Executive is proposing the addition of the treatments in response to views expressed by the committee at stage 1. The drug treatment by hormones and forcible feeding as a treatment for a mental disorder should be specified as special treatments in the bill rather than in regulations.

Amendments 552, 554 and 555 are technical amendments that clarify that the safeguards provided for by section 168 do not apply until two months have passed in relation to medication for mental disorder, other than to reduce sex drive. For forcible feeding and drug treatment for sex drive, as well as any treatment specified in regulations, the safeguards will apply immediately. The amendments also provide that the safeguards apply when the treatments in question, such as medication or forcible feeding, are given as treatment for mental disorder or as a result of the patient's having a mental disorder. That is required because some of the treatments might also be given as treatments for patients who are not mentally disordered.

Amendments 595, 596 and 555A together seek to provide for safeguards for drug treatments that exceed the normal dosage or are used for a purpose other than the recommended purpose. I appreciate Shona Robison's concern to have all safeguarded treatments included in the bill. Our view, which is in line with the Millan recommendations, is that those treatments should be specified in regulations. I hope that I can assure the committee that putting some treatments in regulations will not lessen the scrutiny to which they will be subject or the strength of the safeguards. It will, however, make any necessary changes to the safeguards easier to achieve.

11:15

It might be helpful if I make clear why we want to take such a line on this occasion. Safeguards for high dosage and usage of drugs for other than the recommended purpose are being introduced for the first time in mental health legislation. They have already generated considerable discussion as to how they might be implemented effectively.

The committee will appreciate that, if not carefully worded, the provisions might not have the desired effect and might therefore give rise to operational difficulties. For that reason, we take the view that such matters should be dealt with in regulations under section 168. Because the regulations will be subject to the affirmative procedure, the committee will have the opportunity to scrutinise them further.

Moreover, Shona Robison's amendments would not deal with all the issues raised by Millan. Millan proposed that there should be safeguards for polypharmacy, which would apply where a patient received different drugs that had a similar purpose and that, if taken together, would add up to more than the recommended dosage. The proposed amendments do not appear to cover that.

I appreciate that Shona Robison's amendments have been given careful thought, but we are not able to reassure the committee that they would have the desired effect. For that reason, we do not support the amendments at this time, but we will

ensure that similar safeguards are brought forward in regulations under section 168.

I am grateful to Shona Robison for lodging amendment 556, which seeks to make provision in section 168 for Scottish ministers to consult on regulations made under the section in relation to safeguards for further treatment. It is, of course, Executive policy that consultations should be undertaken on regulations. As currently drafted, the bill makes such provision in earlier sections in part 13. However, the provision seems to have been inadvertently omitted from section 168. I am therefore happy to accept amendment 556.

I move amendment 551 and ask Shona Robison not to move the amendments in her name, other than amendment 556.

Shona Robison: As the minister said, the purpose of amendments 595, 596 and 555A is to ensure that medication for medical disorders that exceeds the recommended dose, or medication for mental disorders that is for a purpose other than its recommended purpose, are specified in the bill as requiring the special safeguards set out in sections 166 and 169. I agree with the minister that the treatments are regarded as controversial. Perhaps that in itself is reason enough to have them explicitly stated in the bill.

I accept that the Millan committee recommended that the treatments should be specified in regulations. However, no reason was given why they could not be expressed in the bill. I make the simple point that, if there is no good reason for them not to be expressed explicitly in the bill, perhaps the bill is the best place for them, especially as they are so controversial.

I seek clarification on a couple of the Executive amendments. The proposed use of the term "drug treatment" in section 168(3)(a) seems a bit inconsistent, because the section refers elsewhere to medicine. It would be confusing, because the proposed amendment to section 168(6)—amendment 555—refers to section 168(3)(a) and uses the term "medicine".

Proposed section 168(3)(c) relates to forcible feeding and uses the term

"without the consent of the patient".

Given that section 168 authorises treatment in accordance with section 166 on patients granting consent or being capable of consenting, or with section 169 on patients refusing consent or being incapable of consenting, it is strange that forcible feeding has been included in the amendments to section 168. By definition, forcible feeding cannot be given to consenting patients. It might have been more appropriate to deal with that matter in a separate section.

The Convener: You have made some good points—I see the officials scrambling around trying to find the relevant sections.

Mr McAllion: I think that I understood the minister's argument for why the two types of treatment—treatments that exceed recommended dosages and treatments that are used for purposes other than their recommended purpose—should not be stated in the bill. This is the first time that such measures have been implemented and there is still debate about how precisely to define the treatments in legal terms. The Executive has therefore chosen to go down the route of introducing regulations, which would be subject to parliamentary scrutiny. However, will the minister assure me that, even though the treatments will be specified in regulations, the same safeguards will apply to them, so that there is no difference in reality?

Mrs Mulligan: They will have the same safeguards. John McAllion is absolutely right that the intention is to continue to review the safeguards. The approach that we propose will give us the ability to do that and to respond more appropriately to what we find, rather than having to go through a process involving primary legislation. There will be safeguards, as the regulations will have to come before the committee.

On the other treatments, we have accepted the arguments about forcible feeding and drugs prescription for the reduction of sex drive. However, as we pointed out, we want to be able continually to review the cumulative effect of the drugs that are being prescribed. We want more time to consider what Shona Robison has said, because her arguments are pertinent—we will consider responding to them at stage 3.

Amendment 551 agreed to.

Amendment 552 moved—[Mrs Mary Mulligan]—and agreed to.

The Convener: Shona, do you wish to move amendment 595?

Shona Robison: A number of guarantees have been provided, so I will not move amendment 595.

Amendment 595 not moved.

Amendments 553 and 554 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 596 not moved.

Amendment 555 moved—[Mrs Mary Mulligan].

Amendment 555A not moved.

Amendment 555 agreed to.

Amendment 556 moved—[Shona Robison]—and agreed to.

Section 168, as amended, agreed to.

The Convener: I suggest that we finish stage 2 consideration at that point. I thank the minister and her team and members for their contributions this morning. I also thank Adam Ingram for attending.

We will suspend for a short comfort break, after which will we discuss lines of questioning to the Minister for Health and Community Care on the next two agenda items.

11:23

Meeting suspended until 11:31 and thereafter continued in private.

11:43

Meeting continued in public.

Hepatitis C

The Convener: Agenda item 2 is on the issue of hepatitis C. We are joined by the Minister for Health and Community Care and his team of advisers.

For a couple of years, the committee has been involved in considering the cases of people who have been infected with hepatitis C as a result of NHS treatment. We asked the minister to return to speak to us about the progress that he has been able to make as a result of the findings of the expert group and about his continuing discussions with Westminster colleagues about possible ex gratia payments to address the concerns of the committee, the expert group and the Parliament. I ask him to bring us up to speed on the present situation.

11:45

The Minister for Health and Community Care (Malcolm Chisholm): There are two sides to the matter. First, we have been working on what we would like to propose in detail, the principles of which I outlined before Christmas. The second side is our discussions with the Westminster Government.

Let me start with the first. I have given much more thought to the details. On 11 December, I said that I was keen to give assistance—particularly financial assistance—to people who were suffering harm through having contracted hepatitis C from blood products. I still adhere to that principle, although I have to say that it was not picked up by everyone in the reporting of what I said.

I have looked at the details of the proposals from the expert group on financial and other assistance for NHS injury, and some difficulties have emerged as a result of my reflections. The main group about which we are all concerned is the group that is made up of people who have contracted hepatitis C from blood products and who are still alive. It would be reasonable to focus assistance on those people who are still with us and who contracted the hepatitis C virus in that way. That is the group that I would like to help.

The problem with the expert group's report is that it divides the people concerned into three groups, and it has proved quite difficult for me to determine exactly when chronic hepatitis begins. The committee will know that the expert group has proposed that there should be an initial payment of

£10,000, another payment at the chronic hepatitis stage and a further payment when the person affected develops cirrhosis and reaches a more advanced stage of illness. The medical advice that I have received indicates that a liver biopsy would be necessary for diagnosis of the chronic stage, which would be undesirable at a relatively early stage of the illness.

My thinking is that I would like to give a payment to everyone who contracted hepatitis C from blood products and who is still alive. I propose the payment of a sum of £20,000 to everyone who is in that position. I still intend to follow the expert group's thinking about a further payment at the cirrhosis, or more advanced, stage of the illness. That is consistent with what I said before Christmas. I propose that £25,000 should be paid at the advanced stage.

The Convener: Did you say £25,000?

Malcolm Chisholm: Yes. I hope that that covers all the people about whom the committee is concerned.

In concentrating on the people who are still alive, I differ from the expert group. That is consistent with what I said about targeting support on those who are suffering now as a result of having contracted the virus in the way in question. Excluding people who are dead and reducing the amounts in one way—although I have increased the initial payment for everyone who has the virus from the figure that was proposed by the expert group—will result in immediate payments that are less than those that were proposed by the expert group. In relation to the health budget, I said on 11 December that I did not want to go into double figures in year 1 and what I have proposed would be manageable within that principle. I think the public will understand that principle, given all the other pressures and demands on the health budget. That is an outline of the development of my thinking on what I hope to be able to offer.

Members will know that I flagged up two issues with reference to Westminster on 11 December, although in their questioning they reacted only to the social security issue. However, I made it clear that there were two Westminster issues. People are familiar with the social security issue in the context of free personal care; however, additional payments have consequences for social security payments, which must be avoided. I was not questioned about the powers of the Scottish Parliament as described in the Scotland Act 1998, which was the other issue that I flagged up. Westminster's thinking on that issue remains unresolved.

I want to find a resolution to both those issues, but members will understand that such matters are not under my control. We have had on-going engagement at official and ministerial level with the Westminster Government but it has not come to a final view on the vires issue. Members will understand that it is impossible to go ahead until that has been resolved.

Progress on our discussions with Westminster is therefore disappointing. Members may want to ask further questions about that. My last word is that it should be self-evident that the issue is under the control of the Government in London, and not something for which I can determine the time scale, although I have indicated that I would like it to be quickly resolved.

The Convener: Thank you, minister. We are happy to hear many of your comments, particularly those about payments being made to everybody. In our report, the committee took the same view as that taken by the expert group. The issue has commanded a great deal of support across the Parliament in the past year or so, so your comments are welcome.

We will now have questions. First, I should like some clarification. You propose an initial payment of £20,000 to everybody, but is the further payment only for those who develop cirrhosis, or is it also for those who have serious consequences that could include cirrhosis?

Malcolm Chisholm: The second payment that I outlined is the same as the expert group's third payment. The difficulty that I have with the expert group's proposal is the distinction between the first group and the second group. I have thought a lot about how I could carry out into practical effect my principle in relation to those suffering harm. It is difficult to distinguish, in the way that the expert group does, between the first and second group. On the second group, the expert group talks about chronic hepatitis, but I am advised that that can be established only by a liver biopsy. I do not think that it is acceptable to require people who are not at an advanced stage of illness to undergo a biopsy unless it is necessary for other reasons. The simple way around that problem is to introduce a virus test. If people have the virus, they should get the first payment. I am therefore collapsing the expert group's proposed first and second groups—my further proposed payment is identical to its third payment.

I repeat that I am focusing on people who are still alive. The test that I propose is clear and would cover people who are alive and who have the virus as a result of the use of blood products.

The Convener: So those people would receive an additional payment. They would receive the £20,000, then a further £25,000.

Malcolm Chisholm: Yes.

The Convener: Do you have a figure for how much that package will cost?

Malcolm Chisholm: Some of the expert group's calculations were extrapolated from UK figures. My immediate focus is the 568 people whom we know about because they are registered with the SCIEH—the Scottish Centre for Infection and Environmental Health. The estimated cost of what I propose for those 568 people is just under £15 million. Further payments may arise in future if other people who have contracted hepatitis C from blood products emerge. However, the people on whom we are focusing most tangibly and whom we all meet from time to time are the group of 568 who have already registered. The figure of £15 million is higher than the one that I flagged up to the committee previously, but payments will be made over two years in practice, although most will be processed in one year.

The Convener: We turn now to the nub of the problem. A parliamentary committee report on this issue has been agreed unanimously. The majority of members of the Scottish Parliament and the Scottish Executive want something to happen, as you have indicated this morning. The nub of the problem appears to be at Westminster.

Nicola Sturgeon (Glasgow) (SNP): I welcome the minister's comments, although his announcement today does not constitute the full implementation of the expert group's recommendations. The people who are affected will want to reflect on that. However, this is a significant breakthrough, especially on the principle that payments should be made to everyone with hepatitis C. I repeat my warm welcome for his announcement and congratulate him on having moved forward on this issue.

As the convener said, everything hinges on whether the issues that relate to reserved powers can be resolved. I intended to ask you about the Scotland Act 1998 angle, but you have already indicated that that remains an outstanding issue.

When you appeared before the committee on 11 December, you said:

"If we do not start making progress by the turn of the year, we will have to consider the different avenues that are open."—[*Official Report*, *Health and Community Care Committee*, 11 December 2002; c 3565.]

What different avenues are being explored? If it is the will not just of the Parliament but of the Scottish Executive that payments should be made to hepatitis C sufferers, it would not be acceptable for Westminster intransigence to prevent that from happening.

Malcolm Chisholm: There are two issues that need to be addressed. Nicola Sturgeon's view of the Scotland Act 1998 is different from the view that some others take—

Nicola Sturgeon: I am not arguing about the legalities of the situation.

Malcolm Chisholm: People will take different views, but the existing law must be applied and any issues of controversy will have to be resolved. Nicola Sturgeon might like us not be constrained by the Scotland Act 1998, but we must abide by that act. We cannot go ahead until the reserved issues have been resolved.

When I made the comment that Nicola Sturgeon cited, I was expressing my desire to make fast progress on the issue. However, it was a general comment; I did not know what the options were. Since 11 December, I have examined the matter in more detail and have concluded that, until the reserved issues have been resolved, we cannot move forward. The Parliament cannot act if its powers are being challenged. We have not yet reached that situation, as Westminster has not taken a definite view. However, any act of the Parliament that is perceived to be outwith the scope of the Scotland Act 1998 is open to challenge, as the act makes clear.

When I made that comment on 11 December, I was also thinking of the mechanisms that are set out in schedule 6 to the Scotland Act 1998. I am sure that all members are familiar with that schedule and with the role of the Judicial Committee of the Privy Council. The provisions of the 1998 act cannot be circumvented. We cannot simply say that we will forget about Westminster, as the Parliament was set up under the arrangements that I have described.

Nicola Sturgeon: I appreciate what the minister is saying. Obviously, we have different views on whether the Parliament should be constrained by the Scotland Act 1998. We need to obtain Westminster's agreement to exempt the payments from clawback. As I understand the situation, it is not a matter of Westminster first saying, "Yes, you can do it," or, "No, you can't." Rather, it is a straight interpretation of the Scotland Act 1998. What route are you going down to get that definitive interpretation? Are you exploring different ways of making those payments that might bring them within the ambit of the Scotland Act 1998? If you think that simply setting up a discretionary trust is outwith that ambit, are other ways of reaching the conclusion that you have outlined actively being explored?

12:00

Malcolm Chisholm: We are proposing a scheme that we believe is consistent with our powers. The reality is that people make different interpretations of the Scotland Act 1998, and we might as well be clear about the fact that the schedule 5 social security reservation, which deals

with payments for sickness and disability among other things, is very much the point in question. People have expressed different views on that, but we came to the view that we can do what our scheme proposes. We would not want in any way to do something that we thought was beyond our powers, but people can interpret the social security reservation in different ways. That is the general issue in relation to the powers of the Parliament.

The other issue overlaps, as Nicola Sturgeon indicated. However, once it has been agreed in principle that there is not a vires problem, we must ensure that there is no knock-on effect on social security benefits. I have recently written again to the Secretary of State for Work and Pensions about that matter. Until the first issue is solved, we cannot definitively solve the second issue. Until the Westminster Government is absolutely clear about the vires issue, it is difficult to resolve the other ones, but that does not mean that we are not discussing them. Members will understand that the issue in relation to the Scotland Act 1998 is the prior issue for what we are proposing.

Nicola Sturgeon: You mentioned the role of the Privy Council, and I am racking my brains to remember the correct procedure for interpreting the Scotland Act 1998. Are you saying that the Scottish Executive will take the matter as far as it can in trying to establish that what you want to do is in fact within the powers under the Scotland Act 1998?

Malcolm Chisholm: It is the Westminster Government that would challenge if something were outwith the ambit of the Parliament. There is more than that in the Scotland Act 1998, but that is the fundamental challenge. There are other challenges in schedule 6, but that is the basic route that would be followed if the Scottish Parliament were doing something outwith its powers.

Margaret Jamieson: You have spoken about the difficulties surrounding the competences of the Scottish Parliament. Given the fact that the Executive and the expert group have both indicated that they believe that there is a moral obligation, rather than a legal one, might not you be in a position to avoid social security clawback? That is certainly an area that the committee homed in on.

Malcolm Chisholm: That is precisely what we are arguing and will argue. The point that I was making is that, until the other issue is resolved, that is not something that can be finally decided. Logically, the other issue must be resolved first, but Margaret Jamieson makes a powerful point and I agree with it. Members all know this, but I might as well say that that is the view that we take. That is why, like the expert group and the committee, we are talking about ex gratia payments. Such payments are not a legal obligation, and we certainly have no intention—any more than the Health and Community Care Committee does—that they should set a precedent. The wider issues that the matter raises are being dealt with by the expert group in its final report, which I have not yet received. I certainly echo the view that Margaret Jamieson has expressed.

Margaret Jamieson: We have asked for legal opinion and have been told that that option may well free the Scottish Executive from the social security reservation in schedule 5 to the Scotland Act 1998, as the matter would then be deemed to be within the gift of the national health service. Are you confident that the solicitors who are advising you have explored every avenue other than the ones that have been discussed in relation to social security and so on?

Malcolm Chisholm: We have come to a view and we are confident about the view that we have expressed. I understand the point that is being made and I presume that that issue may have to be considered in taking a view. People will still come to a view, whether the matter is caught by the social security reservation or not. What Margaret Jamieson has described is relevant to the discussion, but it does not mean that a view should not be taken. That is the point at question.

Margaret Jamieson: We could pass on the legal advice that we have received, in the hope that it will assist you in your deliberations with colleagues at Westminster.

You have emphasised the fact that payment would be applicable only to those who are still alive. What is the cut-off date for that, given the timing of the committee's report and the interim report of the expert group? You have said that you are still awaiting the final report. What will be the operative date?

Malcolm Chisholm: I have not come with that level of detail. The important thing is that I have carried forward the principles that I described previously to the committee. A date will have to be set, but the principle is that help should be given to those who are suffering. The corollary to that is the fact that we are talking about people who are still alive. I do not envisage a great deal of retrospection, as the principle of helping those who are still alive self-evidently means that the date will have to be set at around the time that the help kicks in.

That is the general principle that I would follow, and it is what the public would expect, in so far as they support the principle. I would sympathise with that. We want to help those who are suffering as a result of having contracted the virus in this way. In

a way, I am simplifying what the expert group proposed. If somebody is alive now and has the virus because of NHS treatment, they will get the initial payment.

Nicola Sturgeon suggested that I had narrowed down what the expert group proposed; however, in some ways, I have expanded what the group proposed. I am saying that anybody who contracted the hepatitis C virus in that way will get £20,000, which is double what the expert group proposed for the group of people who have pre-chronic hepatitis C. I hope that I have simplified the recommendation and presented a proposal that everybody readily understands. It focuses on those who are alive who contracted the virus in that way. There are two levels of payment, and the proposal is easy to implement. We do not have grey areas between those who have chronic hepatitis and those who do not, as would have emerged from the expert group's proposals. We do not want to get involved in carrying out liver biopsies on hundreds of people.

Margaret Jamieson: You have identified two specific groups. I agree that people should not undergo liver biopsies for no other reason than to satisfy the requirements of a piece of paper. What process will be used to identify people who have moved from having the hep C virus to having a condition that will trigger further funding?

Malcolm Chisholm: My answer is subject to medical advice. The expert group made a proposal. I think that the proposed cut-off point will be much easier to implement than the other one, because people are more ill by that stage. I am told that they will have had many tests and will have scarring on the liver and various other attributes that have been described to me. I am assured that it will be much easier to identify that third category than to be clear about the second category.

Mr McAllion: Like other committee members, I very much welcome the announcement that £20,000, rather than £10,000, will be paid to all those who contracted hepatitis C through blood transfusion. My concern is that their gain will be others' loss. For example, those who were described as suffering from chronic hepatitis C will receive £20,000 instead of the previously recommended £40,000. Those who were described as suffering from an advanced stage of hepatitis C will receive £25,000 instead of £40,000 plus on-going support. Relatives of those who paid the ultimate price and died will receive nothing under the new scheme. There are big losers under the new proposals.

Two questions arise from that. The expert group included a medical director, the chair of the Scottish joint consultants committee and directors of nursing, all of whom have vast medical experience and who saw no problem in describing people as suffering from chronic hepatitis C and therefore qualifying for payments of £40,000. Why should we believe the minister's advisers instead of that medical opinion?

The expert group's recommendations would have cost between £62 million and £89 million. Your recommendations will cost £15 million. The concern is that what you are offering is what the Scottish Cabinet has allowed you to spend on the problem and not what people deserve to be paid given the moral argument and the suffering that people have undergone.

Malcolm Chisholm: As I made clear in December, the reality is that I must be mindful of all the demands on the health budget. I was and am happy to be open about the fact that I would have considerable difficulties with taking more than £10 million in the first year. That is a lot of money, given the pressures and demands that everybody in the chamber knows are on the health service. I am not oblivious to financial considerations. I have no problem with saying that.

Equally, a system could be established to make the distinction between categories 1 and 2 that the expert group recommended. All that I am saying is that a continuum would be involved and the system would be controversial. I am not saying that such a system could not be used, but it would be difficult to be objective about it. I am attracted by a simple scheme that is easy to implement. Everybody will know how it is applied and who is eligible. That is my objective.

Of course, John McAllion and others can say that less money is involved than the expert group proposed. Obviously, I agree that some people will have less money than the expert group proposed. However, as we have discussed, the claims of that group of people must be balanced with all the other claims on the health budget. We accept that the scheme provides not compensation, but ex gratia payments, which is another relevant consideration. The amount of money is substantial. In general conversations, many people have welcomed and understood the proposal.

The Convener: Just about every committee member wants to ask a question and we have to talk about measles, mumps and rubella vaccinations, too. I am sympathetic to taking as many questions as possible, but I ask people to keep their questions and answers short, so that we get through as many members as possible.

Mary Scanlon: I have a brief question. We are talking about the 568 people who were infected before the Consumer Protection Act 1987 was implemented. Our main obstacle is the social security clawback. How was that overcome for all

those who received substantial payments under the 1987 act on the basis of the defective product? Surely that is a precedent.

Malcolm Chisholm: Obviously, action can be taken; for example, members will be aware that legislation was passed at Westminster in connection with the MacFarlane Trust. We hope to make progress on the matter. I suppose that the difference is that the proposal relates only to Scotland, whereas earlier matters involved UK legislation. The suggestion is not impossible in principle; it is a matter only of working out the detail.

12:15

Mary Scanlon: I am not talking about the MacFarlane Trust, but about the Consumer Protection Act 1987, which made ex gratia payments to people who had been infected by bad blood on the ground that the product was defective. Has not the obstacle of social security clawback been overcome in some form or other? We are concerned only with patients who were infected before 1987. If such an obstacle was overcome in the payments that were made under the Consumer Protection Act 1987, can it not be overcome in this case?

Malcolm Chisholm: We are working towards doing so. I might have confused two separate issues. In the case of the MacFarlane Trust, specific changes had to be made to social security regulations. As far as the Consumer Protection Act 1987 is concerned, the issue is legal liability, which has no implications for social security payments. The point is that this particular case is in the same category as the MacFarlane Trust case, because there is no legal liability.

Nicola Sturgeon: We are in a slightly strange situation in that you have outlined what you want to do, but say that you are not able to do it without somebody else's say-so. As a result, I seek clarification on two points, the first of which is the time scale. That is particularly important, given your comments about focusing on the people who are alive. People might die between now and the commencement of the scheme. Within what kind of time scale do you want the matter to be resolved, and what pressure can you bring to bear to ensure that the Westminster Government meets it?

My second point is slightly hypothetical. If Westminster comes back to you and says that the matter is reserved under the Scotland Act 1998 and so cannot be addressed or does not agree to make exemptions on clawback, will that be the end of the matter as far as you are concerned? Would the Scottish Executive seek to challenge such a decision or would it find different ways of doing what it wants to do?

Malcolm Chisholm: As I made clear the last time I discussed the issue with the committee, I want to make progress in this Parliament. We will also make that absolutely clear to the Westminster Government; however, it has to go through its own processes in relation to the matter.

On the second point, I am not sure how helpful it is to raise hypothetical situations. The fact is that there will be a definitive legal view and, as I have pointed out, the Scotland Act 1988 charges a particular body with reaching such a view. That body is the final court of law in this respect, which means that, at a certain point, there will be no recourse. As a result, we cannot really argue over the matter; that is just the way the Scotland Act 1998 is. Obviously, other people will express different views about other, more general matters, but the position is quite clear: we have to act in accordance with the Scotland Act 1998, and there are procedures for resolving any disagreements or differences.

Dorothy-Grace Elder (Glasgow) (Ind): Although you have moved forward on this issue, the fact remains that there have been six-figure pay-outs in the Irish Republic.

I recently received a letter from the Haemophilia Society, which I will pass over for your consideration. The society is very concerned that you might have based some of your calculations on inaccurate figures for patient numbers. The Executive is obviously concerned about the total number of people who are involved. The society has investigated the matter and claims that the figures have been transposed from English statistics and that the Scottish figures are proportionately much lower. I ask you to study the matter, because if the figures that you have been working with are exaggerated, to some extent that must have influenced your thinking on whom you will pay out to.

We are dealing with an issue of morality. The patients have been fighting for years and, in some cases, decades. You say that there is a difference between those who are diagnosed with hepatitis C and those who are diagnosed with it but who do not have chronic hepatitis C—they have to move on to that stage to get a pay-out. Do you accept that all those who have been diagnosed with hepatitis C have had their lives harmed, for instance, by having jobs blocked or failing to get a mortgage? Will you please reconsider what is to be done about those people? Do you not feel a moral obligation towards them, too?

Malcolm Chisholm: There were lots of points there.

The Convener: That is what we get when I ask for short questions.

Malcolm Chisholm: There was an issue of fault in Ireland. Some people say that that is also the case here, but the general view is that there was no fault here. Our situation is different from the situation in Ireland, where it is accepted that there was fault.

In the interests of clarity and quick progress, I have tried to home in on the people who are registered with the SCIEH. I accept that the larger figure on which the expert group based its calculations is an extrapolation from UK figures. What the Haemophilia Society says may be true—I do not know—but that does not influence in any way the decision that I have made to home in on those 568 people. I accept that other payments might follow in years to come. Dorothy-Grace Elder's point was that those subsequent payments might not be as large as the expert group suggested, with which I will not quarrel because that might prove to be the case.

I am not sure that I picked up Dorothy-Grace Elder's third point correctly, but, for various reasons, I want to help all of those who contracted the virus through contaminated blood products. I would have thought that my proposals cover some of her points about the financial and other difficulties.

Dorothy-Grace Elder: Just to clarify, I mean the people who were diagnosed but who will get nothing—

The Convener: We have two other questions to get through.

Dorothy-Grace Elder: Sure. On you go.

Shona Robison: I have a question about the clawback of benefits. Let us leave aside the question whether the decision on the legal interpretation of the Scotland Act 1998 would be definitive. If the Westminster Government accepted the proposal in principle, but said that it would still claw back benefits in respect of the ex gratia payments, what would be the minister's approach?

Malcolm Chisholm: We would argue our case strongly. The issue is on-going and logically follows the resolution of the fundamental issue of the Parliament's powers. We have pressed hard on the issue of clawback and we will continue to do so because it is in our interest.

Shona Robison: The issue is not really about the Parliament's powers, but about a political decision at Westminster.

Malcolm Chisholm: I hope that my answer flagged up a certain amount of political intent to argue strongly on the issue.

Shona Robison: Do you worry that the free personal care for the elderly issue set a precedent?

Malcolm Chisholm: That was a different issue in many ways, so I do not think that there is a question of precedent. Free personal care does not influence the way in which we will argue on the hepatitis C issue.

The Convener: Do you believe that there is a potential role for a joint ministerial committee, or would the Privy Council have to be involved?

Malcolm Chisholm: All sorts of informal discussion can take place, but the Scotland Act 1998 is clear. I probably missed out a lot of the detail of schedule 6 to the Scotland Act 1998, so that would be good bedtime reading for members.

Janis Hughes (Glasgow Rutherglen) (Lab): My question relates to recent media reports about the difficulties that some haemophilia patients have had in obtaining medical records from a particular period. I welcome the minister's directive to NHS trusts to provide available medical records, which he issued following those reports. However, there is concern that records are not always available or complete. In the course of your investigations into the matter, have you found that to be the case generally in the NHS? Are records sometimes not available, or have they sometimes been destroyed after a given period? If that is the case, could not that hinder the legal action that people might take?

Malcolm Chisholm: I was very concerned about those general issues, which is why I made it clear that records should be available. Indeed, there is legislation on that—it is United Kingdom legislation and it is slightly complicated, but it is clear that it should apply. When concerns were expressed, it was not always clear exactly what was being referred to, although particular trusts were mentioned and we asked their representatives about the concerns. If people have more information, I would be keen to hear it but, as far as I know, the medical records concerned were made available.

There might have been issues around how much information was included on those medical records. That is a different issue, in particular as it pertains to things that happened 20 years ago or so. As far as I know, the medical records were not missing in the sense that Janis Hughes suggested. All that I say on the matter is quite general, because nobody came directly to me and gave details of the records concerned. I am keen to know from people about records that they did not get so that we can carry out more detailed investigations. The trusts that were referred to said that they had handed over the medical records that were available.

Janis Hughes: Will you clarify whether people have legal redress if the records that they seek to help them with their cases are not available? I

understand from having discussed the matter with my local NHS board that there is no legal obligation on boards to maintain records after a certain time.

Malcolm Chisholm: Various issues arise. The issue of legal redress came up with regard to the Scottish information commissioner. Because UK legislation was involved, that individual would have a role in ensuring that data protection legislation was enforced and that any available records were handed over.

I think that Janis Hughes is moving towards the issue of records' being incomplete. I would have to take legal advice on what the position would be now with regard to incomplete records from 20 years ago. The important matter for us now—for which we have responsibility—is to ensure that the records are up to date, complete and so on.

On whether people have legal redress if records were incomplete 20 years ago, I think that I would have to write to Janis Hughes about that, because I would have to hear a legal opinion on the matter.

MMR Vaccination

The Convener: We now move from hepatitis C to the MMR vaccination. I suggest that, given the time and if the minister and committee members are happy with the suggestion, we get a briefing from the Minister for Health and Community Care and the chief medical officer about the present situation. We can thereafter write to the minister and the CMO with questions based on that briefing and with any other questions that we might have.

We have indicated to the minister our concern about the recent media reports about mercury in vaccines. We had intended to ask questions about that but, because of time constraints, I suggest that we give the minister those questions in writing; however, we require the answers to the questions as quickly as possible.

Mary Scanlon: The committee's report on MMR is now one month short of two years in the making, and the election is looming. I have some serious questions that I wish to pose. I am happy to put them in writing, but only if we have a guaranteed time of response from the minister.

The Convener: I am sure that the minister is well aware that if we had been able to ask questions today, we would have heard responses immediately, so there is no reason why we should not expect a response within two weeks at the most. Is that acceptable to you, minister?

12:30

Malcolm Chisholm: I have no problem with that. Obviously, the committee is under time constraints. However, the CMO will be happy to give a separate oral briefing on thiomersal, rather than provide something in writing, if the committee would prefer that. The committee must make that decision.

I do not want to say a great deal about the matter because the CMO will say most about the MMR expert group's report. However, I will make two brief points. First, I remind the committee that we accepted the recommendations that were made, pending discussion with UK departments and other bodies, and we issued a more detailed response in October, with which I am sure members are familiar. I do not know whether Mary Scanlon's questions are over and above the scope of that response or whether they seek information on what has happened since. The CMO will cover some of that in his statement.

Secondly, given that people outside the Parliament are particularly interested in the MMR vaccine, I want to repeat my view, which is the view of the Executive as advised by the chief

medical officer and the Joint Committee on Vaccination and Immunisation, whose advice we take on such matters.

I am committed to the MMR vaccine with respect to the protection that it gives not just to individual children, but to the population as a whole. That is consistent with what the Health and Community Care Committee said in its report, but it is important to restate it. The wealth of expert opinion throughout the world confirms that there is no proven scientific link between the vaccine and autism.

Those are the only two points that I want to make, so I hand over to the CMO.

The Convener: I welcome the chief medical officer and the Very Rev Graham Forbes, and thank them for attending. The committee has had a busy session this morning and has run out of time to ask the witnesses questions in situ. However, I am sure that we will pick up on the many points that you will address in briefing us.

Dr Mac Armstrong (Chief Medical Officer for Scotland): I am grateful for the opportunity to make some opening remarks before responding to questions. I would be happy to follow up any questions in writing, if the committee would prefer me to do so.

MMR remains an important subject, particularly for parents of young children. I intend to say a little about the origins of the strong interest in the subject and what has been done in Scotland to address it. I will also focus on the actions that the Executive and others have taken in response to the recommendations that are set out in the MMR expert group's report.

The combined MMR vaccine was introduced to the UK childhood immunisation programme in 1988. Since about 1998, speculation has surrounded the vaccine as a result of hypothesised connections to inflammatory bowel disease and autism. A minority of parents in Scotland—about one in 10—are declining to have their children immunised by the age of two. There have been calls for a change in policy to allow parents to choose between MMR and single vaccines.

In 2001, the Health and Community Care Committee published a report, which stated:

"On the basis of currently available evidence, there is no proven scientific link between the MMR vaccine and autism or Crohn's disease. The Committee does not recommend any change in the current immunisation programme at this time."

The committee also suggested establishing an expert group to consider the questions that underpin parents' concerns.

The Executive agreed in June 2001 to establish the MMR expert group

"to consider the matters raised by the Health and Community Care Committee relating to immunisation against measles, mumps and rubella, with particular reference to:

a) describing the consequences of pursuing an alternative vaccination policy to MMR;

b) reviewing evidence on the apparent rise in the incidence of autism, taking account of the current work of the Medical Research Council;

c) describing the process of vaccine testing and the monitoring of adverse effects; and

d) in all its work, having regard to the role and remit of the Joint Committee on Vaccination and Immunisation, the Committee on Safety of Medicines and the Medicines Control Agency."

As members know, the expert group's report was published on 30 April last year. It takes account of the Medical Research Council's "MRC Review of Autism Research: epidemiology and causes", which was published in December 2001. That review makes it clear that, on the basis of current research evidence, there is no proven scientific link between MMR and autism spectrum disorders. It also says that more research is needed to establish the causes of autism spectrum disorders and to improve diagnosis and treatment. The review report also acknowledged that autism spectrum disorder, as a whole spectrum disorder, is more common than had been appreciated previously.

The review describes vaccine testing and the monitoring of adverse events, noting the circumstances in which single measles and mumps vaccines can be imported into the UK if prescribed by a doctor to meet what are described as the "special needs" of patients. It also described the likely consequences of a range of possible immunisation policies, such as no immunisation, compulsory immunisation, deferral of MMR, a choice between MMR and single vaccines, or of single vaccines' replacing MMR. The report of the expert group concluded that all those possible policies would be less effective in protecting individuals and the population against measles, mumps and rubella.

The report also included 11 specific recommendations that were designed to improve services for people with autism spectrum disorder; encourage research into autism spectrum disorder and inflammatory bowel disease; maintain and enhance expert consideration of that on-going research, and public awareness of the rationale that underpins the development of immunisation policy; and to improve the level and quality of information that is available to parents of children who are due to be immunised.

As the minister has said, the Executive immediately accepted in principle all the recommendations that are relevant to its statutory

functions, pending discussion with UK Government departments and other bodies, and publication of a more detailed response. That response was published in October 2002; it established a framework for on-going action by the Scottish Executive health department, the Joint Committee on Vaccination and Immunisation, the Committee on Safety of Medicines, the Medicines Control Agency, and health professionals throughout Scotland.

I will now describe briefly the recommendations that are set out in the MMR expert group's report and the action that is being, has been, or will be taken as a consequence of that report. First, the expert group recommended that the Executive and the Medical Research Council should work together to drive forward and to fund, as appropriate, the full research agenda that is outlined in the final chapter of the "MRC Review of Autism Research: epidemiology and causes". It confirmed in paragraph 240 that parents and other representatives of those who have autism should continue to play a key role in developing research strategies.

The Executive and the Medical Research Council welcomed the expert group's endorsement of the conclusions and recommendations of the MRC's review of autism research. We are developing a joint-funded research programme that is based on the agenda that is outlined in the final chapter of the MRC review, including consideration of the design and evaluation of interventions that are key in areas that currently lack a strong evidence base.

The MRC will continue to maintain its portfolio of high-quality research on autism spectrum disorders through its normal funding schemes, with established autism researchers being able to compete successfully for support alongside all other calls on the MRC's resources. An additional £2.75 million will be used to support proposals that are targeted on the areas that are highlighted by the MRC review as being where research evidence is currently lacking. That total is made up of £2.5 million given specifically to the MRC by the Department of Health in England in February 2002, and a proportional £0.25 million from the chief scientist office of the Scottish Executive health department. That programme will take into account international collaboration in ASD research, which is consistent with the expert group's recommendations that we should also, in pursuing that research agenda, seek to maximise international collaboration.

The expert group also recommended that the Executive consult widely in order to publish a firm timetable for addressing all of the detailed recommendations in the Public Health Institute of Scotland's "Needs Assessment Report on Autistic Spectrum Disorders", which was published in December 2001.

The Executive welcomed the expert group's recommendation in that respect because the PHIS report has a key role to play in shaping the strategic direction of services for people with autism spectrum disorders. We recognise the importance of appropriate services to support individuals who are affected by the disorder, and to support their families and carers. We are now taking that work forward with the PHIS reference group, which was set up in June 2002.

On the important issue of the early diagnosis and management of people with ASD, a health department letter will be issued shortly asking all health boards and local authorities to conduct an audit of current services. That should provide a comprehensive picture and will include reference to existing responsibility for diagnosis and subsequent assessment of need by all those involved.

Experts on autism agree that treatment of autistic children should be begun early. They advise that children with autism do not respond best to conventional medical treatment or to a simple medical model of illness but, rather, to a long-term combination of health and educational inputs. The "national initiative on autism: screening and assessment", which is a combined initiative that was established jointly by the Royal College of Paediatrics and Child Health, the Faculty of Child and Adolescent Psychiatry and the Royal College of Psychiatrists, with the support of the National Autistic Society and the UK all-party parliamentary group on autism, is examining issues around screening, diagnosis and early interventions on autism. We support and contribute to that work.

On integrated services, the Executive is committed to reform and improvement across a range of services, notably in health. As the committee will appreciate, much work is already under way and the Executive wants sustainable and long-term improvements in the range and quality of services for those who are affected by autism spectrum disorders in Scotland, working in partnership with local service providers and users.

In that respect, autism spectrum disorders are already included in the work that is being done to implement the initiatives in the document, "The same as you?", which was part of a national review for people with learning difficulties. Its aim is the same as that which is set out in the PHIS report, which is to ensure that services are co-ordinated and seamless.

In relation to people with learning disabilities and autism spectrum disorders, local authorities have been allocated change funds worth £36 million

over the three years to 2003-04 and £16 million in each year thereafter. The Executive's view, which is consistent with the PHIS report, is that early priorities for services should include early assessment, integrated joint planning for resources and management, involving people with ASD and their families or representatives in service development, and the development of a coherent approach to training and work force development. We will work to secure those aims.

On training, professional awareness of autism is improving. Of course, there is more to do in relation to raising awareness and improving expertise. The National Autistic Society and the Scottish Society for Autism are already involved in general awareness training for education and health authorities. The Executive will continue to encourage that. NHS Education for Scotland—the special health board that was established to oversee the education, training and development of all professional staff in the NHS in Scotland—is about to establish a steering group to scope and develop multi-disciplinary training at a variety of levels.

Information is the key to service planning for individuals, localities and the whole country. Local statutory authorities are responsible for ensuring that they have sufficient knowledge of local needs and priorities to inform the pattern of services in their area. The MRC's review of research provides as a background an authoritative overview of the current state of knowledge about the prevalence and incidence of autism. However, we are considering carefully how we can improve data collection on autism.

12:45

The Convener: I am conscious of the time, and that the Very Reverend Graham Forbes is with you; I want to bring him in and ask him whether he is happy with the progress that has been made to date. Is there much more of your briefing statement?

Dr Armstrong: In anticipation of your questions, we have attempted to go through all the recommendations and to try to give you as much information as possible about the work—

The Convener: If we can have the rest of your statement in writing, that will allow me to bring in the Very Reverend Graham Forbes, who has travelled to be with us. It would be nice to hear from him and to thank him for the work he has done through the expert group on MMR. Would that be okay?

Dr Armstrong: I am happy with that.

The Convener: Are you happy with the progress that has been made as a result of the work that has been done by you and the rest of the expert group?

The Very Rev Graham Forbes (MMR Expert Group): Unlike distinguished parliamentarians, I have had sight of what Dr Mac Armstrong was going to say. One of the good things about it is that a positive response is being made to all the things that the group said we wished would happen. The critical thing for the committee is to ensure that Dr Armstrong and the minister are hauled back now and again so that the matter does not remain on the headline-grabbing agenda—"MMR this" and "MMR that" and so on. One of the sobering aspects of the 12 months in which I lived with the project was my discovery that there are 7,000 children in Scotland today who have ASD. There are also probably 30,000 adults who have it, but where are they? We know where only some of them are. Dr Armstrong alluded earlier to conducting the audit. That sort of activity is absolutely essential and if we can continue it, genuine progress can be made. I give a warm welcome to the fact that action is now being taken. My advice to the committee is not to ease up on the pressure.

The Convener: I thank you for you attendance and I thank the CMO and the minister for theirs. It has been an interesting meeting.

12:47

Meeting continued in private until 13:00.

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