HEALTH AND COMMUNITY CARE COMMITTEE

Tuesday 4 February 2003
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
6th 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:

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

Committee Room 2

Scottish Parliament

Health and Community Care Committee

Tuesday 4 February 2003

(*Morning*)

[THE DEPUTY CONVENER *opened the meeting at 10:01*]

The Deputy Convener (Margaret Jamieson): Good morning colleagues. I welcome the minister, who will speak to amendments to the Mental Health (Scotland) Bill stage 2.

Item in Private

The Deputy Convener: I ask for the committee's approval to discuss item 4, on the Office of Fair Trading's report on retail pharmacies, in private.

Mary Scanlon (Highlands and Islands) (Con): I object to the item's being taken in private. We need clarification on reserved and devolved issues, on the purdah period going into an election and on what the committee is able to decide. I therefore propose that we take the item in public.

Shona Robison (North-East Scotland) (SNP): I agree. There is no reason to take the item in private.

The Deputy Convener: Does the committee agree to take item 4 in public?

Members *indicated agreement*.

Subordinate Legislation

Tobacco Advertising and Promotion (Sponsorship Transitional Provisions) (Scotland) Regulations 2003 (SSI 2003/34)

The Deputy Convener: No members' comments have been received. The Subordinate Legislation Committee has made no comment, and no motion to annul has been lodged. The recommendation, therefore, is that the committee makes no recommendation on the instrument. Does the committee agree?

Members *indicated agreement*.

The Deputy Convener: I should indicate at this point that Ian Jenkins is with us as a substitute for Margaret Smith.

Mental Health (Scotland) Bill: Stage 2

Section 169—Treatment mentioned in section 168(3): patients refusing consent or incapable of consenting

Amendments 557 to 560 moved—[Mrs Mary Mulligan]—and agreed to.

Section 169, as amended, agreed to.

Section 170—Treatment not mentioned in section 162(2), 165(3) or 168(3)

The Deputy Convener: Amendment 561 is grouped with amendment 562.

The Deputy Minister for Health and Community Care (Mrs Mary Mulligan): Section 170 deals with compulsory treatment authorised under the bill, or the parallel provision for mentally disordered offenders, which does not attract the safeguards in other sections of part 13.

Amendments 561 and 562 are technical amendments that will correct and clarify the cross-references in section 170 to other sections that deal with safeguards for particular treatments. The amendments make it clear that, apart from treatments that require special safeguards as described in sections 162, 165 and 168, any patient who is subject to a treatment authority under the bill may be given medical treatment by their responsible medical officer when the requirements of section 170 have been met.

I move amendment 561.

Amendment 561 agreed to.

Amendments 562 and 563 moved—[Mrs Mary Mulligan]—agreed to.

Section 170, as amended, agreed to.

Section 171—Urgent medical treatment

Amendment 564 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 616 not moved.

Amendment 597 moved—[Shona Robison]—and agreed to.

Amendment 598 not moved.

Amendment 617 not moved.

Amendment 565 moved—[Mrs Mary Mulligan]—and agreed to.

Section 171, as amended, agreed to.

After section 171

The Deputy Convener: Amendment 566 is in a group on its own.

Mrs Mulligan: Amendment 566 will add to this part of the bill a new section, which will implement the Scottish Executive policy that Scottish Ministers should have powers to make regulations specifying additional safeguards for giving specified treatment to children. That is based on a Millan committee recommendation and is intended to relate to situations in which a child, who is being treated informally and is not able to consent in his or her own right, is given treatments that might attract special safeguards. We will consult further on the type of treatments that should be included.

I move amendment 566.

Amendment 566 agreed to.

Section 172—Certificates under sections 163,164,167, and 169

Amendments 280 and 281 not moved.

Section 172 agreed to.

After section 172

The Deputy Convener: Amendment 567 is in a group on its own.

Mrs Mulligan: Section 166 provides for a certificate where a patient consents in writing to treatment that is authorised by virtue of the bill. The certificate may be completed by the RMO or a designated medical practitioner. Amendment 567 provides for the content of the certificate required under section 166 to be prescribed by regulations made by Scottish ministers.

I move amendment 567.

Amendment 567 agreed to.

Section 173—Scope of consent or certificate under sections 163, 164, 166, 167 and 169

Amendments 282 and 283 not moved.

Section 173 agreed to.

Section 174—Sections 163, 164, 167 and 169: review of treatment etc

Amendments 284 and 285 not moved.

The Deputy Convener: Amendment 568 is grouped with amendment 569.

Mrs Mulligan: Amendment 568 is a simple technical amendment that makes it clear, for the avoidance of doubt, that the reference in section 174 to "the responsible medical officer" refers to the RMO of the patient who is being treated.

Amendment 569 is also a technical amendment, which will correct the drafting of the section. It makes it clear that, at any time when the patient's RMO extends a compulsory treatment order, or makes an application to the mental health tribunal

for Scotland to do so, the RMO must also submit to the Mental Welfare Commission for Scotland a report on the treatment given to the patient and on their condition.

I move amendment 568.

Amendment 568 agreed to.

Amendment 569 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 618 is in a group on its own.

Shona Robison: Amendment 618 concerns the revocation of certificates by the Mental Welfare Commission. Its aim is to correct what I believe to be a technical error. Section 174(2) states:

"The Commission may at any time by notice to the patient's responsible medical officer revoke"

certain certificates. Under the bill as drafted, the commission may revoke

"a certificate given under section 163(3)".

I believe that that reference is incorrect. Section 163(3) refers to a situation in which

"the patient consents in writing to the treatment."

I would not have thought it appropriate for the Mental Welfare Commission to revoke a certificate if the patient has consented. The reference should be to a certificate given under section 164(3), under which

"the patient is incapable of consenting to the treatment".

The amendment would therefore replace the reference to section 163(3) with a reference to section 164(3).

I move amendment 618.

Mrs Mulligan: We are sympathetic to the second part of amendment 618, which seeks to enable the MWC to revoke a certificate given in relation to a patient judged unable to consent to neurosurgery for mental disorders—NMD. We are not convinced of the merits of the first part of the amendment, which would prevent the MWC from revoking a certificate in relation to a consenting patient.

However, on reviewing the amendment and section 174(2), we have identified that their effect would not appear to be in line with Executive policy, which is that the MWC should be empowered to revoke certificates made by medical practitioners in relation to a patient's capacity to consent to NMD. Section 174 refers to certificates from two non-medical people appointed by the MWC.

While accepting in part what we understand to be the principle of amendment 618, we cannot support it because of the drafting difficulties involved; nor can we accept the deletion of the MWC's power in relation to a certificate for a patient who consents to NMD. The Executive will, however, be happy to discuss the revocation of certificates further with the MWC and others, with a view to lodging an amendment to section 174 at stage 3 that, as far as possible, meets the concerns behind amendment 618. I would therefore be grateful if Shona Robison withdrew her amendment.

10:15

Shona Robison: Given the fact that it is the Mental Welfare Commission that raised concerns about this matter, it would seem sensible for the minister to enter into discussions with it and reach an agreement to return with an amendment at stage 3. I am happy with that.

Amendment 618, by agreement, withdrawn.

Amendment 286 not moved.

Section 174, as amended, agreed to.

Section 175—Interpretation of Part

Amendments 570 and 571 moved—[Mrs Mary Mulligan]—and agreed to.

Section 175, as amended, agreed to.

Before section 176

The Deputy Convener: Amendment 663 is grouped with amendments 664, 722 and 723.

Mrs Mulligan: This group of amendments responds to the concerns about "named persons" that were set out in the committee's stage 1 report. Amendment 663 sets out the procedure to be followed by a mental health officer when establishing who an individual's named person is.

The amendment will also confer a power on the mental health officer to apply to the mental health tribunal for an order where the mental health officer has established that the individual has no named person or where the mental health officer cannot establish who the individual's named person is. Where that is the case, the mental health officer also has a duty to record the steps taken to establish who the named person is and to give a copy of that record to the tribunal and to the Mental Welfare Commission.

The amendment will also impose a duty on the mental health officer to apply to the tribunal for an order to appoint a named person for the individual where the mental health officer is of the view that the "apparent named person" is inappropriate.

Amendment 664 is a technical amendment, which will replace the term "individual" with "person" for the sake of greater consistency with the rest of the bill.

Amendment 722 makes provision for an applicant to apply to the tribunal for an order appointing a named person or removing an existing named person. That amendment responds to evidence received by the committee from the Law Society of Scotland, which said that there should be provision to allow someone with an interest to challenge the appointment of a named person who they consider to have exercised undue influence on the person who nominated them.

The amendment does not require that the applicant consider that the named person has exercised undue influence on the person who nominated them, although it allows for an application to be made in a range of other circumstances.

Amendment 722 will also allow a child to apply to the tribunal if that child did not wish their parent to act as the named person. That responds to concerns that Children in Scotland expressed to the committee.

Amendment 723 makes provision for the mental health tribunal to make an order to appoint a named person and to remove any named person where the tribunal is satisfied that it is inappropriate for that person to act in that capacity.

I move amendment 663.

Amendment 663 agreed to.

Section 176—Meaning of "named person": powers of named person

Amendment 664 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 665 is grouped with amendment 666. If amendment 665 is agreed to, it will pre-empt amendment 666.

Mrs Mulligan: Section 176 sets out the definition of "named person". Amendment 665 will delete subsection (2); the subsection is unnecessary because the powers of the named person are expressed elsewhere in the bill.

Shona Robison's amendment 666 seeks to broaden the functions of named persons to deal with people who receive informal treatment for mental disorder. I understand the wish to ensure that patients are able to call on support in their dealings with professionals, which is why we have included new duties in the bill to ensure that patients have access to independent advocacy services. I also recognise that some people will prefer to have support from friends and relatives instead of, or as well as, an independent advocate. Many professionals are happy to involve informal supporters when that is what the service user wants, but we recognise that that has not been everyone's experience.

The question is: What is the best way to encourage professionals to behave flexibly and openly in relation to service users' need for assistance and support? We do not feel that amendment 666 is the answer to that. The provisions in the bill concerning named persons have been developed for a particular purpose; that is, to provide additional protection for patients in connection with tribunal hearings, and to provide the right to initiate reviews by the tribunal. We think that using those provisions for a much broader purpose might create serious problems.

If we say that named persons have certain rights, there is a risk that that will be interpreted as meaning that relatives and supporters who are not named persons do not have any rights to support the service user.

The procedure for nominating a named person is a relatively formal one that involves a signed and witnessed certificate. We do not think that it would be desirable to require patients to go through that process to obtain informal support in relation to their treatment. It is possible to have only one named person at a time, but a service user might want informal support from, for example, both parents or from different people for different issues. A person who provides support in dealing with doctors might not want to have legal responsibilities in relation to compulsory measures.

For all those reasons, we cannot support amendment 666, but we recognise user groups' concerns about the need to ensure that service users have a strong voice in negotiating their care, whether formal or informal. There are a number of ways to address the issue. Our general view is that we should promote best practice rather than establish a formal legal framework. However, I am happy to undertake to discuss the matter further with user interests to discover whether provisions could be included in the bill or in the code of practice that might make a positive difference. Therefore, I hope that Shona Robison will feel that she need not move amendment 666.

I move amendment 665.

Shona Robison: I accept what the minister says and I hope that she will have more discussions with the user groups. The main concern is that informal patients are being denied what could be a useful tool in preventing them from entering formal proceedings. The Scottish Association for Mental Health suggested that the role of a named person at an early stage could help to reduce or prevent the use of compulsory powers under the eventual act. That role might allow a service user to have the assistance of a named person in order to try to resolve issues about their care and treatment before matters reach crisis point, which is often when formal proceedings would be used.

I accept what the minister said about advocacy, but concerns exist as to whether advocacy will always be available to everybody, in particular in the early stages of implementation, given the lack of resources for getting advocacy services established. It could be that the named person is the only resource available to the service user at that stage, if there are no advocacy services. I am sure that the minister is aware of all those arguments from user groups. If she will consider the matter again with the user groups, and take on board our views about the named person, I will be happy not to move amendment 666. However, I want some reassurance.

Nicola Sturgeon (Glasgow) (SNP): I agree with some of Shona Robison's comments. Amendment 666 contains an important point, which is that if a named person were allowed to exercise the powers in section 176 before formal proceedings were commenced under the eventual act, the effect of that in some circumstances might be that the need for compulsory powers would be reduced or removed altogether. That seems to be very much in line with the principles upon which the bill is based.

The minister has highlighted the fact that although some professionals encourage and facilitate the involvement of carers or other individuals at that early stage, others do not. If the minister believes that that is not the right way to tackle the problem, will she say more about alternative ways in which it could be tackled? There is clearly an issue; people are not consistently being allowed somebody to represent them at that early stage. The powers under the act might end up being used more often than is required if amendment 665 were agreed to.

Mrs Mulligan: Everyone here is anxious to ensure that the service user is given as much support as possible, as early as possible. I take on board the points that Shona Robison and Nicola Sturgeon have made about the importance of having support at an early stage to ensure that a service user's situation does not deteriorate. Therefore, we recognise that the named person is the formal part of the process and will be able to give support. We do not, however, want to rule out the informal ways in which other people can offer support. The question is how we bring that about without needing to formalise the process in a way that might be a burden to the service user. However, the inconsistencies to which both Nicola Sturgeon and I referred in terms of the professionals' response to that must be considered. We reassure members that we will have further discussions about the matter and return with amendments at stage 3, if necessary.

Amendment 665 agreed to.

Amendment 666 not moved.

Section 176, as amended, agreed to.

Section 177—Nomination of named person

The Deputy Convener: Amendment 667, in the name of the minister, is grouped with amendments 668, 669, 670, 671, 672, 674, 675, 676, 677, 680, 681 and 682. If amendment 667 is agreed to, it will pre-empt amendment 668.

Mrs Mulligan: Section 177 sets out the procedure by which a person with mental disorder may nominate a named person, the procedure to revoke a nomination and the procedure by which a nominated person may decline to be the named person.

Amendment 667 will replace the term "individual" with "nominator" in order better to reflect the role that is held by the person with mental disorder in relation to the nomination of a named person. The amendment will remove mention of the procedure to revoke a nomination, but will add references to a subsection on revocation of nomination and a subsection on the person nominated declining a nomination.

Amendments 669, 670, 671, 672, 674, 675, 676, 677, 681 and 682 will replace the term "individual" with "nominator" and the term "individuals" with "nominators" as necessary, in order better to reflect the role that is held by the person with mental disorder in relation to the nomination of a named person.

Amendment 680 is a technical amendment that will smooth the drafting of the section that will result from agreement to amendment 667.

Amendment 668 in Shona Robison's name seeks to prevent a child from being nominated as a named person. We agree that it is difficult to envisage circumstances in which it would be appropriate for a child to act as a named person, but we are not sure that the amendment is required. The nomination in section 177 must be by a legally capable adult and it is fairly unlikely that such an adult would nominate a child to be the named person. Even if that happened, Executive amendment 663 will place the mental health officer under a duty to review any case in which the named person appears to the MHO to be inappropriate. We imagine that the MHO would do that if a child was nominated. If members feel that it is necessary to make clear in the code of practice that we will expect MHOs to do that, we will consider doing so. I hope that, with that reassurance, Shona Robison will not move amendment 668.

I move amendment 667.

10:30

Shona Robison: The purpose of amendment 668 was to try to clarify that it would not be appropriate for someone under 16 to take on the

responsibility of a named person. If the minister is satisfied that other elements of the bill will prevent that from happening, I am happy not to move amendment 668.

Mrs Mulligan: I am happy to give that reassurance and to consider what further clarification we can provide in the code of practice.

Amendment 667 agreed to.

Amendment 668 not moved.

Amendments 669 to 672 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 673 is grouped with amendments 679 and 709.

Mrs Mulligan: Amendment 673 will smooth the drafting of section 177 by inserting a reference to the subsection that sets out the procedure by which a nominator may revoke the nomination of their named person. Amendment 679 is a technical amendment that will delete a reference to the procedure by which a nominator may revoke a nomination of the named person. That procedure is expressed elsewhere in section 177.

Section 180 allows a person with mental disorder to provide that someone who would otherwise be entitled to be a named person—for example, the primary carer or nearest relative—should not be so entitled. Amendment 709 is a technical amendment that will smooth the drafting of section 180 by clarifying the procedure for revoking a declaration, and by referring to the two subsections in section 180 that set out the requirements for a declaration and a revocation.

I move amendment 673.

Amendment 673 agreed to.

Amendments 674 to 677 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 678 is grouped with amendments 684 and 708.

Shona Robison: Amendment 678 concerns the capacity to nominate a named person. It is a technical amendment to clarify the bill, which provides that the nomination of a named person shall remain valid

"notwithstanding the individual's becoming … incapable".

However, it does not say of what the person should have become incapable.

The problem is the use of the term "incapable", which gives the impression that a person is either completely capable or completely incapable. That seems to run contrary to the scheme that the Adults with Incapacity (Scotland) Act 2000 introduced, which linked capacity to the function that is to be carried out. For example, a person may be capable of taking medical decisions, but not of handling his or her money.

The bill should make it clear what the test of incapacity is in the case of a nomination. A nomination should be valid notwithstanding that a person is no longer capable of making or revoking a nomination. Amendment 678 seeks to make that clear.

Amendment 708 is a similar amendment to section 180, where the test is whether the person has become incapable in relation to a declaration removing the named person.

I move amendment 678.

Mrs Mulligan: Amendments 678, 684 and 708 seek to bring the bill more closely into line with the Adults with Incapacity (Scotland) Act 2000. Our intention is certainly that that act and the bill should be consistent, but I ask Shona Robison not to press the amendments. I reassure members that the amendments would have no practical effect. They would amend provisions that mean that nominations or declarations have effect regardless of whether the patient who made the nomination subsequently becomes incapable. How "incapable" is defined would make no legal difference, because the point of the provisions is that the nomination or declaration is always effective.

That is a technical point. More important, however, is that there is a need to review how incapacity is defined throughout the bill, as it has so far been amended during stage 2. We will therefore consider whether it is necessary to lodge at stage 3 amendments that would ensure consistency with other parts of the bill and with the approach of the Adults with Incapacity (Scotland) Act 2000. It might be that that will result in a general definition of incapacity elsewhere in the bill.

I hope that Shona Robison will, on the basis of that reassurance, feel able not to press amendments 678.

Shona Robison: It is certainly necessary to have a general definition of incapacity somewhere in the bill. Given that the minister has said that such a definition might be introduced at stage 3, I am happy not to press amendments 678 and 684.

Amendment 678, by agreement, withdrawn.

Amendments 679 to 682 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 683 is grouped with amendments 691, 692, 695 and 718.

Mrs Mulligan: Section 177 sets out the procedures by which a person with mental disorder may nominate a named person, and subsection (5) sets out the procedure by which a person nominated to be the named person may decline such a nomination.

Amendment 683 will require that the declining named person notify the local authority of the area in which the nominator resides, rather than notify the mental health officer who has responsibility for the person with mental disorder. That is because the named person might not be aware of any mental health officer who is involved.

Section 178 sets out the procedures by which the primary carer becomes the named person when no other person is nominated or when the nominated person declines the nomination. That section also sets out the procedure by which the primary carer may decline to be the named person and it sets out that, where the primary carer so defines, the person's nearest relative shall be the named person.

Amendment 691 is a technical amendment. It will delete the subsection that sets out the procedure by which, having become the named person when the nominated named person has declined to act, the primary carer could then also decline to be the named person.

Amendment 692 is a technical amendment that will smooth the drafting of procedure that is expressed elsewhere in section 178. Amendment 695 sets out the procedure by which a person's primary carer, upon becoming the person's named person, may choose to decline to be the named person.

Section 181 sets out the criteria that are to be used to determine the nearest relative. Where the nominated named person declines to act and the primary carer subsequently also declines to act as named person, the nearest relative then becomes the named person. Amendment 718 sets out the procedure by which the relevant person's nearest relative, upon becoming the named person, may decline to be the named person.

I move amendment 683.

Amendment 683 agreed to.

Amendment 684 not moved.

Section 177, as amended, agreed to.

Section 178—Named person where no person nominated or nominated person declines to act

The Deputy Convener: Amendment 685 is grouped with amendments 686, 689, 693, 694, 696 and 724.

Mrs Mulligan: Section 178 sets out the procedures by which the primary carer for a person with mental disorder becomes the named person where no other person is nominated or where the nominated person declines the nomination. Section 179 specifies the named person for a child under 16.

Amendments 685 to 687, 689, 693, 694 and 696 would replace the term "an individual" with the term "a person" to be more consistent with comparable wording elsewhere in the bill. Amendment 724 would rectify an omission in the bill and would clarify that bodies and corporations other than natural persons cannot fulfil the role of named person under the legislation. The exception is section 179, in which a local authority with parental responsibilities can be a named person for a child.

I move amendment 685.

Amendment 685 agreed to.

Amendments 686 and 687 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 688 is grouped with amendment 690.

Mrs Mulligan: Amendment 688 is a technical amendment that will smooth the drafting of section 178 as a result of amendment 691 and allow for the incorporation of amendment 690.

Amendment 690 will allow for the possibility that a person with mental disorder does not have just one primary carer but had two or more. The legislation requires that where the named person declines to act, the primary carer becomes the named person. The amendment seeks to provide that, where the named person has declined to act, the two or more carers may agree between themselves which one will become the named person. Where one carer becomes the named person, amendment 690 also seeks to allow him or her to be deemed to be the person's primary carer for the purposes of section 178.

I move amendment 688.

Amendment 688 agreed to.

Amendments 689 to 695 moved—[Mrs Mary Mulligan]—and agreed to.

Section 178, as amended, agreed to.

Section 179—Named person in relation to child

Amendment 696 moved—[Mrs Mary Mulligan]—and agreed to.

10:45

The Deputy Convener: Amendment 697 is grouped with amendments 698 to 702.

Mrs Mulligan: Section 179 sets out the procedures in respect of a named person for a person under 16. Amendment 697 is a technical amendment that will allow for the subsequent new subsection that would be introduced by amendment 700.

Amendment 698 will augment the procedure for ascertaining the named person for a child. Section

179 allows two or more persons having parental responsibilities for a child to agree which of them is to be the child's named person. By setting out the criteria for determining which of them shall be the named person, the amendment also seeks to make allowance for a situation in which two or more persons have parental rights and parental responsibilities but cannot agree which is to be the child's named person.

Amendment 700 seeks to provide that where a local authority has parental rights and parental responsibilities by virtue of an order under section 86(1) of the Children (Scotland) Act 1995, that local authority shall be the child's named person.

Amendment 701 would add definitions for the terms "parental rights" and "parental responsibilities", which are used throughout section 179 to determine which person shall be a child's named person. Those definitions are the same as those used in the Children (Scotland) Act 1995.

Amendment 699, which is in the name of Shona Robison, would require the mental health officer to determine which parent should act as the named person for a child, if the parents could not agree. We accept the need for a mechanism to resolve such a situation, and I am pleased to say that the Executive amendments in this group provide one. Amendment 698 sets out that, if there were no agreement, the parent who was the main carer would be the named person. It would be up to the mental health officer to reach a decision on the basis of that test. Where he or she is unable to choose between the parents, amendment 663 will provide a mechanism by which the mental health officer can refer the matter to the tribunal. Under amendment 722, if either parent were unhappy with the MHO's decision, they would have a right to go to the tribunal.

Amendment 702, which is also in the name of Shona Robison, would require parents who decide between themselves which of them should be the child's named person to have regard to the views of the child in question. We certainly hope and expect that parents would do that, but we are not sure whether an amendment that would create a legal requirement in that respect would add much to the bill. For a start, it might be difficult and potentially intrusive for a mental health officer to seek to investigate how far the parents had involved the child in such discussions, and we are not sure what would happen if the MHO or anyone else decided that they had not.

The Executive amendments in this group would achieve the main goal of ensuring that a child could ask the tribunal to change the named person if he or she did not wish a particular parent to take on that role. We must also take various technical issues into consideration. For example, as the wording of amendment 702 is linked to amendment 699, it would require to be revised if amendment 699 were not agreed to. Furthermore, we would also need to consider how far the duties in those amendments cut across those set out in amendment 106, which relates to the bill's principles.

On that basis, I am afraid that we cannot support amendment 702. However, we are happy to consider further whether we can emphasise—perhaps in the code of practice—the importance of taking account of the child's views when determining who should be the child's named person. I hope that Shona Robison will feel able not to move amendments 699 and 702.

I move amendment 697.

Shona Robison: As the minister has pointed out, amendments 699 and 702 seek to do two things—to have the child's wishes and feelings taken into account and to have the MHO decide if the parents cannot reach agreement.

There is sense in what the minister said about the decision on which of the parents should be the named person being based on the question of who was the main carer for the child. However, care could be shared equally, which would make it difficult to determine who was the main carer. If I understood the minister correctly, in such a case the mental health officer would have to make a decision that was based on all the circumstances. I am happy with that.

The Children (Scotland) Act 1995 sought to enshrine in legislation the idea that children's views and wishes should be taken into account. I would have thought that it would be important that the child's views and feelings were heard when such a major decision was being made. If the minister were to assure me that the code of practice will make it clear that that should happen, I would be satisfied that it was not necessary to include such a provision in the bill. The principle is important and it should be highlighted for those who are involved in the process.

Mrs Mulligan: Shona Robison is correct to say that, if there were a dispute between the parents, the MHO would make the decision. There would also be a safeguard, in that the parents would have the right to appeal against that decision.

We all support the principle that the views of the child should heard, so we will consider putting something in the code of practice to ensure that that takes place.

Amendment 697 agreed to.

Amendment 698 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 699 not moved.

Amendments 700 and 701 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 702 not moved.

Section 179, as amended, agreed to.

Section 180—Declaration in relation to named person

The Deputy Convener: Amendment 703 is grouped with amendments 704 to 707, 710 and 711.

Mrs Mulligan: Section 180 will allow a person with mental disorder to provide that someone who would otherwise be entitled to be a named person should not be so.

Amendment 703 seeks to make provision for a person with mental disorder to make a declaration that a specified person should not be their named person. The provision to make such a declaration, which must be in writing, is available to people who have attained 16 years of age. Amendment 703 will add a new term: it refers to the person with mental disorder as "the declarer", to reflect their role in making a declaration under section 180.

Amendment 704 is a technical amendment that seeks to smooth the drafting by clarifying that the remainder of section 180(2) constitutes the criteria that must be met for the declaration to be valid.

Amendments 705, 707, 710 and 711 seek to replace "individual" with "declarer" to reflect the role of the person with mental disorder in making a declaration under section 180.

Amendment 706 is a technical amendment that would smooth the drafting by changing the tense of the verb from "shall certify" to "certifies".

I move amendment 703.

Amendment 703 agreed to.

Amendments 704 to 707 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 708 not moved.

Amendments 709 to 711 moved—[Mrs Mary Mulligan]—and agreed to.

Section 180, as amended, agreed to.

Section 181—Meaning of "nearest relative"

The Deputy Convener: Amendment 712 is grouped with amendments 713 to 717 inclusive.

Mrs Mulligan: Section 181 sets out the criteria that are to be used to determine the identity of the patient's nearest relative.

Amendments 712 and 713 are technical amendments that will allow for the introduction of section 181(3A).

Amendment 716 is a technical amendment that seeks to rephrase the existing wording to clarify the nature of the separation between the person with mental disorder—the relevant person—and their spouse.

Amendment 717 will add subsection (3A), which would limit who could be the relevant person's nearest relative by excluding certain persons who were related to the relevant person through specified relationships of marriage where that marriage has ended, either through permanent separation or desertion. The amendment will ensure that a person who was married to one of certain of the relevant person's blood relatives could not be considered their nearest relative where that marriage no longer existed or endured. Amendment 717 will ensure that the nearest relative who was also the named person would be connected by blood or by a relationship of marriage to the relevant person.

Amendments 714 and 715, which are in the name of Shona Robison, would shorten the list of possible nearest relatives by removing two of the more distant categories. The list in the bill is longer than the list in the Mental Health (Scotland) Act 1984. The more distant relatives would be appointed only if there were no nominated person, primary carer or closer relative who could act.

It was our view that it would be useful to ensure that as many patients as possible had a named person as a form of protection for their interests. However, on reflection, given that we are allowing for the possibility that the tribunal will make an appointment where the person has no named person, we are inclined to agree that the list might be too long. We would like to review the issue in consultation with parties that have an interest. If that consultation establishes a consensus for shortening the list, we will seek to amend the bill at stage 3, but we would prefer not to make such an amendment until we have had further discussions with members of the mental health legislation reference group. I hope that my reassurance that the matter will be considered will persuade Shona Robison that she need not move her amendments today.

I move amendment 712.

11:00

Shona Robison: I am certainly happy about the minister's assurance that there will be further discussion on reviewing the list, which I believe needs to be shortened. The husband or wife of the patient's grandson, granddaughter, niece or nephew is unlikely to have a direct interest, although one never knows. I agree that the best way forward is for further discussion to take place, so I am happy not to move my amendments.

Amendment 712 agreed to.

Amendment 713 moved—[Mrs Mary Mulligan]—and agreed to.

Amendments 714 and 715 not moved.

Amendments 716 to 718 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 719 is grouped with amendments 720 and 721.

Mrs Mulligan: Amendment 719 reflects representations made to the committee by the Equality Network concerning unmarried partners. The network was concerned that the definition of a cohabitant in the list of people who might be a nearest relative was inappropriate in requiring proof of a prior or subsisting sexual relationship. The network suggested that the definition in the Adults with Incapacity (Scotland) Act 2000 be used instead, and we have accepted that suggestion. Amendments 720 and 721 are technical amendments that will remove references to the deleted provision.

I move amendment 719.

Amendment 719 agreed to.

Amendments 720 and 721 moved—[Mrs Mary Mulligan]—and agreed to.

Section 181, as amended, agreed to.

After section 181

Amendments 722 to 724 moved—[Mrs Mary Mulligan]—and agreed to.

Section 182—Advocacy

The Deputy Convener: Amendment 636 is in a group on its own.

Mr John McAllion (Dundee East) (Lab): The effect of amendment 636 would be to give a right of access to independent advocacy to every person with a mental disorder. We received numerous written submissions on this issue during stage 1, as well as significant oral evidence. As a result of considering that evidence, we stated in our stage 1 report, in paragraph 12 of the executive summary on page 2:

"The Committee supports the provisions on patient representation in the Bill as a significant improvement on the current law. However, we would like the Bill to give any person with a mental disorder a direct right to access independent advocacy services."

Amendment 636 makes flesh the committee's will, if I can put it that way.

There is a long history of support for the right of access to advocacy. Malcolm Chisholm, in his foreword to the guidance issued to health boards and local authorities, claimed that the guidance simply sought to ensure

"that independent advocacy is available to all that need this support."

In the covering letter that went with that guidance to health boards and local authorities, the minister said:

"Health Boards should work with their local partners to develop proposals to ensure that integrated, independent advocacy schemes are available to all who need this type of support."

Even the Executive's policy document, "Our National Health: A plan for action, a plan for change", said:

"We will require all NHS Boards to work in partnership with Local Authorities to ensure that integrated Independent Advocacy services are available to those who most need them."

Among his many other recommendations, Millan included the following statement at paragraph 101:

"Enabling service users to have access to independent advocacy is an integral aspect of ensuring that the Principles of the Act are upheld. All mental health service users should have a right to obtain access to an advocate."

Looking back through the history of debate on the subject, it seems fairly universal and uncontroversial to say that people with mental disorders should have a right to access independent advocacy. Unfortunately, the Scottish Executive's policy statement and the bill itself do not contain a right for people with mental disorders to access advocacy. Instead, they place a duty on health boards and local authorities

"to secure the availability … of independent advocacy services"

and there is a significant difference between the two.

It is likely that health boards and local authorities would be meeting their legal duty in making available in their areas a certain level of service for independent advocacy, but we know from the map that was provided to every member of the committee that the provision of independent advocacy across the country is still inadequate. Local authorities and health boards may be meeting their duty by saying that they have services available, but the individual may not be able to access those services immediately they require them, because the level of provision is not sufficient to ensure that everyone who needs advocacy gets access to it.

It is important that the bill, as well as placing a duty on health boards and local authorities, should give people with mental disorders the statutory right to access those services. That is the only way to guarantee that health boards and local authorities will make that level of service available.

I move amendment 636.

Nicola Sturgeon: Amendment 636 is fundamentally important. As John McAllion said,

the committee received an awful lot of evidence on the issue, both written and oral, and we reached firm and unanimous conclusions. Our report says that the committee was surprised that there was no direct legal right to advocacy. It went on to say:

"service users' rights would be enhanced if … the Bill conferred a right on all people with mental disorders to obtain independent advocacy services."

We must be aware, as the committee was at stage 1, that mental health service users face a number of difficulties. They face being deprived of their liberty and having treatment against their will, and they suffer, sometimes daily, stigma and discrimination. That reinforces their need for the support services that they require at various stages to make their views known and to allow their voices to be heard. Simply conferring a duty to provide advocacy services is not sufficient. That does not guarantee that people will get access to advocacy services when they need or want them.

I believe firmly that, as the committee said at stage 1, the only way to ensure that people who need advocacy services get them when they need them is to confer a right to advocacy services. I support amendment 636 and hope that the committee will also support it, so that we can live up to the comments that we made at stage 1.

Mary Scanlon: Much of what I wanted to say has been said.

Paragraph 228 of the policy memorandum states:

"NHS Boards and local authorities have discretion to decide whether to meet the duty through advocacy agencies who focus solely on clients with mental disorders or more broadly based providers who would include them within their client group."

Judging from the evidence that we heard, I feel that mental health service users are looking for something more specific to their needs. The policy memorandum talks about a more general advocacy service, which I do not think would meet the expectations of many of the people who spoke to us.

The Millan committee proposed that mental health service users should have a right to advocacy. Paragraph 165 of our stage 1 report confirmed the fact that, as other members have said, the provision of advocacy services is an enormous issue. It stated:

"We received a great deal of written evidence, from service users, carers, and professionals, praising the good work done by advocacy groups in helping people with mental disorders empower themselves, and in supporting them during difficult times. The Committee also took spoken evidence from people involved in advocacy work … who gave us a clear impression of the practical difference advocacy can make to people's lives."

In paragraph 166, we acknowledged what had been said:

"Whilst excellent work is going on, the Committee is aware that advocacy services in Scotland are still patchy."

I confirm that that is true in the Highlands. Unless we confer the right on the user and deal with the discretion that exists at NHS and local authority level, such services will continue to be patchy.

Jim Kiddie, a member of the Millan committee, said:

"I hope that the bill will provide a right to advocacy. Without that, service users the length and breadth of Scotland will feel let down, if not angry."—[*Official Report, Health and Community Care Committee*, 25 September 2002; c 3090.]

I would like to retain the position that was taken by the committee at stage 1 and I support John McAllion's amendment.

Mrs Mulligan: As we have said throughout the passage of the bill, we are committed to the same aim as Millan: that any person with a mental disorder who needs an advocate should have access to one.

At stage 1, the committee encouraged the Executive to amend the bill to confer a right on all people with mental disorders to obtain independent advocacy services. We have considered the matter carefully and have strengthened the provisions regarding advocacy for people who are subject to compulsory measures. However, in general, we still believe that the bill takes the right approach. The difference in wording between what Millan proposed and what the bill proposes does not reflect a difference in intention; it reflects the fact that bills have to be worded in a particular way to ensure that they give proper legal effect to the underlying policy.

In "Our National Health", we set out a requirement that NHS boards demonstrate their plans for making independent advocacy available to all who need it. The bill creates, for the first time, a duty on both the NHS and local authorities to secure independent advocacy for all those in their areas who have mental disorders. Furthermore, section 182 makes it clear that health boards and local authorities must take appropriate steps to ensure that people with mental disorders have the opportunity to make use of those services. In other words, there must be advocacy and the statutory agencies must ensure that people with mental disorders can access it.

I appreciate the concern that a general duty might not always be implemented in individual cases. That is the nub of the issue for John McAllion. However, amendment 636 would not solve that problem. The wording of the amendment is fine as a general statement of purpose, but it does not work well as a piece of legal drafting. It is not at all clear whether the

statement adds something to the existing duty or whether it is meant as some sort of qualification of the duty. Nor is it clear what access to advocacy means in this context.

It might be possible to define the right more precisely, and we could consider spelling out the aim that every service user be allowed a certain amount of a certain kind of advocacy. If members are looking for such a specific right, we are happy to consider what might be done. However, our current view is that that could be a mistake.

11:15

Although advocacy is not a new concept, formal advocacy services have really started to develop in Scotland only over the past few years. There are many different kinds of advocacy at different stages of development. The point was made forcibly in the committee's stage 1 report that,

"as a social service independent advocacy is still in its infancy: it would be ill-advised and inhibiting to attempt to encase developing terms and concepts in the fast-setting concrete of legislative drafting."

We agree with that and we feel that the logic of that argument supports placing a broad duty on the NHS and local authorities, which will support the development of advocacy in all its forms.

I hope that the committee will be persuaded that we are genuinely and strongly committed to ensuring that advocacy is available for people with mental disorders. I hope that, on the basis of that reassurance, John McAllion will not press amendment 636.

Mr McAllion: I hear what the minister says, but I do not think that it is just a matter of a difference in the wording disguising the same intent on both sides. There is a clear difference between what the bill proposes and placing a duty on the NHS and local authorities to provide independent advocacy for every person with mental disorder who needs it. That is not what the bill says. The bill says that an NHS board or a local authority will have a duty

"to secure the availability, to persons in its area who have a mental disorder, of independent advocacy services".

Those services may or may not be adequate for the people who live in that area. Therefore, it would be possible, under the bill as it stands, for people to be left without access to independent advocacy because of the wording of the bill.

If the bill provided a statutory right to access independent advocacy services, health boards and local authorities would be in breach of their statutory obligations if they did not provide the level of service that people required. On that basis, I press amendment 636.

Mrs Mulligan: As I said, I am not sure that amendment 636 will bring about what John McAllion is aiming for. However, I do not think that it would damage the bill in any way and I am happy to accept the amendment.

The Deputy Convener: John, do you want the last word?

Mr McAllion: Just to say thanks very much.

Amendment 636 agreed to.

The Deputy Convener: Amendment 725 is grouped with amendment 637.

Mrs Mulligan: Amendment 725 will remove the word "advice" from the list of services that an independent advocate would provide. That is a response to representations that were made to the committee by independent advocacy organisations, which said that an advocate's role is to provide support and to empower a person to have their views listened to. Those witnesses said that advice was more akin to legal assistance and that, even if we think of advice in general terms, the word does not reflect the supportive and representative role that an independent advocate plays.

We understand the concerns behind amendment 637, which reflects a wish to ensure that the bill does not water down the fundamental principle that an advocate is not someone who decides for the service user, but someone who gives support to the service user. Our guidance to commissioners sets out what advocacy is:

"Advocacy is about standing up for and sticking with a person or group, taking their side, helping them get their point across. Advocacy adds weight to people's views, concerns, rights and aspirations.

Advocacy has two main themes:

- Safeguarding individuals who are in situations where they are vulnerable
- Speaking up for and with people who are not being heard, helping them to express their own views and make their own decisions."

Section 182(4) is an attempt to put that into legal language. Subsection (b) was included because we feel that it is important not to deny advocacy to the group of people who are most vulnerable—those who are so affected by their mental disorder that they cannot express an opinion on matters affecting them.

We agree that people can be too ready to assume that a person with a mental health problem or a disability cannot express a view. One of the tasks of an advocate may be to challenge that assumption and demonstrate that a service user has got a point of view and should be listened to. However, it is also true that some people who have serious illnesses or profound disabilities will not be able to state an opinion on some of the decisions that might be made about their lives.

"Principles and standards in Independent Advocacy organisations and groups" states:

"As well as following any agenda that has been identified by the person or group they support, advocates also initiate action based on basic human rights, needs, decency and service standards."

In essence, that is what we are seeking to allow for in section 182(4)(b). The subsection makes it clear that the purpose is additional and not something that should be pursued at the expense of the main advocacy role as set out in subsection (4)(a).

We are reluctant to delete subsection (4)(b) for the reasons that I have outlined, but we recognise that the groups who support advocacy organisations have concerns that, as drafted, it might give the wrong emphasis. We would like to discuss further with advocacy interests whether some redrafting might meet their concerns and whether we can look at the balance between what goes in the bill and what is included in the code of practice. On that basis, I hope that John McAllion will be prepared not to press amendment 637.

I move amendment 725.

Mr McAllion: The minister has covered the concerns that lie behind amendment 637. There was concern about what subsection (4)(b) implied about the role of advocates. The minister has touched on that very well. In all the definitions of independent advocacy, there is no reference to what is contained in subsection (4)(b). Although advocacy groups recognise what the minister is concerned about, they are also concerned to make it clear that the role of advocates is not to make judgments on behalf of those for whom they advocate but to try to work with them to find out their views.

In view of what the minister said about being happy to talk to advocacy groups about the issue before stage 3, I would be happy not to press amendment 637.

Amendment 725 agreed to.

Amendment 637 not moved.

The Deputy Convener: Amendment 726 is grouped with amendment 638. If amendment 726 is agreed to, I cannot call amendment 638, due to pre-emption.

Mrs Mulligan: Amendment 726 will add

"a National Health Service trust"

and

"the State Hospitals Board for Scotland"

to the list of persons whose role, in relation to the person seeking advocacy, would exclude them from being independent, and thus rectify an omission in the bill as introduced.

We are sympathetic to the aims of John McAllion's amendment 638, which relates to bodies who provide services under arrangements with the health board or local authority. It is important that anyone who provides an independent advocacy service should not have any conflicts of interest. However, we believe that amendment 638 could, in some cases, have unintended consequences, which might work against the interests of some service users. Our guidance to commissioners sets out some key principles that underpin good independent advocacy. Two of those principles are:

"Advocacy groups should be constitutionally and psychologically independent of local and national government"

and

"Advocacy groups can not be providers of a service and advocates for users of that service".

Those principles apply to independent advocacy services that are established to implement the duties under the bill in the same way as they apply to other independent advocacy services. However, we are concerned that amendment 638 would go further than that and might cause practical difficulties, especially for groups with particularly complex needs and for those in rural areas.

For example, a local council for voluntary service might be the most suitable, or even the only, agency to develop an independent advocacy service for patients at a particular hospital, but if the body also provided, say, a lunch club for elderly people under contract to the local authority, it would be prevented from running an advocacy service for a completely separate group of people. The same kind of problem might arise with, for example, people from minority ethnic communities or people with dementia. There are well-established voluntary agencies working in those fields, who might be the best people to develop advocacy services for the groups that they serve. We agree that such agencies should not provide advocacy for the same individuals to whom they are providing services, but amendment 638 would go further than that and could prevent them from developing advocacy services at all.

We also have concerns that amendment 638 might bar individuals who work for voluntary organisations from acting as independent advocates in their own time, even with a different client group.

Although we are unable to accept amendment 638, we do not want anyone to be in any doubt that we are not seeking to water down in any way what we have said in our guidance to commissioners about what is and is not independent advocacy. I am happy to undertake that we will discuss the matter further with

advocacy interests to see whether we can deal with any outstanding concerns, either by an amendment at stage 3 or by making the issue clear in the code of practice. I hope that John McAllion will feel able not to press amendment 638.

I move amendment 726.

Mr McAllion: Amendment 638 would fill a gap in the bill by adding at the end of section 182(5):

"nor persons providing health or community care services on behalf of the Health Board or local authority".

Amendment 726 recognises the need to spell out exactly who should not be permitted to provide an advocacy service because of their involvement in providing some other service to the user. However, it does not state that individuals or organisations who provide direct services in any particular health or local authority area cannot also provide independent advocacy. That applies as much to voluntary and private sector providers as it does to statutory providers.

For example, the carers movement, which understands the conflicts of interest involved, says that a person's carer cannot be their independent advocate. I hear what the minister says about services such as meals on wheels and translation, but at the core of the argument is the fact that bodies that provide such services are not providing core care to people with a mental disorder. They provide the kind of care that is available to everybody and there is no real conflict. We are concerned about the people who provide support—through the private or voluntary sectors—to those with mental disorders and who may also be independent advocates under the current terms of the bill.

If the minister is giving a commitment that she will discuss the matter with independent advocacy organisations before stage 3, I am prepared not to move amendment 638, but I give notice that, if she does not do much about it, we will lodge the amendment again at stage 3.

Mrs Mulligan: I hear what John McAllion says.

The Deputy Convener: You take on board his threat.

Mr McAllion: His advice.

Amendment 726 agreed to.

Amendment 638 not moved.

The Deputy Convener: Amendment 727 is in a group on its own.

Mrs Mulligan: Amendment 727 rectifies an omission from the bill as introduced. It adds a duty on the State Hospitals Board for Scotland to make provision for its patients to access independent advocacy services. The amendment also requires the State Hospitals Board for Scotland to collaborate with each relevant local authority and health board to make provision for independent advocacy services to persons with mental disorder.

I move amendment 727.

Amendment 727 agreed to.

Section 182, as amended, agreed to.

Section 183—Access to medical practitioner

11:30

The Deputy Convener: Amendment 639 is grouped with amendments 640 to 649, 728 and 650 to 652. If amendment 649 is agreed to, I cannot call amendment 728 because it will be pre-empted.

Mrs Mulligan: Section 183 gives doctors who are advising a patient or the patient's named person in relation to an appeal against compulsory powers the right to examine the patient and the patient's medical records. The Executive amendments in the group will make various drafting improvements and extend the right of access to cover the records of patients who are not detained.

Amendments 639 to 641 are technical amendments that will improve the clarity of the phrasing. Amendments 642 and 644 are required to ensure that the named person can obtain advice and information on the patient through the medical practitioner in the same way that the patient might do so. Amendment 643 will clarify that the reference to applications by a patient means applications to the tribunal. Amendments 645 and 646 will rectify an omission in the bill by providing that the duly authorised medical practitioner may provide information to

"the patient, or, as the case may be, the patient's named person"

for the purposes of any of the proceedings before the tribunal.

Amendment 647 will set out the definition of the term "duly authorised medical practitioner", which amendment 640 will introduce. Amendment 648 will improve the clarity of the existing phrasing to emphasise that the duly authorised medical practitioner may require any person who holds records that relate to the detention or treatment of the patient to produce such records. Amendment 649 will specify that the duly authorised medical practitioner may at any time require records of medical treatments that have been given to the patient. The amendment will clarify that the duly authorised medical practitioner may request records of the patient's full medical treatment history, including records of the medical treatment

that the patient received before his detention in hospital.

Amendment 650 is a technical amendment that will remove an unnecessary repetition. Amendment 651 will make provision for access to the records of a patient who is not detained but who is subject to a compulsory treatment order or a compulsion order. Amendment 652 is technical and will improve the structure of section 183 by grouping together in one section the subsections on access for a medical practitioner for purposes of medical examination, and grouping together in a separate section the subsections that relate to the inspection of records by a medical practitioner.

Shona Robison's amendment 728 is intended to broaden the scope of section 183(4) by removing the reference to a compulsory treatment order, which would mean that the provisions would apply to other detained patients, such as patients who are on short-term detention. I am pleased to point out that Executive amendment 649 has the same effect and I therefore hope that Shona Robison will not press the issue further.

I move amendment 639.

Shona Robison: Given that, as the minister pointed out, amendment 649 will do what amendment 728 intended, I do not need to press the matter further.

Amendment 639 agreed to.

Amendments 640 to 649 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 728 is pre-empted.

Amendments 650 and 651 moved—[Mrs Mary Mulligan]—and agreed to.

Section 183, as amended, agreed to.

Amendment 652 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: That concludes today's stage 2 business.

11:36

Meeting suspended.

11:42

On resuming—

Retail Pharmacies (Report)

The Deputy Convener: The next item, on the Office of Fair Trading report on retail pharmacies, will be taken in public, as agreed.

Mary Scanlon: Last week, on my train journey to Inverness, I sat beside a pharmacist. He had three and a half hours in which to lobby me on the issue.

The report has far-reaching implications for Scotland, and particularly for rural areas. It is important for the committee to have a view. However, first, we should seek clarity.

The report is by the Office of Fair Trading. I appreciate that the matter is reserved, although health is a devolved issue in Scotland. Before we go any further, I would like it to be clearly stated what part of the report and recommendations is reserved and what is devolved. Given the work that we have to do on the Mental Health (Scotland) Bill, I do not see any point in discussing a reserved matter.

I also seek clarification on the 90-day consultation period. I am sure that I read that views should be given before 28 February. Then I heard that the period was 90 days, which would take us beyond 31 March. How does the 90-day consultation period tie in with the purdah of the Parliament?

Finally, can we have a separate Scottish solution to the issues raised by the report? Given the implications of the report, it is important that the committee should take evidence and present a view on the report. Having said that, we must have legal clarification and I suggest that we get it as soon as possible.

The Deputy Convener: The 90 days that you are talking about is the 90-day period within which responses have to be sent to the OFT.

Mary Scanlon: That period ends on 17 April.

The Deputy Convener: The OFT is required to consult the devolved health departments and the Scottish Executive health department has come up with 28 February for the end of its consultation period.

Mary Scanlon: So pharmacists and anyone else in Scotland who has concerns must get their responses to Frank McAveety by 28 February, so that those views can be fed into the response going to Westminster by 17 April.

The Deputy Convener: Yes. It is a staged process. I have spoken to pharmacists in my

constituency. If they miss the 28 February deadline, there is nothing to prevent them from sending their concerns to the UK Health Department.

Mary Scanlon: I would be concerned if there was only one opinion from Scotland—if all the views go to the minister and only one view is sent to Westminster. I hope that the minister will present all the views. Obviously the supermarkets are in favour of the proposals and the small independent pharmacists are very much against them. I hope that the minister will submit a broad and impartial view.

11:45

The Deputy Convener: You seem to be saying that, given the amount of work that the committee has to do on the Mental Health (Scotland) Bill, we need to ask the minister what his intentions are and whether 28 February is a flexible date.

Nicola Sturgeon: I am concerned about the implications of the OFT report. I understand the time scale and the consultation process; the Scottish Executive will seek views until 28 February and they will then be fed into the 90-day consultation.

I would appreciate clarification on who takes the decision. My understanding is that although the OFT report deals with consumer issues, which are reserved, whether to change the control of entry to national health service prescribing is a health matter and therefore devolved. I am confused because if the Scottish Executive is just feeding into a UK consultation, that implies that the Executive believes that the decision has to be taken by the UK Government. I would have thought that the opposite was true. We need clarification about that.

If the decision lies with Scottish ministers and not the UK Government, we should know what the time scale is beyond the consultation period: in what time scale is the minister intending to take the decision? We need some speedy clarification from the minister so that we leave ourselves time to feed into whatever consultation is going on and try to influence the decision.

The Deputy Convener: It is difficult to extricate all the information from the OFT report. From what I have seen of it so far, the OFT has not considered the issue of dispensing NHS prescriptions. It considered the wider issues—some might even say that it considered the peripheral issues.

Mr McAllion: I, too, have been lobbied, but not on a train.

There are local pharmacies in cities, so the issue is important not just for rural areas but for the survival of many local pharmacies in towns. They, too, are concerned.

The clerk's note says that it is for Scottish ministers to determine what action, if any, should be taken regarding the statutory arrangements for control of entry to NHS lists. Does that mean that before any change could happen, a statutory instrument would have to come before the committee?

The Deputy Convener: Yes.

Mr McAllion: We cannot just let the matter slip through. We need a briefing about the full implications of such a statutory instrument so that we know what we are voting on. Would it be possible for us to block such a statutory instrument?

The Deputy Convener: Yes. Could we agree that we should ask for extra information before we decide what we are going to do? Is it agreed that we give the committee clerks two weeks in which to get a response from the Executive?

Members *indicated agreement*.

Janis Hughes (Glasgow Rutherglen) (Lab): Given that Executive responses are not always expeditious, can we emphasise in the letter the time scale and the committee's concerns?

The Deputy Convener: Yes.

I will see you all tomorrow morning at 9.30.

Meeting closed at 11:49.

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