HEALTH AND COMMUNITY CARE COMMITTEE

Wednesday 5 February 2003
(*Morning*)

Session 1

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HEALTH AND COMMUNITY CARE COMMITTEE
7th 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 1

Scottish Parliament

Health and Community Care Committee

Wednesday 5 February 2003

(*Morning*)

[THE DEPUTY CONVENER *opened the meeting at 09:32*]

Mental Health (Scotland) Bill: Stage 2

The Deputy Convener (Margaret Jamieson): Good morning. Amendment 287, in the name of Shona Robison, is in a group of its own. I ask Shona Robison to speak to and to move the amendment.

The Deputy Minister for Health and Community Care (Mrs Mary Mulligan): I would like, if I may, before we start this morning's session to make a short announcement for the committee's information.

The Deputy Convener: Okay. We make up the rules as we go along.

Mrs Mulligan: During the stage 1 debate on 11 December 2002, the Minister for Health and Community Care, Malcolm Chisholm, announced that, in response to concerns that were expressed by the committee, the Executive would undertake a comprehensive assessment of mental health services in Scotland to take account of the introduction of the bill.

This morning, the Minister for Health and Community Care outlined the review of mental health services and has written to the convener and to the president of the Convention of Scottish Local Authorities to inform them of that. The review is to be led by Dr Sandra Grant, the former chief executive of the Scottish Health Advisory Service. The intention is to examine the current provision of mental health services, the effect of the introduction of the bill and the response to that. It is hoped that the work will be complete by 31 August. The announcement was made in response to a question from committee member Bill Butler. I thought that the committee would like to know about that before we started this morning.

The Deputy Convener: Every member has been issued with a copy of the letter. We were going to discuss the matter at the end of the meeting. I thank the minister for getting that on the record.

Before section 184

Shona Robison (North-East Scotland) (SNP): Amendment 287 arose from concerns that were expressed by several mental health organisations about the large increase in the number of people being sectioned during the past few years. As members are aware, mental health organisations are concerned that there will be an increase in the number of compulsory treatment orders, in particular those that are community based.

Amendment 287 seeks to include in the bill a safeguard that would place a duty on Scottish ministers to inquire as to the reasons for any increase beyond the number of compulsory treatment orders that were expected and to report back to Parliament on that. Such a safeguard is sensible and would provide reassurance to the many organisations that have expressed concerns about the matter.

I move amendment 287.

Mrs Mulligan: Members might recall that the committee considered and rejected a similar amendment—amendment 235—on the first day of stage 2. As I said in our earlier discussion, the Executive is sympathetic to the general concerns that have been expressed; however, I must argue that amendment 287 should be rejected for reasons that are similar to those that we highlighted then.

First, I reassure the committee that the Executive will monitor the operation of the legislation in general, and the use of compulsory treatment orders in particular. We will certainly want to know about any increase or decrease in the frequency of use of hospital-based and community-based orders over time, and we will want to know whether there are any variations in practice throughout Scotland.

However, we believe that specific aspects of arrangements for monitoring the bill's operation should not be set out in legislation because the Mental Welfare Commission for Scotland will have general duties to monitor and report on the operation of the legislation. Furthermore, the Executive is planning a research programme on the operation of the legislation, of which compulsory treatment orders are likely to constitute a significant part.

The bill's new duties on notification and the improved statutory forms should make it easier to monitor how the legislation is working in practice, and the Executive and the commission will monitor the implementation of the orders in more detail than amendment 287 proposes. I hope that, with that reassurance, Shona Robison will feel able to seek to withdraw amendment 287.

Shona Robison: We were looking for more than that. Would there be a more formal way in which to feed such research into the Parliament to ensure that, for example, the Health and Community Care Committee would have some responsibility for monitoring? It would be helpful if that could be confirmed. I very much welcome the establishment of a research programme, but there should be some mechanism by which to feed its results into the Parliament, thereby addressing concerns.

Mrs Mulligan: If the committee accepts that the Executive will report back to it after a certain time, Shona Robison's suggestion would be acceptable.

Shona Robison: On that basis, I will not press the amendment.

Amendment 287, by agreement, withdrawn.

Section 184—Code of practice

The Deputy Convener: I call the minister to speak to and to move amendment 621, which is grouped with amendments 622, 623, 624 and 625.

Mrs Mulligan: Amendments 621, 622 and 623 will confirm the various stages that ministers must follow in producing a code of practice for the legislation. The bill already provides that ministers must consult such persons as they think fit—which could include the Health and Community Care Committee—and that they must lay a draft code before Parliament. The amendments will provide that, before its being brought into effect, a code of practice must be confirmed by order of ministers, which would be subject to annulment by resolution of the Scottish Parliament. As a result, Parliament would have an opportunity to vote down a code of practice that it considered to be inadequate.

The amendments also seek to provide that, once a code has been confirmed, ministers will bring it into effect on a day that they appoint. That will allow for a code to be confirmed some time before it comes into effect, which will allow time for those to whom the code will apply to become familiar with its terms.

Amendment 624 is purely technical, and will reorder the wording of section 184(4) for clarity. Amendment 625 confirms that the code will not apply to certain bodies, including any court or tribunal and the Mental Welfare Commission for Scotland. The bill as introduced stipulated that those bodies did not have to "have regard to" the code, but it suggested that they could be among the bodies to which the code of practice would give guidance. Amendment 625 confirms that the code will not give guidance to those bodies.

Together, the amendments will provide for a code of practice that is subject to appropriate parliamentary scrutiny and that applies in the right way to the right bodies.

I move amendment 621.

Amendment 621 agreed to.

Amendments 622 to 625 moved—[Mrs Mary Mulligan]—and agreed to.

Section 184, as amended, agreed to.

Section 185—Provision of information to patient

The Deputy Convener: The next amendment for debate is amendment 729, in the name of the minister, which is grouped with amendments 730, 733, 734, 739, 740 and 748. I ask the minister to move amendment 729 and to speak to all the amendments in the group.

Mrs Mulligan: Amendments 729, 730, 733, 734, 739 and 740 are technical amendments to section 185 of the bill. They will clarify that the section applies to patients in the community who are the subjects of compulsory treatment orders, interim compulsory treatment orders and compulsion orders, as well as to any patient who is detained in hospital under the bill or the Criminal Procedure (Scotland) Act 1995.

Amendment 748 will provide similar clarification in section 186 and it will correct an error in the bill as introduced. By definition, if the patient is totally unable to communicate, it is not possible for the appropriate person to assist the patient to communicate. Amendment 748 will restrict the application of section 186 to patients who have difficulty in communicating.

I move amendment 729.

Amendment 729 agreed to.

Amendment 730 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: The next amendment for debate is amendment 731, in the name of the minister, which is grouped with amendments 735, 736, 741, 742, 743, 744, 745 and 746. I ask the minister to move amendment 731 and to speak to all the amendments in the group.

Mrs Mulligan: Amendments 731 and 745 will clarify the steps that the appropriate person must take under section 185 of the bill. Amendment 731 specifies that the information that is given to a patient must be

"appropriate to the patient's needs"

and—separately, if necessary—"in permanent form".

Amendment 745 will remove advocacy services from the list of relevant matters at section 185(6) of the bill, because those are covered separately and more thoroughly by amendment 731. Section 185 is intended to cover the provision of

information to patients after the patient is detained or made subject to a compulsory order.

Amendment 735 will remove section 185(4)(b), which refers to the provision of information before an application is made to the tribunal. That point is already covered in earlier provisions of the bill.

Amendment 736 will provide for regulations to prescribe other times at which the patient must be provided with information in accordance with this section, and amendment 741 will provide that the patient must be informed of all the powers that the patient's responsible medical officer and the tribunal have in relation to the compulsory measures to which the patient is subject. Amendment 746 is a technical amendment that is consequential on amendment 741.

Amendments 742, 743 and 744 will clarify the duties of the Mental Welfare Commission for Scotland. Amendments 742 and 743 will remove the commission from the list of bodies to which the patient has the right to make an application or appeal. The commission has a discretionary power to investigate individual cases on its own initiative, but it is not under a duty to act in response to contact by a patient. Amendment 744 will require that the patient be informed of the functions that the commission has in relation to the patient. Some of those functions apply whether or not the patient is subject to any form of compulsion.

I move amendment 731.

Amendment 731 agreed to.

09:45

The Deputy Convener: Amendment 732, in the name of the minister, is grouped with amendments 737, 738, 751 and 752. I ask the minister to move amendment 732 and to speak to all the amendments in the group.

Mrs Mulligan: As drafted, section 185 would place on the mental health officer the duty to provide information to the patient, except in the case of emergency detention. Section 186 will in all cases place on the mental health officer the duty to provide assistance to patients with communication difficulties. The amendments in the group provide that, for both sections 185 and 186, the duty will fall on the mental health officer when the patient is in the community, and on the managers of the hospital when the patient is detained in hospital.

I move amendment 732.

Amendment 732 agreed to.

Amendments 733 to 746 moved—[Mrs Mary Mulligan]—and agreed to.

Section 185, as amended, agreed to.

The Deputy Convener: Amendment 747, in the name of the minister, is grouped with amendment 753. I ask the minister to move amendment 747 and to speak to both amendments in the group.

Mrs Mulligan: Amendments 747 and 753 are technical amendments that move sections 185 and 186 into part 14, in view of the increased scope of those provisions now applying to the Criminal Procedure (Scotland) Act 1995.

I move amendment 747.

Amendment 747 agreed to.

After section 185

The Deputy Convener: Amendment 168, in the name of Adam Ingram, is in a group of its own. Does anyone wish to move the amendment in Adam Ingram's absence?

Nicola Sturgeon (Glasgow) (SNP): Adam Ingram has asked me to move the amendment. The purpose of amendment 168 is to extend the right to information to those who are receiving treatment, but who are not under compulsion. The amendment is motivated by feedback from service users who have had treatment both as voluntary patients and under compulsory measures. Many of those people report that they have felt better informed about their rights when they have been treated as detained patients than when they have received treatment as voluntary patients.

The view is that people who are capable of understanding their illness and their treatment should be involved in deciding the treatment options and in the ultimate choice of care, and that voluntary patients should have a right to receive both verbal and written explanations of their care packages, including treatment options. That is the thinking behind the amendment, and I would be interested to hear the minister's views.

I move amendment 168.

Mrs Mulligan: We agree that it is extremely important that doctors communicate effectively with patients and that they ensure that patients have a full understanding of the consequences of treatment. However, we believe that amendment 168 is too broad in scope and cuts across existing professional and legal obligations on doctors. It would apply to any treatment for mental disorder given by any doctor to any patient in hospital or in the community. For example, a general practitioner renewing a prescription for anti-depressants would need to comply with all the provisions in the amendment.

Doctors already have legal and professional obligations to ensure that patients properly understand and consent to their treatments, and guidance from the General Medical Council sets out clear requirements. That guidance applies to

people with mental disorders just as it does to other patients.

If we add a new set of duties in the bill, we will create a legal minefield. It will not be clear whether the duties replace or add to existing professional and legal obligations and it will not be clear what should happen if they conflict.

Of course, there might be cases in which individual doctors do not live up to current standards, but that problem is not confined purely to mental health. If doctors are not complying with their existing duties, the answer is not to create a new duty but to ensure that proper action is taken to enforce the existing duties.

I hope, therefore, that Nicola Sturgeon will feel able to seek to withdraw amendment 168.

Nicola Sturgeon: I appreciate what the minister says. If the minister gives a commitment—similar to the one that she gave yesterday when we discussed the lack of consistency regarding the role of named persons prior to formal proceedings under the legislation—to consider finding a way, perhaps through the code of practice, to ensure that there is a consistent approach by general practitioners and other professionals, I will not press the amendment.

The Deputy Convener: I am happy to try to find out whether there is a way in which we can give that reassurance.

Dorothy-Grace Elder (Glasgow) (Ind): Can I make a comment?

The Deputy Convener: No, we have finished that part of the proceedings.

Amendment 168, by agreement, withdrawn.

Section 186—Provision of assistance to patient with communication difficulties

Amendment 748 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 749, in the name of Shona Robison, is grouped with amendment 750.

Shona Robison: Amendment 749 concerns information being given to patients whose first language is not English. The purpose of the amendment is to ensure that patients who are subject to compulsory measures and whose first language is not English receive in their own language the information that they need.

The bill makes provision for assistance to patients with communication difficulties and it requires that special arrangements be made to assist them when they are subject to a medical examination and when the doctors or the tribunal review their compulsion. However, it does not make similar arrangements for patients whose first language is not English. Amendment 129 would rectify that situation.

I move amendment 749.

Mrs Mulligan: An argument could be made that amendment 749 is not absolutely necessary because any communication difficulty relating to the language that is spoken by a patient is covered by the duty to provide assistance that is appropriate to the patient's needs. That would clearly involve consideration of the patient's language needs. However, we accept that there is room for doubt as to the extent of the duty; for example, in relation to patients who can speak some English, but who would prefer to communicate in another language. On that basis, we are happy to accept amendment 749.

I do not know whether the member intends to move amendment 750 at some point.

Shona Robison: I do not intend to do so.

The Deputy Convener: We have not reached that bit of the script.

Shona Robison: I am pleased that the minister intends to accept amendment 749, because it will ensure that there is no room for doubt about the situation relating to information being given to patients whose first language is not English.

Amendment 749 agreed to.

Amendment 750 not moved.

Amendments 751 and 752 moved—[Mrs Mary Mulligan]—and agreed to.

Section 186, as amended, agreed to.

Amendment 753 moved—[Mrs Mary Mulligan]—and agreed to.

After section 186

Amendment 94 moved—[Mrs Mary Mulligan]—and agreed to.

Section 187—Advance statements: making and withdrawal

The Deputy Convener: Amendment 754 is grouped with amendment 755.

Mrs Mulligan: Amendment 754 will remove reference to incapacity from the description in section 187(1) of when an advance statement is intended to take effect. Amendment 754 will replace the reference to incapacity with a reference to the patient's decision-making ability being "significantly impaired" as a consequence of mental disorder. Incapacity is too strong a test, and advance statements are intended to inform health professionals' decisions in a wider range of circumstances.

I move amendment 754.

Amendment 754 agreed to.

Amendment 755 moved—[Mrs Mary Mulligan]—and agreed to.

Section 187, as amended, agreed to.

Section 188—Advance statements: effect

The Deputy Convener: Amendment 756 is grouped with amendments 757 to 759, 765, 769, 774 and 776 to 779.

Mrs Mulligan: Amendments 756, 758, 759, 765, 769 and 774 will broaden the range of circumstances in which the mental health tribunal must have regard to the wishes that are specified in an advance statement. Section 188 currently applies only when the tribunal considers whether to make, or is making, a compulsory treatment order. Amendment 756 will modify section 188(1) and expand the section's scope to cover any decision that the tribunal makes. Amendments 758, 759, 765, 769 and 774 are technical amendments. They will replace references to compulsory treatment orders with references to decisions that the tribunal makes.

Amendment 757 is a technical amendment to clarify that the impairment is to the person's ability to make decisions about the way in which he or she wishes to be treated or not treated.

Amendments 776 and 777 are technical amendments to section 188(7). They provide that measures as well as treatments that are withheld in contradiction to an advance statement also come under the provisions of section 188(7).

Amendments 778 and 779 will ensure that, where a measure is authorised or not authorised in conflict with an advance statement, the reasons are recorded in writing.

I move amendment 756.

Amendment 756 agreed to.

Amendments 757 to 759 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 760 is grouped with amendments 761 to 764, 766 to 768, 770, 771, 773 and 775.

10:00

Mrs Mulligan: Amendments 760 and 763 will remove reference to "qualifying medical treatment" being defined as treatment authorised by a compulsory treatment order. Amendments 771 and 775 are technical amendments that are consequential on amendments 760 and 763.

Amendments 761 and 762 are technical amendments that will correct the drafting of section 188(3). Amendment 763 requires designated medical practitioners to have regard to the wishes specified in an advance statement before they make a decision concerning neurosurgery for mental disorder, electroconvulsive therapy and other treatments specified in regulations, in respect of patients who are incapable of consenting. Furthermore, the designated medical practitioner should have regard to those wishes in respect of drug treatments lasting more than two months and other treatments specified in regulations, where the patient is not capable of consenting or refuses to consent. Amendments 766, 768 and 770 are technical amendments that are consequential on amendment 763.

Amendment 764 will broaden the scope of the provision under section 188(5) to cover when treatment might be given, as well as when it is to be given. Amendment 767 makes provision for when the tribunal has authorised treatment in ignorance of the withdrawal of an advance statement. Section 188(7) defines the circumstances in which a conflict has arisen between an advance statement and the treatment given to a patient. Amendment 773 will correct an error in the drafting.

I move amendment 760.

Amendment 760 agreed to.

Amendments 761 to 771 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 259 is grouped with amendments 772, 780, 781 and 260. I must point out that, if amendment 259 is agreed to, I cannot call amendments 772, 780 and 781, or amendments 773 to 779 and 224, which have already been debated, as they would be pre-empted.

Mary Scanlon (Highlands and Islands) (Con): The question of advance statements was a controversial part of our proceedings at stage 1 and it gets to the heart of patients' rights in the bill. The purpose of amendments 259 and 260 is to ensure that the decision to provide treatment that conflicts with an advance statement rests with the tribunal rather than with individual professionals.

I note that the policy memorandum says:

"the validity of a statement may be questioned if it is old, if it is ambiguous, or if the person may have been mentally unwell at the time of making the statement."

In our stage 1 report, we considered circumstances in which a patient wanted to indicate a willingness to accept treatment and said that a doctor should be able to ask the tribunal to consider allowing treatment even if it contradicted the advance statement. The committee saw a role for the tribunal where there was a contradiction with the advance statement.

In considering whether to make a compulsory treatment order, a tribunal must have regard to the terms of an advance statement, provided that it complies with specified requirements. Patients subject to CTOs may be given treatment that conflicts with their advance statement, provided that the person giving the treatment has regard to the wishes in the advance statement and complies with certain requirements.

At stage 1, service users expressed disappointment about the status that the bill affords advance statements. Many users might not feel encouraged to go through the formality of making an advance statement in accordance with the requirements of section 187 if that statement can be overridden at the discretion of professionals and service users have no way of challenging those decisions.

In talking about safeguards for ECT, the minister said:

"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."—[*Official Report*, *Health and Community Care Committee*, 29 January 2003; c 3718.]

As advance statements are to play an important role, they should be given proper weight. Amendments 259 and 260 would give advance statements more weight. They would help service users to feel that their advance statements will be taken seriously and that decisions to override them will be impartial. I suggest that the authority to give treatment that conflicts with an advance statement should rest with the tribunal. The only exception would be for treatment that was required urgently.

If a patient's responsible medical officer wished to give or to direct others to give treatment that conflicted with the advance statement, amendment 260 would require that officer to apply to the tribunal for the authority to do so. Moreover, the patient, named person and others would have the opportunity to have their views heard before the decision was made. That would strike the right balance between giving advance statements significant weight and allowing the tribunal to override them in appropriate circumstances.

Much formality, including the need for witnesses, is attached to making an advance statement and a cost might be involved if a solicitor were needed. Many service users were concerned that their views would not be given proper regard, yet their views are supposed to be at the heart of the bill. The tribunals would provide an opportunity for all views to be heard.

Professor David Owens was concerned that advance statements could inhibit psychiatrists' duty of care—the committee took that concern seriously. The availability of an appeal to the tribunal would help and would protect psychiatrists in their judgments about care for and treatment of the patient.

I move amendment 259.

Mrs Mulligan: The committee paid great attention—rightly—to advance statements at stage 1 and heard evidence both from people who felt that they should have greater legal force than the bill provides for and from people who had profound reservations about legislating for advance statements. The committee concluded that the bill struck the appropriate balance. Members will not be surprised to hear that the Executive agreed with that conclusion, which is why we cannot support Mary Scanlon's amendments 259 and 260.

We want tribunals to consider advance statements and we want doctors to take them seriously. We will add provisions that will strengthen advance statements by ensuring that the commission can oversee the actions of doctors who do not comply with advance statements and by providing that second-opinion doctors also take account of such statements. However, going further than that would cause serious problems in principle and in practice.

Amendments 259 and 260 would require any doctor who felt it necessary to treat a patient in a way that was inconsistent with an advance statement to seek the tribunal's approval. The tribunal would have to allow the interested parties the opportunity to give evidence before deciding whether to authorise the treatment. The amendments make no provision for emergencies, and without that, the safety of patients could be seriously compromised. Even if such a provision were added, we would be concerned that the need to approach the tribunal before giving treatment in a situation that was not urgent enough to amount to an emergency could harm patients. It would also add to the administrative burden on the tribunal service and on doctors.

We believe that the amendments cross over the proper boundary between the role of the tribunal and the roles of the responsible medical officer and the second-opinion doctor. The same issue has already been considered by the committee in relation to amendment 161, concerning whether the tribunal could rule out specific treatments.

We think that it is important to maintain the tribunal's function in determining whether compulsory measures are justified and what those measures should be. Although the tribunal will have a medical member, that member will not have examined the patient, and the tribunal does not have the RMO's clinical experience and

knowledge of the patient or the specialised expertise of a commission-appointed second-opinion doctor. We do not think, therefore, that it is right for the tribunal to decide that it is appropriate for a patient to receive compulsory medical treatment and then to restrict the discretion of the responsible clinician regarding what the treatment should be. I hope that Mary Scanlon will feel able not to press her amendments.

Executive amendment 772 is a technical amendment to section 188(7). The subsection defines the circumstances in which a conflict has arisen between an advance statement and the treatment that is given to a patient. Amendment 772 will clarify that the subsection applies to patients who have made an advance statement, not to any person.

Amendment 780 will ensure that the guardian of the person who made the advance statement and the commission are made aware of any measure that is authorised or any treatment that is given in conflict with the advance statement. We believe that ensuring that the commission is notified of any decision not to comply with an advance statement is a significant additional safeguard. It will help to ensure that a doctor who decides not to implement an advance statement has truly thought through his or her reasons for doing so and will allow the commission to monitor practice.

I am pleased to say that Executive amendment 780 will do what Shona Robison's amendment 781 seeks to do. It will add the commission to the list of people to be notified of a decision not to comply with an advance statement. I hope, therefore, that Shona Robison will feel able not to move her amendment.

Shona Robison: My amendment 781 will be pre-empted by Executive amendment 780. I will not, therefore, move amendment 781.

Mary Scanlon: This has always been a difficult issue, even at stage 1 when Professor Owens gave evidence and spoke about his duty of care to the patient. I was also moved by the evidence that we heard from people such as Marcia Reid, who stressed that voices such as hers should be heard through advance statements. I am very much in favour of advance statements, so it worries me that they can be overturned so easily. It worries me that the patients' rights are not going to be taken into account.

I ask the minister for two points of clarification. First, in section 188(3), what does "have regard to" mean? Does it mean that the person giving the treatment can look at an advance statement and then throw it in the bin? What is the weight of an advance statement?

Secondly, the policy memorandum tells us that

"the validity of a statement may be questioned if it is old"—

how old? It may also be questioned "if it is ambiguous"—that is not very helpful—or

"if the person may have been mentally unwell at the time of making the statement."

Most people who would write an advance statement are those who would tend to use the service fairly regularly. They would write the advance statement when they were feeling quite well, relative to feeling extremely unwell. They might still be on medication, perhaps anti-depressants. Would that mean that their advance statement meant nothing?

I am very much in favour of advance statements. I want patients to be encouraged to use them and to feel that they have some security in using them and that their wishes will be heard. I am not sure that I have been assured of that by what the minister has said.

The Deputy Convener: I shall deviate from normal procedure. As Mary Scanlon has asked for clarification from the minister, I will allow the minister to respond.

10:15

Mrs Mulligan: Thank you, convener. The phrase "have regard to" would mean giving the advance statement serious consideration. The phrase is already used in legislation and means something to those who would have to interpret it.

I will respond briefly to the other points that were raised. In developing an advance statement, a person would be given assistance to ensure that they were quite clear about the meaning of the statement. The advance statement will be taken seriously.

Another safeguard is that anyone who deviated from the advance statement would have to report back to the commission. That would make people think clearly before they deviated from the statement about whether the move that they were making was the right one. That kind of follow-on is provided for and it adds additional safeguards for the patient in ensuring that the advance statement is taken seriously.

However, there may be times when, in order to benefit the patient, a deviation needs to be made from the statement. We must allow the flexibility for that to happen. I appreciate the difficulties that Mary Scanlon is having. The question is one of balance, but I think that the committee was right when it said at stage 1 that the balance was about right.

The Deputy Convener: The question is, that amendment 259 be agreed to. Are we agreed?

Members: No.

The Deputy Convener: There will be a division.

FOR

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

AGAINST

Butler, Bill (Glasgow Anniesland) (Lab)
Hughes, Janis (Glasgow Rutherglen) (Lab)
Jamieson, Margaret (Kilmarnock and Loudoun) (Lab)
Jenkins, Ian (Tweeddale, Ettrick and Lauderdale) (LD)

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

We have a tied vote. I have the casting vote and I will use it to vote against amendment 259.

Amendment 259 disagreed to.

Amendments 772 to 779 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 224, in the name of Adam Ingram, was debated with amendment 149. Does anyone want to move amendment 224?

Nicola Sturgeon: Not unless the minister said that she would accept it.

Amendment 224 not moved.

Amendment 780 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 781 not moved.

Section 188, as amended, agreed to.

The Deputy Convener: We will now take a short break. I hope that we will be able to get some more heating into the room. I am advised that the boilers have gone kaput. We will have to get alternative heating. A short suspension will give us the opportunity to warm up and allow time for more heating to be provided.

10:18

Meeting suspended.

10:29

On resuming—

After section 188

Amendment 260 not moved.

Section 189—Education of persons who have mental disorder

The Deputy Convener: Amendment 782, in the name of the minister, is in a group on its own.

Mrs Mulligan: Section 14(1) of the Education (Scotland) Act 1980 places a duty on local authorities to make special arrangements for pupils who, because of their ill health, cannot reasonably attend school. Section 189(2) of the bill as drafted amends that section to include within its coverage those pupils who cannot reasonably attend school because they are subject to a CTO. Amendment 782 will further broaden the provision of section 14(1) of the 1980 act, by including within its coverage pupils whose inability to attend school stems from any measure authorised by the bill, or, where it relates to the pupil's mental disorder, by the Criminal Procedure (Scotland) Act 1995. This amendment will therefore ensure that the full range of situations that might need to be covered is covered.

I move amendment 782.

Amendment 782 agreed to.

Section 189, as amended, agreed to.

Section 190—Duty to mitigate adverse effect of compulsory measures on parental relations

The Deputy Convener: Amendment 783, in the name of the minister, is grouped with amendments 784 to 788.

Mrs Mulligan: Section 190 as drafted places a duty on local authorities and health boards to take practicable and appropriate steps to mitigate the adverse effects on parental relations of measures authorised by a CTO to which a parent or child is subject and for which the local authority or health board is responsible. However, it is not just measures authorised by a CTO that could have an adverse effect on parental relations. It could be any measure authorised under any section of the act, or under the Criminal Procedure (Scotland) Act 1995, in so far as it relates to mental disorder.

Amendments 783 and 784 will therefore extend the scope of section 190(1) to include children and parents who are subject to any measures authorised under any section of this act, or as far as mental disorder is concerned, under the Criminal Procedure (Scotland) Act 1995.

Furthermore, it is not just a local authority or health board that might be able to mitigate the adverse effects of these measures. It could be any person who has functions under the act that include responsibility for the administration of the measures. Amendment 785 will therefore extend the scope of section 190(2) so that the duty to take mitigating steps applies to this wider group. Amendment 786 is simply a drafting amendment.

Section 190 as drafted also provides that, in making any decision in pursuance of this section, the local authority or health board should as far as is practicable ascertain the views of the child, parent and certain others, and take account of those views and certain other factors. However, those provisions are now rendered unnecessary by the generally applying provisions on

consultation and respect for diversity that were inserted into part 1 by amendments 105 and 106. Subsections 3 and 4 of section 190 are therefore unnecessary and potentially confusing, and should be deleted. That will be the effect of amendment 787.

Finally, amendment 788 is secondary to amendment 787; since the term parental rights no longer appears in the section, it does not need to be defined in section 190(5).

The amendments will ensure that all situations that should be covered are covered, and that the provisions are consistent with other parts of the bill.

I move amendment 783.

Amendment 783 agreed to.

Amendments 784 to 788 moved—[Mrs Mary Mulligan]—and agreed to.

Section 190, as amended, agreed to.

Section 191—Information for research

The Deputy Convener: Amendment 626, in the name of the minister, is in a group on its own.

Mrs Mulligan: Section 191(9)(a) defines what information should be considered "relevant" for the purposes of the section. As it stands, section 191(9)(a) defines as "relevant" any information relating to the operation of the act or to anything that is, or might have been but was not, done under the act by persons having functions under it. Section 191(9)(a) also confirms that that includes information relating to the equal treatment of persons under the act.

On reflection, however, we consider that the definition is much more complex than is required and that it can be simplified. We consider that the phrase "operation of the Act" is broad enough to include anything that is, or that might have been but was not, done under the act. We also consider that the phrase is broad enough to include information relating to equal treatment. Amendment 626 will remove those additional, unnecessary and potentially confusing provisions. I move amendment 626.

Amendment 626 agreed to.

Section 191, as amended, agreed to.

Section 192 agreed to.

Section 193—Correspondence of certain persons detained in hospital

The Deputy Convener: Amendment 789, in the name of the minister, is grouped with amendments 790 to 793.

Mrs Mulligan: Amendment 789 will amend the references to the health service commissioner for Scotland and the commissioner for local administration in Scotland, to reflect the fact that these roles have been combined into the new post of Scottish public services ombudsman.

Amendments 792 and 793 are technical amendments that will remove the unnecessary references to the fact that it is Scottish ministers who make regulations.

Amendments 790 and 791, in the name of Shona Robison, seek to add health boards and independent advocacy services to the list of persons in section 193(5). That would mean that hospital managers could not withhold correspondence from patients to those people on the grounds that it might cause distress or danger to any person. We agree that health boards should be added to the list, and I am happy to accept amendment 790.

We are also sympathetic to the aims of amendment 791. However, we would like to consider the details further. As the amendment stands, it would prevent any interference with correspondence addressed to anyone involved in any advocacy service, even one that has nothing to do with the particular patient. Also, it is not clear that the definition is restricted to services that have been commissioned by health boards or local authorities. Without that restriction, there is a danger that we could create a loophole that might affect provisions that are designed to protect patients and the public.

There are a number of other issues concerning the drafting of sections 193 to 195, which we would like to review. They include the extent to which it is right to restrict certain powers to the state hospital, given that local forensic services will, in future, take patients who might previously have been in the state hospital. We will discuss these matters with interested parties, including the State Hospitals Board for Scotland, advocacy interests and organisations representing user interests, before lodging amendments at stage 3. I hope that those amendments will be able to give effect to the general intention behind amendment 791. On that basis, I hope that Shona Robison will move only amendment 790.

I move amendment 789.

Shona Robison: The minister has outlined the intention behind my amendments. A patient may want to make a complaint about hospital services or service provision in writing to the appropriate health board. It is quite right that they should do so, and the minister has accepted that.

On the issue of advocacy services, the relationship between the patient and the advocate will be quite a special one. I am concerned that it could be weakened considerably if staff were able to read the correspondence between them.

I am not too sure about the minister's argument about a loophole, but I am prepared, in the interests of making sure that we get the legislation right, to allow her to go away and discuss the situation further, with a proviso that she deal with the concerns with an amendment at stage 3.

Mrs Mulligan: I thank Shona Robison for her comments, which we will bear in mind.

Amendment 789 agreed to.

Amendment 790 moved—[Shona Robison]—and agreed to.

Amendment 791 not moved.

Amendments 792 and 793 moved—[Mrs Mary Mulligan]—and agreed to.

Section 193, as amended, agreed to.

Sections 194 and 195 agreed to.

Section 196—Certain persons detained in hospital: use of telephones

The Deputy Convener: Amendment 794, in the name of the minister, is grouped with amendments 795 to 797, 828 and 829.

Mrs Mulligan: Section 196 deals with the use of telephones by persons detained in hospital. Amendment 794 is purely technical: as no hospital has yet been specified in the section, "the hospital" should be "a hospital".

Section 196(1) provides a regulation-making power in relation to the use of telephones and 196(2) sets out areas that the hospital regulations might cover.

Amendment 795 will add four more areas, all relating to the oversight, monitoring and control of the use of powers granted by the regulations. They provide that the commission may give directions to hospital managers on any matters specified by regulations. They further provide that regulations may require hospital managers to make and keep records, to inform specified persons of specified matters and to comply with directions made by the commission on such matters. Because of the amendment, two technical amendments to section 226 are required. Because it is the regulations, rather than the legislation, that would confer on the commission the power to make directions, section 226 needs to refer to directions being made "by virtue of" the act rather than "by" or "under" the act. That will be the effect of amendments 828 and 829.

Amendment 796 is also a technical amendment. It makes explicit that it is the managers of the hospital in which the person is detained to whom the safeguards provided by section 196(4) apply.

Amendment 797 will create a new section that provides ministers with the power to make directions, with which hospital managers would have to comply when making use of their powers under regulations made under section 196. The new section will also require ministers to require of hospital managers a statement setting out specified information concerning their use of those powers.

The amendments will provide additional safeguards and controls over the use of powers that regulations may grant on the use of telephones and otherwise clarify and correct section 196.

I move amendment 794.

Amendment 794 agreed to.

Amendments 795 and 796 moved—[Mrs Mary Mulligan]—and agreed to.

Section 196, as amended, agreed to.

After section 196

Amendment 797 moved—[Mrs Mary Mulligan]—and agreed to.

Section 197—Safety and security in hospitals

The Deputy Convener: Amendment 627, in the name of the minister, is grouped with amendments 628 to 630 and 798.

10:45

Mrs Mulligan: Amendment 798 is the most significant amendment in the group. It will provide a series of safeguards and constraints on the use that hospitals make of their authority to carry out various activities relating to safety and security, where they have been granted that authority by regulations made under section 197.

The amendment will provide that the use that hospitals make of their authority to carry out such activities may be subject to directions by ministers. It will also provide that hospitals may be required by regulations to provide ministers with a statement of how they have made use, are making use, or plan to make use of the authority—in other words, a statement of their safety and security policy.

Amendment 798 will also mean that hospitals may be required to provide the Mental Welfare Commission with information on the incidence and circumstances of the use of their authority, in ways specified by regulations.

Finally, the amendment will provide that the commission may be enabled by regulations to give directions to hospitals to prohibit the use of their authority in particular ways or to place certain requirements of notification on hospitals regarding the use of their authority.

There are four further amendments in the group. Section 197(d) includes the placing of prohibitions and restrictions, in relation to visitors to the hospitals concerned, within the activities that may be authorised by regulations made under the section. Amendment 627 will provide that the definition of "visitors" for those purposes includes all persons who enter or who seek to enter a hospital, rather than just persons who visit someone who is detained in the hospital. In other words, one does not have to be visiting a patient to be a visitor.

Amendments 628 to 630 are technical amendments that are designed to simplify the wording of section 197. Because "visitors" is a defined term, there is no need for the section to refer to "those visitors" and the amendments will delete the three unnecessary instances of the word "those".

The amendments in the group provide a wide-ranging and appropriate regime for the authorisation, oversight and control of the use that may be made of the authority to carry out safety and security activities in hospitals that may be granted by regulations under section 197.

I move amendment 627.

Amendment 627 agreed to.

Amendments 628 to 630 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 798 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 261, in the name of Mary Scanlon, is in a group on its own.

Mary Scanlon: Section 197 is controversial and amendment 261 is intended to ensure that the Scottish ministers consult appropriately before they make regulations under the section. The section deals with the controversial issues of safety and security in hospitals, including searches and surveillance of detained patients, surveillance of visitors and

the taking … of body tissue, blood or other body fluid or other material".

Anyone who reads that would want to seek clarification and would voice concern. I am not sure why it would be necessary to take such action, which is why I want the minister to advise us on the intention behind the measure.

A similar consultation requirement applies to other provisions in the bill that allow regulations to be made on controversial issues such as medical treatments that require special safeguards. For example, the provisions in sections 162(3) and 165(4) are of that type. I believe that safety and security issues are sufficiently controversial to justify the same requirement on Scottish ministers to consult appropriate persons before making regulations under section 197.

I move amendment 261.

Mrs Mulligan: I am grateful to Mary Scanlon for lodging amendment 261, which we are happy to accept. I should say, however, that there is a slight technical problem, in that the amendment refers to regulations under subsection (1), while Executive amendment 798 adds two further subsections with regulation-making powers. The consultation requirement should apply to all regulations under section 197. We will lodge a technical amendment at stage 3 to resolve the matter but, in the meantime, we are happy to accept Mary Scanlon's amendment.

The Deputy Convener: Mary Scanlon is gobsmacked.

Mary Scanlon: Could I ask the minister to respond to the points of clarification that I requested?

The Deputy Convener: I think that the minister provided that clarification.

Mrs Mulligan: Could you specify which points, please Mary?

Mary Scanlon: Could you tell me what the intention is behind the provisions concerning searches and surveillance and

"the taking, from external parts of the body of … samples of body tissue, blood or other body fluid or other material"?

What is meant by that and why is that necessary?

Mrs Mulligan: I think that that relates to procedures that are used when testing for drugs and such. It may be considered necessary.

Amendment 261 agreed to.

Section 197, as amended, agreed to.

Section 198—Removal to place of safety

The Deputy Convener: Amendment 799 is grouped with amendments 653, 800, 654, 657 to 661, 803 and 662.

Mrs Mulligan: Amendment 657 will introduce a new section in new part 15A, relating to entry to premises. Under a number of the bill's provisions, a specified person may be authorised to take a specified patient to a specified place, or into custody. In doing so, it might be necessary for the authorised person to enter premises, even if they have not been given authority to do so.

The new section that will be introduced under amendment 657 gives a sheriff or justice of the peace the power to grant a warrant authorising a person who has already been given authority to take a patient to a place or into custody to enter premises where that is necessary for the purposes

for which the person has previously been authorised. Such a warrant can be granted only where the sheriff or justice of the peace is satisfied that the person cannot obtain—or reasonably expects that they will not be able to obtain—entry to those premises.

Amendment 658 will introduce a new section relating to removal to a place of safety and, in doing so, will give effect to one of the recommendations of the Scottish Law Commission in its report on vulnerable adults.

If a sheriff is satisfied that a person over the age of 16 has a mental disorder, is vulnerable in one of a number of specified ways and is likely to suffer significant harm if not removed to a place of safety, then, on the application of a mental health officer, the sheriff may grant an order authorising the removal of the person to a specified place of safety and the detention of that person in that place for a specified period, which cannot be more than seven days. The circumstances in which a person would be considered vulnerable match those that can be grounds for a local authority's duty to inquire.

Section 198 also provides that, before determining an application for a removal order, the sheriff must give the person who is the subject of the application, and such other persons as may be prescribed by regulations, the opportunity to make representations or to lead or produce evidence. That requirement may be dispensed with where the resultant delay would be likely to be prejudicial to the person concerned.

Amendment 659 will introduce another new section. It provides that, where it is impracticable for an application for a removal order to be made to a sheriff, and where any delay in obtaining an order is likely to be prejudicial to the person concerned, the application may instead be made to a justice of the peace.

Amendment 660 seeks to introduce a new section that relates to the recall or variation of a removal order. A person who is subject to a removal order, or anyone who claims an interest in that person's welfare, may apply for a further order that recalls the removal order or that varies it by specifying a different place of safety and by authorising the removal of the person to that place of safety and their detention there for the remainder of the period originally specified. If a person is to be moved to a different place of safety, that must happen within 72 hours of the variation order being granted.

Amendment 661 seeks to introduce a new section that confirms that no appeal will be possible against a decision of a sheriff or justice of the peace under the sections that I have just described.

Amendments 653 and 654 seek to move sections 198 and 199 into new part 15A, so that all such powers of entry, removal and detention will appear in the same part of the bill.

Amendments 799, 800 and 803, which deal with the definition of a place of safety, are consequential on the creation of new part 15A.

Amendments 799 and 803 together will remove the definition of a place of safety from section 198 and will place it in a new section after section 202 in new part 15A. That reflects the fact that the definition is relevant to a number of new sections in the new part. Amendment 800 is secondary to amendments 799 and 803, in that it will remove the now unnecessary provision that "place of safety" means the same in section 199 as it does in section 198.

Amendment 662 seeks to remove from section 205 provision for a constable to apply for a warrant to enter premises and open lockfast places on those premises for the purposes of returning a patient who has absconded. Amendment 657, which will introduce a new section that makes more general provision for warrants to enter premises for the purposes of taking a patient, means that that provision is no longer necessary.

I move amendment 799.

Amendment 799 agreed to.

Section 198, as amended, agreed to.

Amendment 653 moved—[Mrs Mary Mulligan]—and agreed to.

Section 199—Removal to place of safety: further provision

Amendment 800 moved—[Mrs Mary Mulligan]—and agreed to.

Section 199, as amended, agreed to.

Amendment 654 moved—[Mrs Mary Mulligan]—and agreed to.

Section 200—Nurse's power to detain pending medical examination

The Deputy Convener: Amendment 632 is grouped with amendment 655.

Mrs Mulligan: Amendments 632 and 655 deal with section 200, which is about detention pending medical examination. Such detention is sometimes known as the nurse's holding power.

Amendment 632 will provide that a person who is in hospital because of a probation order that has a condition of treatment can be subject to the nurse's holding power. That is because a condition of probation does not amount to detention.

Amendment 655 will move section 200 into new part 15A, alongside other similar powers.

I move amendment 632.

Amendment 632 agreed to.

The Deputy Convener: Amendment 801 is in a group on its own.

Shona Robison: Amendment 801 concerns the duties of nurses who exercise the holding power and would ensure that a nurse who prevented a patient from leaving hospital would have to explain to the patient why that was being done.

The bill provides that, if a patient wishes to leave hospital against medical advice and a nurse believes that the patient is at risk, the nurse can prevent him or her from leaving. The nurse can arrange for a doctor to examine the patient and to decide whether emergency or short-term detention is necessary. In accordance with the principle of ensuring that patients are given adequate information, amendment 801 would simply require the nurse to explain to the patient what he or she was doing and the legal authority for the action that was being taken.

I move amendment 801.

11:00

Mrs Mulligan: We are sympathetic to the aims of amendment 801, which has been lodged by Shona Robison, but we feel that the issue might more appropriately be dealt with in the code of practice.

The nurse's holding power is used only in an emergency situation, when an informal patient is seeking to leave the hospital and the nurse believes that the patient must be immediately restrained. The power lasts for a maximum of three hours only, including the time taken for a doctor to complete a medical examination.

In such a fraught situation, it might be difficult for the nurse to communicate anything to a distressed patient, so we are hesitant about placing too heavy a legal burden on individual nurses. We accept that amendment 801 seeks to express the duty in terms of taking "reasonable steps", but nevertheless we think that the primary responsibility of the nurse in such a situation is to ensure the safety of the patient and of other patients. Although it is important to explain as much as possible to the patient, such explanation may need to be a secondary consideration in what is in effect an emergency.

The code of practice will give details of the responsibilities of nurses when they exercise that power. I am happy to give an undertaking that that will include guidance on the importance of attempting to communicate with the patient about what is happening and why. On that basis, I hope that Shona Robison will feel able to withdraw amendment 801.

Shona Robison: So long as that guidance is in the code of practice, I am happy to withdraw amendment 801. Obviously, the patient must be given the information at the most appropriate time, and I appreciate that that might not be possible when, for example, the person is in a heightened state of anxiety. If the guidance is to stipulate that, at the earliest possible opportunity, a full explanation should be given to the person about what has happened to them, why it has happened and what their rights are, I am happy to withdraw the amendment.

Amendment 801, by agreement, withdrawn.

Section 200, as amended, agreed to.

Amendment 655 moved—[Mrs Mary Mulligan]—and agreed to.

After section 200

The Deputy Convener: Amendment 656 is in a group on its own.

Mrs Mulligan: Amendment 656 is necessary to remedy an omission in the bill as introduced. The amendment will introduce a section to implement the policy that the Scottish ministers should be able to make payments to persons in hospital in respect of occasional personal expenses. Provided that the person meets certain basic criteria, the power is totally discretionary. The amendment will more or less re-enact the provisions of section 114 of the Mental Health (Scotland) Act 1984.

I move amendment 656.

Amendment 656 agreed to.

Section 201—Cross-border transfer of patients

The Deputy Convener: Amendment 802 is in a group on its own.

Shona Robison: Amendment 802 is concerned with the removal from Scotland of patients who are not resident in Scotland or the United Kingdom. The amendment would ensure that a person would not be removed from Scotland under the provisions of the bill unless that removal was in his or her interests.

The bill provides that ministers may make regulations that authorise the removal both of patients subject to compulsory measures and of informal patients to a place outside the UK, but the detailed provisions are to be left to regulations. However, the Law Society of Scotland and the Mental Welfare Commission have pointed out that the bill should state clearly that removal under its provisions should be authorised only if that would be in the patient's interests. That provision appears in the corresponding measure in the 1984 act.

As other legislation permits the removal of a person in the national interest rather than in the interests of the person, there should be no concerns on that issue. Amendment 802 would not detract from existing powers but would simply provide that the bill should not be used to remove a person who is receiving treatment for a mental disorder unless that would be in his or her interests.

I move amendment 802.

Mrs Mulligan: We are not able to support amendment 802, although we fully understand the wish to protect the interests of patients with a mental disorder who might be moved outwith the UK. There are some technical problems with the amendment. It refers to the managers of a hospital; however, it is theoretically possible that a person with a mental disorder who is in this country and who needs to be returned home might not be in hospital. The responsibility to satisfy any duty as to the person's welfare might more appropriately be placed with ministers than with local hospital managers.

Section 83 of the 1984 act places relevant duties on ministers. Given the legal and technical complexities involved, rather than spell out in detail the arrangements for cross-border transfers, section 201 provides for regulations, which will detail how patients' interests will be protected.

Before proceeding with those regulations, we will consider how best to accommodate the concerns that underlie amendment 802. Section 225 provides that the regulations must be made by affirmative procedure. The committee will have an opportunity to scrutinise the detail before the regulations are passed. On that basis, I hope that Shona Robison will be prepared to withdraw amendment 802.

Shona Robison: As the regulations will deal with patients' interests and, importantly, the committee will have a chance to consider them, I am happy not to press my amendment.

Amendment 802, by agreement, withdrawn.

Section 201 agreed to.

Section 202—Application to Tribunal in relation to unlawful detention

The Deputy Convener: Amendment 633 is grouped with amendments 634 and 635.

Mrs Mulligan: Amendments 633 to 635 relate to section will widen the range of people who may apply to the tribunal with regard to a particular patient. The provision would include anyone who is a named person with respect to the patient, whether or not they have been formally nominated as such under section 177. If the patient were a child, the provision would also include anyone with parental responsibilities for that patient.

Amendment 635 seeks to provide that the expressions "child" and "parental responsibilities" introduced by amendment 635 have the same meanings as in the Children (Scotland) Act 1995, ensuring consistency between the two acts.

I move amendment 633.

Amendment 633 agreed to.

Amendments 634 and 635 moved—[Mrs Mary Mulligan]—and agreed to.

Section 202, as amended, agreed to.

After section 202

Amendments 657 to 661 and 803 moved—[Mrs Mary Mulligan]—and agreed to.

The Deputy Convener: Amendment 804 is grouped with amendment 805.

Shona Robison: Amendments 804 and 805 are two of the most important that the committee will deal with. Their purpose is to make provision—as recommended in the Millan committee report—for a right of appeal against detention in conditions of excessive security. The Millan committee's review of the Mental Health (Scotland) Act 1984 noted with concern the position of patients who are detained under levels of security in excess of those required. The Millan report stated that the detention of a patient in such conditions is inconsistent with a patient's rights and with the general principle of least restriction.

The amendments are directed largely at addressing the situation of patients who become entrapped at the state hospital. Some patients no longer meet the criteria for admission to the state hospital but cannot be transferred as a result of the inadequate provision of medium-secure and other psychiatric facilities and services in Scotland. Some of those patients are detained under civil procedures, while others have been sent to hospital by a criminal court.

I accept that patients and others can apply to the tribunal to have a compulsory treatment order varied, but the relevant provisions lack a clear indication of the tribunal's powers if it is established that a patient is contained in conditions of excessive security. In addition, the importance of the issue from a human rights perspective would be better expressed in a direct right of appeal.

The Mental Welfare Commission's best estimate is that, at any time over the past few years, about 30 patients could be considered to be entrapped. The committee heard from one such patient, Darren Crichton, whose parents petitioned the Parliament and who was in Carstairs for two and a half years longer than required.

In its stage 1 report, the committee described the entrapment of patients in the state hospital:

"In the Committee's view it is scandalous that patients have been, and are continuing to be, entrapped in the State Hospital, when carers and staff are agreed that a high security setting is not only unnecessary and inappropriate but may be inhibiting the patient's chance of recovery. We strongly believe that all patients should be able to appeal against the level of security at which they are detained.

The Committee agrees with the recommendation of the Justice 1 Committee that the Bill should provide for an appeal against excessive security."

The committee's view at stage 1 could not be clearer.

Amendment 804 has widespread support in the mental health community. Let me indicate how widespread that support is. In addition to the support of the Health and Community Care Committee and the Justice 1 Committee for the idea at stage 1, the amendment has the support of the Mental Welfare Commission, the Law Society of Scotland, the National Schizophrenia Fellowship (Scotland), the Royal College of Psychiatrists, the Advocacy Safeguards Agency, the patients advocacy service at the state hospital, the Scottish Association for Mental Health and the other 63 signatories to the let's get it right campaign. The amendment has the support of everyone who gave evidence on the bill and I hope that the minister will accept it.

I move amendment 804.

The Deputy Convener: Before I call other members, I will add to what Shona Robison said. Throughout its evidence taking, the committee was concerned about the excessive security in which some individuals were being held in the state hospital at Carstairs. I am concerned that, although the bill talks about using the least restrictive measures, that does not appear to apply to the matter in question.

We might want to raise the situation with the Procedures Committee, as we are unable to examine amendment 804 to ensure that it complies with human rights legislation because we were not allowed time to do so. However, I believe that, through amendment 804, Shona Robison is supporting the human rights of individuals who are entrapped at Carstairs and I am grateful to her for lodging the amendment.

Bill Butler (Glasgow Anniesland) (Lab): I am interested, as I am sure we all are, in what the minister has to say about the Executive's position on amendments 804 and 805. We have before us amendments that are detailed, coherent and entirely fitting. What the committee said in its stage 1 report was powerful and correct, and the amendments would provide what all of us would expect to receive: natural justice and an essential human right—the right of appeal. People should not be trapped in an inappropriate level of security.

I hope that the Executive will look on amendments 804 and 805 favourably. Unless it does so, we will perpetuate cruel and unusual treatment, which would make the bill entirely unacceptable for 21st century Scotland.

11:15

Nicola Sturgeon: The case for amendments 804 and 805 is overwhelming and has been made convincingly throughout the progress of the bill. Entrapping someone in the state hospital without a right of appeal is a gross breach of human rights. It also makes a mockery of the principle of using the least restrictive option, on which the bill is supposed to be based.

I want to emphasise the sheer weight of evidence and support that is behind the amendments. The Millan report recommended the introduction of a right of appeal against excessive security. The Health and Community Care Committee received evidence on that issue, even when we did not ask explicitly for such evidence. As a result, in its stage 1 report the committee recommended unanimously that patients subject to compulsory treatment should be given a right of appeal against being held in conditions of excessive security. That was one of the committee's 15 key recommendations.

The Health and Community Care Committee was not the only committee to make such a recommendation. The Justice 1 Committee, which considered the bill as a secondary committee, made the same recommendation very forcefully. Shona Robison has already noted that, but it is worth making the point explicitly. As she said, there is huge support among mental health professionals and organisations for the right that the amendments would provide.

I hope that the Executive will listen to what is being said, not just by the committee and one or two organisations, but by virtually every individual and organisation that has an opinion on the bill. If the Executive ignores their views, it will fail to respect the democratic legislative process.

Ian Jenkins (Tweeddale, Ettrick and Lauderdale) (LD): I will not take up much of the committee's time. I am here as a substitute for the convener, Margaret Smith and I am sure that she would want the committee's views on the matter to be taken strongly into consideration. We are dealing with humanitarian issues and issues of natural justice. At today's meeting, the minister and the committee have interacted superbly: people have been willing to accept assurances and to be flexible. I hope that the minister and the Executive are able to be flexible in this case.

Mary Scanlon: I support my colleagues fully and congratulate Shona Robison on lodging amendment 804. However, the right of appeal against conditions of excessive security will be of

no benefit unless medium-secure units are in place.

The latest figures that I have received from Carstairs show that 29 people are, in effect, bed-blocking. Their discharge has been delayed because of a lack of medium-secure units. We found the same problem when we visited the Orchard clinic, where people were held in conditions of excessive security because of a lack of provision in the community.

The letter that we have received from Malcolm Chisholm states that Sandra Grant will carry out

"a comprehensive assessment of existing mental health service provision"

to

"meet the objectives of the Mental Health (Scotland) Bill."

Sandra Grant is to respond to the Executive by August, but the bill is to be implemented by April next year.

I fully support amendment 804, but the required provision of mental health services is lacking. How can we amend the bill when we know that the services that are required to care and treat people are not in place? What is the minister doing to address that issue?

Janis Hughes (Glasgow Rutherglen) (Lab): I support the views that my colleagues have expressed. Anyone who has an interest in mental health issues or who suffers from mental health problems will be particularly interested in this part of the bill. I welcome amendments 804 and 805 and await with interest the minister's comments.

When the committee visited Carstairs—we also visited the only medium-secure unit in Scotland—what really made an impression on me were the differences between the levels of security. Our visit emphasised what we mean by entrapment, and what it means to the people who are subjected to it.

I have a constituency interest in the matter and I really feel that if we want to make a difference, amendments 804 and 805 would provide the appropriate means to do that. We need to ensure that the strong views that the committee expressed at stage 1, and which were expressed by other organisations that have been mentioned, are represented. Amendments 804 and 805 should be supported.

Dorothy-Grace Elder: I support fully the views of all my colleagues. I draw the minister's attention to the fact that patients in Carstairs, in particular those who could be in much more suitable local environments, are increasingly being cut off from their families. They are, in effect, lost people because of the location of Carstairs. It takes the most dedicated family member to make what can be a long trip although, to their great credit, some do. In summary, patients in Carstairs are being cut off from their families and from society.

Public safety is very important. Many of us might originally have approached the issue without knowing much about it and from the viewpoint of protecting the public. We discovered that the type of patient who was being entrapped was the harmless patient or the patient who had been cured—somebody who needed to be eased back into the community. I ask the minister to give serious consideration to the amendments, given the strong united front that is being presented by committee members and, indeed, many others.

Mrs Mulligan: We are debating a very important area of the bill, so I hope that members will bear with me, because I have quite a detailed response to make. If I miss anybody's particular points, I am sure that members will come back to me.

I am grateful to Shona Robison for lodging amendments 804 and 805. The issue of entrapped patients has greatly concerned the committee and many of those who gave evidence at stage 1; we share that concern fully. It is not acceptable for people to remain in high security conditions for long periods if they are well enough to be moved to less secure surroundings.

As the committee knows, we were not initially persuaded that an appeal right was the way forward. If the problem was the lack of appropriate local facilities, it seemed that it would be necessary to develop local facilities. An appeal right is meaningless if there truly is nowhere else that can accommodate the patient. We also felt that a separate appeal right might not be necessary because the bill already allows the tribunal the opportunity to consider the level of security that is provided. The tribunal must consider a care plan before making or renewing a compulsory treatment order. We have added to the bill provisions that will allow the tribunal to make an interim order so that it can explore any concerns that it has about the care plan, including the level of security. The bill already makes it possible for the patient or the named person to apply to the tribunal to ask it to move him from the hospital in which he is detained under a compulsory treatment order.

We have listened carefully to what has been said by the committee during the meeting, by members individually and by others outside the committee who have an interest. We now accept that it would be desirable to strengthen the rights of patients under the bill by the addition of a specific right of appeal against excessive security.

We have considered carefully the terms of amendment 804, but I am afraid that we cannot accept it as it stands because a number of

practical and legal difficulties need to be resolved. For example, we want to be sure that the criteria for making a declaration that a patient is being held at a level of excessive security are workable. We need to consider how those relate to the public safety test, which was introduced under the Ruddle act—the Mental Health (Public Safety and Appeals) (Scotland) Act 1999. We also need to be sure that a patient would not be found to be detained at a level of excessive security simply because it would be theoretically possible to accommodate that patient elsewhere but at a cost that was wholly unreasonable.

There are many practical considerations: for example, we would need to be clear about the mechanism for identifying which health board was to be made responsible and we would need to think carefully about the extent of any legal duty that would be imposed. We are not sure that the time scales in the amendments would always be appropriate, nor do we think it appropriate to provide for finding health boards in contempt of court.

We also wish to consider whether an appeal right should apply only to patients at the state hospital, or more widely. The main focus of concern is on patients at the state hospital and there would be a number of difficulties in broadening that right to a wider group. Therefore, I ask the committee not to support the amendments at this stage, on the basis that it is our intention to introduce a suitable amendment at stage 3. I will be unable to give precise details of that amendment until we have worked through the legal and practical issues in consultation with health boards and other interested parties, but I reassure the committee that it is our firm intention to put into the bill a provision that will give patients in the state hospital the right to appeal against the level of security at which they are held. If the tribunal establishes that a patient is being held in conditions of excessive security, there will be a legal obligation for a specified health board to arrange for the patient to be accommodated at an appropriate level of security.

However, I must be frank with the committee and say that, as Mary Scanlon mentioned, we are not sure that such an appeal right will be workable until local forensic services are better developed. It might be, therefore, that such a right could not be brought into effect until later than the other provisions in the bill, but we are committed to the development of those services and to the introduction of the right as soon as is feasible.

I have given a commitment that we will introduce an amendment at stage 3 that will reflect the views that have been made known this morning. I appreciate each member's view on the issue and I hope that our amendment will be able to address the committee's clear desire to ensure that people are not inappropriately entrapped in the state hospital. I hope, therefore, that Shona Robison will feel able to withdraw amendment 804 and not to move amendment 805.

Shona Robison: The minister will appreciate that this is an opportunity to ensure that what we get on the record is absolutely clear, so I hope that she can give commitments on the following points. First, I know that the minister has gone some way towards this, but will she make it absolutely clear that the amendment that she will lodge to provide a right of appeal will achieve the same objectives as are sought by amendments 804 and 805? I understand that such an amendment will need to address the technical issues that she raised.

Secondly, will she give a commitment that that amendment will be lodged in plenty of time to allow committee members to consider it? We will want time to ensure that the amendment achieves the objectives of amendments 804 and 805, so that any concerns that we have can be dealt with in other amendments. The organisations that have expressed interest will all want time to have a good look at the amendment to ensure that it meets their requirements.

Thirdly, I appreciate that there is a problem with development of services, but that is why amendment 804 is so important. Given that there is a need to ensure that services are developed, I suggest that the right of appeal will be a strong lever in getting local health boards to move on the issue, so we should not have too long a delay. Another reason why we want the Executive amendment to be lodged soon is so that we can consider the delay that is proposed. Any delay beyond three years would be excessive, because we need to ensure that health boards move quickly to get such facilities established.

If the minister can give me and the rest of the committee assurances on those points, I will be happy—in the interests of compromise and of getting the right outcome for patients—not to press the amendments.

11:30

The Deputy Convener: Could you respond to that, minister? Perhaps you could consult members of the committee before such an amendment was lodged.

Mrs Mulligan: If the aim of amendments 804 and 805 is to ensure that people are not restricted to remaining in the state hospital when that is not appropriate, I can certainly guarantee that the amendment that we lodge will seek to address that issue. I think that that is what Shona Robison was looking for.

We will make every effort to lodge that amendment as early as possible, but there are

obviously other amendments that we have already said need to be lodged at stage 3 and there is a lot of pressure on those who are drafting them. I appreciate that members will want time to consider stage 3 amendments, and to discuss them with the relevant organisations and people who have asked for them, in order to ensure that any new amendment covers the areas that members wish it to cover. I am happy to agree that consultation on the amendment should take place with members of the committee.

We all recognise that developing services has been one of the difficulties that has resulted in people being kept in inappropriate places and we must make progress on that. I am sure that there are people in the health service throughout Scotland who feel that, beyond their duties, the role of an appeal will be to add weight to their development of services. We must consider the development of those services and, if necessary, we will place a time limit on that in the amendment, but we would do that in consultation with members. I am happy to do that, and I hope that that will reassure Shona Robison that the Executive's aim is to address the issue that we have been discussing.

The Deputy Convener: Could I have an assurance that you will consult the committee no later than two weeks before the stage 3 debate? Given that there is only one amendment that the committee is asking to be consulted further on, I do not think that that is an unreasonable request. It is an important issue for patients.

Mrs Mulligan: Given the importance of the issue, if that is what the committee would like, we will make every effort to do that.

The Deputy Convener: Thank you.

Shona Robison: On the basis of all that the minister has said, which will all be in black and white, I am happy to withdraw amendment 804.

Amendment 804, by agreement, withdrawn.

Amendment 805 not moved.

11:32

Meeting suspended.

11:41

On resuming—

Section 203—Absconding etc by patients subject to compulsory treatment order

The Deputy Convener: Amendment 806 is grouped with amendments 599, 807 to 811, 600 and 601.

Mrs Mulligan: Amendment 806 will remove unnecessary text from section 203(1)(a). There is no scenario in which the patient can abscond from the hospital in which he is to be detained. The patient can either abscond prior to being admitted to hospital during the removal phase, or after being admitted to hospital during the detention phase; both of those are adequately covered by existing provisions in section 203.

Amendments 599, 600 and 601 are technical amendments to section 204, which will clarify references to interim compulsory treatment orders. Amendments 807 and 808 will amend section 204(1) so that detention under section 86—following breach of an interim compulsory treatment order, covered by section 86(2B), or a compulsory treatment order, covered by section 86(2)—will also be subject to the provisions of part 16.

Amendment 809 will make the five-day extension to short-term detention under section 56 subject to the provisions of part 16. Amendments 810 and 811 are technical amendments that will ensure that section 204 covers properly all the necessary certificates, orders and powers.

I move amendment 806.

Amendment 806 agreed to.

Section 203, as amended, agreed to.

Section 204—Absconding etc by other patients

Amendment 599 moved—[Mrs Mary Mulligan]—and agreed to.

Amendments 807 to 811 moved—[Mrs Mary Mulligan]—and agreed to.

Amendments 600 and 601 moved—[Mrs Mary Mulligan]—and agreed to.

Section 204, as amended, agreed to.

Section 205—Taking into custody and return of absconding patients

The Deputy Convener: Amendment 812 is grouped with amendments 813, 832, 814, 262 and 815.

Mrs Mulligan: Amendments 812, 813, 814 and 815 are technical amendments that will clarify that only the patient's responsible medical officer—rather than any responsible medical officer—can exercise functions in relation to a patient who has absconded.

Amendment 832 seeks to tighten up the list of persons who may take into custody a patient who has absconded. In particular, it will remove the ambiguity about hospital staff who may do so: the policy intention was that a member of staff of any hospital may take such a patient into custody. Furthermore, for patients who are required to reside at a particular establishment in the

community, the amendment seeks to clarify that only staff at that particular establishment, as opposed to any similar establishment, may take the patient into custody.

11:45

Amendment 262, in the name of Mary Scanlon, seeks to modify the power to use reasonable force to take into custody and return a patient who has absconded. Currently, any of the persons who are entitled to take into custody and return a patient may use "reasonable force". The amendment would add the requirement that that may be used

"only if and for so long as it is immediately necessary".

We believe that the sentiments behind the amendment are right; however, the amendment itself is unnecessary because such limitations are contained in the definition of "reasonable". To use force when it is unnecessary or to use it for longer than is necessary is, almost by definition, unreasonable. That said, we will consider what can be usefully said in the code of practice about the circumstances in which it is necessary to use force. With that reassurance, I hope that Mary Scanlon feels able not to move amendment 262.

I move amendment 812.

Mary Scanlon: As the minister pointed out, the bill allows reasonable force to be used when taking into custody and returning absconding patients. Amendment 262 seeks to tighten up the provision by specifying that the use of reasonable force is authorised

"if and for so long as it is immediately necessary".

That proposal emanates from service users, who are a bit worried about the use of force and are concerned that the approach that is taken is more heavy-handed than is necessary. Section 205 is very important because it refers to the police. Furthermore, with the increased number of community treatment orders, such reasonable force is likely to be used in and around a patient's home and in the community. I realise that compulsion is likely to require the use of some force; however, amendment 262 simply attempts to ensure that such force is used only as necessary and

"for so long as it is … necessary".

Given the minister's assurance that she recognises service users' concerns and that she will consider addressing the issue in the code of practice, I will not move amendment 262.

Amendment 812 agreed to.

Amendments 813, 832 and 814 moved—[Mrs Mary Mulligan]—and agreed to.

Amendment 262 not moved.

Amendments 662 and 815 moved—[Mrs Mary Mulligan]—and agreed to.

Section 205, as amended, agreed to.

Section 206—Effect of unauthorised absence

The Deputy Convener: Amendment 833 is grouped with amendments 816 to 826.

Mrs Mulligan: Amendment 833 is a technical amendment that will improve the clarity of section 206. It will harmonise the reference to unauthorised absence with other such references in the bill. It will also make it clear that unauthorised absence does not affect the duration of any certificate or order made under the bill, in that the clock does not stop simply because the patient has absconded. That was always the intention of section 206.

The procedure that must be followed when a patient is returned from a period of absence without leave exceeding 28 days has been simplified, making the distinction between sections 207 and 208 unnecessary. Amendment 819 will remove section 208, which will be redundant.

Amendment 818 will modify the procedure that must be followed when a patient who has been absent without leave for more than 28 days is returned more than 14 days before the expiry of the CTO. It provides that when such a patient is returned, the RMO must carry out a first or further review, as appropriate, to authorise the continuation of the CTO beyond 14 days from the patient's return. If a patient's absence were to begin when a review under part 7, chapter 2 was already under way, any part of that review which had been carried out before the patient absconded would also be valid for the purposes of the review now required under part 16. Amendment 818 will prevent unnecessary duplication of effort.

Amendments 821 and 835 will ensure that the procedure to be followed when the patient is returned within 14 days of the expiry of the CTO, or after its expiry, reflects the new procedure at section 207. Amendments 822 and 826 will remove redundant provision from sections 209 and 210. Amendments 820 and 824 will ensure that in sections 209 and 210, the RMO is required to carry out a review of the CTO in accordance with the terms of section 63 under the new procedure, within 14 days of the patient's return. The amendments are necessary to connect with the new provisions in section 207. Amendment 823 is a technical amendment that will make the reference to the CTO more specific.

I move amendment 833.

Amendment 833 agreed to.

Section 206, as amended, agreed to.

Section 207—Effect of long unauthorised absence ending more than 2 months before expiry of compulsory treatment order

Amendments 816 to 818 moved—[Mrs Mary Mulligan]—and agreed to.

Section 207, as amended, agreed to.

Section 208—Effect of long unauthorised absence ending less than 2 months before expiry of compulsory treatment order

Amendment 819 moved—[Mrs Mary Mulligan]—and agreed to.

Section 209—Effect of unauthorised absence ending simultaneously with or within 14 days before expiry of compulsory treatment order

Amendments 820 to 822 moved—[Mrs Mary Mulligan]—and agreed to.

Section 209, as amended, agreed to.

Section 210—Effect of unauthorised absence ending after expiry of compulsory treatment order

Amendments 823 to 826 moved—[Mrs Mary Mulligan]—and agreed to.

Section 210, as amended, agreed to.

Section 211—Effect of unauthorised absence of patient subject to short-term detention certificate

The Deputy Convener: Amendment 827, in the name of the minister, is in a group on its own.

Mrs Mulligan: Amendment 827 will bring detention under section 86 into line with the provisions for short-term detention made at section 211. If the patient is returned within two weeks of the expiry of the detention certificate, the detention of the patient will be authorised for a period of two weeks from the day of his return.

I move amendment 827.

Amendment 827 agreed to.

Section 211, as amended, agreed to.

Section 212 agreed to.

The Deputy Convener: That concludes today's business. Thank you.

Meeting closed at 11:55.

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